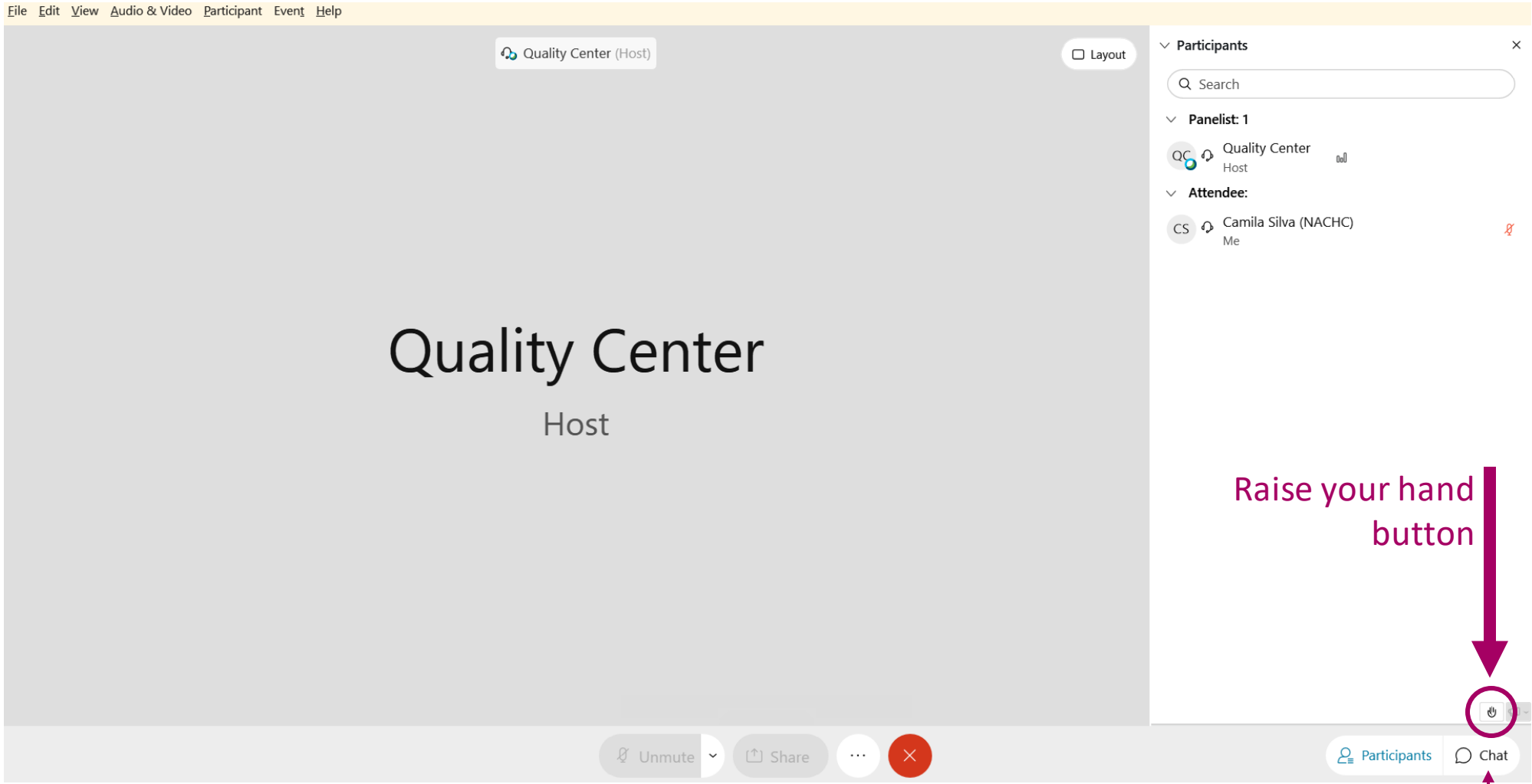
NATIONAL ASSOCIATION OF Community Health Centers®

elevate

Together, our voices elevate all.

Care Teams

May Learning Forum
05.11.21


File Edit View Audio & Video Participant Event Help
Quality Center (Host)
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Panelist: 1
QC
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Attendee:
CS
Camila Silva (NACHC)
Me
Raise your hand button
Unmute
Share
Participants
Chat
Chat: When using the chat, please send the message to “Everyone”

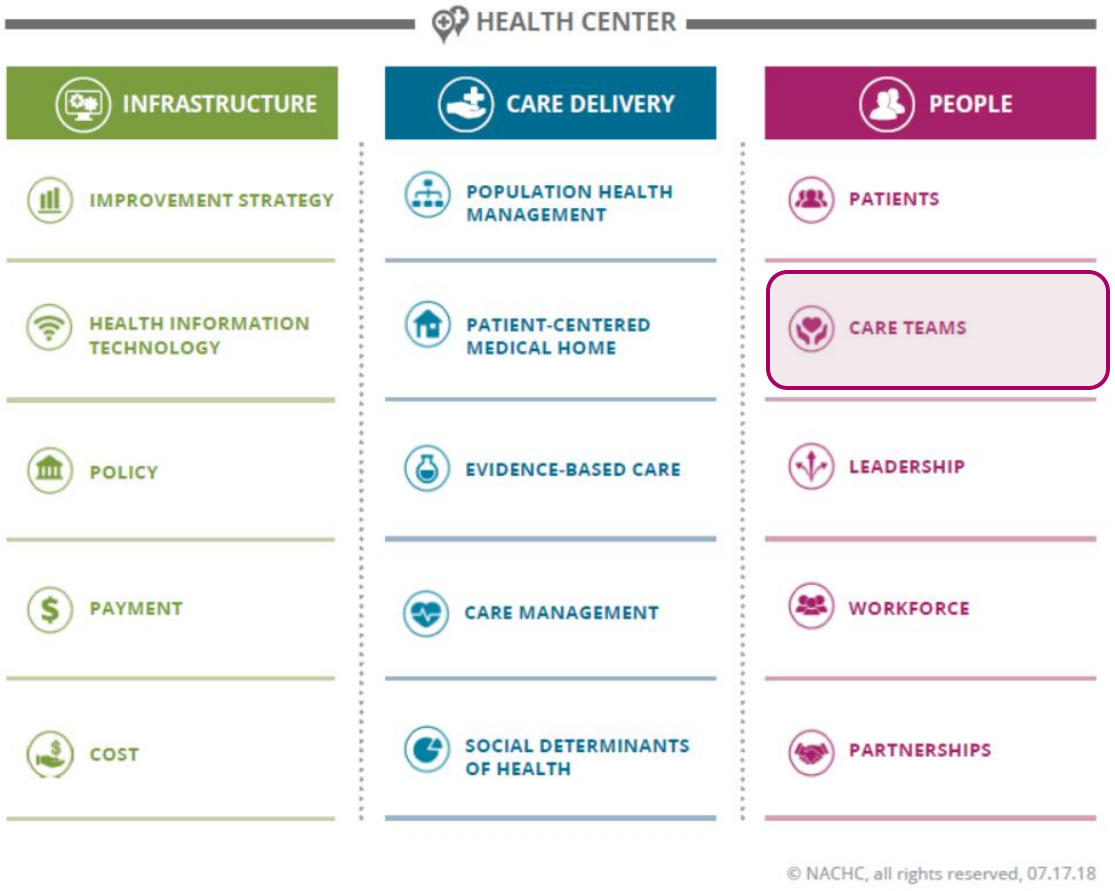
THE NACHC MISSION

America's Voice for Community Health Care

The National Association of Community Health Centers (NACHC) was founded in 1971 to promote efficient, high quality, comprehensive health care that is accessible, culturally and linguistically competent, community directed, and patient centered for all.

NATIONAL ASSOCIATION OF Community Health Centers®

Value Transformation Framework



https://www.nachc.org/clinical-matters/value-transformation-framework/

LAST MONTH

CHANGE AREAS

MODELS OF CARE

- Design care models that based on subgroups identified through risk stratification. Create **unique models of care for each targeted subgroup** of your patient population.

HIT

- Outline steps to use population health management tools and other HIT resources to **push care team action and pull required data.**

CARE TEAMS

- **Define care standards and services** within each targeted care model. **Reorganize care team roles** within each care model, giving more responsibility to supportive members of the care team.

Elevate…Connecting to FY 2021 American Rescue Plan Funding (H8F)

- Plan, prepare for, promote, distribute, administer, and track COVID–19 vaccines, and carry out other vaccine-related activities.
- Detect, diagnose, trace, and monitor COVID–19 infections and related activities necessary to mitigate the spread of COVID–19, including activities related to, and equipment or supplies purchased for, testing, contact tracing, surveillance, mitigation, and treatment of COVID-19.
- Purchase equipment and supplies to conduct mobile testing or vaccinations for COVID-19, purchase and maintain mobile vehicles and equipment to conduct such testing or vaccinations, and hire and train laboratory personnel and other staff to conduct such mobile testing or vaccinations, particularly in medically underserved areas.
- **Establish, expand, and sustain the health care workforce** to prevent, prepare for, and respond to COVID–19, and to carry out other health work force-related activities.
- **Modify, enhance, and expand health care services and infrastructure.**
- Conduct community outreach and education activities related to COVID–19.

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https://bphc.hrsa.gov/program-opportunities/american-rescue-plan/allowable-uses-funding

Elevate Change Areas and Curriculum (May-Dec 2021): Connecting to American Rescue Plan Fund (H8F) Priorities

Recovery & Stabilization

- Pent Up Demand
- Patient Registries
- Virtual Care
- Care Transitions and Coordination
- Outreach
- Population Health and Social Determinants
- Patient Engagement
- Workforce Well-Being
- Continuity of Care
- Strategic Planning

Infrastructure: Improve & Reimagine

- Physical Infrastructure Improvements
- Facilitating Access
- Virtual Care Access
- Team-Based Care
- Mobile Units/Vehicles

Maintaining & Increasing Capacity

- Care Teams/Personnel
- Care Management
- Virtual Visits
- Behavioral Health
- Community Partnerships

Infrastructure Care Delivery People

Health Centers Need to Remain Alert to Rising Competitors

*Health Care 2030: The Coming Transformation**		
	Community Health Centers	Walmart+
#	1,400	5,342
People served	~30 million/year	~265 million/week (worldwide; it is estimated nearly 200 million/week in the US)
Locations	13,000 communities across the US/territories	There is a Walmart store within 10 miles of 90% of the US population+

+Illustrates a retail provider and competitor that seeks to move into the health care arena in the coming years. Other examples include CVS, Walgreens, and more. https://corporate.walmart.com/our-story/locations/united-states?multi=false.
+Store N°8. The incubation arm of Walmart. Formed in 2017. https://www.storeno8.com/about-us/our-story.

