PARTICIPANT HANDOUTS

Distance Learning Event:
Strategies for Maximizing Use of the Care Team

Presented by:
Alexia Eslan, Senior Consultant, John Snow, Inc.
Malia Davis, Nurse Practitioner and Director of Nursing Services and Clinical Team Development, Clinica Family Health
Evan Neufeld, Behavioral Health Provider, AspenPointe and Peak Vista Community Health Centers

Live Broadcast Date/Time:
Wednesday, February 21, 2018
12:00–1:30pm Mountain Time / 1:00–2:30pm Central Time

Event Overview:
This webinar will provide an overview of the main roles within care teams that work closely with primary care clinicians, along with concrete examples of best practices across the country and Colorado to maximize each role in improving the care provided to patients as well as staff and provider work satisfaction.

Learning Objectives:
By the end of the webinar, participants will be able to:

- Evaluate the structure of their own care teams
- Learn from best practices from across the country and in Colorado on enhancing primary care team roles
- Discuss challenges and potential solutions to enhancing the roles of their care team members
- Share experiences from the field

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COLORADO COMMUNITY HEALTH NETWORK
Access for All Colorado

Community Health Association of Mountain/ Plains States

CCHN ARCHIVE
This event will be archived online. The online version will be available within two weeks of the live event. For information about all CCHN archives, please visit http://cchn.org/webinar-archive/.

DESCRIPTION OF CCHN

Colorado Community Health Network (CCHN) is a non-profit organization representing the 20 Colorado Community Health Centers (CHCs) that together are the backbone of the primary health care safety-net in Colorado. CCHN is committed to educating policy makers and stakeholders about the unique needs of CHCs and their partners, providing resources to ensure that CHCs are strong organizations, and supporting CHCs in maintaining the highest quality care. For more information about CCHN, please visit www.cchn.org.

DESCRIPTION OF CHAMPS

Community Health Association of Mountain/Plains States (CHAMPS) is a non-profit organization dedicated to supporting all Region VIII (CO, MT, ND, SD, UT, and WY) federally-funded Community, Migrant, and Homeless Health Centers so they can better serve their patients and communities. Currently, CHAMPS programs and services focus on education and training, collaboration and networking, workforce development, and the collection and dissemination of regional data. For more information about CHAMPS, please visit www.CHAMPSonline.org.

SPEAKER BIOGRAPHY

Alexia Eslan has extensive expertise working with providers, staff and management at community health centers and clinics across the country to achieve the quadruple aim – increase quality, improve the patient experience, increase provider and staff satisfaction, and reduce costs. Her experience at JSI as a senior consultant and prior to JSI as Business Operations Manager at Kaiser Permanente and Manager of Market Strategy at Colorado Access, have provided Ms. Eslan with a keen understanding of the operations of health care systems and proven-practices to maximize outcomes by focusing on strategic planning, process design and improvement, and bringing together diverse groups and interests throughout the patient and revenue cycle.

Evan Neufeld is currently a Behavioral Health Provider employed by AspenPointe, an organization committed to providing exceptional behavioral health care to the community one patient at a time. For the past 8 years, Evan has worked with many different integrated primary care teams within the Peak Vista Community Health Care system. Evan is a Licensed Professional Counselor who obtained his Master's degree in clinical psychology from the University of Colorado at Colorado Springs.

Malia Davis is a Nurse Practitioner and the Director of Nursing Services and Clinical Team Development at Clinica Family Health. She has worked in community health for 14 years. She is a recent graduate of the Robert Wood Johnson Executive Nurse Fellowship program for nurse leaders across the country. Malia got her undergraduate degree in sociology and women's studies at The Colorado College and did her Masters in Nursing at the Yale School of Nursing. She lives in Denver with her husband and two young boys.

