Forming Your PCMH Team - How to Determine the Composition

Transformation to a patient centered medical home requires that health centers evaluate and realign their current staffing models. Today’s webinar is the second in a three-part series that will explore three building blocks to assemble and strengthen the clinical workforce of a patient centered medical home: the National Health Service Corps, Integrated Care Teams, and Educational Health Centers.

Today’s webinar will present two health center practices that are transforming their teams to better reach their patient centered medical home goals. Speakers will offer clinical and administrative perspectives on the steps to develop integrated care teams and the impact of these teams on daily work. Speakers will discuss tools to assist health centers, important state partners, and metrics to determine the success of their staffing efforts.

Welcome to our Webinar!
The webinar is now beginning. You should be hearing the Moderator speaking.
By the end of today’s webinar, you will be able to:

• Identify the clinical and administrative considerations that need to be addressed in developing PCMH teams.

• Develop a PCMH staffing plan, based on what is currently in place and where your organization needs to go.

• Propose four specific next steps you are committing to take to more fully implement your PCMH teams.

Welcome to our Webinar!
The webinar is now beginning. You should be hearing the Moderator speaking.
Donald L. Weaver, M.D.

Dr. Weaver has a lifelong commitment to improving the health of underserved communities and vulnerable populations through the provision of community-responsive, culturally competent care by interdisciplinary teams.

Dr. Weaver is the Chief Medical Officer for the National Association of Community Health Centers (NACHC). In addition to leading NACHC’s Clinical Affairs Division, he oversees NACHC’s activities regarding clinical workforce issues, residency and medical school training. He also provides technical assistance to primary care associations, residency programs, and hospitals regarding health profession training issues.

Prior to joining NACHC, Dr. Weaver had a distinguished career as a Commissioned Officer in the United States Public Health Service (USPHS), retiring with the rank of Assistant Surgeon General in January 2011. Dr. Weaver began his career in the USPHS in 1975 as a National Health Service Corps (NHSC) volunteer physician in Tooele, Utah. During his career he served in a variety of regional and national leadership positions with both health professions and service delivery programs; including Director of the Division of Medicine, Director of the NHSC, and Deputy Associate Administrator for Primary Health Care at the Health Resources and Services Administration. A 1973 graduate of Harvard Medical School, Dr. Weaver completed a two-year pediatric residency at Boston's Children's Hospital Medical Center and is a diplomate of the American Board of Family Medicine.
Forming Your PCMH Team –
How to Determine the Composition

Donald L. Weaver, M.D.
National Association of Community Health Centers
Building Blocks for the Patient Centered Medical Home

• Three-part webinar series to help you “build” your patient centered medical home

• Retaining and recruiting clinical team members through the National Health Service Corps

• Developing teams for your patient centered medical home

• Providing educational experiences in health centers
The Patient Centered Medical Home

- Includes oral and behavioral health
- Practice transformation
- Team approach to care
- Not just more of the same
Multnomah County Health Department
Portland, Oregon

Susan Kirchoff, RN
Director of Health Center Operations

Veronica Garcia, CMA
Certified Medical Assistant
Clinica Family Health Services
Lafayette, Colorado

Joanna Harrison, RN, BSN
Nursing Services Manager

Carolyn M. Shepherd, M.D.
Executive Vice President
of Clinical Services
Susan Kirchoff, RN

Susan Kirchoff is currently Director of Health Center Operations for the Multnomah County Health Department, in Portland, Oregon. She has 25 years of experience in health care leadership. Over the past 6 years, Susan has led the largest FQHC in Oregon, which serves over 60,000 individuals through 250,000 annual visits. Ms. Kirchoff has a special interest in the role of leadership in the success of patient centered medical homes (PCMH) and health care transformation. She led the implementation of PCMH at Multnomah County and is involved in the transformation of health care for the Medicaid population in Oregon.