**Health Care 2030: The Coming Transformation*. A commentary on the transformation of health systems propelled by opportunities such as digital health, growing consumerism, and mounting financial constraints. Sponsored by the International Academy of Quality. Authors: Zimlichman, E., Nicklin, W., Aggarwal, R., Bates, D. Health Care 2030: The Coming Transformation. NEJM Catalyst. March 3, 2021. https://catalyst.nejm.org/doi/full/10.1056/CAT.20.0569#.YJqyA-IggBY.twitter

NACHC Announces the launch of the
Center for Community Health Innovation

- RCHN Community Health Foundation Awards $5 Million To Establish the new **Center for Community Health Innovation**

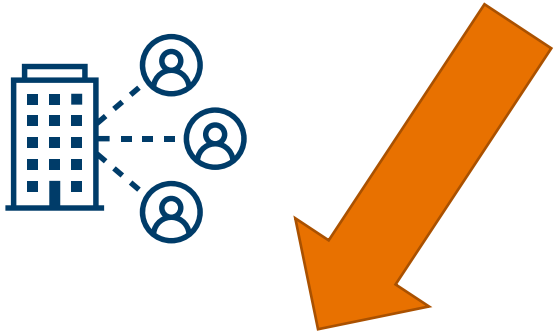
- The **Center for Community Health Innovation** (CCHI) will work to:
  - **identify, support, and replicate** groundbreaking approaches to practice innovation, workforce development, and collaborative arrangements in the delivery of community-based health care.
  - **evaluate** existing best and promising practices and determine opportunities for value and scalability to further the health center mission.
  - **prepare** Community Health Centers for sustainable operational and clinical success.

Virtual Care as a Disruptor

- **Theory of disruptive innovation**: business scholar Clayton Christensen (1990s)
- Disruption requires 3 enablers:

Simplifying Technology
Telehealth

Disruptive Value Network
Teladoc Health, Cricket, PillPak, VillageMD



Business Model Innovation

Christensen. CM. A Disruptive Solution for Health Care. Harv Bus Rev March 2, 2011. https://hbr.org/2011/03/a-disruptive-solution-for-heal.html

How Will Your Health Center Shape Virtual Care Alongside In-Person Care?

Virtual care opportunities:

- Improved patient monitoring and data/feedback loops to inform care
- Use of artificial intelligence (AI) and AI-enabled algorithm to drive care delivery
- Personalized feedback and care informed by the data
- Automated and personalized patient messaging
- Robust care team communication

NEW CARE TEAM DESIGN

- New workforce opportunities: mid-levels providers, community health workers, health coaches, navigators
- New workflows and role distribution
- New communication channels

Pre-Requisites to Effective Care Teams

1. **Leadership Support**
2. **Risk Stratification**
3. **Models of Care**

- Empanelment
- Psychological Safety

Missed this content?

View February - April Learning Forums on the Elevate Learning Forum.

CARE TEAMS

Utilize groups of staff with different skills to work together to delivery and improve care, offering a wider range of services more efficiently than a provider alone.

Care Teams Action Guide: http://www.nachc.org/wp-content/uploads/2019/11/NACHC-VTF-Care-Teams-AG_November-2019.pdf

Care Teams Action Guide

NATIONAL ASSOCIATION OF Community Health Centers®

VALUE TRANSFORMATION FRAMEWORK

Action Guide

HEALTH CENTER

CARE DELIVERY | INFRASTRUCTURE | PEOPLE

CARE TEAMS

WHY

Focus on Care Teams?

Much has been written about the success of the "care team model" in delivering high-quality, low-cost, impactful health care (the Quadruple Aim). Developing an effective team-based model of care is at the heart of health center efforts to deliver on the Quadruple Aim: improved health outcomes, improved staff and provider experiences, and lower costs.

Transitioning to value-based care requires a significant shift in the way care delivery, infrastructure, and people are engaged and deployed in the health care system. In the volume-based system, a primary care physician would need to spend an estimated 21.7 hours per day to provide all recommended acute, chronic and preventive care to a panel of 2500 patients[1]. It is, therefore, not surprising that physicians face burnout and adults in the U.S. receive only 55% of recommended services[2]. The volume-driven model of care coupled with the complexity of preventive, acute and chronic care needs in the context of a primary care visit, limits the quality of service delivered[3]. A reinvention of the care team model—with more responsibility given to supportive members of the care team—has proven to optimize the experience and outcomes of primary care for patients, providers and staff[4]. In addition to improving service for chronic disease and preventive care, re-organizing care team roles can help address the widely-documented problem of primary care physician shortages[5,6,7].

CARE TEAMS

The Value Transformation Framework addresses how to utilize groups of staff with different skills to work together to deliver and improve care, offering a wider range of services more efficiently than with a provider alone. This Action Guide offers steps for health centers seeking proven strategies to develop effective care teams.

Ultimately, patient care is a team sport. All members of the health center team are accountable for the delivery of high quality care to patients. Patient engagement, also crucial to care, is addressed in the Patient Engagement Action Guide.

While many health centers report using a team-based approach to care, these systems may not be functioning optimally to achieve desired outcomes. This Action Guide offers steps health centers can take to more effectively distribute, or share, responsibility and accountability across the team.

"Sharing the care involves both a paradigm shift and a concrete strategy for increasing capacity. The paradigm (culture) shift transforms the practice from an "I" to a "we" mindset. Unlike the lone-doctor-with-helpers model, in which the physician assumes all responsibility, makes all decisions, and delegates tasks to team members (but cannot increase capacity), the "we" paradigm uses a team comprising clinicians and non-clinicians to provide care to a patient panel, with a reallocation of responsibilities, not only tasks, so that all team members contribute meaningfully to the health of their patient panel."[8]

STEPS #1-3

STEP 1 Define Care Standards: Identify a minimum set of patient services (standards), by age and/or risk group.

STEP 2 Distribute Tasks to Meet Standards and Document Workflow: Reconsider who within the care team completes tasks for each standard. 'Share the care': assign an appropriate staff position to each task defined. Map workflow.

STEP 3 Update Job Descriptions: Summarize tasks for each role within the health center. Include this information in updated job descriptions (formalization).

http://www.nachc.org/wp-content/uploads/2019/11/NACHC-VTF-Care-Teams-AG_November-2019.pdf

Models of Care

NATIONAL ASSOCIATION OF Community Health Centers

VALUE TRANSFORMATION FRAMEWORK

Action Guide

HEALTH CENTER

CARE DELIVERY | INFRASTRUCTURE | PEOPLE

POPULATION HEALTH MANAGEMENT

MODELS OF CARE

WHY

Design Different Models of Care Based on Risk Level?

Population management is key to successful value-based care. Effective population health management requires that health care organizations group patients based on their needs to direct care and target resources (See *Risk Stratification* Action Guide). Top performing health centers segment patients by risk and design models of care tailored to each subgroup. The purpose is to offer more appropriate and cost effective care to patients who fall into different levels of risk, rather than using a "one size fits all" approach. Identifying unique subgroups of patients, and analyzing each group's health needs, trends, and outcomes, allows health centers to best intervene for improved outcomes.

WHAT

are Care Models Based on Risk?

Designing care models based on risk allows patients to be paired with more appropriate clinical and other services. This Action Guide outlines approaches to building models of care for high, rising and low-risk target populations. Models for highly complex patients are very specialized and not addressed here.

- **High-risk** patients are assigned a care manager who coordinates care across the continuum.
- **Rising-risk** patients are managed within the Patient Centered Medical Home (PCMH) model, with scalable strategies to manage their immediate needs and prevent them from becoming high-risk.
- **Low-risk** patients are managed with more remote, group, and technological solutions. Strategies may include care other than in-person visits, including self-care.

POPULATION HEALTH MANAGEMENT

within the Value Transformation Framework speaks to the systematic process of utilizing data on patient populations to target interventions for better health outcomes at lower cost, with a better care experience. This Action Guide outlines a framework for the design of unique models of care to subgroups of the population identified through risk stratification.

https://www.nachc.org/wp-content/uploads/2019/11/NACHC-VTF-Pop-Health_Models-of-Care-AG_November-2019.pdf

Highly complex. Require intensive, pro-active care management.

→ Care Management Action Guide

High-risk. Engage in care management to provide one-on-one support for medical, social and care coordination needs.

Rising-risk. Manage within PCMH model; support in managing risk factors (e.g., obesity, smoking, blood pressure, cholesterol).

Low-risk. Manage using more remote, group, and technological solutions; focus on keeping patients healthy and engaged.

Define Care Standards

Patient:_____ Date: _____

IMPORTANT

As a ***woman age 50-75 years of age***, your doctor wants you to receive the following screenings based upon the *BEST MEDICAL information. Be sure to ask your doctor, nurse practitioner or physician assistant at today's visit to check if you need the tests which can ***save your life*** ☺.

ROUTINE CARE:
- Blood Pressure
- Depression screening
- Weight screening and counseling for better weight control
- Screening for use of aspirin or a cholesterol lowering medication to prevent heart disease

CANCER SCREENINGS:
- Breast cancer (mammogram every 1-2 years)
- Cervical cancer (Pap test every 3 years ages 21-64 or every 5 years for women age 30-64 who get a Pap and HPV test.
- Colon cancer (FIT test annually or other screening/ diagnostic tests and frequencies depending on risk.

BLOOD TESTS:
- HbA1c for diabetes
- Hepatitis C screening
- HIV
- Diseases transmitted through sexual activity

LIFESTYLE:
- Tobacco use
- Alcohol use
- Relationship violence

*BEST MEDICAL INFORMATION/RESEARCH: US Preventive Services Task Force (USPSTF):
- Aspirin Use in some adults 50-59 years can lower your risk for heart attack, stroke and colorectal cancer. Drugs that lower cholesterol may be used in some adults 40-75 years of age with risk factors to prevent cardiovascular disease. Check with your doctor before taking aspirin or any medication
- Cervical Cancer screening recommended through age 65 years.
- Blood glucose monitoring recommended in overweight adults 40-70 years of age.
- Hepatitis C one-time monitoring or additional screening as needed.
- HIV Screening through 65 years of age.

WOMAN 50-75_ Mar. 8, 2018

Patient:_____ Date: _____

IMPORTANT

As a ***woman age 50-75 years of age***, your doctor wants you to receive the following screenings based upon the *BEST MEDICAL information. Be sure to ask your doctor, nurse practitioner or physician assistant at today's visit to check if you need the tests which can ***save your life*** ☺.

