

CIN Partners Share:

The Engine for Excellent Care: New Directions for Primary Care Teams

Team-based care is an essential ingredient in achieving the Quadruple Aim: improved population health, improved patient experience, improved provider and staff experience, and reduced cost. Evaluators have cited team-based care as the most promising strategy for improving primary care, but also one of the most challenging changes associated with practice transformation.

The partner organizations of the California Improvement Network (CIN) met in May 2016 to reflect on the continued evolution of team-based care. Participants and invited presenters shared how they are changing the composition and the work of care teams to meet new challenges (such as better tailoring care for patient populations with different needs) and to capitalize on new opportunities (such as virtual care and changing payment models). The meeting included presentations from Los Angeles County's Care Connections Program, Permanente Medical Group of Southern California, Health Management Associates, and Tiburcio Vasquez Health Center.

Background

Building Effective Care Teams

According to researchers, highly effective care teams have five attributes:

1. Shared sense of purpose and responsibility to a defined patient panel
2. Stable team structure that is recognizable to patients
3. Good communication, including daily huddles and ground rules
4. Organization, with defined workflows and standing orders
5. Confidence and trust among team members (a result of role clarity), effective orientation for new staff, and ongoing training and performance management

Partners shared their perspectives on what it takes to develop and maintain strong care teams. The list includes effective hiring practices, cross-training of team staff across roles, alignment across the organization from senior leaders to frontline staff, a clear focus on accountability and resources at the team level, and facility space to meet and work as a team.

Partners agreed that the biggest unmet need in care team evolution was an organized approach to training. They discussed the importance of developing a standard role for support staff and providing training on these responsibilities, instead of relying on the providers to train staff individually to each provider's practice style.

The Institute for High Quality Care, the meeting's host, shared examples of the effective practices of high-performing care teams:

- Colorado's **Clinica Family Health Services** went through a 15-year process of continual redesign, which resulted in patients embracing care from a team instead of from a single provider, innovative visit types including long-running group visits and nurse co-visits, and renovation of the clinic to create team workspace pods.

Main Takeaway:
High-performing primary care teams provide comprehensive care for more patients than ever before, seeing patients in their homes and communities. The flexibility provided by payment reform and new technologies can support the work of these teams.

- **LifeLong Medical Care**, with locations throughout the East Bay, instituted an eight-week program of formal discussions within care teams, called Getting to the Heart, during which teams develop and commit to specific work roles and responsibilities.
- **Kaiser Permanente's** Proactive Office Encounter model fosters smooth teamwork and visit efficiency, including the shared expectation by team members to have the room, the patient, and the data ready simultaneously, so that each provider visit starts on time and runs smoothly.
- The design of Oakland's **Asian Health Services** Rolland and Kathryn Lowe Medical Center facility supports its model of team care, as featured in the April 2016 *Partner Meeting Report*.

From the Field

Paraprofessionals on the Team at Los Angeles County's Care Connections Program <http://dhs.lacounty.gov/wps/portal/dhs>

Clemens Hong, MD, MPH, is a primary care physician and a health services researcher who serves as the medical director for community health improvement in Community Health and Integrated Programs of the Los Angeles County Department of Health Services.

Los Angeles County's Care Connections Program (CCP) relies on paraprofessional community health workers (CHWs) to meet the needs of patients who are at high risk for continued frequent use of services. These patients have complex biopsychosocial needs and use services frequently, and many have been difficult to engage in regular primary care services. They represent the highest 5% of patients based on scores used by the county delivery system to predict risk for high utilization and high cost of future care.

Customization of Care to Meet Patient Needs

The CCP was developed based on an analysis of the needs of high-risk patients. Expectations for the duration of intensive services for the population were developed:

- Approximately 10% of patients are expected to stay in the program long-term, based on their ongoing needs.
- Approximately 50% are expected to graduate within three to six months.
- The remaining 40% are expected to rotate in and out of active CCP services, based on their individual episodic needs.

In the CCP, CHWs are responsible for patient engagement and care navigation. They are members of a primary care-based team, including a primary care clinician and a nurse care manager, and are supported by a care management team, including a behavioral health-trained social worker who supervises the CHWs, and a CCP medical director working across Los Angeles County who practices within a "complex care management hub." The hub adds capacity and expertise to the existing primary care team (see Figure 1, p. 3).

