NATIONAL ASSOCIATION OF Community Health Centers®

elevate

Applying the VTF to Your Work

Optimizing Care Teams
&
Leveraging Elevate to Train, Learn, Master, Prepare….Upskill

April 11, 2023

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.

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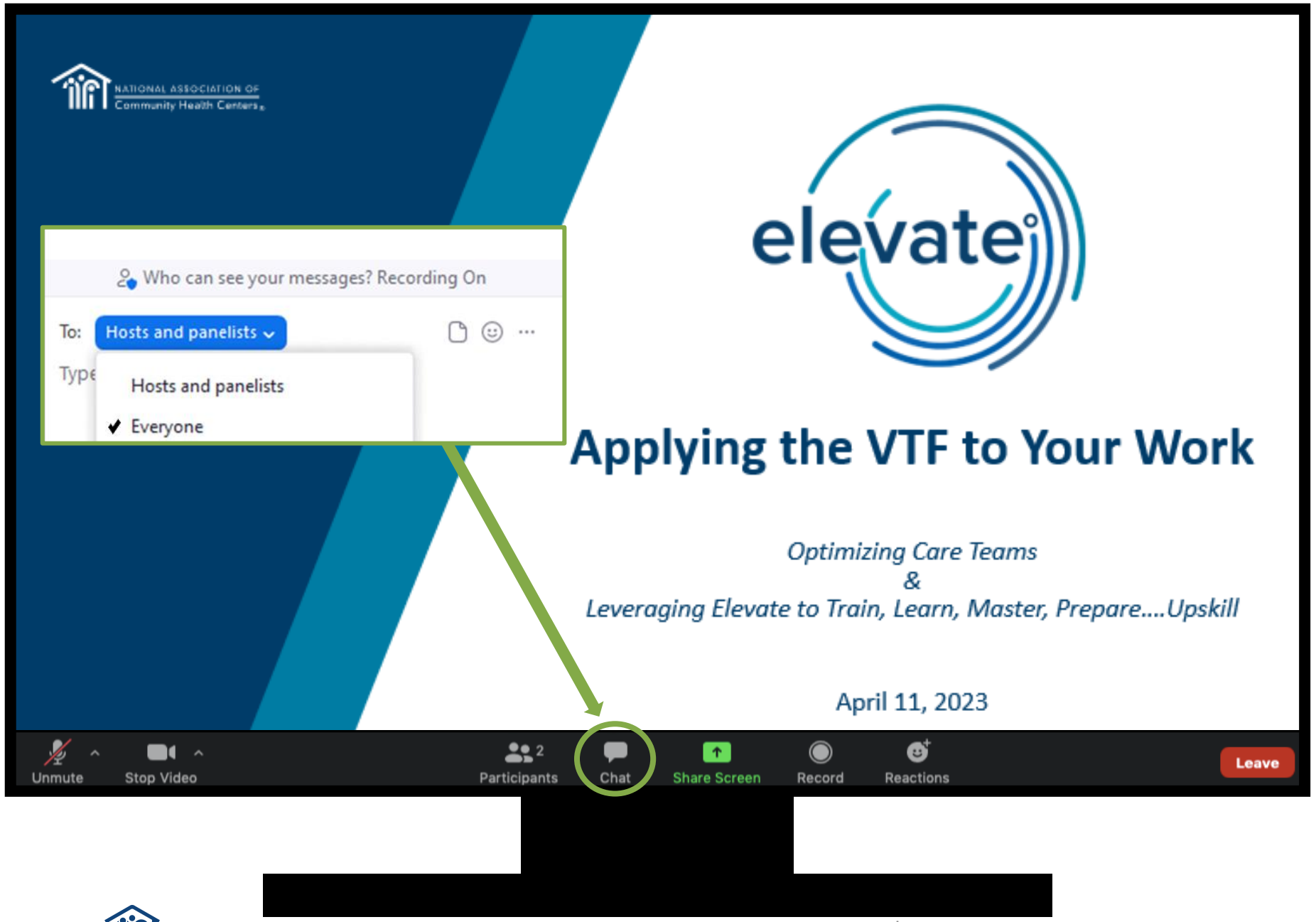

During today's session:

- **Questions:** Throughout the webinar, type your questions in the chat feature. Be sure to select "Everyone"! There will be Q&A and discussion at the end.
- **Resources:** If you have a tool or resource to share, let us know in the chat!

Packaging and implementing evidence-based transformational strategies for safety-net providers

Bringing science, knowledge, and innovation to practice

Cheryl Modica

Director, Quality Center

Cassie Lindholm

Deputy Director, Quality Center

Holly Nicholson

Manager, Instructional Design & Learning

Addison Gwinner

Specialist, Quality Center

Agenda:

- **Value Transformation Framework**
  - Organize Transformation Efforts Using the VTF
  - Leverage Elevate to Train, Learn, Master, Prepare…Upskill
  - Continue VTF Systems Approach: Care Teams, Care Model, Improvement Strategy, & Workforce
- **Optimizing Care Teams**
  - Optimizing Care Teams
  - CHCACT Case Study: A Systematic Approach to Optimizing Care Team Roles & Responsibilities
- **Elevate 2023**
  - Health Center Elevate Pathway
  - Elevate *'University'* Offerings and Tracks
  - Use the VTF Assessment 2.0 to Drive Transformation

Value Transformation Framework

The Value Transformation Framework (VTF) is ***an organizing framework*** to guide health center systems change

- ***Supports change*** in many parts of the health center simultaneously
- ***Organizes and distills evidence-based interventions*** for discrete parts of the systems called 'Change Areas'
- ***Incorporates evidence, knowledge, tools and resources*** relevant for action within different parts of the system, or Change Areas
- ***Links health center performance to the Quintuple Aim***

Opportunities to Expand Care Team Skills

National Learning Forum:
Guided application of the VTF

Register
https://bit.ly/2023Elevate

Assess https://reglantern.com/vtf
Ideally 3+ staff complete the VTF Assessment

Unlock Workforce Upskill Opportunities!