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- HIV Screening through 65 years of age.

Distribute Tasks to Meet Standards and Document Workflow

'SHARE THE CARE' Model of Care Delivery

- Paradigm shift
- Concrete strategy for increasing capacity
- Redefine 'team' (clinicians and non-clinicians providing care to a panel of patients)
- Reallocate tasks and responsibilities
- From lone provider-with-helpers model to **reallocation of responsibility** to a team
- Design care teams where all members contribute meaningfully and to full capacity

Ghorob, A. Bodenheimer, T. (2012). Sharing the Care to Improve Access to Primary Care. New England Journal of Medicine. 366, 1955-1957.

Distribute Tasks to Meet Standards and Document Workflow

RESPONSIBILITY / TASK	ROLE - Current	ROLE - Future	WHEN IN VISIT CYCLE	Notes
Check-in patient				
Verify and update insurance information				
Verify and update demographic information (address, phone, etc)				
Verify and update PCP selection	RN	LPN		
Print summary lists (meds, dx, allergy); give to patient to review	MA	LPN		
Verify and update missing preventive / chronic care services	Provider	Front Office		
Track and follow up on lab & imaging results	LPN	LPN		
Notify patient of normal results	Front Office	Front Office		
Notify patient of abnormal results	Pharmacist	RN		
Track and follow up on completion of referral visits, tests & procedures				
Receive/review reports or other communications from facilities notifying practice of service provided to patients				
Obtain notes from facilities – inpatient or rehab, emergency department, urgent care centers				
Review appointment history and follow up as needed				
Perform and document lab tests performed in-office				
Collect and/or process specimens to send to external laboratory				
Conduct clinic services (ECG, pulse oximetry, hearing & vision testing)				

ACTION ITEMS: Assign appropriate staff positions to each task needed to complete defined set of standards.

- Adapt the *"Team-Based Planning Worksheet"* developed by the Safety Net Medical Home.
- Create workflow maps that define and standardize work processes.

Accomplish **individual tasks**
Emphasize
team responsibility

GENERATIONS
FAMILY HEALTH CENTER

Generations Family Health Center
Creating Integrated Care Teams
May 11, 2021

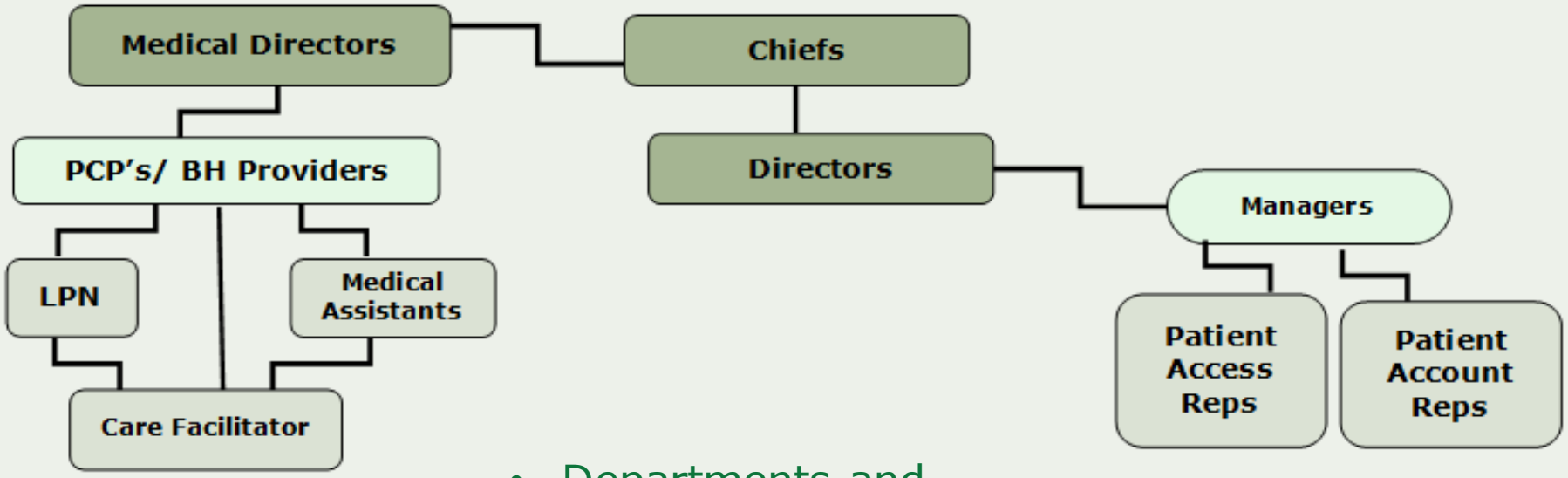
GFHC Swimlanes

	Schedule Appt	Check In	Appt Prep	Provider Visit	Appt F/Up	Labs/ Diagnostics	Check Out
Front Desk	•Appts for patients calling in	•Arrival	• Assure Reminder call received		•Document No Show and contact pt per	•Print lab slip on check out if needed	• Schedule follow up appts or place in recall per
Pt Access	•Appts @ Checkout	•Intake/Update Demo	• Ref uninsured to ACA		Sched F/U Appt		•Encourage patient to
Pt Acct Rep	•Appt requests from	•Verify Insurance eligibility	• Ref uninsured to care				•Send portal invite
	•Appts from recall	•Data Entry •Slide Fee Applications					•Encourage patient to
Medical	•F/u per standing orders		•Pull recent Labs/	• Gather supplies before	• Schedule any ordered	•obtain diagnostic results,	•Encourage patient to
			•Huddle with Care Team as	• Perform vitals	•Assure medication	•obtain lab results not	•Send portal invite
				• Perform standing	•Use secure messaging		•Encourage patient to
LPN	•F/u per standing orders		•Review immunization	• Administer	• Monitor scheduled labs	•Receive critical values	•Encourage patient to
	•Enabling Visit i.e. patient		•Notify provider if	• Administer wound care	• Notify patients of med	•Call pt to notify results	•Send portal invite
			•Gather wound care	• Provide pt education as	•Assure encounter notes	•Review resulted labs,	•Encourage patient to
			•Huddle with Care Team as	• Administer on site meds	Phone contact with		•Encourage patient to
Provider			•Review Labs/	•Review Of Systems	•Assure prescriptions	•Notify MA or LPNto	•Send portal invite
			•Huddle with Care Team as	•Address reason for visit	•Respond to patient		•Encourage patient to
			•Initiate Care Level	•Discuss goals and plan	•Complete any forms		
				•Diagnostics/ Labs/			
				•Complete Clinical			
Care Coordinator	•F/u ED & Hosp Admission	•Enabling Services Appts	•Contact pt to bring all	•Meet with pt while on	•Continue to address		•Enabling Services Appts
	•Care Coordination Face		•Complete Social	•Confirm contact	Assist with Community		•Encourage patient to
	•Face To Face Enabling			Confirm acceptance of CC	Schedule f/u		•Send portal invite
	Use Gaps In Care Reports		Address Gaps In Care	•Identify Goals, share	Communicate regularly		•Encourage patient to
			•Assure Care Plan and	•Update Care plans and			
			•Huddle with Care Team as	• Complete Needs Assessments			
				• Refer for community resources			
Care Facilitator	•Referrals	•Enabling Services Appts	•Contact pt to bring all required documentation	•Meet with pt while on site/Confirm contact	•Complete referral (When appt scheduled, if		•Enabling Services Appts
	•Face To Face Enabling		•Complete Social	•Discuss specialist	*Complete referral follow		•Encourage patient to
			•Huddle with Care Team as	•Confirm pt accepts	*using referral protocols		•Send portal invite
			•Help pt apply for	Call patient to discuss	*Scan notes and result		•Encourage patient to
Community Health Worker	•Insurance Applications	•Enabling Services Appts	•Contact pt to bring all	Provide Interpretation	Assist with Community	F/u with pateint re lab &	•Enabling Services Appts
	•Program Intake		•Complete Social		Coordinate Medication		•Encourage patient to
	•Face To Face Enabling		Schedule Transportation		Coordinate Shelter		•Send portal invite
			Assure program				•Encourage patient to