Resources

Core Competencies for Behavioral Health Providers Working in Primary Care – Eugene S. Farley, Jr., Health Policy Center

Enhancing the Role of the Nurse in Primary Care: The RN "Co-visit" Model – Karen A. Funk, MD MPP and Malia Davis, MSN, ANP-C

Registered Nurses: Partners in Transforming Primary Care – Recommendations from the Macy Foundation

High Plains Community Health Center – Redesign Expands Medical Assistant Roles – Lisel Blash, Catherine Dower, and Susan Chapman, Center for the Health Professions at UCSF

The Primary Care Team Guide

The Physician Experience of Team-Based Care (Video)

Scribing Model: Two Clinical Assistants with One Provider (Video)

Institute of Medicine Future of Nursing Report (2010)

Isa the Rockstar Nurse (Video)

Team Based Care

Strategies for Maximizing Use of the Care Team

Wednesday, February 21, 2018

Presented by:Alexia Eslan, MBA, John Snow, Inc. (JSI)

Hosted by: www.cchn.org www.champsonline.org

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Interactive Question

- **How knowledgeable do you feel about the role of others on your team?**
  - Not at all knowledgeable
  - Somewhat knowledgeable
  - Knowledgeable
  - Pretty knowledgeable
  - Completely knowledgeable

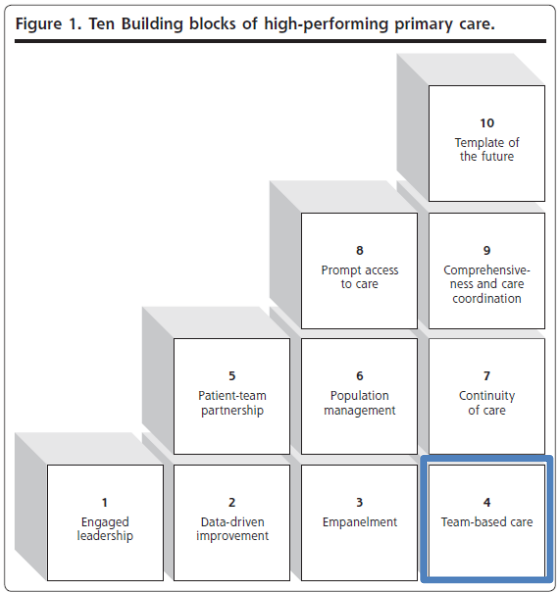
Interactive Question

- How many total people are watching this event at your computer (yourself included)?

John Snow, Inc. (JSI) has more than 30 years of experience assisting organizations with all aspects of health care transformation from conducting and analyzing community, system, and practice assessments; developing tailored implementation plans; providing the training and technical assistance needed to make strategic and sustained change; to monitoring and evaluating outcomes.

Objectives

- Evaluate the structure of your own care teams
- Learn from best practices from across the country on enhancing primary care team roles
- Discuss challenges and potential solutions to enhancing the roles of your care team members
- Share experiences from the field



Reference: Bodenheimer, Tom et al, 2014, 10 Building Blocks of High Performing Primary Care, *Ann Fam Med* 166-171

Steps to achieving consistent high team performance

- Build trust and communication
- Identify and assign tasks
- Train staff
- Develop standard work
- Enable staff to work independently
- Monitor process and goal attainment

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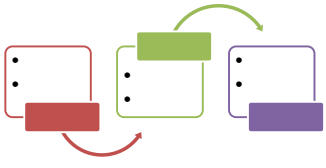
Flow for today's webinar

- Core Team Roles
- Extended Team Roles
- Examples from the Field



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Team Based Care

Provision of health services by a health care team who work collaboratively with patients and caregivers to accomplish shared goals across settings to achieve coordinated, high-quality care.

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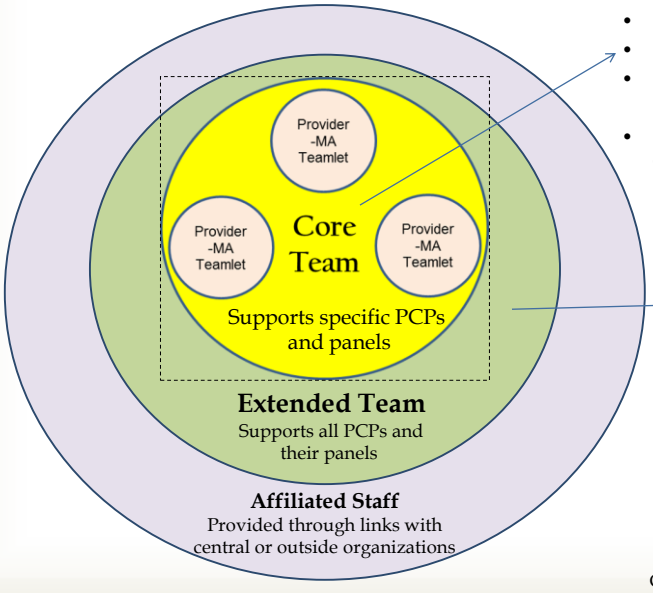
Primary Care Team



