NTTAP
National Health Center Training & Technical Assistance Partners

Fundamentals of Comprehensive Care Webinar

Thursday November 4th, 2021

12:00-1:00pm Eastern / 9:00-10:00am Pacific

Continuing Education Credits

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National Training and Technical Assistance Partnership

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

Objectives

(1) Discuss the core concepts of team-based care

(2) Introduce elements of team-based care that build upon the basics to support teams in advancing their capability to provide satisfying and effective care to complex patient populations

(3) Review the responsibilities/duties of each member of the team to ensure team members work at the top of licensure

Introduction to Comprehensive Care

- Access to comprehensive care is facilitated through implementation of integrated and team-based models of care

- Such models of care are value-based systems of coordinated, preventive, and primary care to promote self-management behavior, maximize health outcomes, and avoid preventable hospitalizations

Source: Patient-Centered Primary Care Collaborative. Summary of Patient- Centered Medical Home Cost and Quality Results, 2010-2013. July, 2014

Introduction to Comprehensive Care

- Implementation of comprehensive care leads to improvements in:
  - Patient access
  - Provider satisfaction
  - Chronic disease outcomes
  - Disease management indicators, especially for medically underserved and vulnerable populations[1]
- There is strong evidence that a team-based approach to providing patient care results in (1) better health outcomes, (2) higher patient satisfaction, (3) decreased provider burnout, and (4) improved patient access, all at a lower cost[2]

1. Patient-Centered Primary Care Collaborative. Summary of Patient- Centered Medical Home Cost and Quality Results, 2010-2013. July, 2014
2. Berry, L. L., and D. Beckham. 2014. Team-based care at Mayo Clinic: A model for ACOs. Journal of Healthcare Management 59(1):9-13.; Bodenheimer, T., and C. Sinsky. 2014. From triple to Quadruple Aim: Care of the patient requires care of the provider. Annals of Family Medicine 12(6):573-576.

Why do we need to transform primary care?

(1) Not enough clinicians choose primary care careers compared to patient needs

(2) Continuity of care is under stress

(3) The downward spiral of large panels and burnout

Primary Care Providers in Health Centers

- NPs and PAs are a critical component of the primary care system in low-income communities around the U.S.
  - HRSA's 2020 UDS report shows that NPs and PAs FTEs combined (14,565) compared to physicians FTEs (14,317) in FQHCs.
    - Nurse Practitioners: 11,086
    - Physician Assistants: 3,479
  - AANP reports that the vast majority of NPs (89.9%) are certified in a primary care specialty and 78% care for Medicaid patients[1]

1. National Academies of Sciences, Engineering, and Medicine. 2019. Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being. Washington, DC: The National Academies Press. https://doi.org/10.17226/25521

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
- 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 between the clinicians

Continuity of care is associated with:

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

https://www.cdc.gov/nchs/products/databriefs/db234.htm

Empanelment

- Empanelment: the act of assigning each patient to a primary care provider who, with support from a care team, assumes responsibility for coordinating[1]
  - Care is better coordinated and managed by a team that knows the patient and can address important care gaps[2]
- The provider and provider team are expected to build relationships, track, and manage the care of all the patients in their "panel," as well as coordinate the care of those patients with other providers within and external to the practice[3]
- People are empaneled at the individual level but the group of patients becomes a panel and multiple panels rolls up to a population health approach.

1. https://www.safetynetmedicalhome.org/sites/default/files/Implementation-Guide-Empanelment.pdf
2. www.careinnovations.org/wp-content/uploads/CCI-Population-Health-Toolkit.pdf
3. Kahn, K. L., Timbie, J. W., Friedberg, M. W., Lavelle, T. A., Mendel, P., Ashwood, J. S., Hiatt, L., Brantley, I., Weidmer, B. A., Rastegar, A., Kofner, A., Malsberger, R., Kommareddi, M., Quigley, D. D., & Setodji, C. M. (2015). *Evaluation of CMS's Federally Qualified Health Center (FQHC) Advanced Primary Care Practice (APCP) Demonstration: Final Second Annual Report*. RAND Corporation. http://www.jstor.org/stable/10.7249/j.ctt19w73g8