Engage: Monthly Forum & Supplemental Sessions
registered participants

Access: Online Resources
https://nachc.docebosaas.com/learn/signin

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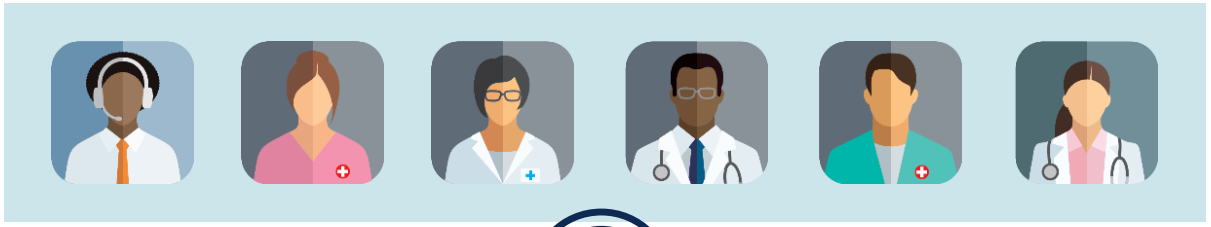
Elevate *'University'* Tracks

Content tailored to health center *roles*

Care Management
Outreach & Enrollment
Community Health Workers
Quality Improvement
Leadership & Staff (Value-Based Care)



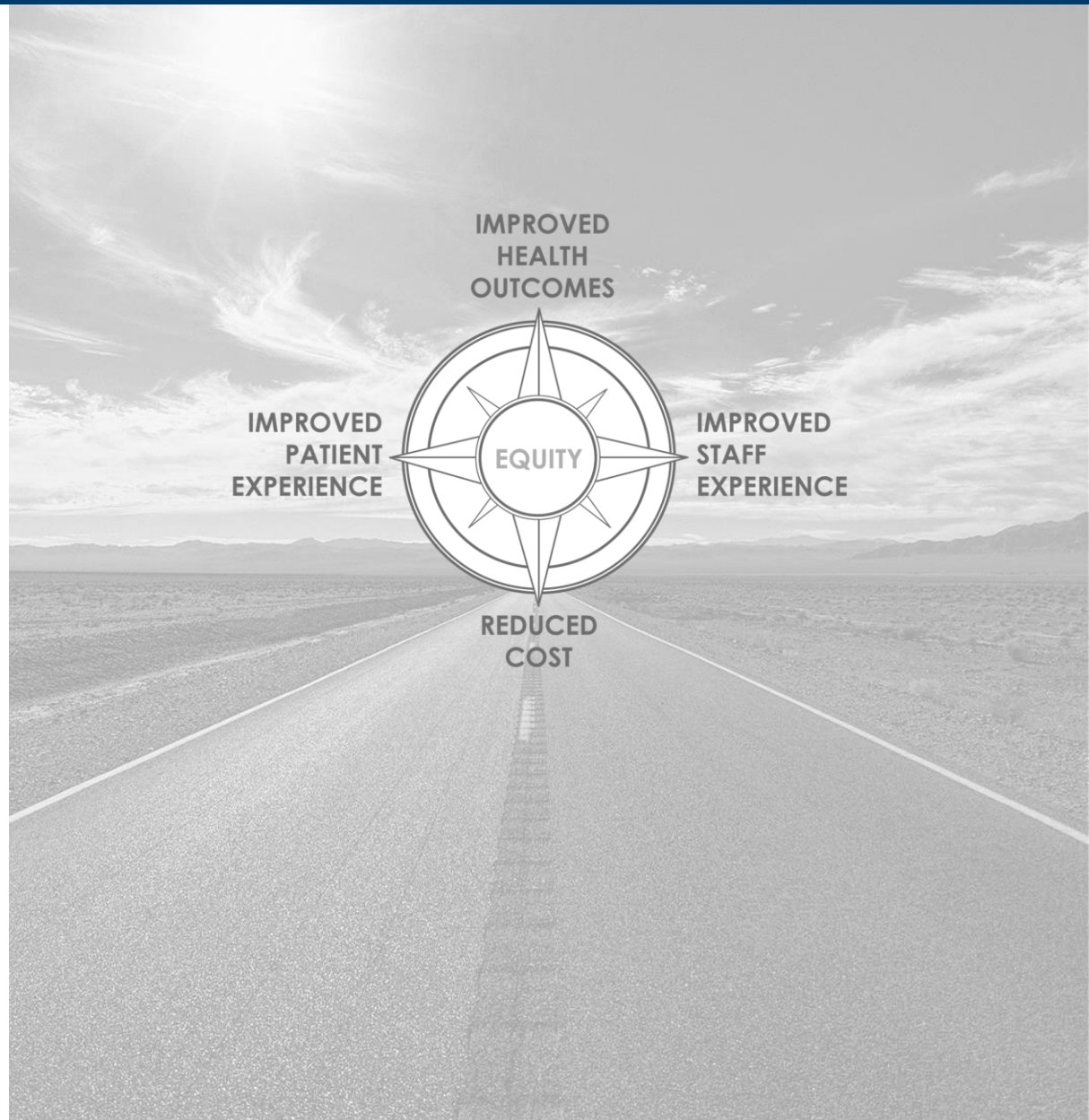
Unlock Workforce Upskill Opportunities by completing VTF Assessment!
https://reglantern.com/vtf

Content tailored to health center *transformation readiness*

Elevate 2023: Year-at-a-Glance

The VTF's systems approach weaves discussion of all 15 Change Areas continuously throughout the year

- Leadership
- Cost
- Population Health
- Care Teams
- Workforce
- Care Management
- Payment
- Policy
- Evidence-Based Care
- Improvement Strategy
- Patient-Centered Medical Home
- Social Drivers of Health (SDOH)
- Health Information Technology
- Patients
- Partnerships



Optimizing Care Teams

WHAT is an optimized care team?

Care Teams

Workforce

Leverage a trained and fully engaged staff to successfully address the health center's mission and goals, with optimal joy in work.

Care Models

Design care models based on patient risk level to enable patients to be paired with more appropriate care team members and services.

Improvement Strategy

Define vision, goals, and action steps that drive transformation and improved performance.

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

Care teams and the tasks that team members are assigned are developed, based on the needs of the patient population (care models) and the availability of personnel, services, and other resources.