- Provider(s)
- MA/LPN
- ?RN
- ?Health Coach/Patient Navigator
- ?Behavioral Health Specialist

- RN Care Managers
- Lay Caregivers
- Pharmacists
- Oral Health Staff
- Behavioral Health Specialists
- Administrative Staff

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Define Teams

- Determine what your core team(s) will look like
- Who is part of your extended team(s)?

POLL Question

Which members are part of your practice's Core Team(s)? (*select all that apply*)

- ❑ Have not yet identified core teams
- ❑ Provider
- ❑ MA/LPN
- ❑ RN
- ❑ BH Specialist
- ❑ Front Desk/Front Office Staff
- ❑ Health Coach/Patient Navigator/Patient Educator

Develop and test Core Team configuration(s)

- Single provider or Pod?
- Are receptionists linked with teams?
- Number of MAs per provider?
- What role(s) will RNs play?
- Who in the practice will do self-management counseling? Follow-up phone calls?
- Is co-location possible?

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Three Frequent Core Team Roles

- PCP
- MA
- RN

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Ways to maximize the PCP role

- Assess what PCPs are currently doing in your practice.
- Build trust through co-location, increased communication, team building, quality improvement, and skills assessments.
- Decide which tasks and responsibilities can be transferred to non-PCP clinical staff.
- Develop and test role changes and related processes and workflows.
- Ensure roles changes decrease stress and increase job satisfaction for PCPs.
- Hire and retain the right people.
- Provide training and support for PCPs.

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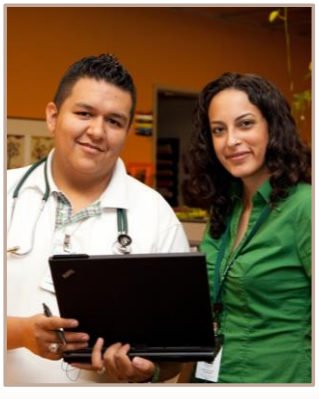
Why rethink the role of the PCP?

http://www.improvingprimarycare.org/team/pcp



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PARTICIPANT POLL
RATE YOUR PRACTICE
Medical Assistants (MA)

Component	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 services, and services to chronically ill patients such as self-management coaching, or follow-up phone calls.

Ways to maximize the MA role

- Determine what functions/roles you'd like the MA to have
- Check state policies
- Make the business case
- Hire the right people
- Provide training and supervision
- Provide a career ladder and opportunities for growth

Examples of two models

- High Plains model
- Video: Scribing model at Family Care Network (http://www.improvingprimarycare.org/team/medical-assistant-ma)

PARTICIPANT POLL
RATE YOUR PRACTICE
Registered Nurses (RN)

Component	Level D	Level C	Level B	Level A
RNs in our practice…	are not part of the core practice team.	mostly triage phone calls and do injections or other procedures.	manage transitions within and across levels of care (home care, hospital, specialists). Provide specific intensive care coordination and management to highest risk patients.	provide care management for high risk patients and collaborate with providers in teaching and managing patients with chronic illness, monitoring response to treatment, and titrating treatment according to delegated order sets in independent nurse visits .

Ways to maximize the RN role

- Assess what RNs are currently doing in your practice.
- Offload work that can be done by other team members.
- Develop phone triage protocols that put other team members as the first point of contact.
- Provide RNs with tasks that maximize their clinical skills.
- Hire the right people.
- Provide training and supervision.

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RN Co-Visits

Malia Davis, NP
Director of Nursing Services and Clinical Team Development
Robert Wood Johnson Executive Nurse Fellow 2014-2017

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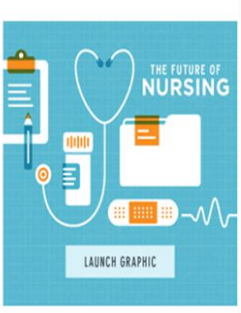
Why RNs ?