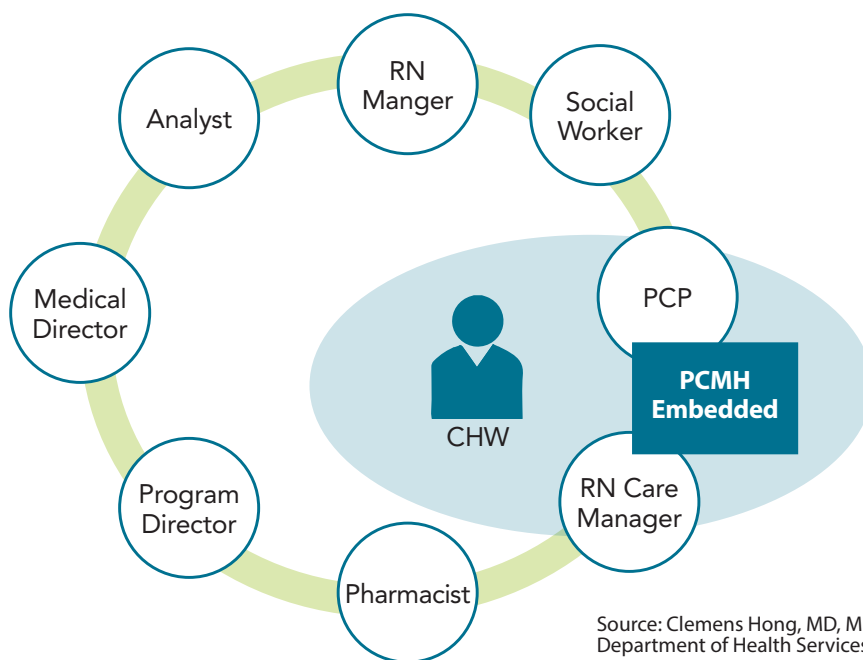
The CCP team developed workflows with clear roles for each team member, outlining specific protocols for events such as a hospital discharge or a patient transition from jail to the community. Through in-person meetings, phone calls, and text messages, CHWs provide social support to patients, help them navigate the health and social service delivery systems, and also help patients prepare for provider visits, attend visits with them, and help them complete follow-up care activities.

"The most important question we can ask is, 'How can we make the experience better for the patient?'"

—Clemens Hong, MD, MPH

CHWs provide a level of support beyond that of a clinician. "CHWs sometimes respond to five or six texts a day," shared Hong. In these frequent interactions, CHWs' shared life experience with their patients can be critically important — most CHWs live in the communities they serve and come from low-income families, just like many of their patients.

Figure 1. Care Connections Team



Source: Clemens Hong, MD, MPH, Los Angeles County Department of Health Services

Recruiting and Training Community Health Workers

To recruit the new CHW workforce, CCP leaders worked with community partners such as social service agencies and community-based organizations who referred people with the attributes needed in the workforce, including good facilitation skills and personal warmth. CHW staff participate in the interview process, which includes role plays, workshops, and immediate feedback on performance to assess their comfort with this level of evaluation. New CHWs are trained on a long list of skills and practices, starting with motivational interviewing.

Training and support are provided to the CHWs and to their supervisors. Primary care providers and nurse care managers, many of whom are initially unsure of how to work with the CHWs, are also trained. Part of the provider education includes CHW-led patient case conferences, which highlight the value of CHWs in providing high-quality care for patients with complex needs.

The CCP currently employs 25 CHWs and will soon expand to 50. The organization hopes to maintain and increase the support needed to grow the program over the next several years to serve the top 5% of high-risk patients seen in county-run primary care clinics, a population of about 20,000. County supervisors approved funding for the CCP, in part because the program serves as a workforce initiative for low-income and/or formerly incarcerated people who are difficult to employ.

Virtual Care at Permanente Medical Group of Southern California

<http://scpmgphysiciancareers.com>

Khang Nguyen, MD, is a family medicine physician and the regional call center physician leader for the Southern California Permanente Medical Group’s seven call center sites.

The Permanente Medical Group of Southern California includes 7,000 doctors and covers a large geographic region that extends from Bakersfield and Los Angeles County south to San Diego. As part of the group’s work to support patients and providers in effective and convenient clinical interactions, the medical group is using email communication, telephone provider appointments, and other alternatives to traditional face-to-face provider visits.