GENERATIONS
FAMILY HEALTH CENTER

Clearly define roles and responsibilities for each leg of the patient experience

Generations Family Health Center Care Team Flow Chart

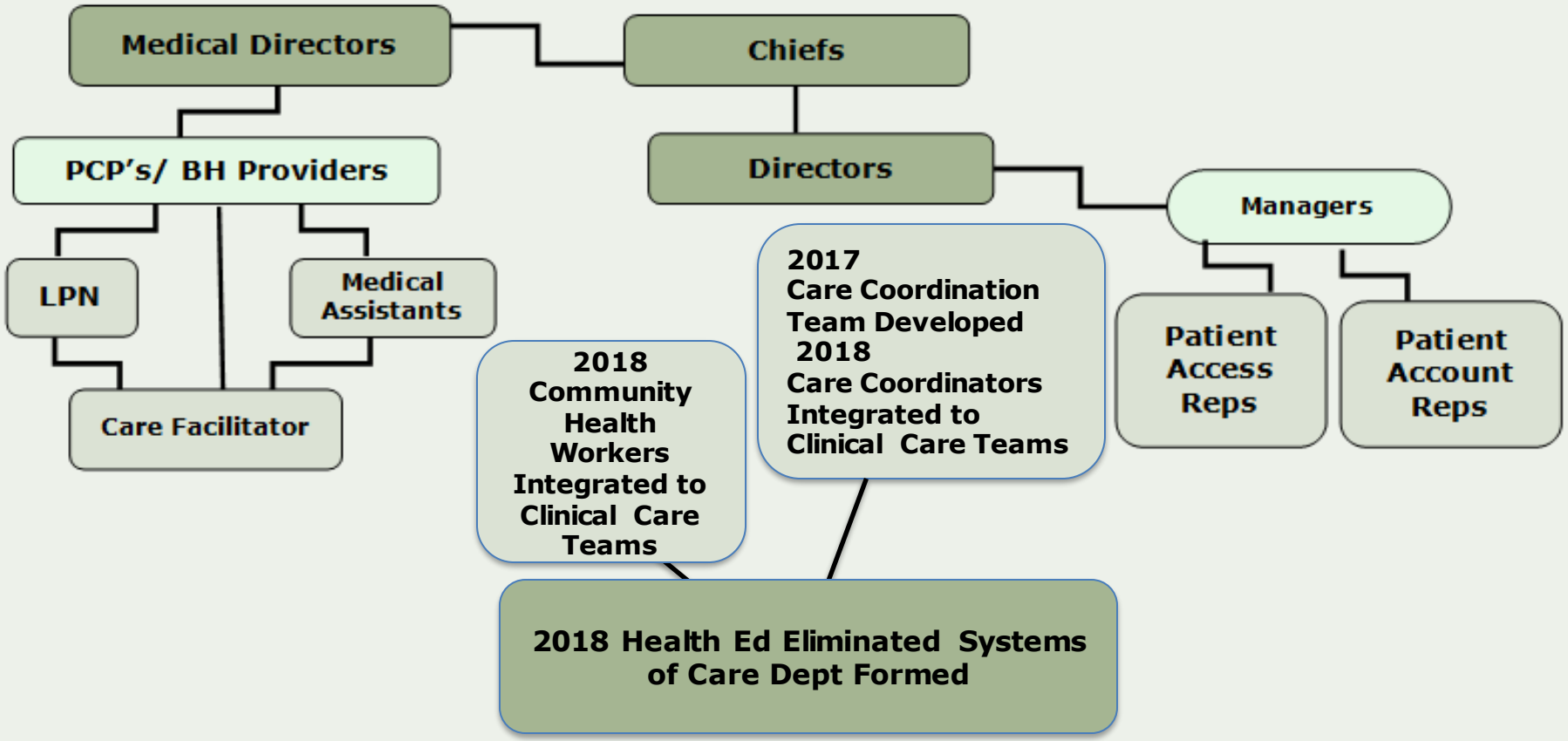


- Departments and disciplines acted in Silos.
- Duplication of work existed.
- Gaps in care went unnoticed.

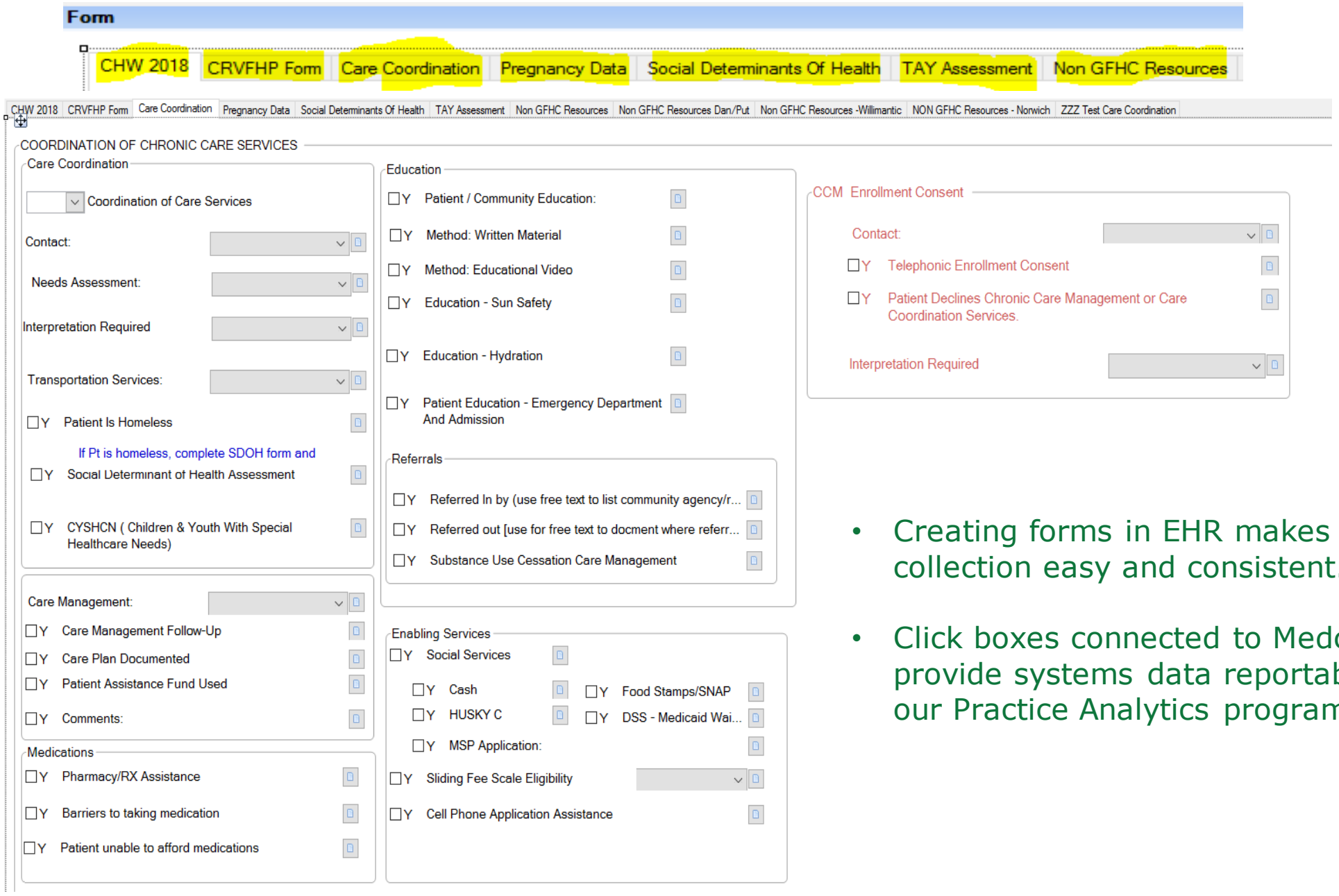
2017
Care Coordination Team developed as part of the Medicaid Quality Improvement Shared Savings Program. (PCMH+)

Health Ed Dept was it's own silo

Generations Family Health Center Care Team Flow Chart



- Integrating enabling services as part of the care teams addresses Social Determinants of Health (SDOH), closes gaps in care and improves clinical outcomes.



- Creating forms in EHR makes data collection easy and consistent.
- Click boxes connected to Medcin ID's provide systems data reportable through our Practice Analytics program.

Form

CHW 2018 | CRVFHP Form | Care Coordination | Pregnancy Data | Social Determinants Of Health | TAY Assessment | Non GFHC Resources

Social Determinants Of Health | TAY Assessment | AUDIT-C / HARK | Depression / Social Isolation | CYSHCN

☐Y TAY (Transition Aged Youth) Assessment (Age 16-24) ☐Y CYSHCN (Children & Youth With Special Healthcare Needs) ☐Y Social Determinant of Health Assessment

Race and Ethnicity

Obtaining broader categories of race and ethnicity must be done with each SDOH form. ☐Y ☐N **Patient Information Entered Into System (If declined, click no and document "Declined" in**

We Ask Because We Care? is a national campaign to collect more granular data related to Race , Ethnicity and Linguistic preferences using drilled down CDC codes. It is used to ensure we?re understanding and meeting the unique ethnic and cultural needs of our patients. This data collection marks an

☐Y **Race Sub P...** ☐Y **Ethnicity Sub...**

RISK/UTILIZATION

☐Y Needs additional Care Plan Manageme...
☐Y Recent ER visit within the past 90 days.
☐Y Inpatient Admissions witin 90 days.
☐Y Patient Disch From Inpatient Facility Within Last 60 Davs

SOCIAL HISTORY

CAGE AID AND HARK 2018

Alcohol Usage/Treatment

○ **Alcohol**

If any concerns complete a CAGE AID (3 or more drinks)

☐Y ☐N Therapy For Alcohol Abuse/Dependence

Drug Usage/Treatment

☐Y ☐N **Drug Use**

If any concerns (Y) complete a CAGE AID

○ ☐Y ☐N Therapy For Drug And Alcohol Abuse/Dependence

HOUSING & EMPLOYMENT STATUS

Are you worried about losing your ho...

☐Y **Patient is homeless** ☐Y **Economic Issues /Unmployment**

EDUCATIONAL/FINANCIAL RESOURCES/TRANSPORT

How hard is it for you to pay for the very basics like food, housing, medical care, and heating?

What is the highest grade or level of school you have completed or the highest degree you have received?

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed? Check all that apply. (14P)

Food | Clothing
Utilities | Child Care
Phone | Other (ple...

Medicine or Any Health Care (Medical, Dental, Mental Health, Vision)

Has lack of transportation kept you from medical appointments, meetings, work, or from getting things needed for daily living? Check all that apply. (15P)

Patient kept from medical appointments or from getting me...

Patient kept from non-medical meetings, appointments, work, or from getting things that he/she needs

Physical Activity [SAMHSA]

How many days of moderate to strenuous exercise, like a brisk walk, did you do in the last 7 days?

On those days that you engage in moderate to strenuous exercise, how many minutes, on average, do you exercise?

Social and Emotional Health

How often do you see or talk to people that that you care about and feel close to? (For example: talking to friends on the phone, visiting friends or family, going to church or club meetings)

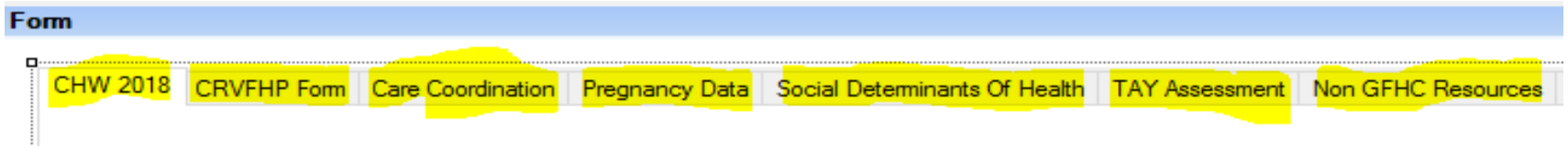
Stress is when someone feels tense, nervous, anxious, or cannot sleep at night because their mind is troubled. How stressed are you?

Optional Additional Questions

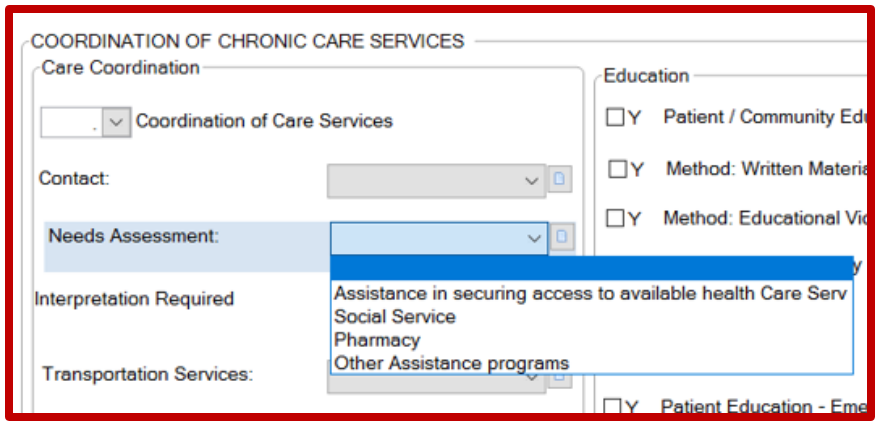
In the past year, have you spent more than 2 nights in a row in a jail, prison, detention center, or juvenile correctional facility?