IOM Future of Nursing 2010

- Who is the best person on our care team to serve you today?
- Maximize nurse skill set / work at top of scope
- Provide direct patient care
- Triage, intake, medication reconciliation, patient education, culturally responsive care to patient population, schedule management, nursing assessment skills, care planning, and on and on and on….

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Why RNs?

Enhancing the Role of the Nurse in Primary Care: The RN "Co-Visit" Model

Karen A. Funk, MD, MPP and Malia Davis, MSN, ANP-C

Clinica Family Health, Lafayette, CO, USA.

KEY WORDS: nursing; access to care; physician satisfaction; team-based care.

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Every day, Dr. D felt exhausted by the end of a care session and wondered how much longer she could survive double-booked appointments, paperwork, and charting. While finishing her charting late each evening, she considered leaving.

JC., one of the clinic's RNs, spent all day phone-triaging patients who needed care new but had no access. She wondered if her nursing skills were being used and valued. She was tired of begging providers to double-book patients she felt should be seen. She left most days without her work done, and though she loved the patients, she wondered how long she could continue.

With more and more Americans gaining access to primary care, clinics face the challenge of increasing demand for services with no enhanced capacity to meet the demand. The tension that arises in such a system is exacerbated by provider and nurse burnout and a recurring sense of under-providing healthcare. We addressed this issue by initiating RN-led visits that required little provider time, thereby increasing access without worsening burnout.

Clinica Family Health is a community health center with five clinical sites in communities northwest of downtown Denver, Colorado. We serve approximately 45,000 patients annually, with 98 % of our families living at or below 200 % of the federal poverty level. For 60 % of our patients, Spanish is the primary language, and virtually all of our providers and staff speak English and Spanish. We have a long history of innovation in care delivery, but by 2012, found ourselves struggling to maintain access with an eroding base of providers.[1] We decided to restructure our care delivery model in order to maintain our success in achieving the triple aim, while increasing job satisfaction among care team members.

Our goal was to increase access by modestly expanding panel sizes and enhancing the team surrounding our providers. At the same time, we wanted to promote work/life balance for care team members and inspire loyalty in order to retain physicians, nurse practitioners, and physician assistants who were leaving for jobs with less pressure, more pay. We started with a literature review and analysis of our existing pod model: 14 care teams, or "pods," composed of medical doctors, nurse practitioners, physician assistants, nurses, medical assistants, a care manager, a behavioral health provider, and operations support staff. We evaluated each pod member's role and scope. We completed time studies on 34 visits prior to implementation, focusing on patient experience. We also interviewed Clinica leaders and employees in other high-performing practices.

We learned through this process that we were not optimizing a hallmark of Clinica's care team transformation—utilizing each team member to better serve patients while increasing joy in work. Of the 34 observed visits, only one involved a patient seeing a nurse. Our nurses' primary role had become phone triage, not direct patient care. What's more, a dearth of appointments had led to an uptick in triage calls. As one RN explained it, "Triaging with no access creates only more work, electronic tasks to finish, and extra phone calls… I hate telling patients to seek urgent care when I know we could help them here if we had space…"

Through financial analysis, we determined that increasing total daily visits per provider by approximately 2 would achieve our access goal, while generating enough revenue to cover the cost of additional care team staff. Yet adding provider visits was in direct conflict with reducing provider burnout. Engaging our nurse colleagues in direct patient care was a solution to this dilemma.[2]

In 2014, we tested an RN "flip visit" or co-visit in two pods through a pilot program we called Pods 2.0. Co-visits address same-day acute complaints, and each nurse can perform up to eight co-visits a day. During a co-visit, the nurse elicits and records the history of present illness and past medical, family, and social histories. She collects vital signs, implements pertinent standing orders, and creates a nurse note. When the provider enters the room, the nurse presents the history to the provider in front of the patient, allowing the provider to clarify details. At this point, the nurse switches to a scribe role, documenting the provider's physical exam, assessment, and plan. After the provider moves on to the next patient encounter, the nurse reviews the care plan and provides appropriate education with the patient. Later, the provider quickly reviews and authenticates the visit documentation before submission for billing, in accordance with Center for Medicaid and Medicare Services (CMS) guidelines.[3]

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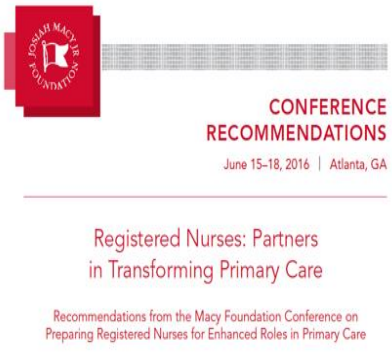
Why RNs?