WHAT is an optimized care team?

Care Teams

Workforce

Leverage a trained and fully engaged staff to successfully address the health center's mission and goals, with optimal joy in work.

Workforce development: Programs, learning opportunities, and other efforts that allow employees to improve their skills and advance in their career.

Leverage Elevate content tailored to health center roles:

- ✓ Care Management
- ✓ Outreach & Enrollment
- ✓ Community Health Workers

...and more!

WHAT is an optimized care team?

Care Teams

Care Models

Design care models based on patient risk level to enable patients to be paired with more appropriate care team members and services.

Low Risk	*Focus is keeping patients engaged in the health care system without use of unnecessary services.*
Rising Risk	*Focus is on managing risk factors more than disease conditions.*
High Risk	*Requires structured care management and one-on-one support.*
Highly Complex	*Requires intensive, pro-active care management.*

WHAT is an optimized care team?

Care Teams

Improvement Strategy

Define vision, goals, and action steps that drive transformation and improved performance.

	Planning	Improvement	Control	Assurance
Focus	• Strategic planning • Set priorities, goals, and measures • Establish structures & processes	• Operationalize the strategy • Test ideas • Scale improvements	• Measure, monitor, & maintain improvement • Adjust, as needed, to improve performance	Checking performance against external standards
Timeframe	Regular, recurring (e.g., annually)	Over time Often small, rapid bursts	Daily work	Scheduled; often driven by external entities
Tools	• Goals • Leadership endorsement • Job descriptions/roles • Measures • Improvement model selection	• Improvement Model (PDSA, Lean, Six Sigma, etc.) • Tools (flow charts, pareto charts, A3, etc.) • Project Charters	• Visual management to display and track measures • Team huddles • Escalation processes	Audit, inspection, gap analysis

WHAT is an optimized care team?

Care Teams

Workforce

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WHY optimize care teams?

Transitioning to value-based care requires a shift in the way care is delivered:

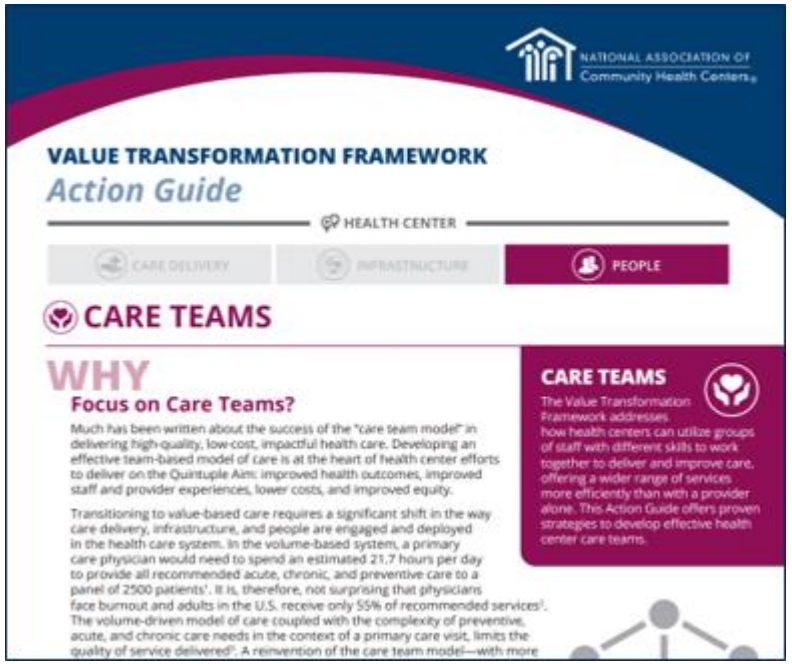
- Increase capacity for the number of patients served
- *'Share the Care'*[+] - provide care as a team with varying staff roles providing care to a panel of patients together
- Reallocate tasks and responsibilities so all team members contribute meaningfully and to full capacity
- Leverage opportunities to capture revenue outside of PPS

... All while balancing staffing challenges and limited resources!

Optimizing care teams has been demonstrated to improve the experience and outcomes of primary care for patients, providers, and staff.

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

HOW do health centers optimize care teams?



[NACHC Care Teams Action Guide]

STEP 1 Define care standards

STEP 2 Distribute tasks to meet standards and document workflow

STEP 3 Update job descriptions

STEP 4 Train staff

STEP 5 Monitor task performance in dashboards

STEP 6 Hardwire accountability into personnel systems and performance reviews

STEP 7 Educate patients on redesigned care team

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Case Study

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A Systematic Approach to Optimizing Care Team Roles & Responsibilities

Objectives

- Illustrate use of a tool for supporting QA/QI efforts
- Understand the process of applying a swimlane to care teams
- Recognize how to apply a Care Team swimlane