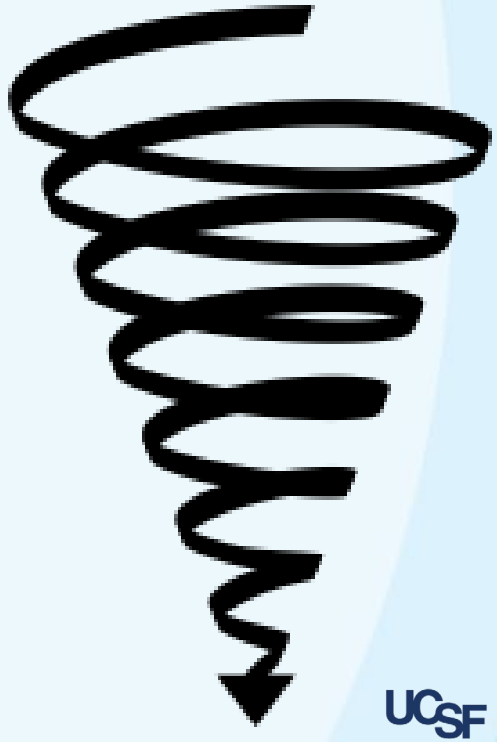
Burnout

- Stressors associated with burnout are threats to **professionalism** – the fundamental ethical norms that are essential to the professional fulfillment of clinicians and learners and to the delivery of high-quality care[1]
  - Clinician and learner burnout adversely affects the **quality of patient care**[1]
  - Clinician burnout is associated with an **increased risk of patient safety incidents** and **malpractice claims**, **reduced patient satisfaction**, and **diminished and ineffective communication between patients and clinicians**[1]
- A 2019 literature review of 21 studies found that the primary care practice environment was the most common predictor of primary care provider burnout[2]

1. National Academies of Sciences, Engineering, and Medicine. 2019. Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being. Washington, DC: The National Academies Press. https://doi.org/10.17226/25521
2. Abraham, C. M., Zheng, K., & Poghosyan, L. (2020). Predictors and Outcomes of Burnout Among Primary Care Providers in the United States: A Systematic Review. Medical Care Research and Review, 77(5), 387–401. https://doi.org/10.1177/1077558719888427

Downward spiral of large panels and burnout

- Primary care clinician shortage means panel sizes cannot go down.
- Large panel size is major contributor to burnout.
- Burnout leads to physicians reducing work hours. Reduced work hours worsens the physician shortage.
- Greater physician shortage means even larger panel size which in turn makes burnout worse.
- Patient access continues to drop.



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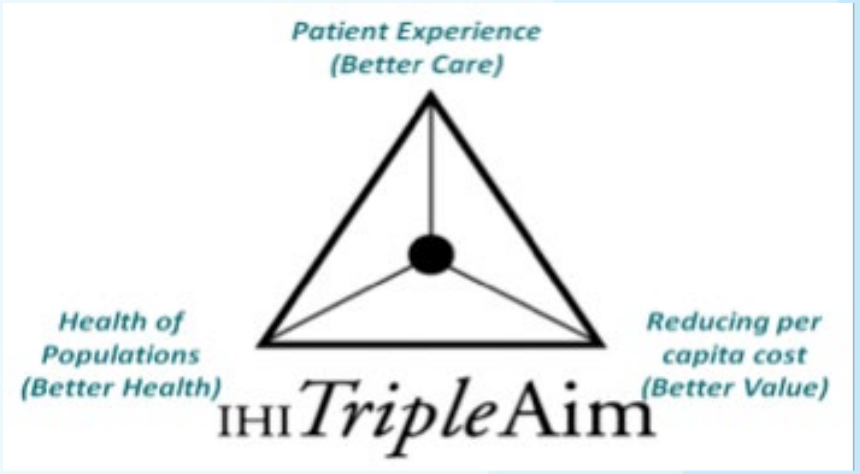
Source: Shanafelt et al. Mayo Clinic Proc 2015;90:1600-1613; Shanafelt et al. Mayo Clin Proc 2016;91:422-431.

Don Berwick and the Triple Aim

- In 2008, Don Berwick, a pediatrician and the nation's foremost leader on improving health care, unveiled the doctrine of the triple aim
- The triple aim:
  - Improving the patient experience of care
  - Improving the health of populations
  - Reducing the cost of health care
- The triple aim was widely accepted as health care's overarching goals
- Improving the health of populations is the most basic of the 3 goals