Conference Themes

The second day of the conference built upon the discussion themes that emerged during the first day, and conferees broke into groups to begin crafting recommendations in the following areas.

I: Changing the Healthcare Culture

II: Transforming the Practice Environment

III: Educating Nursing Students in Primary Care

IV: Supporting the Primary Care Career Development of RNs

V: Developing Primary Care Expertise in Nursing School Faculty

VI: Increasing Opportunities for Interprofessional Education

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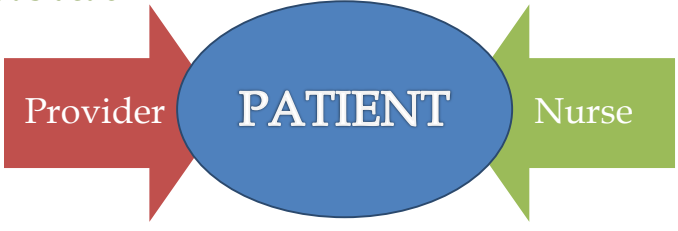
Co-Visits Defined

- Co-visits are visits shared between a nurse and a provider that enable our patients to be seen the same day (increase access)
- Co-visits were designed as a new model to help increase patient access to care and to improve staff satisfaction



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Why Co-Visits?

- Improves patient access to same day care, more appointments can be available every day
- Expands nursing role at Clinica
- Can help eliminate double booking while adding visits
- Improved patient care and education (discharge instructions)
- Decreases telephone triage
- Improved team based care and communication with care team and patient
- Improved Patient and Care team satisfaction

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Who Schedules Co-Visits

- Co-visit appointments are scheduled by the communication center. They can also be scheduled by other team members (typically triage nurse)

- Co-visit appointments can occur almost anywhere within a Provider's schedule

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Co-Visit Visit Types

Typically minor acute visit type requesting same day appointment

- UTI/dysuria
- Ear Pain
- Any nurse protocol visit
- Lice
- Thrush
- Emergency contraception and birth control
- INR / lab follow up
- Conjunctivitis
- Rash
- Newborn bilirubin
- Cold and cough / flu
- Sore throat
- Fever
- Cast removal
- ER follow up
- Wound care
- Breast feeding support

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Documentation requirements:

Nurse note
Provider note
Face to face (in the presence of the patient)
Scribe box on E and M (see example later)
Chart review from the provider
Billing and coding

it is your responsibility to research your billing and coding requirements in relation to your electronic record to meet your compliance standards

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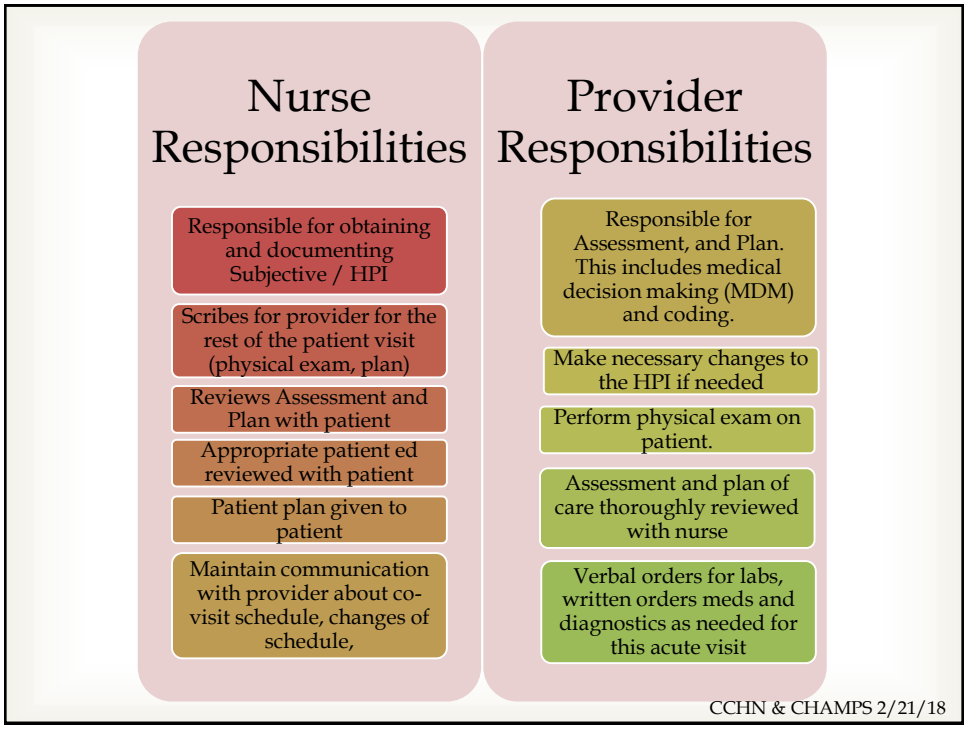