Email Communication with Care Teams

When the medical group began offering email communication with its providers in 2009, practices chose whether to allow patients to contact providers directly or to route messages through a care team member. Kaiser found that the team approach to email is more effective and efficient, so they now use that model across the region.

The team approach to email works like this: Patients email their primary care provider. The message is first reviewed by a member of the provider's care team. Care team staff, usually nurses, handle nonclinical needs such as scheduling visits, medication refills, and follow-up information from a lab test. Clinical concerns are passed to the provider to respond. With this process, patients receive a speedy response to most messages, and providers are not faced with email requests better handled by non-provider staff, like driving directions or a provider's office hours.

Kaiser found that email does not reduce or replace face-to-face visits. In Southern California, encounters per patient stayed consistent at 3.5 visits per year (both primary and specialty care visits) as email volume increased. Email, then, increases access to the care team as an added channel for communication.

The greatest impact of email has been on the patient experience. "Patients loved it. Email was a huge customer service benefit, a connectivity benefit," said Nguyen. Email messaging allows providers to monitor care between in-person visits.

Phone Appointments

Kaiser has offered provider appointments over the phone since 2013. In Southern California, 14% of provider appointments are currently by phone. In Northern California, phone appointments have been available for longer and compose 25% of visits. In Southern California, some patients reported that they perceive an offer of a phone visit as a denial of access to a face-to-face provider visit. Yet most patients who try phone appointments see their value and continue to use them.

Phone appointments are available for two types of encounters: a "continuity care" appointment with a patient's primary provider, and a "new-problem visit" for an emergent issue with a dedicated phone provider. Pilot projects are underway to study both of these phone appointment types.

In the appointment schedule, two phone appointments take the place of one 20-minute in-person appointment, increasing the visit supply per day. New-problem visits are scheduled by the call center and are available 24 hours a day. These visits allow flexibility in scheduling these providers and allow round-the-clock access for patients. The current schedule for these providers during this pilot phase consists of 20 visits per half-day.

The most common reasons for phone visits of both types include upper respiratory infection, sinusitis, urinary tract infection, and lab test follow-up consultations. The show rate, or completion rate, for phone appointments is very high, with less than 2% of patients failing to answer the provider's call. Patients are asked to be available 30 minutes before and 30 minutes after the phone appointment time.

Kaiser has found that 20% of phone appointments conclude with the scheduling of an in-person appointment, which is less than for email encounters and more than the 10%-12% of in-person encounters that result in scheduling of another in-person encounter.

Overall, Kaiser has found email communication with providers and care teams and phone provider appointments to be valuable and clinically effective options to offer to patients. These alternatives to traditional face-to-face provider visits are particularly important to patients who are not mobile (for example, frail elderly or disabled people), do not have access to transportation, or live far from health care facilities, and for busy parents of small children.

Payment Reform Supports Care Team Evolution

Art Jones, MD, principal with consulting firm Health Management Associates, was the founding physician and CEO of Lawndale Christian Health Center, one of Chicago's largest urban community health centers. He talked about how he saw payment reform shape the evolution of care teams in his community's health centers.

Starting in the late 1980s, several Federally Qualified Health Centers (FQHCs) in the Chicago area moved into a capitated payment arrangement for primary care services with their Medicaid health plans. Since then, this funding model has evolved to a Medicaid Accountable Care Organization (ACO), providing the flexibility to develop care teams to support patient needs.

Throughout the 1990s, the clinics expanded the initial capitation agreement to include specialty care, outpatient diagnostics, pharmacy, behavioral health, and both professional and facility charges for emergency department visits. They negotiated shared savings arrangements for inpatient care and in some cases progressed to shared risk, and added commercial and Medicare managed care patients. In 2000, they made an agreement with the state's Medicaid agency to replace the fee-for-service wraparound payment with a set per-member-per-month rate.

As the clinics' efforts to redesign care progressed, the clinics' average number of primary care visits per year fell from 4.2 to 2.8 per patient, allowing them to effectively use the full care team and expand primary care physician (PCP) panel size without increasing the workload of that PCP. During this period, some of these clinics were among the top performers in achieving Healthcare Effectiveness Data and Information Set quality metrics targets among peers in statewide pay-for-quality programs.