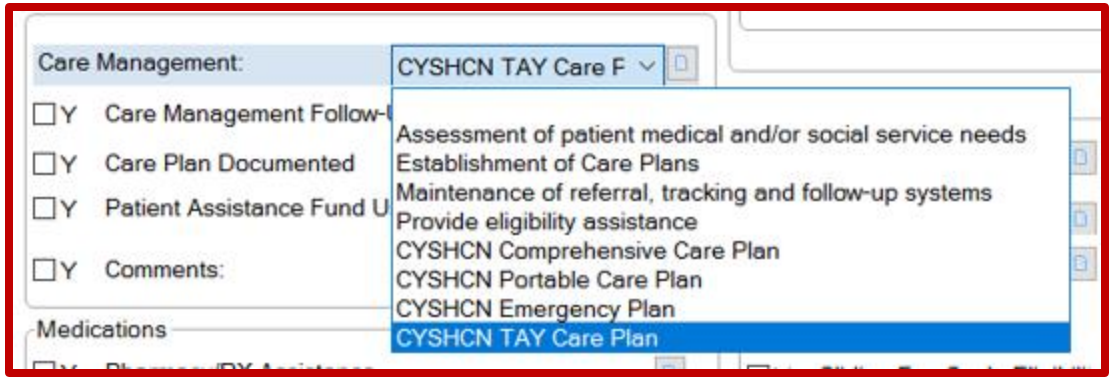
Do you feel physically and emotionally safe where you currently live?

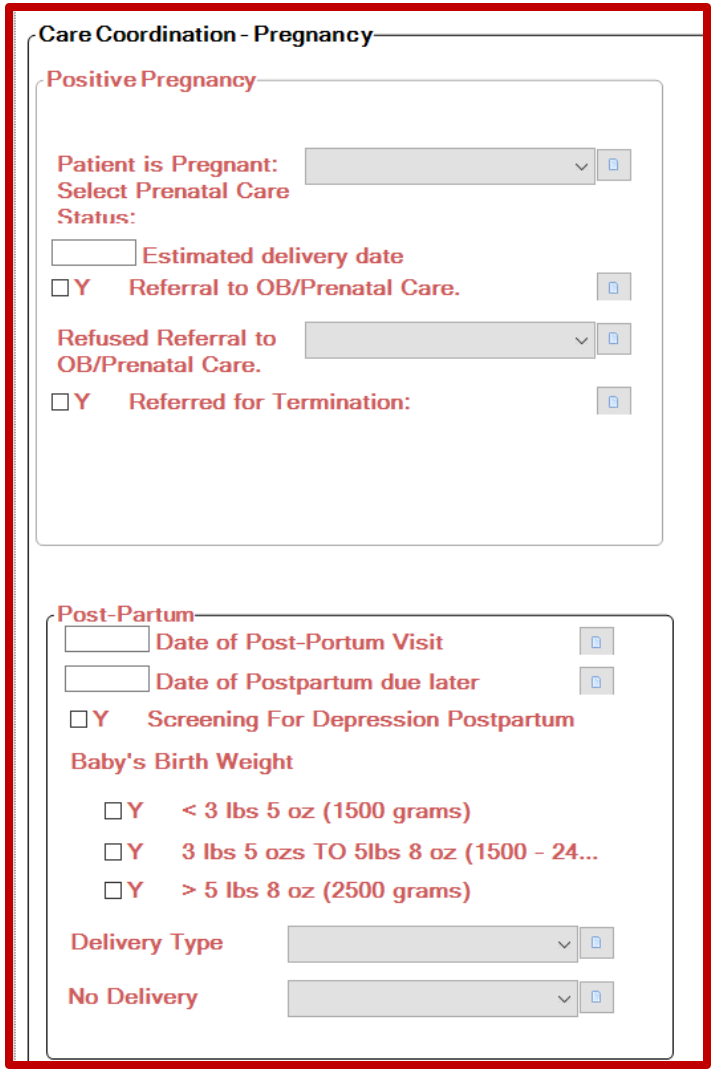
In the past year, have you been afraid of your partner or ex-partner?



- Click boxes and drop-down menus connected to Medcin ID's provide systems data reportable through our Practice Analytics program.







- Information saved to Documents can be printed with resources and contact information and given to patient.
- Documents are saved chronologically so providers and staff are able to see what is being done for the patient and develop a whole person plan of care.

Patient: 5240 - 21 Patient Test
DOB: 11/02/1948

Date: 04/08/2021 08:36
Provider: NB, Doctor
Encounter: Care Coordination Document

SOCIAL HISTORY

Recent Events: Has lack of transportation kept patient from medical appointments or from getting medications: Yes and lack of transportation has kept patient from beneficial non-medical activities: Yes.
Behavioral: Smoker: Current some day smoker.
Alcohol: Alcohol use 2 drinks / day or fewer.
Drug Use: Drug use.
Housing And Economic Circumstances: Lack of housing.
Financial: In the past year, patient or family members in household were unable to get needed child care: Yes, unable to get needed phone: Yes, unable to get needed utilities: Yes, and unable to afford food unable to get needed food: Yes.
• Needs additional Care Plan Management Support:
• Transportation: Gas Card

ASSESSMENT

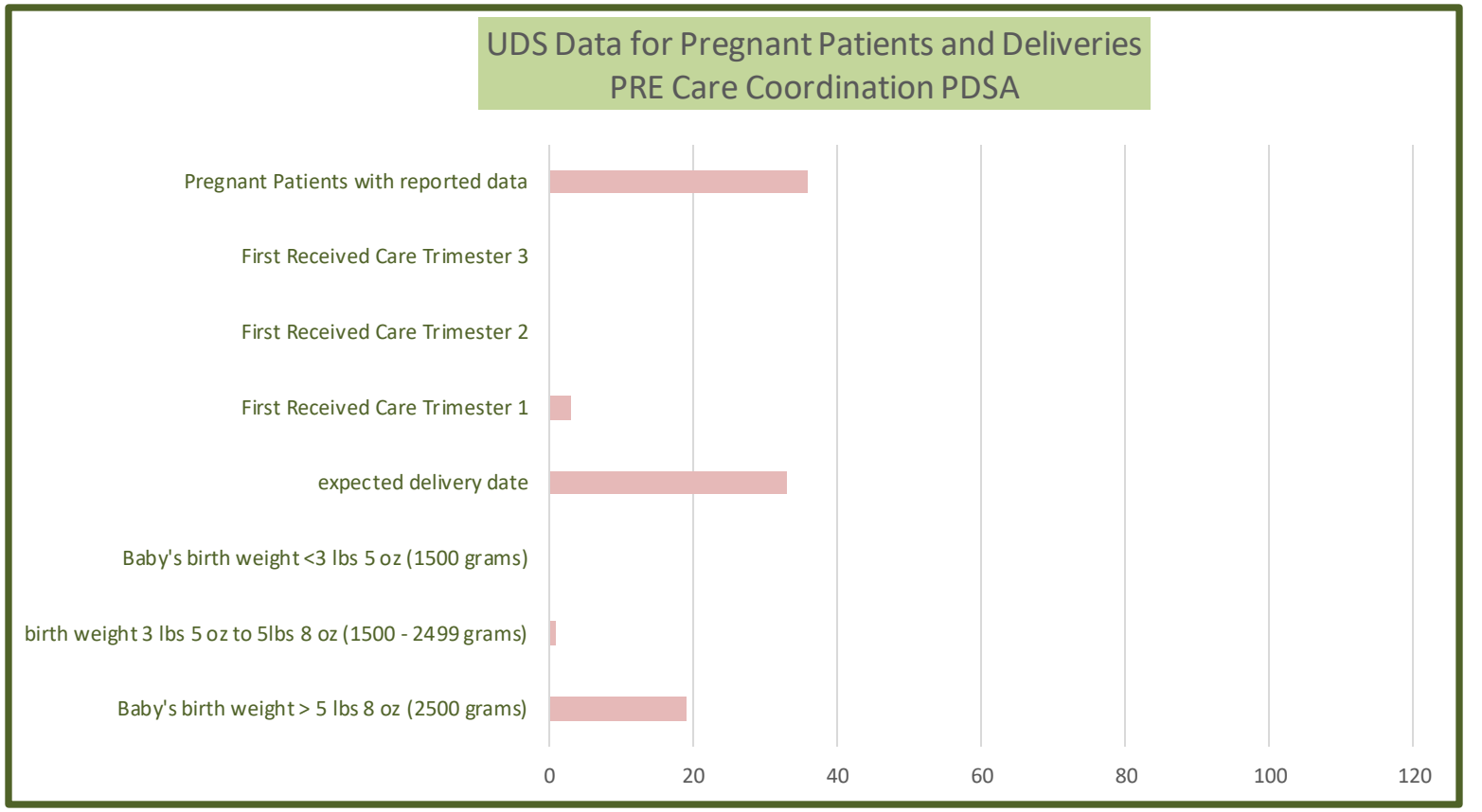
- Case Management: CYSHCN TAY Care Plan
- Food Stamps/SNAP
- Contact: Face-To-Face interactions
- Coordination of care services 34 min enc total
- Cash
- Eligiblility Assistance: Other Assistance programs
- Sliding Fee Application

THERAPY

- Community resources DDS-Department of Developmental Services 1-866-433-8192.
- Community resources CT Family Support Network (CTFSN) - 1-860-481-9663.
- Community resources CT Dept. of Social Services & Family Support Grant - 465-3500.
- Community resources ACCESS Energy, Food Bank, Shelter, WIC - 450-7400.
- Community resources WAIM - Windham Interfaith Ministry - 456-7270.
- Community resources No Freeze Hospitality Shelter - 450-1346.
- Community resources Holy Family Shelter - 423-2591.
- Community resources Windham Housing Authority - 456-1413.

GENERATIONS
FAMILY HEALTH CENTER

UDS – 7A Reports patients who received prenatal care and who gave birth during reporting Period. Live Births Categorized by Birth weight.