Who We Are & What We Do

Heather Adams
Director of Training & Education

Colleen Rankine
VP, Operations

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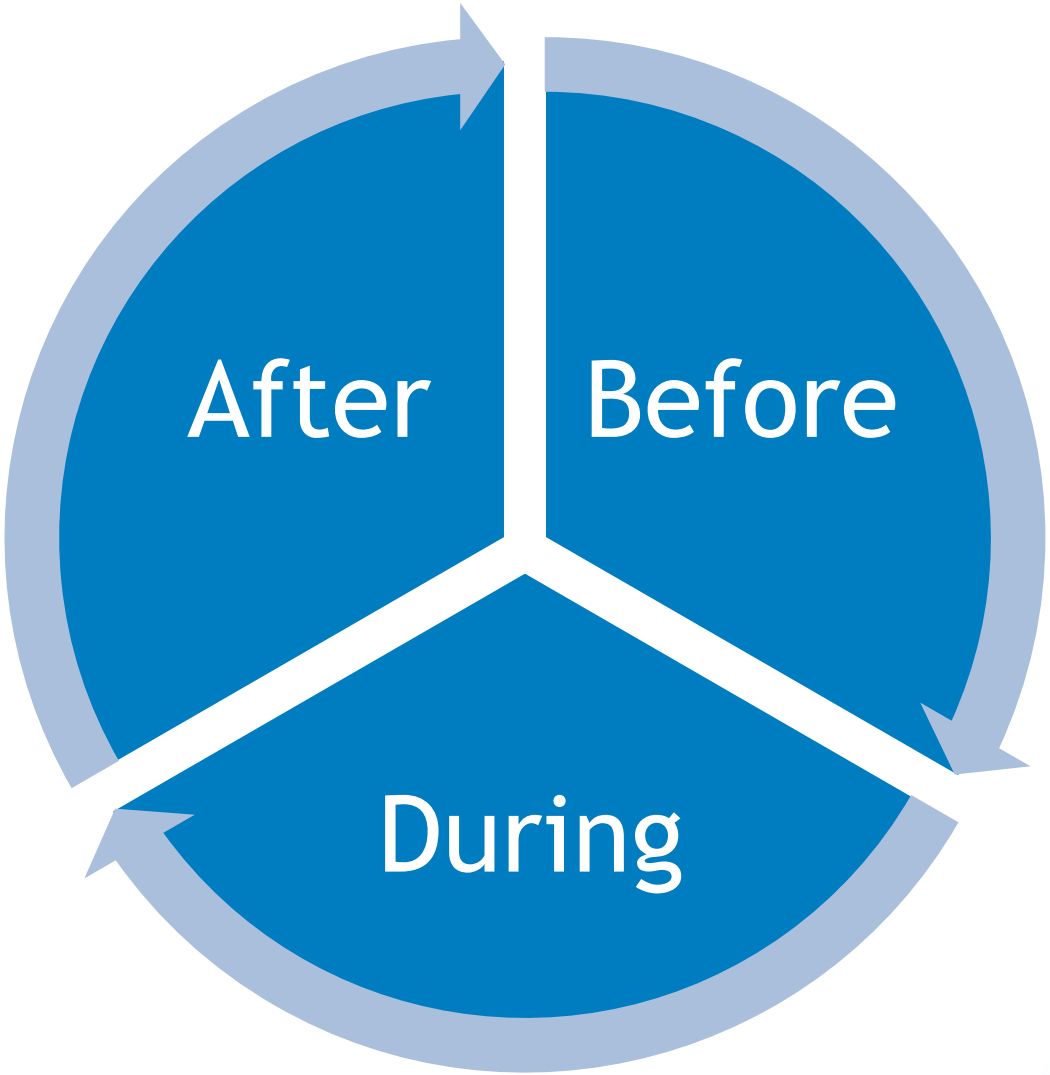
What is a Swimlane

- Supports systematic change
- Outlines who does what in a process; owned by the participants
- Empowers team by showing opportunities for change
- Engages participants doing the work in making the changes


After
Before
During


Before

Define Optimization Reasons

- Reduce duplication of tasks
- Improve patient experience
- Improve staff experience
- Improve visit cycle times
- Improve clinical measures (immunizations, screenings, etc.)
- Visit type

