NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS®

ACTION GUIDE

Learner Roles:
Clinical & Quality
Leadership
Patient & Community Support

Learner Level: 100 | 200 ✓ | 300

The **Care Teams** change area of the Value Transformation Framework addresses how health centers can 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 proven strategies to develop effective health center care teams.

What You'll Learn from This Guide

- ✓ Why care teams are essential to delivering value
- ✓ The core elements of effective care teams
- ✓ Practical steps to build and optimize care teams

Care Teams

WHY Focus on Care Teams?

The care team model is central to delivering high-quality, low-cost, value-based care aligned with the Quadruple Aim: improved patient outcomes, enhanced patient and staff experiences, and reduced costs.

Primary care under a volume-driven system is unsustainable. One physician would need approximately 21.7 hours per day to provide all recommended acute, chronic, and preventive care for a panel of 2,500 patients.[1] This workload contributes to physician burnout and results in adults receiving only 55% of recommended services.[2] The complexity of care in traditional primary care visits limits service quality.[3]

Reinventing the care team by redistributing responsibilities to supportive team members optimizes patient care and outcomes, addresses primary care shortages,[5-7] and improves provider and staff experience.[4] Patient care is a team sport, with all members accountable for delivering high-quality care.

While many health centers report using team-based care, these systems may not be functioning optimally. This Action Guide provides concrete steps to share responsibility and accountability, ensuring all team members optimally support patient health.

> *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… with a reallocation of responsibilities, not only tasks, so that all team members contribute meaningfully to the health of their patient panel.*[8]

WHAT Can Health Centers Do Differently When it Comes to Care Teams?

Team structure can vary by organization, and even within a health center. Care teams are developed based on the needs of the patient population and the availability of personnel, services, and other resources.

Care teams are most commonly led by a provider and typically include medical assistant(s) and nursing staff. Some teams include behavioral health professionals, pharmacists, or administrative staff. Health coaches, patient navigators, community health workers, and partner organizations also play a critical role in delivering care as part of a team. Patients are central players in their own care and should be recognized for their important role as part of the care team.

While 9 out of 10 health centers report using a care team, these teams often do not deliver desired outcomes. Formalization and mechanisms to ensure accountability to the model can help.[9]

- Formalization refers to the development of procedures, clear job descriptions, training, and other mechanisms to more effectively structure the actions and activities of individuals and teams.
- Accountability refers to individuals and teams accepting responsibility for the actions and activities formally assigned to them. This requires a system to measure and report on individual and team performance, linked with systems for skill development and training, and tied to overall performance goals.

> *Team formalization (via job descriptions) meaningfully correlates with how a health center team is structured and implemented.*[9] *Health centers with greater degrees of formalization are more likely to have more teams, a greater diversity of team members, and expanded job roles. Most of the health centers with high degrees of formalization report having received [patient-centered medical home] PCMH recognition from a recognized entity.*[9]

HOW to Develop Care Teams Using Formalization and Accountability?

Given the critical role that care teams play in health center performance, it is important to optimize their role and function. A prerequisite to delivering quality care through teams is empanelment. A clear, up-to-date panel is critical for this type of shared responsibility.[10]

CARE TEAM ACTION STEPS:

Care teams play a central and pivotal role in transforming to value-based care and achieving the Quadruple Aim. This Action Guide provides steps health center systems can take to maximize the role of care teams. 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 Workflows.** Reconsider who within the care team completes tasks for each standard. To '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 updated roles within care teams. Include quality improvement.

STEP 5 **Monitor 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 their Role as Active Partners with the Care Team.** Create patient education tool(s) that orient patients to each care team member role, include their own role with self-care.

STEP 1

Define Care Standards. Delivering on the Quadruple Aim requires attention to the clinical and non-clinical drivers that impact health. For instance, has the health center outlined the set of care and services to be delivered to a 50-year old woman or 30-year old male based on evidence and current clinical guidelines? Will care be measured against U.S. Preventive Services Task Force Grade A recommendations? Uniform Data Systems (UDS) measures? Healthcare Effectiveness Data and Information Set (HEDIS)? High levels of clinical performance on measures requires defining care and standardizing systems to consistently deliver agreed upon standards.

Using the 50-year old female example, a health center may establish that care to individuals in this age group includes: blood pressure, weight, body mass index, glucose screening, breast, cervical and colorectal cancer screening, depression screening, tobacco screening, immunizations, and sexual risk screening (which could trigger additional testing for HIV, chlamydia, gonorrhea, syphilis, or other diseases or infections). Other pre-determined screenings or services could include a review of medications and assessment for non-clinical drivers of health.

Clinical staff and leadership should establish the minimum set list of clinical, social, and other services by age group and/or risk stratification, recognizing that some patients may need additional or different care or services based upon individual risk, conditions, social, or other factors. This defined list can then serve as the basis for re-distributing care team tasks.

Action Step: Identify the minimum set of care and services (care standards) to be provided to patients by age and/or risk group (e.g., 0-2 years, 2-17 years, males/females 18-39 years, males/females 40-49 years, males/females 50-64 years; and 65+ years).