Veronica Garcia, CMA

Veronica is a Clinic Medical Assistant at East County Health Center. She has six years of experience and worked with Multnomah County before and after the implementation of team based care and integrated team roles. Ms. Garcia has participated in many process improvement initiatives as well as volunteering her services for healthcare events in the community.
Joanna Harrison, RN, BSN

Joanna Harrison has worked at Clinica Family Health Services for 12 years, the past 5 as Nursing Services Manager. Ms. Harrison supports the clinical processes of the nurses and medical assistants at the health center’s 5 sites as well as oversees their clinical skills. Ms. Harrison works with Nurse Team Managers to implement clinical quality improvements and has regulatory responsibilities associated with the Joint Commission, Occupational Safety and Health Administration, and Clinical Laboratory Improvement Amendments.

Carolyn M. Shepherd, M.D.

Over the last 24 years Carolyn Shepherd has worked to transform the clinic processes of care, including clinic-wide implementation of an EHR, patient portal access, appointment scheduling redesign, architectural work space redesign, office efficiency improvements centered around team care, population-based management, and alternative visits for the 40,000 patients who access care from Clinica Family Health Services, a FQHC. This work led to a NCQA Level 3 Primary Care Medical Home Recognition for the organization in 2010. Dr. Shepherd is a frequent national speaker on clinical quality improvement and a regular presenter at the Institute for Healthcare Improvement (IHI) office redesign summits. She served as the national Co-chair of the 2010 IHI International Summit on Redesigning the Clinical Office Practice.
PCMH Integrated Care Teams: Administrative Considerations
Multnomah County Health Department
Portland, Oregon

Susan Kirchoff, RN
Veronica Garcia, CMA
FQHC embedded in traditional Public Health Department

- 7 primary care clinics and specialty HIV clinic
- 13 school based health centers
- 5 dental clinics
- 65,000 medical and dental users
- >250,000 visits
Multnomah County Health Department

40+ integrated care teams

- 100 providers (MD/NP/PA)
- 200 clinical staff
- 40 team based clerical staff
Team Composition

- (2) Providers (MD/NP/PA)
- (2) Medical Assistant
- (1) Panel Manager (LPN or CMA)
- (1) Registered Nurse
- (1) Team Clerical Assistant
- (.25-.5) Social Worker and Psychiatric Nurse Practitioner
Integrated Care Teams

Where We Started

• Co-located team members to facilitate communication
• Analyzed current staffing and developed “prototype” team
• Defined team roles and provided training
• Developed processes to integrate Behavioral Health staff with team functions
Implementation Challenges

• Roles needed did not match current staffing at some clinics.
• Team members learning to work together, trust each other and communicate required significant attention.
• Some team members had entrenched beliefs about their role (e.g. RN triage).
• Providers had difficulty “letting go” of some responsibilities.
• Individual performance issues became more prominent.
Integrated Team Roles

Key Support Strategies

• Daily team “huddles”
• Biweekly team meetings with standard agendas to facilitate communication and problem solving
• Role-based “communities of practice” across the organization to create support and sharing of best practices
Definition of Team

“Before I begin, I’d just like to make it known that I didn’t volunteer to do this presentation.”
Advantages of Integrated Teams

• Co-location improves communication
• Easier to cover for each other and share the workload
• Adding a telephone line so that patients can call and speak to someone on the team
• Panel manager role proactive outreach to patients has improved chronic disease outcomes
• Pre-visit “scrubbing” and daily team “huddles”
Challenges with Integrated Teams

• There is not as much time to collaborate with other staff outside of the team.
• Some team rooms are small and feel confined.
• Individual personalities can be difficult.
Integrated Team Roles

What We Have Learned

• Changes to one team role affects all other team roles.
• You’re never “done” — need to constantly reevaluate and optimize team roles.
• One size does not fit all — willingness to adapt team roles and composition based on population needs.
• Need to plan for team member turnover and on-boarding of new team members.
• Team interpersonal issues need to be addressed promptly.
PCMH Integrated Care Teams:
Clinical Considerations
Clinica Family Health Services
Lafayette, Colorado