Create Interest

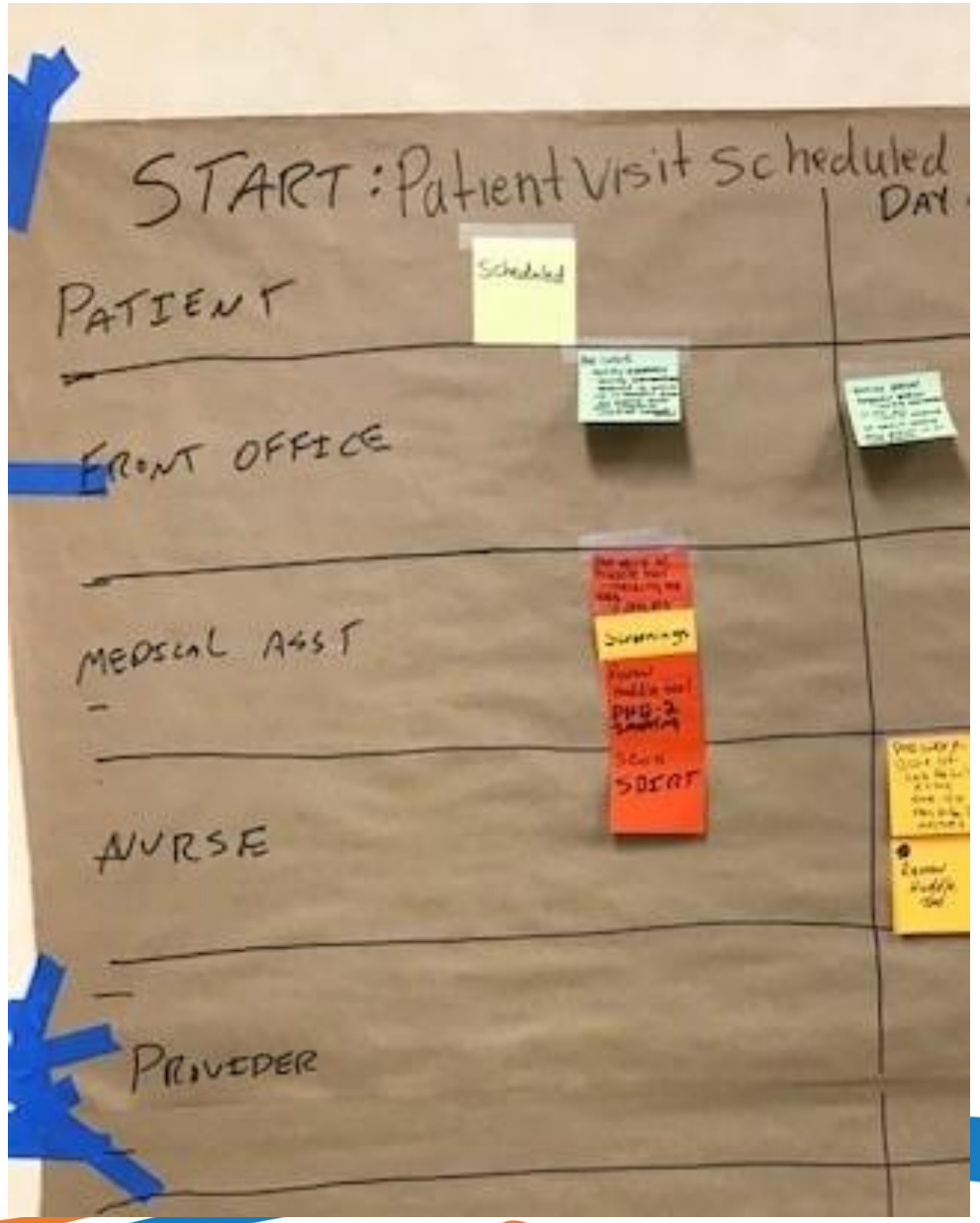
Leadership

Core Care Team roles

Extended care team role

Define Core Care Team

- Providers
- Medical Assistant
- Nurse*



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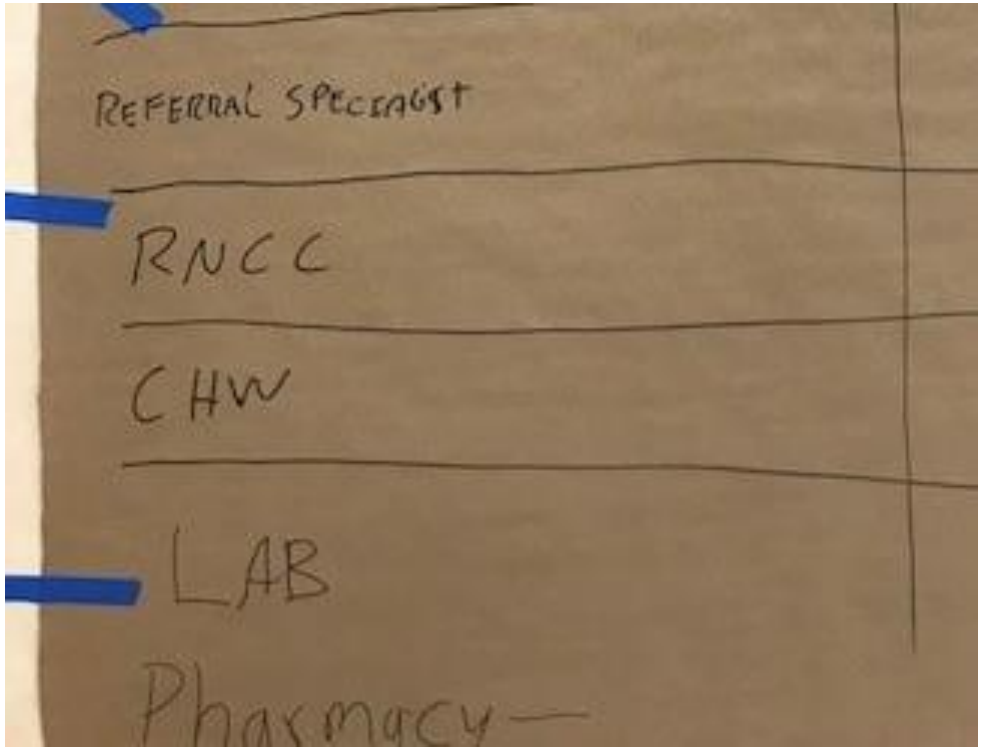
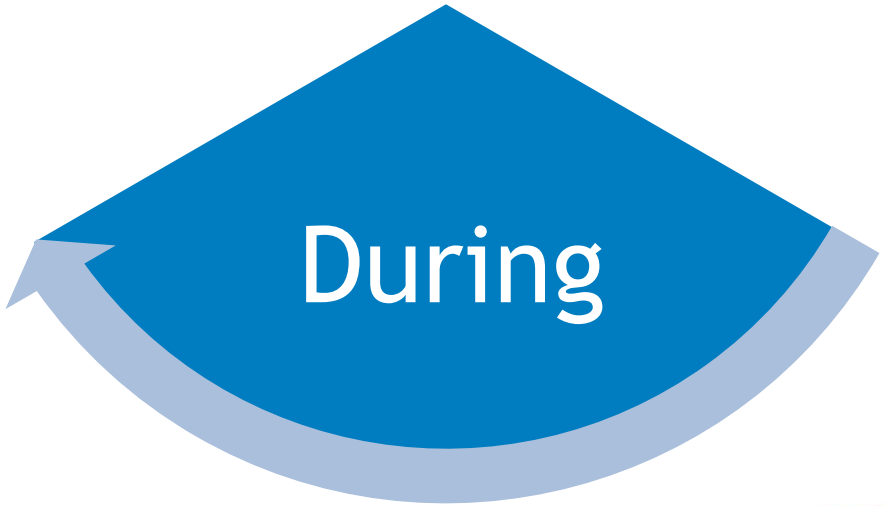
Define Extended Care team



- Nurse*
- Behavioral Health Consultant/staff
- Dental
- Front-desk/Check-in
- Call-center
- Care Coordinator/CHW
- Pharmacy staff


During

Define the Current State

- Determine “type of visit”
- Define the “Start” and “End’ of the visit
- Determine the care team participants to invite
- Request participants create a list the tasks they complete
  - Distribute “Team Based Care Planning Worksheet”

Team Planning

Assigning responsibilities and timing of tasks is important as the care team takes shape and becomes more sophisticated. Additionally, the team benefits if everyone knows what the rest of the team are doing.
Use this spreadsheet to define who accepts responsibility for or performs certain tasks. This may be a starting point to start thinking about who else can perform a task. For each current and future role, there is a drop-down box that includes commonly occurring team roles. WHEN IN VISIT CYCLE also has drop-downs for your convenience. If a choice does not match the reality of your clinic and care team, you can type in a role or time during the visit cycle.
If you develop improvements or have issues with this worksheet, don't hesitate to contact Trudy Bearden at trudyb@qualishealth.org

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			
Print summary lists (meds, dx, allergy); give to patient to review	MA			
Verify and update missing preventive / chronic care services	Provider			
Track and follow up on lab & imaging results	LPN			
Notify patient of normal results	Front Office			
Notify patient of abnormal results	Pharmacist			
Track and follow up on completion of referral visits, tests & procedures				
Receive/review reports or other communications from facilities				