Illinois continued in a voluntary Medicaid managed care environment. In 2013, nine FQHC clinics and three health systems participated in a shared savings pilot for those Medicaid beneficiaries who remained in fee-for-service reimbursement, with a primary care case management fee. The pilot offered an enhanced care management fee and a pay-for-performance opportunity that rewarded organizations based on measures of reduction of potentially avoidable hospital use. The network developed a health risk assessment tool that queried for barriers to treatment compliance that could be impacted by primary care. These were incorporated into a data warehouse that also included real-time hospital admission and discharge feeds from 20 hospitals, weekly claims data, and next-day pharmacy fill data that informed the care teams with actionable, current data. These data also helped care teams identify and manage not only the historically complex and high-cost members but also the population of patients at risk for future high utilization of hospital and other intensive services. In a risk-adjusted comparison performed by the state's actuary, total cost of care fell 5% over a two-year period for the pilot's 180,000 lives compared to 900,000 other Medicaid beneficiaries in the same region.

Encouraged by the results, these providers created Medical Home Network (MHN), a Medicaid ACO with financial and clinical integration under an LLC business structure. MHN contracted for a delegated care management fee, a pay-for-performance opportunity, and a share savings arrangement for total cost of care that resulted in a \$17 million payout in its first year. This was the result of 80,000 of MHN's Medicaid members choosing the organization's first contracted managed care organization as Illinois transitioned to mandatory managed care.

To achieve their goal of delivering high-quality care, the network of clinics focused their provider teams on moving beyond patient-centered medical home (PCMH) certification to a continuous quality improvement effort. They chose 20 of the National Committee for Quality Assurance PCMH criteria that they felt had the closest connection with excellent care. Other quality improvement efforts resulted in the network exceeding a 70% pay-for-performance target for completion of the required health risk assessment tool, with the use of these data to define care goals and to improve social determinants of health that the clinics could impact, such as food access, transportation, and depression.

“The capitation allowed us to transform the way we cared for our patients. You can't move to a patient-centered medical home approach without changing the payment system.”

—Art Jones, MD, principal, Health Management Associates

In this capitated payment environment, the clinics’ ongoing care team development includes regular review of what services patients need, and use of the flexible funding to develop the resources, including staff, facilities, and training, to support these needs.

Behavioral Health Providers on Care Teams at Tiburcio Vasquez Health Center www.tvhc.org

Anitha Mullangi, MD, is the chief medical officer at Tiburcio Vasquez Health Center (TVHC) in the East Bay area of Northern California.

TVHC operates 15 clinic sites for a patient population that is majority Spanish-speaking. Over the past four years, the health center has grown, not only expanding its care team to integrate behavioral health staff, but also adding four new clinic sites, one of which is colocated with a fire station.

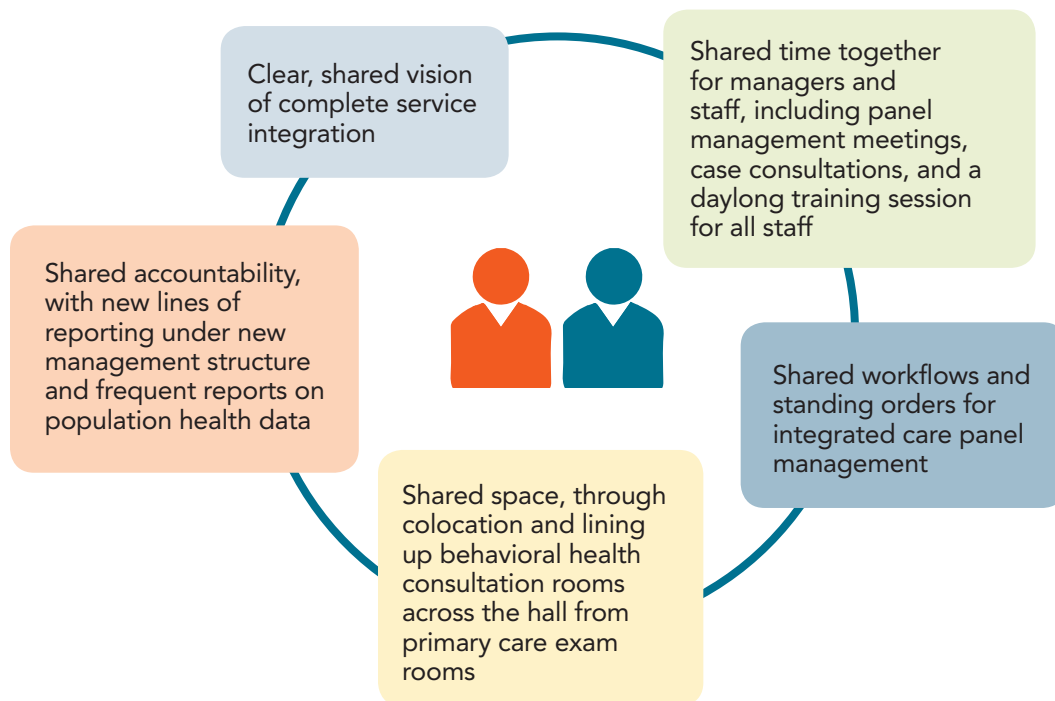
In 2012, when the organization began care team integration, TVHC had already offered behavioral health services to community members, including in its primary care clinic sites. Yet prior to the integration initiative, there was no effort to connect patients being seen for behavioral health to primary care, or vice versa, nor did the clinic staff know which patients were being seen for both types of care.