Workflow

- MA rooms patient: Vital signs
- RN begins visit / communicates to provider that patient is here and will be ready to co-visit soon
- Any in-office testing obtained as needed (UA, Strep culture, Hemoglobin)
- Nurse starts visit with a NURSE NOTE for HPI and history, ROS and documents this work in her/his note. (nurse documentation separate from provider documentation)
- Nurse performs limited physical exam as needed to assess HPI. NO documentation of physical exam is done at this time (remember: nurses ARE taught physical assessment but provider must complete the PE)

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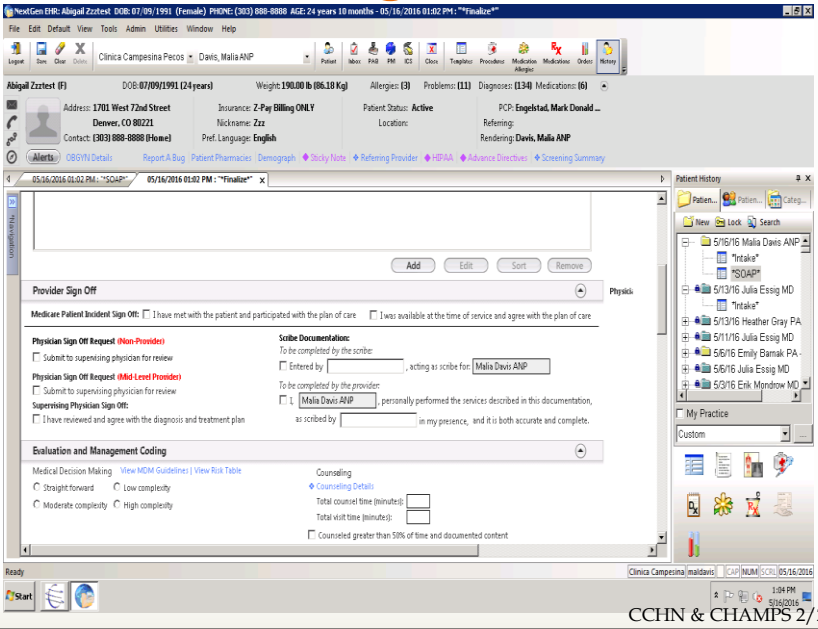
Workflow

- Nurse then changes the visit type to Office Visit
- Nurse informs provider that co-visit is ready
- Nurse and provider enter patient room together
- Nurse presents case to provider, in the presence of the patient
- The provider can obtain more information as needed and can add any more pertinent information
- Nurse then briefly switches to scribe role to document the physical exam while the provider performs the physical exam
- Provider performs physical exam and advises nurse where and what to document in the physical exam template

Workflow

- Provider decides on assessment and plan (medical decision making) nurse can scribe this /use 'my phrases' as guided by provider
- Provider orders medications , labs, diagnostics if needed
- Provider ends her/his part of the visit while the nurse completes any discharge instructions and patient education
- Immunizations, blood work are completed if needed
- Then nurse completes documentation and sends to provider for review and sign off / E and M coding.