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Role of the Facilitator

https://www.merriam-webster.com/dictionary/facilitator

Tips for Successful Session

Review the submissions

Date & time: 90-min time frame

Location: Long flat wall, free from interruptions

Food and beverage

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Facilitating the First Session

- Senior Leadership/ C-Suite Support
- Goals & Objectives
- Establish the “garden plot”
- Document one task per sticky note
- Place the tasks by role in the order they take place
- Make note of duplicative

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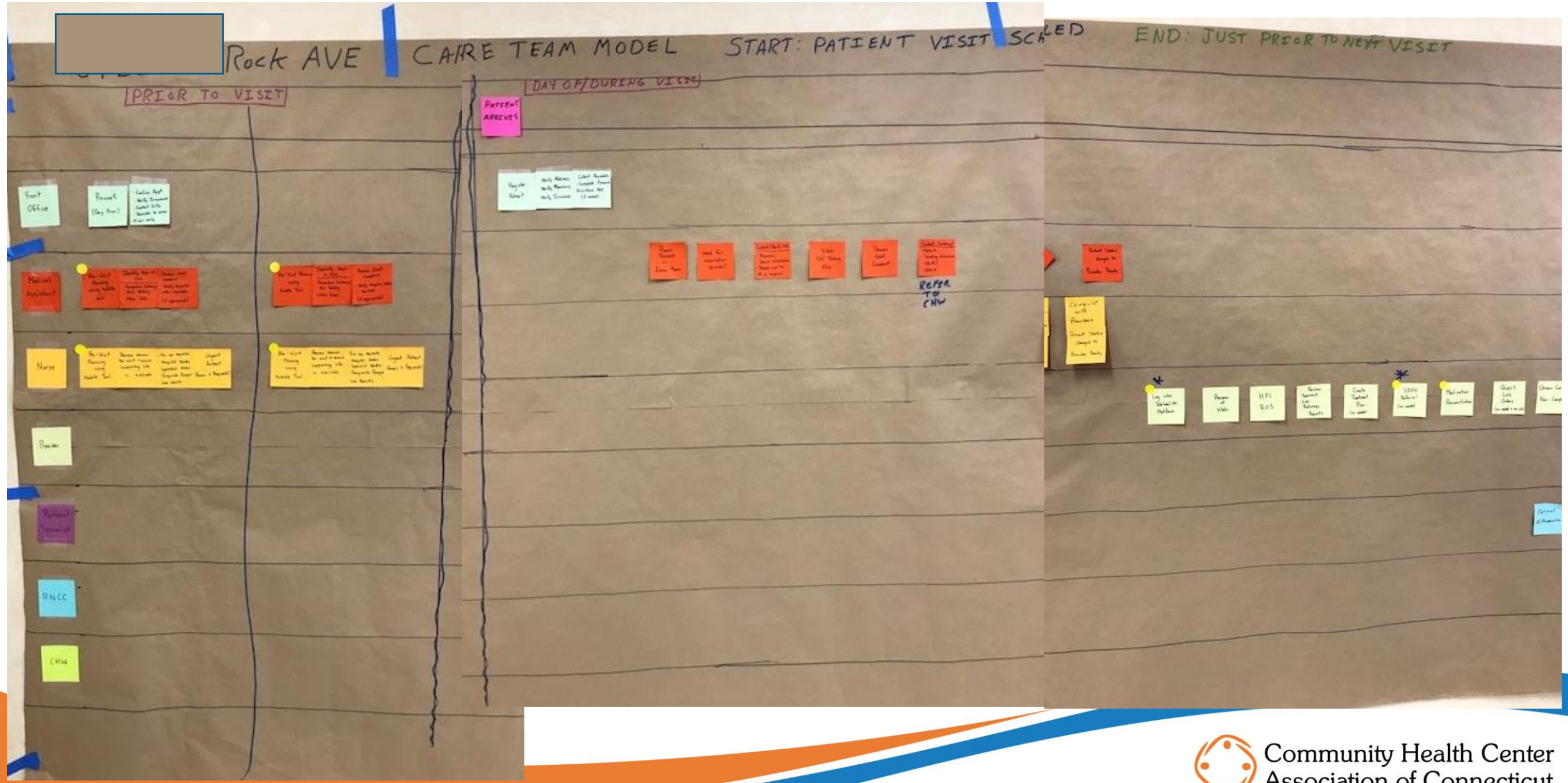
Facilitator Points

- Who “owns” a task
- Common tasks vs occasional tasks
- Reminders of sharing tasks associated to a specific type of visit
- Seek agreement/consensus on the “Current State” of tasks
- Seek agreement/consensus on “Start and Finish of the visit