Joanna Harrison, RN, BSN
Carolyn Shepherd, M.D.
The Patient’s Team

- 3 FTEs of Provider (1 Doc, 2 Mid-levels)
- 3 FTEs of Medical Assistant
- 0.5 FTE Medical Assistant Team Manager
- 1 Nurse Team Manager
- 1 Case Manager
- 1 Behavioral Health Professional
- 2 Front Desk
- 1 Medical Records
- ½ Referral Case Manager
- Dental Hygienist seeing kids for WCC visit
• Nurse
  - Case manage clinically complex patients
  - Co-visits to help with access
  - Manage conditions by standing order

• Medical Assistant
  - Condition specific history of presenting illness
  - Mental health and substance abuse screening
  - Disease specific templates drive services
We All Do What We Do Best

• Case Managers
  ➢ Self management goals
  ➢ Group visit education

• Front Desk
  ➢ Manage chronic disease registries
# Diabetes Planned Care Ruler

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>DOB</th>
<th>Visit Date</th>
<th>BP Syst</th>
<th>BP Dias</th>
<th>Tobacco</th>
<th>Eye Exam</th>
<th>SM Goal</th>
<th>Foot Exam</th>
<th>LDL Date</th>
<th>LDL</th>
<th>A1c Date</th>
<th>Value</th>
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<tbody>
<tr>
<td>Bonnie</td>
<td></td>
<td>1/20/52</td>
<td>11/13/2006</td>
<td>122</td>
<td>80</td>
<td>Current</td>
<td>05/01/00</td>
<td>11/13/08</td>
<td>05/15/08</td>
<td>04/03/08</td>
<td>59</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>1/13/2008</td>
<td></td>
<td></td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Angelica</td>
<td></td>
<td>1/19/75</td>
<td>03/26/2009</td>
<td>115</td>
<td>69</td>
<td>Never</td>
<td>12/11/08</td>
<td>03/26/09</td>
<td>02/15/08</td>
<td>90</td>
<td></td>
<td></td>
<td></td>
</tr>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Teresita</td>
<td></td>
<td>1/19/74</td>
<td>03/26/2009</td>
<td>110</td>
<td>72</td>
<td>Never</td>
<td>10/10/08</td>
<td>1/30/09</td>
<td>10/16/08</td>
<td>01/30/09</td>
<td>75</td>
<td></td>
<td></td>
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</tbody>
</table>

**Group Visit**
- Bonnie: No
- Angelica: Yes
- Teresita: Yes

**High Risk:** Last A1c >= 7
**Medium Risk:** Last A1c > 5 Months
**Low Risk:** Last A1c < 7 and < 5 Months
• Patients get a team of qualified staff.

• Team is collaborative and the plan of care is discussed by team members.

• Responsibility for care is shared among all staff on the pod.
### Patient Centered Registry

#### Planned Care Registry Outreach

**Print Date:** 5/10/2012

<table>
<thead>
<tr>
<th>Name</th>
<th>PCP:</th>
<th>PCP Phone</th>
<th>Payer:</th>
<th>Last Visit</th>
<th>Next appt</th>
<th>Date Reviewed</th>
<th>Comments:</th>
<th>Call Attempt:</th>
<th>Call Status:</th>
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<tbody>
<tr>
<td>Melissa</td>
<td>Amy Russell</td>
<td>857-xxx-xxxx (Home)</td>
<td>Pending Medicaid</td>
<td>05/04/2012 Bulkacz, A-OB</td>
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<tr>
<td>Maria</td>
<td>Amy Russell</td>
<td>857-xxx-xxxx (Home)</td>
<td>Medicare Clinica New FQHC</td>
<td>05/01/2012 Bulkacz, A-RE</td>
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<tr>
<td>Rosa</td>
<td>Amy Russell</td>
<td>720-xxx-xxxx (Home)</td>
<td>Clinica N Sliding Scale</td>
<td>01/27/2012 Russell, A-BRF</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Rosa</td>
<td>Amy Russell</td>
<td>720-xxx-xxxx (Home)</td>
<td>Clinica N Sliding Scale</td>
<td>12/16/2011 Russell, A-DIA</td>
<td>Appt on 05/18/2012 at 10:00AM for DIA-Complete DM</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Edit:** 5/4/2012
- **Comments:** Phone number out of service, sent letter.
- **Call Attempt:** 2nd Call
- **Call Status:** Sent Letter