Provider Billing Documentation



Time

On average:

- Face to face provider time with nurse
  20-30 minutes
- Provider time 7-10 minutes
- Charting completed by nurse
- Sign off review by provider

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Measures

- Triage volume: baseline 30-100 calls/wk = decrease by 2/3rds
- Total visits : goal 2-3 per provider per session = 1.5 *
- Nurse utilization: (Co-visits) 40-60 week
- Patient satisfaction: peaked at 97%
- Staff satisfaction: goal 80% we made 79%
- Access: TT3rd goal 3, achieved 2 in one month
- Continuity PCP goal 70 =67% Team goal 90 = 87%
- Complex care management
- Cycle time: no change

*no show rate / 1 vs 3 pod data

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Overcoming resistance to change

- Train nurses and providers about shared visits from orientation forward
- Foster culture of collaboration, teamwork, and communication
- Allow leadership from all levels of the organization
- Give time to be a better team: we used a version of 'Getting to the Heart' over 5 weeks for team to learn about power dynamics, ways to appreciate and work together, foster respect among all team members
- Train and practice feedback / We like SBI
- Identify champions other than the early adaptors to help lead change
- PRACTICE!

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Training Pearls

Nurses

- How to present patients
- Collaboration
- Feedback
- Documentation
- Live nurse coach during orientation
- Competency assessment an *new nurse privilege document for co-visits (great for new nurses)

Providers

- Coaching on how to explain templates
- Slow down to scribe PE
- Remind of nurse skillset and training vs med school
- Not a glorified MA /secretary
- Live nurse coach during orientation

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Isadora Abel

Isa and Rachel: short story on the power of co-visits

https://youtu.be/zsSb5f6XEFM

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Additional Core or Extended Team Roles

- Lay Person – A non-clinical staff person – Examples include patient navigator, front office staff, etc.
- Behavioral Health Specialist

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PARTICIPANT POLL
RATE YOUR PRACTICE
Non-Clinical Staff

Component	Level D	Level C	Level B	Level A
Non-clinical staff (laypersons) …	are not part of the core practice team.	mostly provide non-clinical patient-facing roles such as reception or referral management.	include individuals who do one or more of the following: provide self-management coaching, coordinate care, help patients navigate the health care system, or access community services.	perform the functions in Level B and are key members of core practice teams.

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Ways to maximize the non-clinical role

- Assess how you are using non-clinical staff in your practice
- Explore new roles your lay team members can play
- Hire the right person
- Provide training and supervision
- Provide a career ladder

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Examples of possible roles

Patient-facing administrative roles:

- Shepherding prior authorization forms
- Helping with population management

Specialized administrative roles:

- Lead quality improvement efforts.
- Liaison between the PC team and EHR vendor.

Specialized patient services:

- Health coaching
- Connect patients with community resources

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PARTICIPANT POLL
RATE YOUR PRACTICE
Behavioral Health Integration

Component	Level D	Level C	Level B	Level A
Behavioral health services…	are difficult to obtain reliably.	are available from mental health specialists but are neither timely nor convenient.	are available from community specialists and are generally timely and convenient.	are readily available from behavior health specialists who are on-site members of the care team or who work in a community organization with which the practice has a referral protocol or agreement.

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Ways to maximize the BH Specialist role

- If your practice has a behavioral health specialist, assess whether they are part of your core team.
- If your practice does not have a behavioral health specialist, determine your approach to acquiring the expertise and services you seek.
- Define the behavioral health specialist role(s) clearly.
- Hire the right person.
- Provide training for the BH Specialist.
- Provide training for other members of the PC team.

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Maximizing the Behavioral Health Role

Evan Neufeld, MA, LPC
Evan.Neufeld@AspenPointe.org

Standard Expectations

- Behavioral health diagnosis
- Psychotropic medications
- Crisis
- Emotional patients

The Challenge

- Entering the chronic disease realm
- Barriers
  - Seen as physical disease – patient, providers, staff, admin, etc.
  - Scope of practice
  - Lack of education on chronic diseases
  - Time

BHP in Chronic Disease

- Chronic diseases can share the following symptoms
  - Sleep disturbance
  - Appetite disturbance
  - Stress
  - Loss of coping skills due to physical limitations
  - Loss of support due to physical limitations
  - Loss of lifestyle due to physical limitations
  - Etc.
- Behavioral Health Providers (BHP) have skills to address anything that might be helped through habit, behavioral, cognitive, and/or emotional change