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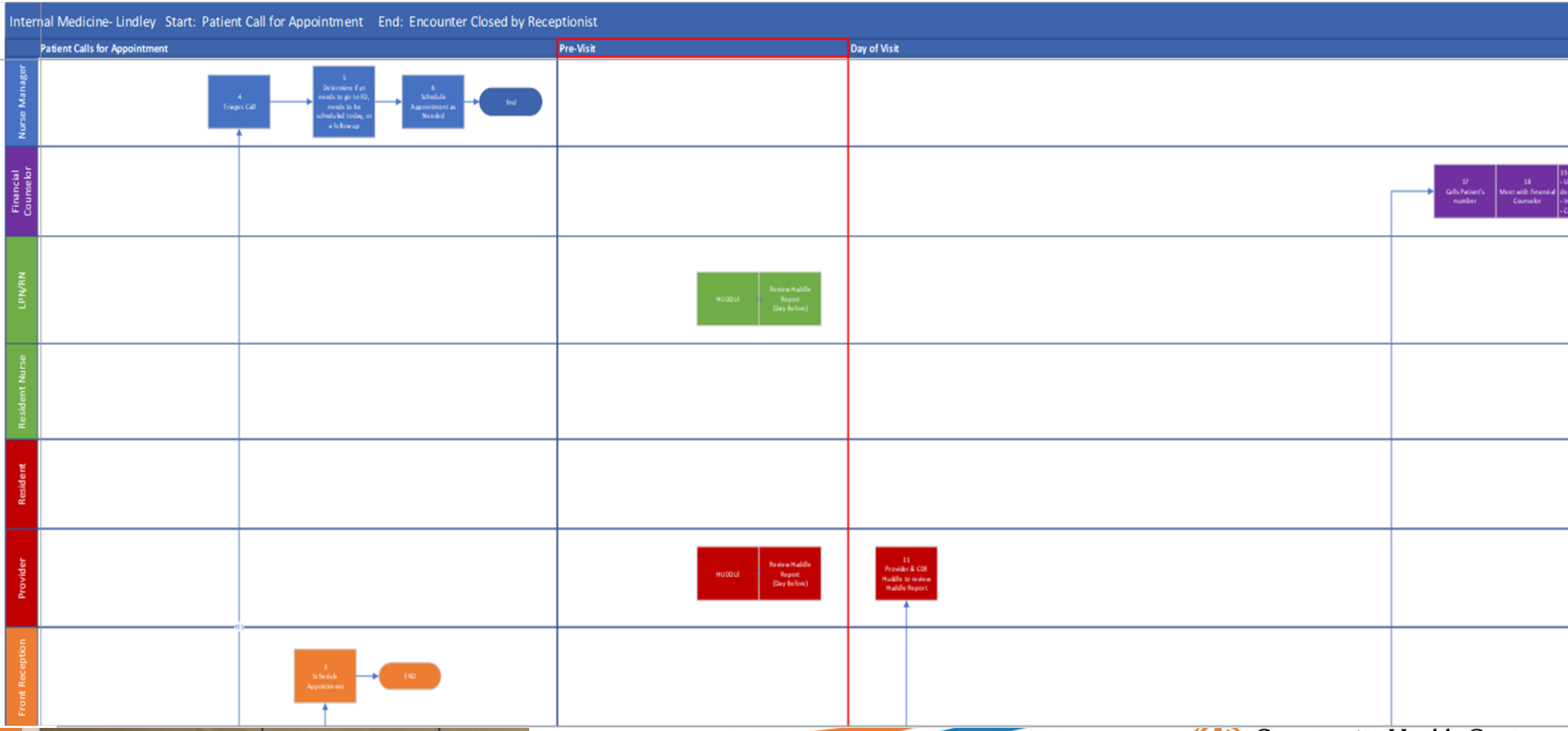
After

Go to Gemba



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Facilitate the Future State Session

- Bring same care Team members back together
- Review the current state swimlane
- Discuss how it can be improved
  - Refer to tasks identified as an opportunity for improvement
  - Garden plot items

Tips for Success

- Document recommendations for improvement
- Share the recommendations for improvements
- Start with small changes
- A combination of QA and QI

Health Center Experience

- Implemented huddles
- Interdisciplinary team meetings for patients at high-risk
- Clarification of external specialty referral process
- Role clarification
- SDOH screening improvement
- Care coordination role & responsibilities

Discussion

2023 Elevate Calls

SAVE THE DATES!

Monthly Forums: 2nd Tuesday of the month, 1-2 pm ET

January 10th

February 14th

March 14th

April 11th

May 9th

June 13th

July 11th

August: Summer break, no Elevate call this month

September 12th

October 10th

November 14th

December 12th: Year in Review

Supplemental Sessions

Outreach & Enrollment Learning Community
6-part series, March – June (filled)

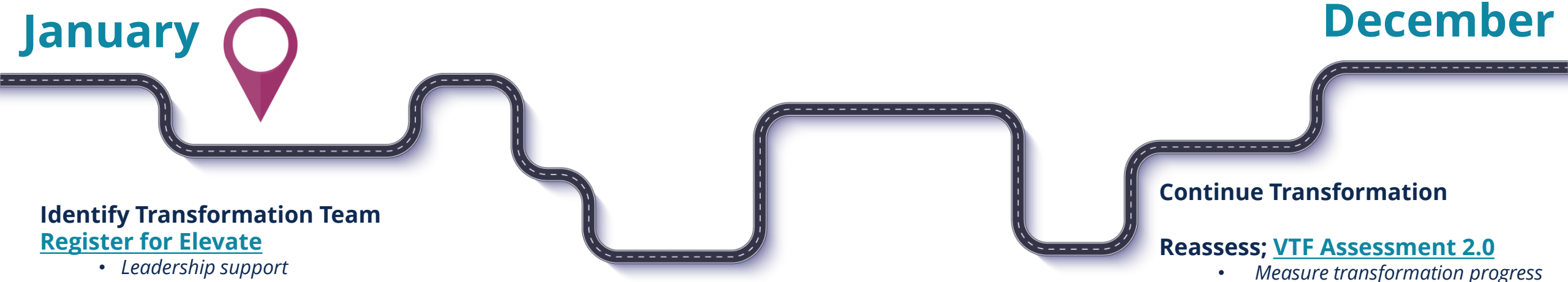
National Diabetes Prevention Program & NACHC's Healthy Together Project
April 6th, 12-1 pm ET. Access recording (here)

Brain Health
3- part series: May 3rd, 17th, 31st, 1-2 pm ET. **Register** here

Coming soon...opportunities around care management, Community Health Workers, value-based care and more!

Elevate 2023: Health Center Pathway

January



Identify Transformation Team
Register for Elevate

- *Leadership support*
- *Interdisciplinary (QI, clinical, finance, HIT)*
- *Care team member engagement*

Complete the VTF Assessment 2.0

- *Assess progress on transformation continuum*
- *Identify areas for focused improvement*

Set Goals Based on VTF Assessment Results
Incorporate into Health Center QI Plan

- *Which Change Areas are most in need of improvement?*
- *Opportunities to leverage other health center initiatives?*

Leverage the VTF

- *Organize transformation efforts using VTF*

Access Elevate Resources

- *Attend monthly Elevate learning forums*
- *Attend Supplemental sessions*
- *Participate in Upskill opportunities*
- *Apply evidence-based Action Guides*
- *Access eLearning modules & microlearnings*
- *Engage with peers nationally*