- **Edit:** 05/18/2012
- **Date Reviewed:** 05/18/2012 at 10:00AM for DIA-Complete DM
- **Call Status:** Recheck with Russell, Amy

- **Edit:** 06/16/2012
- **Date Reviewed:** 06/16/2012 - DM Visit
- **Call Status:** Past Due - BP >= 140/90
- **Past Due - Last BP:** >= 140/90
- **Past Due - Eye Exam:** Past Due - Foot Exam
- **Past Due - LDL Lab:** Past Due - A1c 7 - 9
- **Past Due - Microalbumin:** Past Due - SM Goal
- **Past Due - Last BP:** >= 140/90
- **PN Plus Status:** Undetermined

- **Edit:** 06/16/2012
- **Date Reviewed:** 06/16/2012 - DM Visit
- **Call Status:** Past Due - BP >= 140/90
- **Past Due - Eye Exam:** Past Due - Foot Exam
- **Past Due - LDL Lab:** Past Due - A1c 7 - 9
- **Past Due - Microalbumin:** Past Due - SM Goal
- **Past Due - Last BP:** >= 140/90
- **PN Plus Status:** Undetermined
What Makes it Work

Coordination

• Two managers on each team assist with flow
  ➢ The Nurse Team Manager focuses on big picture quality goals for the team.
  ➢ Medical Assistant (MA)Team Manager focuses on individual performance of other MAs on the team.

• Color coded flags for communication

• Daily huddles to plan care for the patients that are scheduled that day
Co-location of Teams

- Team has line of sight to exam rooms.
- Structure facilitates easy discussion between team members.
- No one is isolated from their team or patients.
- Easy to manage flow when nurse or MA Team Managers can see exam rooms.
PCMH-It Takes a Team!
Who is on the Team…

As small as possible to build relationships, while being as big as possible for convenience

- Centered around services for patients when they come to clinic
- Centered around services to patients who are on our panels to provide non-visit based care
- Constant pressure around funding services
  - Comprehensive primary care-dental, behavioral health
  - Urgent care for all needy people in our community
Explicit Team Roles

• This does not occur naturally in health care.
• Use algorithms to expand the role of staff and support care.
• Clinical expertise is needed to decide what should be done, but not necessarily to do the work.
  - Front desk does the majority of panel management.
  - MAs help with providing indicated care.
Aim: To maintain a comprehensive and accurate registry of our patients with Diabetes in order to perform appropriate and timely care.

### Diabetes Registry Measures:

<table>
<thead>
<tr>
<th>Average A1c</th>
<th>% of patients with two A1cs in the last 12 months</th>
<th>% of patients with last BP &lt; 130/80</th>
<th>% of patients with last LDL &lt; 100</th>
<th>% of patients are current smokers</th>
<th>% of patients have an annual foot exam</th>
<th>% of patients have an annual eye exam</th>
<th>% of patients with an annual self-management goal documented</th>
</tr>
</thead>
</table>

### Actions

#### Operations
Print off Diabetes registry and workflow the first Tuesday of every month.

#### Front Desk
- **Visit**
  - If more than six months, make appointment.
  - Otherwise, review Blood Pressure, Lipids and A1c for follow-up guidelines.
- **Blood Pressure**
  - If blood pressure $<130/80$ use other risk factors to determine follow up needs. If BP Systolic is $>130$ or BP Dyastolic is $>80$ follow up at least every month.
- **Eye Exam**
  - Add patients without eye exam in the last 12 months to wait list for eye clinic. Contact patient when slot opens with date of clinic.
- **Foot Exam**
  - If no foot exam in the last 12 months, schedule an appointment.
- **Lipids**
  - If LDL $<100$ use other risk factors to determine follow up needs. If LDL $>100$ but $<130$ follow up should be at least every three months. If LDL $>130$ follow up should be at least once a month.
- **A1c**
  - If Hgb A1c $>9$, follow up every month. If Hgb A1c $>7$ but $<9$ follow up should be at least every 3 months. If Hgb A1c $<7$ follow up should be every three to six months.