STEP 2

Distribute Tasks to Meet Standards and Document Workflows. Once a health center has agreed to a minimum set of care standards for each target group, the tasks necessary to accomplish these standards can be assigned to individual roles across the health center. In much the same way that airline pilots use pre-flight checklists, health care organizations can delineate each step to accomplish a clinical or service task and then delegate each task to a member of the team. Workflows document and assign individual tasks, while acknowledging overall team accountability.

The simple, yet profoundly impactful, step of assigning accountability for the full set of tasks necessary to complete a set of care standards is not typically a part of health care operations. Workflow maps are important tools to visually represent the actions, steps, or tasks needed to achieve a certain result. For a health center, registering patients for appointments, rooming patients, refilling medication, and ordering screening tests are all processes that happen daily. A workflow map breaks down each part of the process and helps everyone understand who is doing what, allowing for better coordination and less duplication. While delegation of tasks provides structure and accountability, all members of the team should generally have the freedom and authority to provide care and services as needed and appropriate, within their scope of practice.

Health centers should avoid automatically assigning tasks to staff who have traditionally performed the work. The goal is to enhance the role of each care team member, focus provider roles on essential tasks, and include other key members of the staff, such as support and administrative staff. Care team optimization provides an opportunity to maximize the professional capacity of non-provider staff, while freeing the provider to focus on diagnosis and treatment. Take this opportunity to assign tasks across team members, where legal and possible.

For example, although a provider's recommendation is the most powerful influencer of a patient's decision to get screened for cancer,[11,12] the task of discussing screening tests and test processes can effectively be completed by support staff using standing orders.[11-13] The provider's role then centers on the clinical recommendation and answering questions not otherwise addressed by other members of the team.

Action Step: Create workflows that document agreed upon processes and assign staff to each task to complete a defined set of standards.

- Adapt the "Team-Based Planning Worksheet" developed by the Safety Net Medical Home Initiative.
- Utilize the capacity and licensure of team members to expand responsibilities beyond the primary provider.
- Consider applying care team tools available through the American Medical Association's STEPSforward initiative.
- Consider the Agency for Healthcare Research and Quality workflow mapping tips.

STEP 3

Update Job Descriptions. It is not enough to determine clinical and care standards, identify the tasks needed to accomplish the standards, and assign those tasks to members of the care team. These responsibilities then need to be hardwired into the expectations of staff. Staff job descriptions need to be updated to include the agreed upon set of tasks for each role. Job descriptions should also reference team accountability as well as individual tasks and patient engagement. Accompanying work processes, such as standing orders or protocols should also be updated, as needed, following changes to job descriptions.

Action Step: Update job descriptions for all members of the care team to fully reflect the set of skills and tasks required for each position. Include patient engagement as a responsibility across all staff.

STEP 4

Train Staff. Health centers improve performance by training staff in required skills and offering ongoing support and advancement. Appropriate training begins in new hire orientation and continues through the professional development of each staff member.

Action Step: Train staff in job skills relevant to job descriptions, including quality improvement. Incorporate necessary training into new hire orientations and offer ongoing professional development to retain staff and support performance.

STEP 5

Monitor Task Performance in Dashboards. 'What gets measured gets improved'. Applying this concept to the newly defined tasks for each job role requires the step of listing tasks for each role into a spreadsheet or dashboard so performance can be measured, monitored, and shared. For instance, a medical assistant dashboard may track performance in completing tasks connected to vitals, colorectal cancer screening, and depression screening. The provider dashboard may track the percent of patients with uncontrolled diabetes (per UDS guidelines) and percent of hypertensive patients who have blood pressure control. A team dashboard could also monitor performance on a series of measures that relate to the Quadruple Aim for a panel of patients.

Once the dashboard is used to measure and track progress, it will be important to regularly (e.g., monthly) share dashboard data on individual and team performance. Individual level data can be shared in care team meetings as well as meetings by job role (e.g., provider or nursing meetings). Individuals and teams with lower levels of performance should be offered appropriate training and support. Systems of formalization and accountability must be established within a supportive structure. See the Leadership Action Guide for information on training structure with 'psychological safety'.

Action Step: Summarize job tasks for each role into a performance dashboard.

STEP 6

Hardwire Accountability into Personnel Systems and Performance Reviews. Health centers should monitor staff performance (using individual and team dashboards) on an ongoing basis and incorporate overall progress in formal annual performance reviews.

Action Step: Update the organization's employee performance review process to measure against new job expectations and overall organizational goals.

STEP 7

Educate Patients on their Role as Active Partners in Care Team. Providers' job responsibilities should include introducing patients to the broad role of the care team and reinforcing its importance. This includes addressing the fact that care team members, including the MA and RN, are highly skilled and trained professionals that can discuss screenings, perform tests, offer education, and provide other services. Tools such as fact sheets, letters, care team business cards, and other materials, may be used to help communicate the care team's role in patient care. Consider ways to visually distinguish and personalize care teams for patients (e.g., colors or graphics).

Action Step: Create patient education tools that orient patients to updated care team member roles. Create or access patient education resources to help patients understand their own role within the care team and improve their skills. self-care and making treatment decisions. See Patient Engagement Action Guide.

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