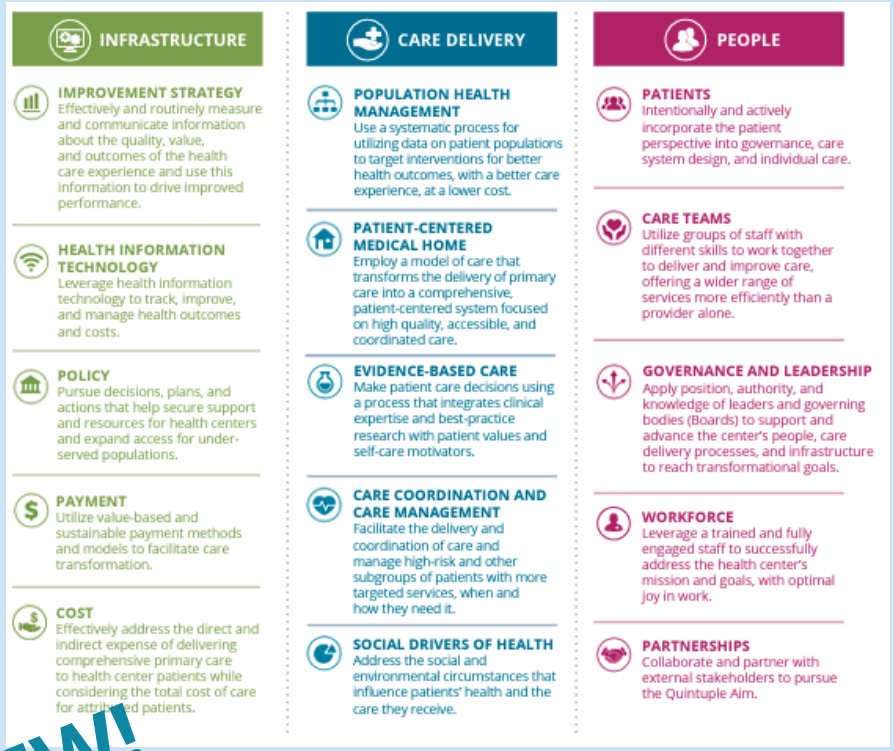
December

Continue Transformation

Reassess; VTF Assessment 2.0

- *Measure transformation progress*
- *Identify areas for focused improvement*

VTF Assessment: Use To Drive Transformation



INFRASTRUCTURE

IMPROVEMENT STRATEGY
Effectively and routinely measure and communicate information about the quality, value, and outcomes of the health care experience and use this information to drive improved performance.

HEALTH INFORMATION TECHNOLOGY
Leverage health information technology to track, improve, and manage health outcomes and costs.

POLICY
Pursue decisions, plans, and actions that help secure support and resources for health centers and expand access for under-served populations.

PAYMENT
Utilize value-based and sustainable payment methods and models to facilitate care transformation.

COST
Effectively address the direct and indirect expense of delivering comprehensive primary care to health center patients while considering the total cost of care for attributed patients.

CARE DELIVERY

POPULATION HEALTH MANAGEMENT
Use a systematic process for utilizing data on patient populations to target interventions for better health outcomes, with a better care experience, at a lower cost.

PATIENT-CENTERED MEDICAL HOME
Employ a model of care that transforms the delivery of primary care into a comprehensive, patient-centered system focused on high quality, accessible, and coordinated care.

EVIDENCE-BASED CARE
Make patient care decisions using a process that integrates clinical expertise and best-practice research with patient values and self-care motivators.

CARE COORDINATION AND CARE MANAGEMENT
Facilitate the delivery and coordination of care and manage high-risk and other subgroups of patients with more targeted services, when and how they need it.

SOCIAL DRIVERS OF HEALTH
Address the social and environmental circumstances that influence patients' health and the care they receive.

PEOPLE

PATIENTS
Intentionally and actively incorporate the patient perspective into governance, care system design, and individual care.

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

GOVERNANCE AND LEADERSHIP
Apply position, authority, and knowledge of leaders and governing bodies (Boards) to support and advance the center's people, care delivery processes, and infrastructure to reach transformational goals.

WORKFORCE
Leverage a trained and fully engaged staff to successfully address the health center's mission and goals, with optimal joy in work.

PARTNERSHIPS
Collaborate and partner with external stakeholders to pursue the Quintuple Aim.

NEW!

VTF Assessment 2.0

- ✓ Still only 15 questions – 1 for each Change Area
- ✓ Refreshed to reflect current state of value-based care

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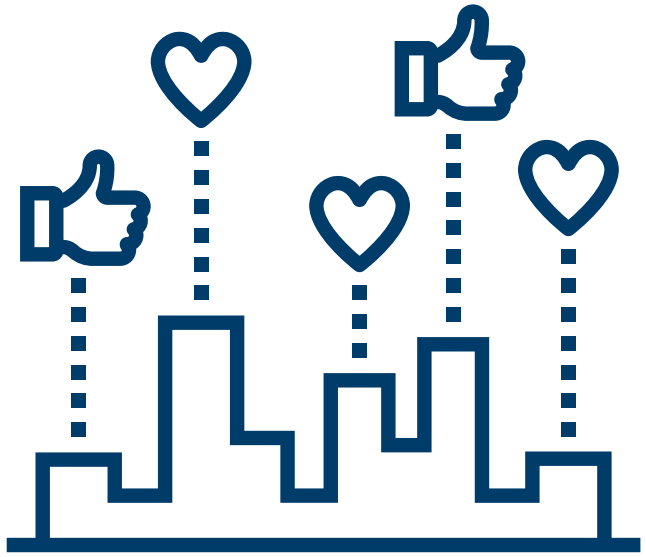
- ✓ Assess organizational progress in 15 areas of systems change important to value transformation.
- ✓ Recommended that 3 or more health center staff complete the assessment to get a balanced perspective of organizational progress in areas of systems change



Provide Us Feedback

FOR MORE INFORMATION CONTACT:

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SHARE YOUR FEEDBACK

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

Next Monthly Forum Call:

May 9, 2023
1:00 – 2:00 pm ET

NATIONAL ASSOCIATION OF Community Health Centers®

elevate°

Together, our voices elevate° all.

The Quality Center Team

Cheryl Modica, Cassie Lindholm, Holly Nicholson, & Addison Gwinner

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