GFHC does not provide prenatal care. As a result, Maternal Child Data Collection for UDS reporting was pulled by manual audit with low results.

GENERATIONS
FAMILY HEALTH CENTER

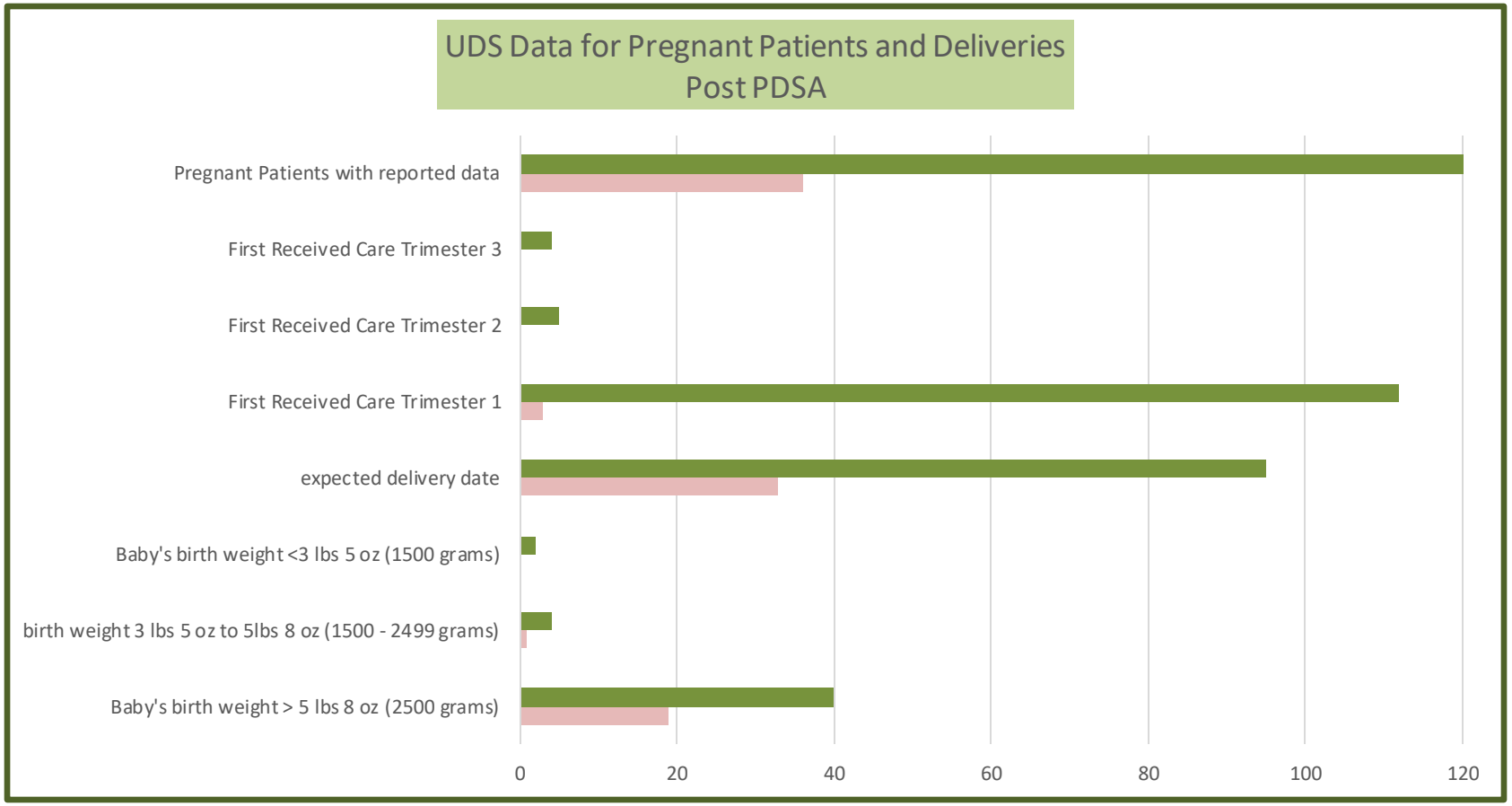
Care Coordinators

- Contacted patients identified as pregnant and conducted telephonic survey.
- Added prenatal data collection tab to Care Coordinator form in EHR.
- Assessed SDOH and assisted with community resources as needed.
- Tracked deliveries and recorded birth weights.
- Assisted in scheduling 6-week post-partum visit.
- Continued Care Coordination until needs were met and made referrals as appropriate for infant needs and services.

Results of PDSA were evaluated.

GENERATIONS
FAMILY HEALTH CENTER

With appropriate data collection tools, reports can be easily run to support the system change.



GENERATIONS
FAMILY HEALTH CENTER

Results supported the process, policy written for Maternal Child Care Coordination

Generations Family Health Center

Maternal Child Care Coordination

Policy: Generations will monitor and record Maternal Child data for all female patients of child bearing age.

Procedure: Upon identification of pregnancy in female patients of child bearing age, providers will document available information in pregnancy tab in Intergy, EHR. Once documented, a Maternal Child Care Coordination order will be sent. Care coordinators will complete a Social Determinants of Health Assessment on each patient and open a care plan in patient's chart. Demographic, cultural, clinical and social health determinants will be included in the assessment, and incorporated into the patient's care plan. All pertinent information obtained throughout pregnancy and delivery will be documented in patient's chart under "pregnancy tab".

1. When a provider identifies patients as pregnant, or recently giving birth (current reporting year only), they will complete all known information in the "pregnancy tab" in EHR. (DO NOT USE THIS TAB TO DOCUMENT HISTORICAL DATA AS IT SKEWS UDS DATA.)
2.
3. Upon completion of visit, provider will send a Maternal Child Care Coordination order, in "Order/Charges" in EHR. to the designated Care Coordinator.
4. PCP will include in the referral, all pertinent information related to pregnancy.
5. These orders will come as a "Task" in the EHR to the designated Care Coordinator, as assigned at each GFHC site, and is electronically attached to the specific patient's health record.
6. As each Care Coordinator opens his/her EHR desktop on a daily basis, he/she will go to "My Day" and see the "Task" list for assignments regarding "Order Requests".
7. When a task appears regarding an order for Maternal Child Care Coordination, the designated staff person will open that task to proceed with order.
8. Care Coordinator will contact patient to verify demographics and pregnancy data. Review all necessary info to support the patient to discuss Care Coordination services and receive "opt in" from the patient.

GENERATIONS
FAMILY HEALTH CENTER

jgaudet@genhealth.org

Pre Survey Results 1/1/202 - 8/31/2020

Selected Item	Patient Person Nbr	
Calculation	Count Distinct	
Global Query	133	
Baby's Birth Weight > 5lbs 8 oz (2500 grams)	19	
Baby's Birth Weight 3lbs 5 oz to 5lbs 8oz (1500-2499 grams)	1	18%
Baby's Birth Weight < 3lbs 5 oz (1500 grams)	0	
Expected Delivery Date	33	31%
First Received Care Trimester 1	3	
First Received Care Trimester 2	0	2%
First Received Care Trimester 3	0	

Post PDSA Results Year End 12/31/2020

Selected Item	Patient Person Nbr	
Calculation	Count Distinct	
Global Query	133	
Baby's Birth Weight > 5lbs 8 oz (2500 grams)	40	
Baby's Birth Weight 3lbs 5 oz to 5lbs 8oz (1500-2499 grams)	4	76%
Baby's Birth Weight < 3lbs 5 oz (1500 grams)	2	
Expected Delivery Date	95	90%
First Received Care Trimester 1	93	
First Received Care Trimester 2	4	94%
First Received Care Trimester 3	2	

GENERATIONS FAMILY HEALTH CENTER

jgaudet@genhealth.org

genhealth.org

Example: Stanford Coordinated Care

MA Care Coordinators have their own panel of patients:

- ✓ Work under protocols to refill meds
- ✓ Perform routine health maintenance and chronic disease monitoring tests (e.g., CRCS, blood glucose, BP)
- ✓ In-basked management (calls & emails)

https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/primary-care/workforce-financing/case_example_1.pdf

Other Examples

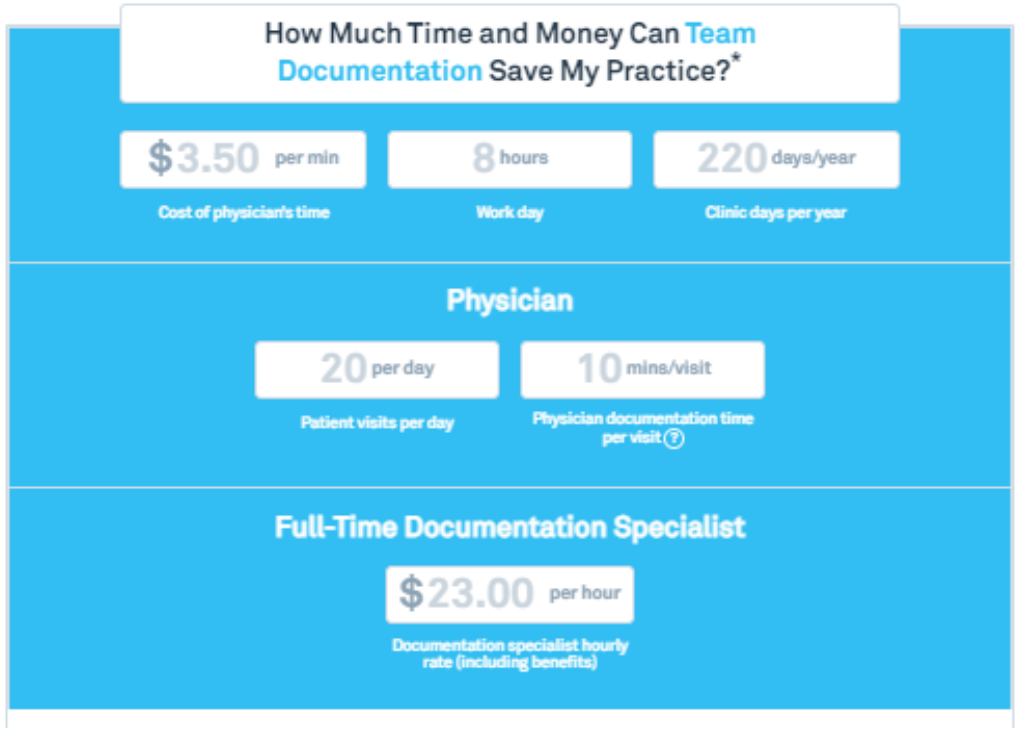
Medical Assistants
- Care Coordinators, Health Coach, Navigator, Scribe, Phlebotomist