The Research

- Federal Agency for Healthcare Research and Quality (AHRQ 2008): "Integrated care occurs when MH specialty and general medical care providers work together to address both the physical and MH needs of their patients (p.1)"
- Integrated health care services are effective in terms of improved treatment outcomes for mental health, substance abuse, AND physical illness (Jaen et al, 2010; Butler et al. 2008)
- Integrated care models can increase consumer satisfaction, decrease provider burnout, increase access to care, improve patient adherence to treatment recommendations, and reduce stigma towards accessing behavioral health (Blount, 2003)

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Ambulatory Team Visit

- RN, PCP, BHP as core team
- Diabetes
- Targets to measure
- Identifying patients
- Identify barriers, concerns, options for treatment planning prior to appointment
- Give patient a voice on the team

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Potential Areas for BHP Involvement

- Communication skills coaching
- Teaching RN and PCP basic coping skills
- Joining and simplifying treatment plan
- Identifying barriers
- Information gathering
- Patient care advocating
- Opportunity to approach behavioral change without the stigma

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The Outcome

- 68.8 % of patients improved A1C after one year
- BH utilization was increased
- Team knowledge was increased
- Treatment Plans simplified
- Coordinated visits
- More efficient team

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Final Thoughts

- Consider using BHP more broadly
- Shadow
- Providing care as a team
- Communication and teamwork
- Consider how current workflows may be creating duplicate work - treatment plans, symptoms, barriers, coping strategies/interventions, etc.
- Be a champion

References

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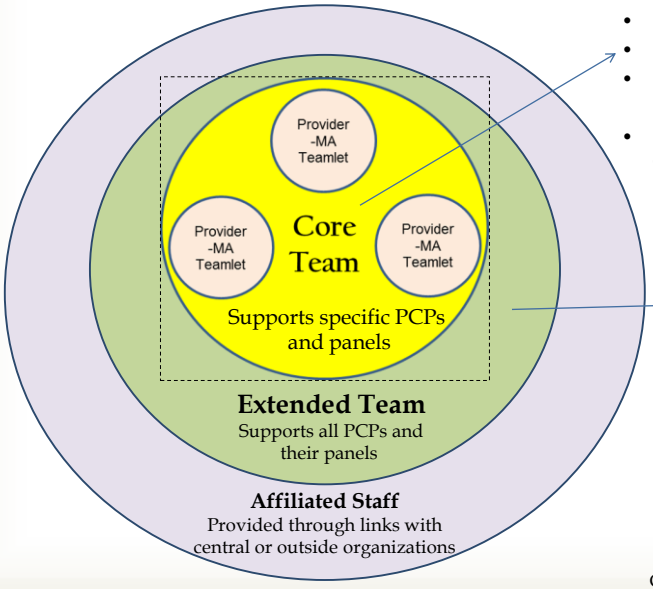
Primary Care Team



- Provider(s)
- MA/LPN
- ?RN
- ?Health Coach/Patient Navigator
- ?Behavioral Health Specialist

- RN Care Managers
- Lay Caregivers
- Pharmacists
- Oral Health Staff
- Behavioral Health Specialists
- Administrative Staff

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RESOURCE

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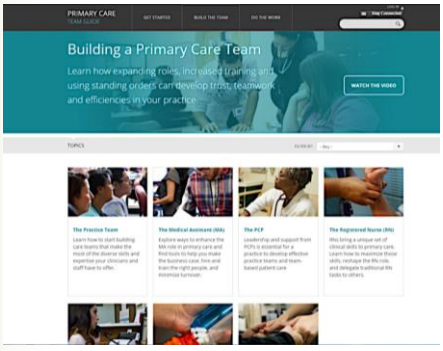
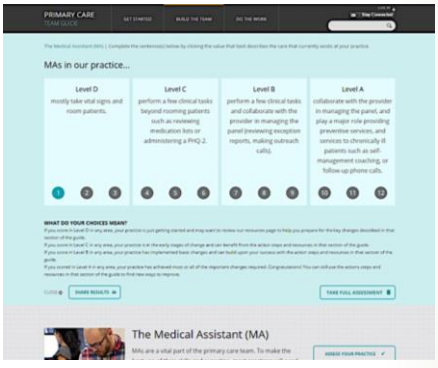
ImprovingPrimaryCare.org





QUESTIONS AND ANSWERS

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THANK YOU

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Thank you for joining us!

Your opinions are very important to us.

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Each person should fill out their own Evaluation Survey.

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