#### Case Manager
Review registry for risk stratification, tobacco, and self-management goal. **Note:** For patients who do not have information populated in the flowsheet, CM will open NextGen and determine if patient is actually a diabetes patient. Alert clinical team to patients on huddle report.

- **Tobacco**
  - If current smoker, review for tobacco cessation counseling. Advise patient to quit at next contact.
- **Self-Management**
  - Monitor patients on registry for annual goal. Responsible for connecting with patient to set goal when in for a visit.
- **Group Visits**
  - Determine which patients/providers do groups. Coordinate DM group visits for pod by doing the following:
    - Determine provider availability
    - Denise's schedule availability
    - Coordinate with NTM on support staff availability
    - BHP schedule availability
    - Call pts and schedule for DM GV as needed.

#### Provider
Review the flowsheet every visit and enter any new data. Review registry for any patients for which there are concerns and patients who are MOGE. Provide information to CM.

#### MA
Review the flowsheet every visit and enter any new data. Responsible for patients on registry who are in for visit today.

#### Nurse
Reviews copy of registry given by CM to ensure all follow-up has been completed and is accurate.
Traditional space places barriers to team work

- Providers are isolated from the rest of staff.
- No line of sight means that people loiter while patients are being worked up.
- Hand offs require looking for someone.
- Work collects at the bottle necks.
- It is difficult to SEE the queuing when it happens.
Architecture to Support Teams
Helping Patients Understand the Team

• Color branding

• Reinforce their team-everyone assigned to a team
  ➢ Ask and tell at the call center-evaluate patient’s understanding
  ➢ Add to documents
  ➢ Measure, manage and report continuity rates

• Scripts to help patients understand the importance

• Keep the patient on the same team, even if there is turnover
  ➢ Patient still has a relationship with the front desk, the MA, the nurse, the behavioral health professional....
Direct Leadership Support

• Assure executive understanding

• Support staffing and funding
  ➢ Wages
  ➢ IT support for team based registries, care plans
  ➢ Report outcomes by teams
  ➢ Reward outcomes by teams
  ➢ Ensure sharing of best practices

• Prepare for transition to pay for performance-non-visit based work

• Support time in schedule to huddle
Tobacco Counseling Documented

Month Axis

Clinica Family Health Services
Lessons Learned

• Working in teams facilitates
  ➢ Doing what you do best every day
  ➢ Patient’s relationships with a team of qualified staff
  ➢ Communication through huddles
  ➢ Improved hand-offs through co-location
  ➢ Improved cycle time when receiving services in clinic
  ➢ Population and panel management

• Important steps
  ➢ Explicit team roles and algorithms
  ➢ Facilities that don’t create barriers to team work
  ➢ Include the patient in designing of solutions to problems
  ➢ Advocate for the investment of time and $$
Thank you for joining us today!
We welcome your questions . . .

Please submit your questions to Katja Laepke in the “Chat” box in the right bottom corner of your screen or please feel free to ask them directly.

Please remember:

• Immediately after logging off from today’s webinar, you will be directed to a brief evaluation. We value your honest feedback – please respond. Thank you!

• The recording of this webinar and presentation will be posted in the NACHC LiveLEARNING CENTER in about two weeks.

• The next webinar in this Clinical Workforce series will be So You Want to Educate Health Professionals at Your Health Center: What You Need to Know. Date and registration information coming soon!