Community Health Workers
- Care Coordinators, Health Coach, Navigators

Nurses
- Co-visits with provider

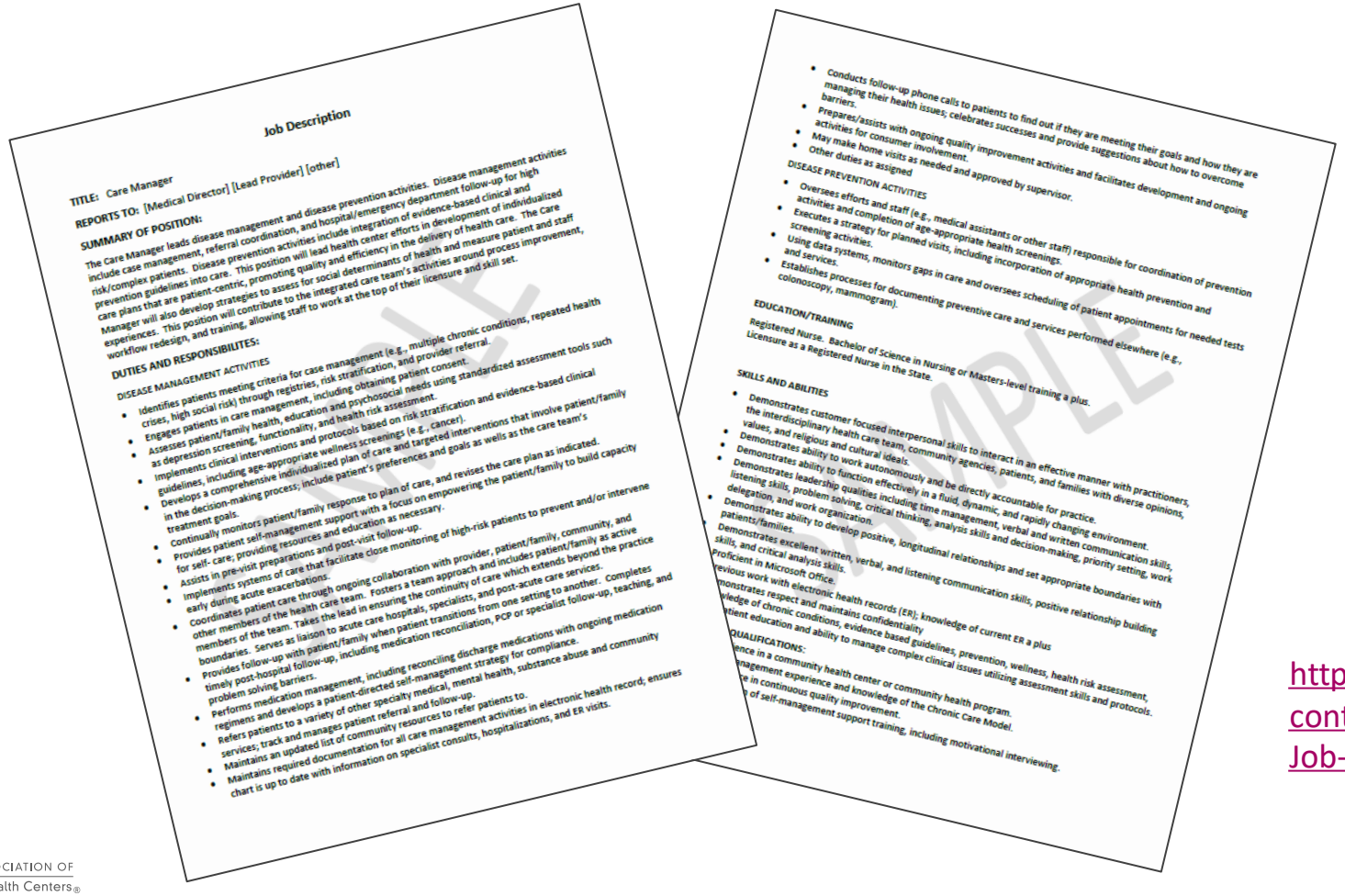
The Primary Care Team: Learning from Effective Ambulatory Practices (LEAP Project). http://www.improvingchroniccare.org/index.php?p=Team-based_Care&s=1265.
The Primary Care Team Guide. http://www.improvingprimarycare.org/.

Example of Cost Savings with Expanded Team Roles: Team Documentation



Source: AMA. Practice Transformation Series: implementing team-based care. 2021. https://www.stepsforward.org/modules/team-documentation

Update Job Descriptions



Job Description

TITLE: Care Manager

REPORTS TO: [Medical Director] [Lead Provider] [other]

SUMMARY OF POSITION:

The Care Manager leads disease management and disease prevention activities. Disease management activities include case management, referral coordination, and hospital/emergency department follow-up for high risk/complex patients. Disease prevention activities include integration of evidence-based clinical and prevention guidelines into care. This position will lead health center efforts in development of individualized care plans that are patient-centric, promoting quality and efficiency in the delivery of health care. The Care Manager will also develop strategies to assess for social determinants of health and measure patient and staff experiences. This position will contribute to the integrated care team's activities around process improvement, workflow redesign, and training, allowing staff to work at the top of their licensure and skill set.

DUTIES AND RESPONSIBILITES:

DISEASE MANAGEMENT ACTIVITIES

- Identifies patients meeting criteria for case management (e.g., multiple chronic conditions, repeated health crises, high social risk) through registries, risk stratification, and provider referral.
- Engages patients in care management, including obtaining patient consent.
- Assesses patient/family health, education and psychosocial needs using standardized assessment tools such as depression screening, functionality, and health risk assessment.
- Implements clinical interventions and protocols based on risk stratification and evidence-based clinical guidelines, including age-appropriate wellness screenings (e.g., cancer).
- Develops a comprehensive individualized plan of care and targeted interventions that involve patient/family in the decision-making process; include patient's preferences and goals as wells as the care team's treatment goals.
- Continually monitors patient/family response to plan of care, and revises the care plan as indicated.
- Provides patient self-management support with a focus on empowering the patient/family to build capacity for self- care; providing resources and education as necessary.
- Assists in pre-visit preparations and post-visit follow-up.
- Implements systems of care that facilitate close monitoring of high-risk patients to prevent and/or intervene early during acute exacerbations.
- Coordinates patient care through ongoing collaboration with provider, patient/family, community, and other members of the health care team. Fosters a team approach and includes patient/family as active members of the team. Takes the lead in ensuring the continuity of care which extends beyond the practice boundaries. Serves as liaison to acute care hospitals, specialists, and post-acute care services.
- Provides follow-up with patient/family when patient transitions from one setting to another. Completes timely post-hospital follow-up, including medication reconciliation, PCP or specialist follow-up, teaching, and problem solving barriers.
- Performs medication management, including reconciling discharge medications with ongoing medication regimens and develops a patient-directed self-management strategy for compliance.
- Refers patients to a variety of other specialty medical, mental health, substance abuse and community services; track and manages patient referral and follow-up.
- Maintains an updated list of community resources to refer patients to.
- Maintains required documentation for all care management activities in electronic health record; ensures chart is up to date with information on specialist consults, hospitalizations, and ER visits.
- Conducts follow-up phone calls to patients to find out if they are meeting their goals and how they are managing their health issues; celebrates successes and provide suggestions about how to overcome barriers.
- Prepares/assists with ongoing quality improvement activities and facilitates development and ongoing activities for consumer involvement.
- May make home visits as needed and approved by supervisor.
- Other duties as assigned

DISEASE PREVENTION ACTIVITIES

- Oversees efforts and staff (e.g., medical assistants or other staff) responsible for coordination of prevention activities and completion of age-appropriate health screenings.
- Executes a strategy for planned visits, including incorporation of appropriate health prevention and screening activities.
- Using data systems, monitors gaps in care and oversees scheduling of patient appointments for needed tests and services.
- Establishes processes for documenting preventive care and services performed elsewhere (e.g., colonoscopy, mammogram).

EDUCATION/TRAINING

Registered Nurse. Bachelor of Science in Nursing or Masters-level training a plus.
Licensure as a Registered Nurse in the State.

SKILLS AND ABILITIES

- Demonstrates customer focused interpersonal skills to interact in an effective manner with practitioners, the interdisciplinary health care team, community agencies, patients, and families with diverse opinions, values, and religious and cultural ideals.
- Demonstrates ability to work autonomously and be directly accountable for practice.
- Demonstrates ability to function effectively in a fluid, dynamic, and rapidly changing environment.
- Demonstrates leadership qualities including time management, verbal and written communication skills, listening skills, problem solving, critical thinking, analysis skills and decision-making, priority setting, work delegation, and work organization.
- Demonstrates ability to develop positive, longitudinal relationships and set appropriate boundaries with patients/families.
- Demonstrates excellent written, verbal, and listening communication skills, positive relationship building skills, and critical analysis skills.
- Proficient in Microsoft Office.
- evious work with electronic health records (ER); knowledge of current ER a plus
- monstrates respect and maintains confidentiality
- wledge of chronic conditions, evidence based guidelines, prevention, wellness, health risk assessment, tient education and ability to manage complex clinical issues utilizing assessment skills and protocols.

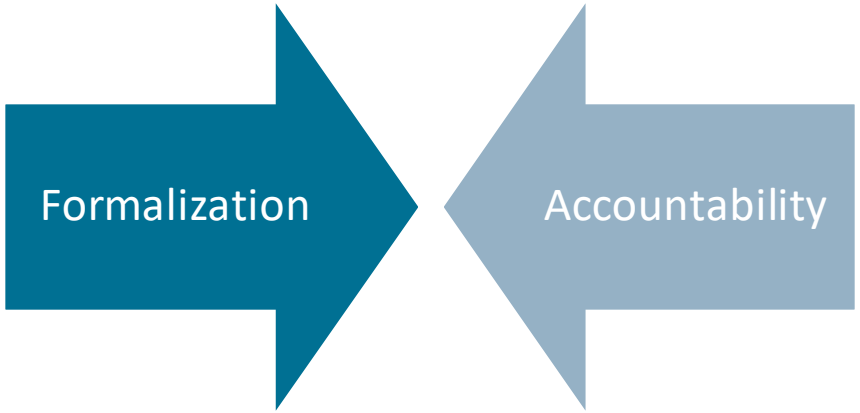
QUALIFICATIONS:

- ence in a community health center or community health program.
- nagement experience and knowledge of the Chronic Care Model.
- e in continuous quality improvement.
- of self-management support training, including motivational interviewing.