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

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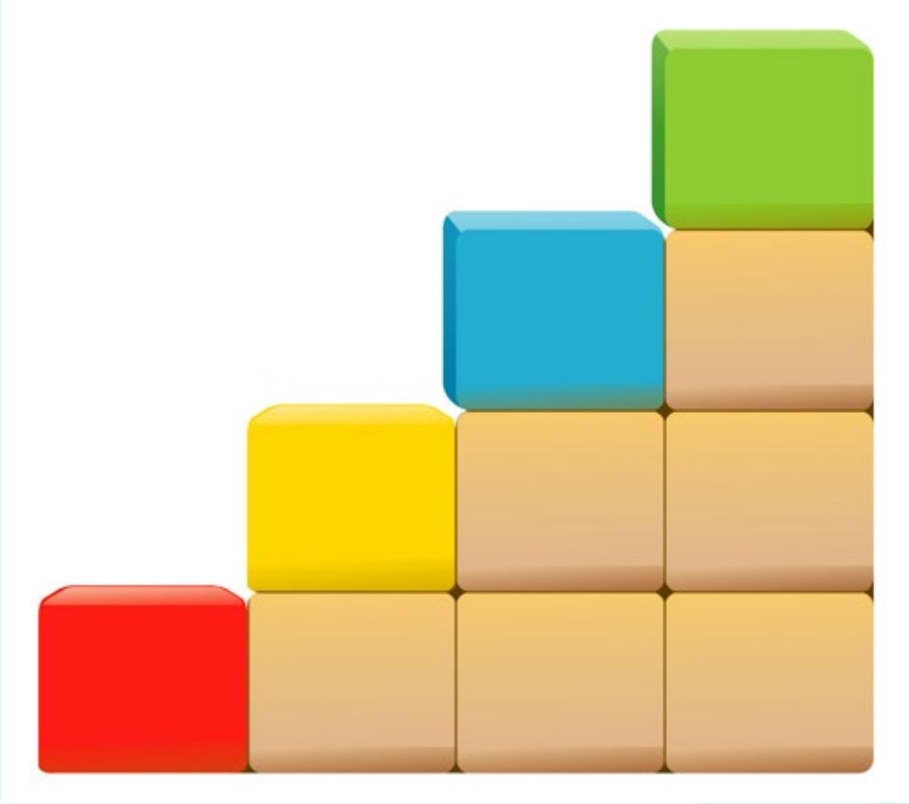
The Quadruple Aim

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

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

An Overview of the 10 Building Blocks of High-Performing Primary Care



10 Building Blocks:
How were they developed?

Case Study Methodology

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

→ 8 hospital-based clinics

7 integrated delivery system sites

6 FQHCs

2 independent private practices

7 of 23 had 5 or fewer physicians

What do we mean by "high-performing"?

- Practices known as innovators (snowballing)
- Reputation for high performance in one or more of the quadruple aim

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23 High-Performing Practices

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

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Patient-team partnership

Population management

Data-driven improvement

Template of the future

Empanelment

Access

Team-based care

Comprehensiveness and care coordination

Engaged Leadership

Continuity

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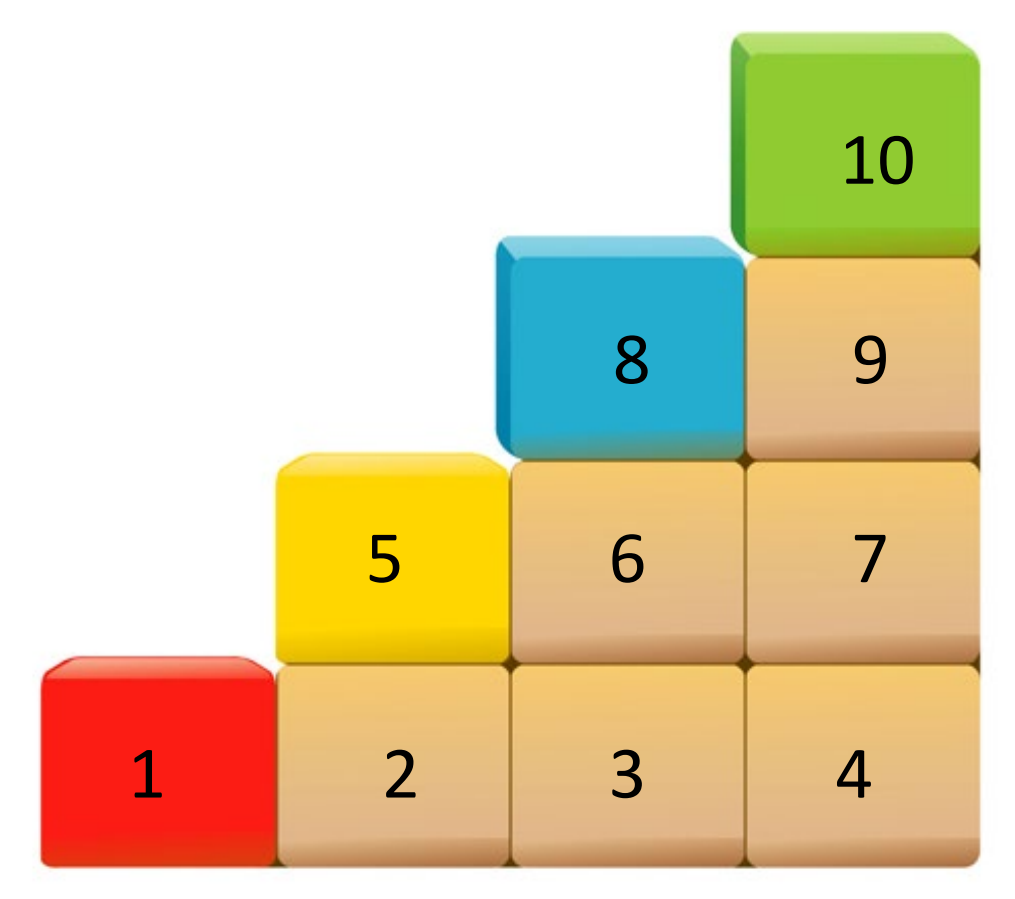
What's Your Order?