Of the changes made to integrate care, the most important was in the management structure. Mullangi began to oversee behavioral health services along with primary care. She says, “By changing the management structure, we were able to remove barriers to integrated care.”

The work of integrating care boiled down to building relationships between primary care and behavioral health providers, and with the other team members. TVHC developed these strong relationships through several mechanisms, represented in Figure 2, below.

These investments and work structures have allowed TVHC to overcome resistance to care integration, which initially included concerns like primary care provider reluctance to prescribe psychiatric medications. The work ahead includes

Figure 2. Primary Care and Behavioral Care Integration



continued team staffing changes: Mullangi's vision for the future includes hiring one behavioral health licensed clinical social worker for every two providers. The clinic hopes, as many do, to someday be able to bill for both a primary care visit and a behavioral health visit that occur on the same day.

Asked and Answered !

What is the make-up of the ideal primary care team?

Experts agree that no single care team model will work in every practice. "The ideal team can be very different depending on patient population needs and local resources," said Hong. CIN partners employ a range of care team compositions, with different visions for the next phase of their teams. For instance, AltaMed reported that, based on patient interviews, they are shifting to a "Kaiser-inspired model with a provider-licensed vocational nurse pair supported by both a medical assistant charged with care coordination and a medical records specialist." The independent practice association (IPA) Monarch Health is moving some of its staff offsite to do remote care coordination and add additional expertise and resources to its provider networks' capacity.

The overall approach endorsed by CIN partners and national experts is to put patients first, using population data and design thinking to design care teams for delivering high-quality and culturally competent care with continuity. Partners are focused on population segmentation and designing care teams that target these groups' needs, as LA County is doing with Care Connections.

How do remote team members develop warm relationships with patients when interactions are mostly or completely by phone or email?

Many patients want the warmth and connection of an in-person visit with their personal provider and care team, whereas other patients prefer the convenience of a virtual encounter with any available provider or team member. Partners discussed opportunities to design phone and other remote care encounters carefully, to preserve the personal connections they see as driving high-quality clinical care as well as patient experience. To foster this personal connection, remote care team members contact patients to identify themselves as part of the care team, using the provider's name and demonstrating knowledge of the patient's individual goals and care needs.

Where do team-based care and team leadership fit into medical education?

Partners agreed that medical schools have a long way to go in teaching physicians how to be a part of a care team. Providers and providers-in-training need help delegating effectively to other care team members for effective population health work. Providers also need support navigating their relationships with other team members, which includes important differences in decisionmaking power, clinical expertise, education, and socioeconomic status.

Is there a role for a clinical pharmacist on the primary care team?

Pharmacists are valuable for medication reconciliation and as ongoing support for patients with chronic conditions, but it can be challenging to fund these positions within primary care. AltaMed is using a three-year grant to fund pharmacists on care teams, and Monarch Health uses its own IPA pharmacists to do outreach and education to its members with congestive heart failure and diabetes, in partnership with a nurse and a diabetes educator.



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