SAMPLE

http://www.nachc.org/wp-content/uploads/2020/03/Sample-Care-Mgr-Job-Description-NACHC-03.01.19.docx

Update Job Descriptions



Formalization

The extent to which work roles are structured

- Job descriptions
- Training
- Formal procedures

Accountability

The obligation or willingness of individuals and teams to accept responsibility

- Performance reviews

Formalization & Patient Engagement

Include “patient engagement” as part of job descriptions

ACTION STEPS

CHANGE AREA: CARE TEAMS

CARE TEAM ACTION STEPS:

The below action steps assume a health center is practicing empanelment and team huddles with mechanisms to ensure psychological safety (see Leadership Action Guide).

STEP 1 **Define Care Standards:** Identify a minimum set of patient services (standards), by age and/or risk group.

STEP 2 **Distribute Tasks to Meet Standards and Document Workflow:** Reconsider who within the care team completes tasks for each standard. 'Share the care': assign an appropriate staff position to each task defined. Map workflow.

STEP 3 **Update Job Descriptions:** Summarize tasks for each role within the health center. Include this information in updated job descriptions (formalization).

STEP 4 **Train Staff:** Train staff in job-specific tasks based on their redefined roles within care teams, including quality improvement.

STEP 5 **Montior Task Performance in Dashboards:** Provide dashboard access to each staff member and encourage regular performance reviews (accountability).

STEP 6 **Hardwire Accountability into Personnel Systems and Performance Reviews:** Create role-specific dashboards that monitor performance on job tasks. Create team dashboards that monitor team performance on key clinical, quality, and cost metrics. Document individual and team accountability via dashboards and performance reviews.

STEP 7 **Educate Patients on Redesigned Care Team:** Create patient education tool(s) that orient patients to new roles of care team members, including their own role with self-care.

UPCOMING EVENTS

May 2021

SUN	MON	TUE	WED	THU	FRI	SAT
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

June 2021

SUN	MON	TUE	WED	THU	FRI	SAT
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

- **01. IHI Open School Scholarships Starts**
- **11. May Elevate Core Webinar**
- **12. Business Continuity, *Part 2 of 3*** *(Deeper Dive)*
- **19. Care Management, Part 1 of 2** *(Deeper Dive)*
- **26. Business Continuity, *Part 3 of 3*** *(Deeper Dive)*

- **03. Care Management, Part 2 of 2** *(Deeper Dive)*
- **08. June Elevate Core Webinar**
- **15. Evidence-Based Care (Hypertension)** *(Deeper Dive)*
- **23. Evidence-Based Care (Cancer)** *(Deeper Dive)*
- **30. Evidence-Based Care (Diabetes)** *(Deeper Dive)*

Dive Deeper

Improvement Strategy | Health Information Technology | Policy | Payment | Cost | Population Health Management | Patient Centered Medical Home | Evidence-Based Care | **Care Coordination & Management** | Social Determinants of Health | Patients | Care Teams | Leadership | Workforce | Partnerships

NATIONAL ASSOCIATION OF Community Health Centers

VALUE TRANSFORMATION FRAMEWORK

Action Guide

HEALTH CENTER

CARE DELIVERY | INFRASTRUCTURE | PEOPLE

CARE MANAGEMENT

WHY

Use Care Management with High-Risk Patients?

Value-based care requires health care organizations to better control the clinical and financial risk associated with high-risk patients. A systematic process for managing the care of high-risk patients, using proven interventions in a supportive one-on-one environment, has been shown to improve health outcomes[1,2,3]. High-risk patients, by definition, have multiple health needs often compounded by complex social and other issues. These patients are at risk for poor health outcomes, inadequate quality of care, and increased costs [4,5,6]. The Centers for Medicare and Medicaid Services (CMS) recognizes care management as a critical tool to achieve the Quadruple Aim (better care, better patient and provider experiences, and lower costs)[7].

This Action Guide provides the steps to start a health center care management program for high-risk patients. The outlined recommendations meet the requirements of Chronic Care Management (CCM) services defined by CMS and, therefore, are eligible for reimbursement.

CARE MANAGEMENT

The Value Transformation Framework addresses how health centers can effectively deliver and coordinate care and manage high-risk and other subgroups of patients with more targeted services. This Action Guide outlines steps health centers can take to develop a comprehensive care management program for high-risk patients that meets the requirements for reimbursement from the Centers for Medicare and Medicaid Services (CMS).

WHAT

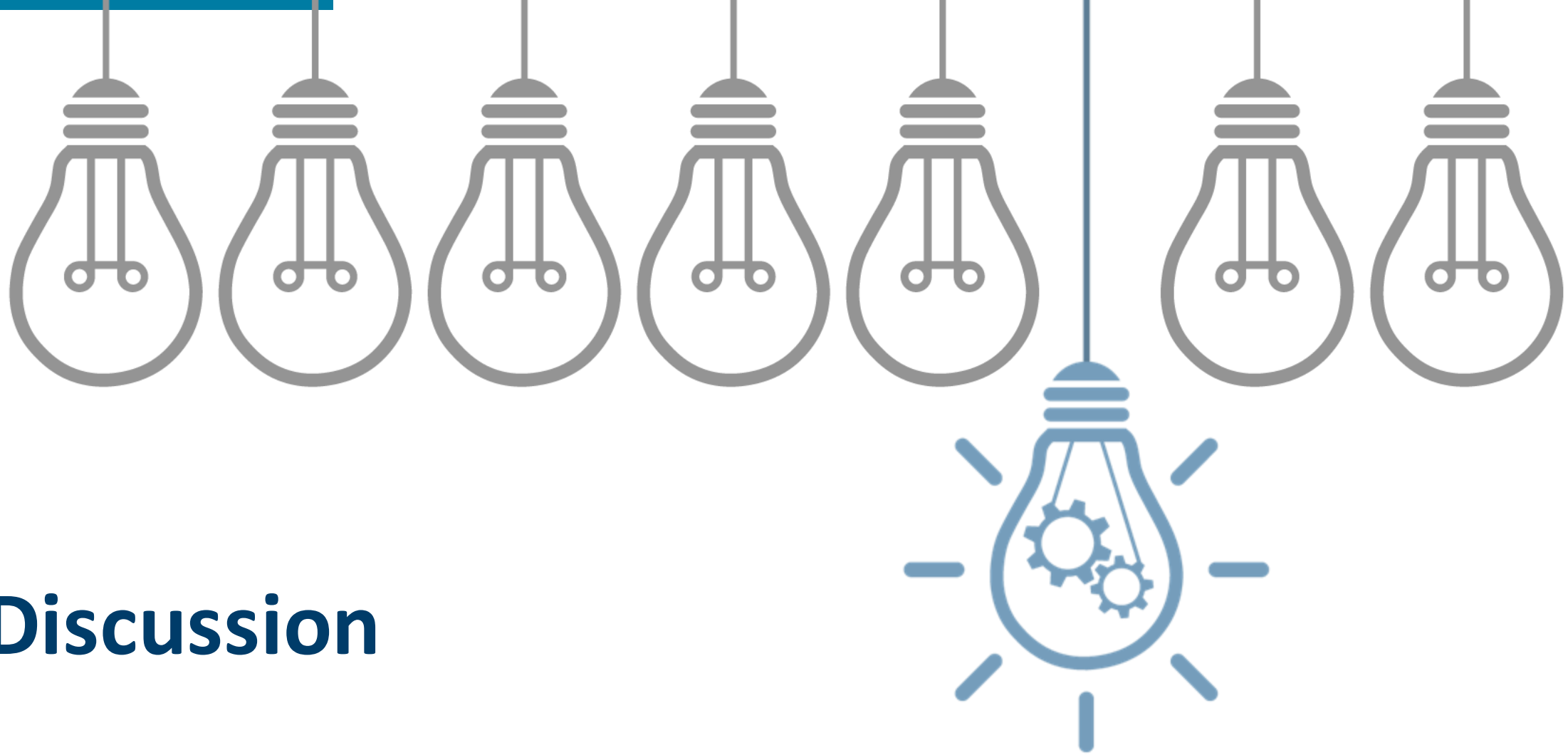
Does a High-Risk Care Management Model Look Like?

High-risk care management involves intensive, one-on-one services, provided by a nurse or other health worker, to individuals with complex health and social needs. The formal design of a health center care management program can ensure a standardized approach to managing high-risk patients by a care manager. The model discussed in this Action Guide is based on a nurse in the role of care manager. Other staffing models can be employed with some modification. Key components of care management include: identifying and engaging high-risk individuals, providing a comprehensive assessment, creating an individual care plan, engaging in patient education, monitoring clinical conditions, and coordinating needed services[8,9,10].

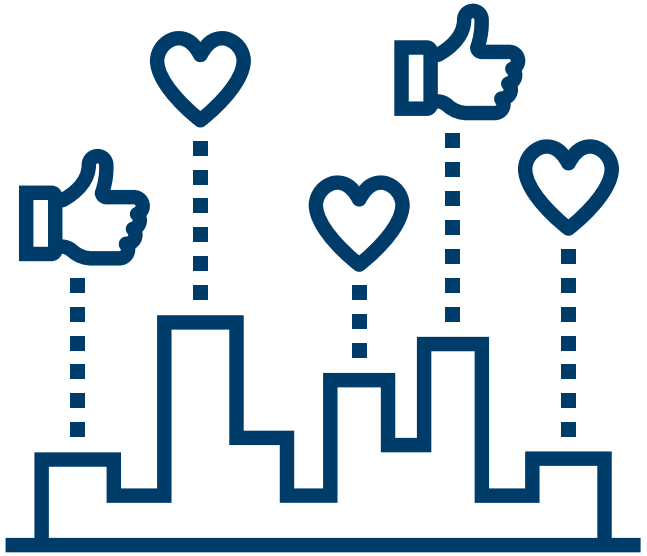
May 19th & June 3rd

Join us for a special series around Care Management! Learn how you can apply NACHC's Value Transformation Framework to develop a comprehensive care management program for high-risk patients that meets the requirements for reimbursement from the Centers for Medicare and Medicaid Services (CMS).

Scan QR code to register



Discussion



Provide Us Feedback

FEEDBACK

Don't forget! Let us know what you thought about today's session.

FOR MORE INFORMATION CONTACT:

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Next Monthly Forum Call:

June 8th, 2021
1 -2 pm ET

NATIONAL ASSOCIATION OF Community Health Centers®

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Together, our voices elevate all.

The Quality Center Team
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