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



Website: cepc.ucsf.edu

How Do We Get There?

The Building Blocks are not a cookie-cutter formula.
They serve as a roadmap for the
ongoing journey towards high performance.

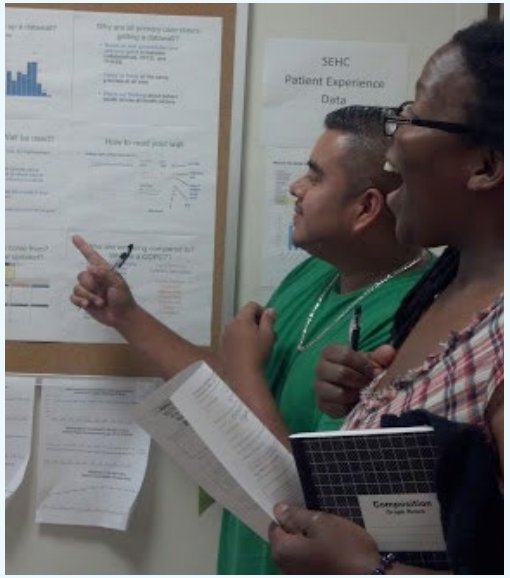
BB1 | Engaged Leadership

1. Building a culture of transformation
2. Getting upper level leadership buy-in
3. Building leadership skills across a team

BB2 | Data-Driven Improvement

- ❑ Relevant data
- ❑ Accurate data
- ❑ Shared openly
- ❑ Assessed with curiosity

VS



BB3 | Empanelment

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
8. Communication

Physiology

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

Teamlets Are Better

- 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 providers
  - "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"

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Transition to Team-Based Care: Restructuring and Redesign

- Transition to team-based care requires revamp of practice from silos to fully integrated team-based care
- Effective team adds capacity by reducing duplication of efforts and sharing the care between clinicians and non-clinicians using protocols and standard workflows[1]
- High-performing health centers empower registered nurses, medical assistants, and other staff to assist with chronic care conditions and to be trained as health coaches.

1 Ghorob, A., & Bodenheimer, T. (2012). Sharing the care to improve access to primary care. *The New England Journal of Medicine,* (366) doi:10.1056/NEJMp1202775

Primary Care Team

- The exact composition of the core and extended teams may vary based on setting and the types of services the team provides, but the guiding principles of co-location, sharing an electronic health record and a panel of patients remain the same
- While providers may initially resist co-location, studies indicate that co-location, which fosters face-to-face communication among team members, is associated with improved team collaboration and coordination[1]

1. MacNaughton K et al, BMC Health Services Research 2013;13:486; Sims S. et al. J Interprof Care 2015;29:20; O'Malley AS et al, JGIM 2015;30:183], and with higher quality cardiovascular disease care at a lower cost [Mundt et al, Ann Fam Med 2015;13:139-148

The Role of the Primary Care Provider

- Clinical lead and empowers the team
- Focus on both prevention, health promotion and management of health conditions
- Assess patient readiness for treatment
- Templated visits for care (e.g. diabetes care)
- Disease management and monitoring
  - Examples:
    - Hypertension
    - Diabetes
    - Depression
    - Substance Use Disorders
- Addressing positive screens
- Close loop referrals to address the social determinants of health (SDOH)

The Role of the Registered Nurse

- Function within key domains of primary care:
  - Prevention and health promotion
  - Episodic/acute and routine care
  - Chronic disease management
  - Education
  - Key link between team members

The Role of the Medical Assistant

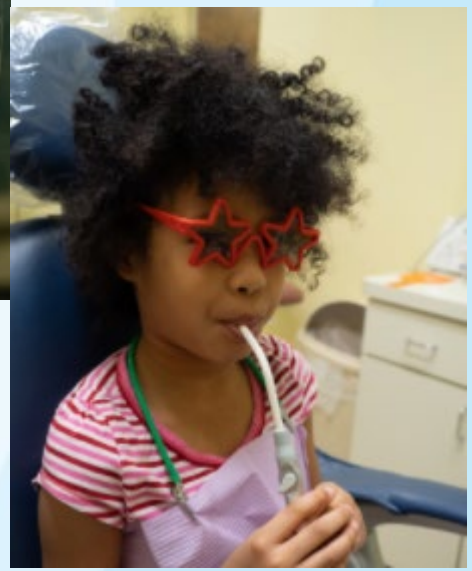
- Pre-visit planning/planned care
- Begin process of medication reconciliation
- Delivering or arranging prevention services
- Care coordination
- Participating in quality improvement work
- Health coaching and motivational interviewing
- Providing telephone or in-person follow-up

Role of Behavioral Health

- BH Warm Hand Offs (WHOs) – reactive and proactive
- Initial assessment
- Psychiatry and medication management
- Individual and group therapy
- Consultation
- Substance Use Disorder Services

Oral Health Services

- Hygiene
- Restorative Care
- Integrated Fluoride Treatment
- Different Modalities and Settings
  - School Based Health Centers
  - Mobile Dental
- Opportunity to screen for other conditions



Telehealth is Here to Stay– New Team Functions

- Telehealth navigation experts
- Preparing patients & team for in-person visits
- Outreach to vulnerable patients
- Navigation of resources (e.g., pharmacy delivery)
- Health coaching to support patients doing more self-monitoring for their own health
- Remote monitoring

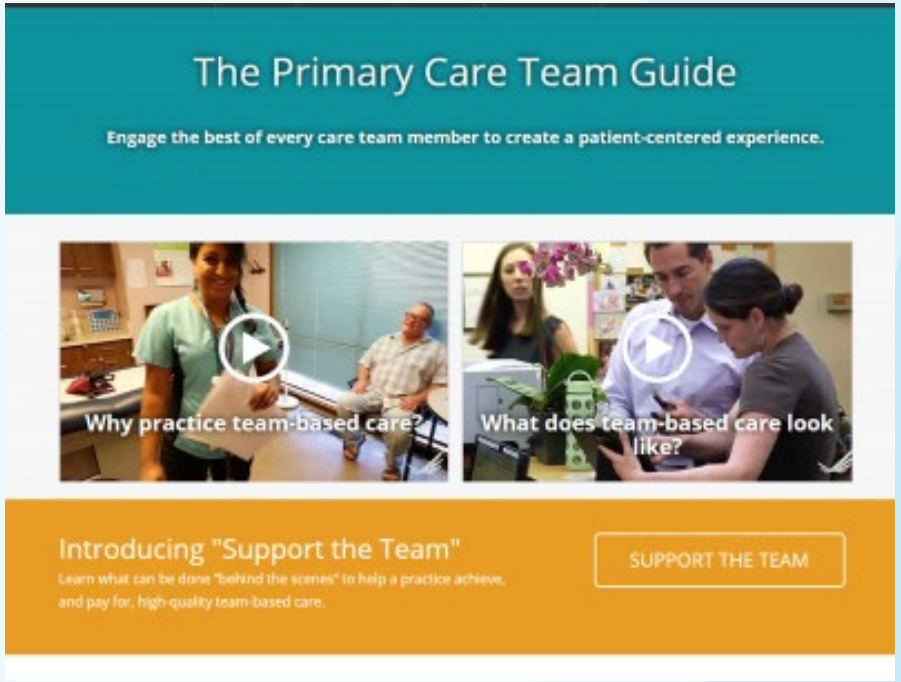
Weitzman COVID-19 Resources

CHCI has curated a series of resources, including webinars to support your health center through education, assistance and training.

https://www.weitzmanlearning.org/coronavirus

The LEAP Project
Learning from Effective Ambulatory Practices

- 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



http://www.improvingprimarycare.org

Contact Information

For information on future webinars, activity sessions, and learning collaboratives: please reach out to nca@chc1.com or visit https://www.chc1.com/nca