

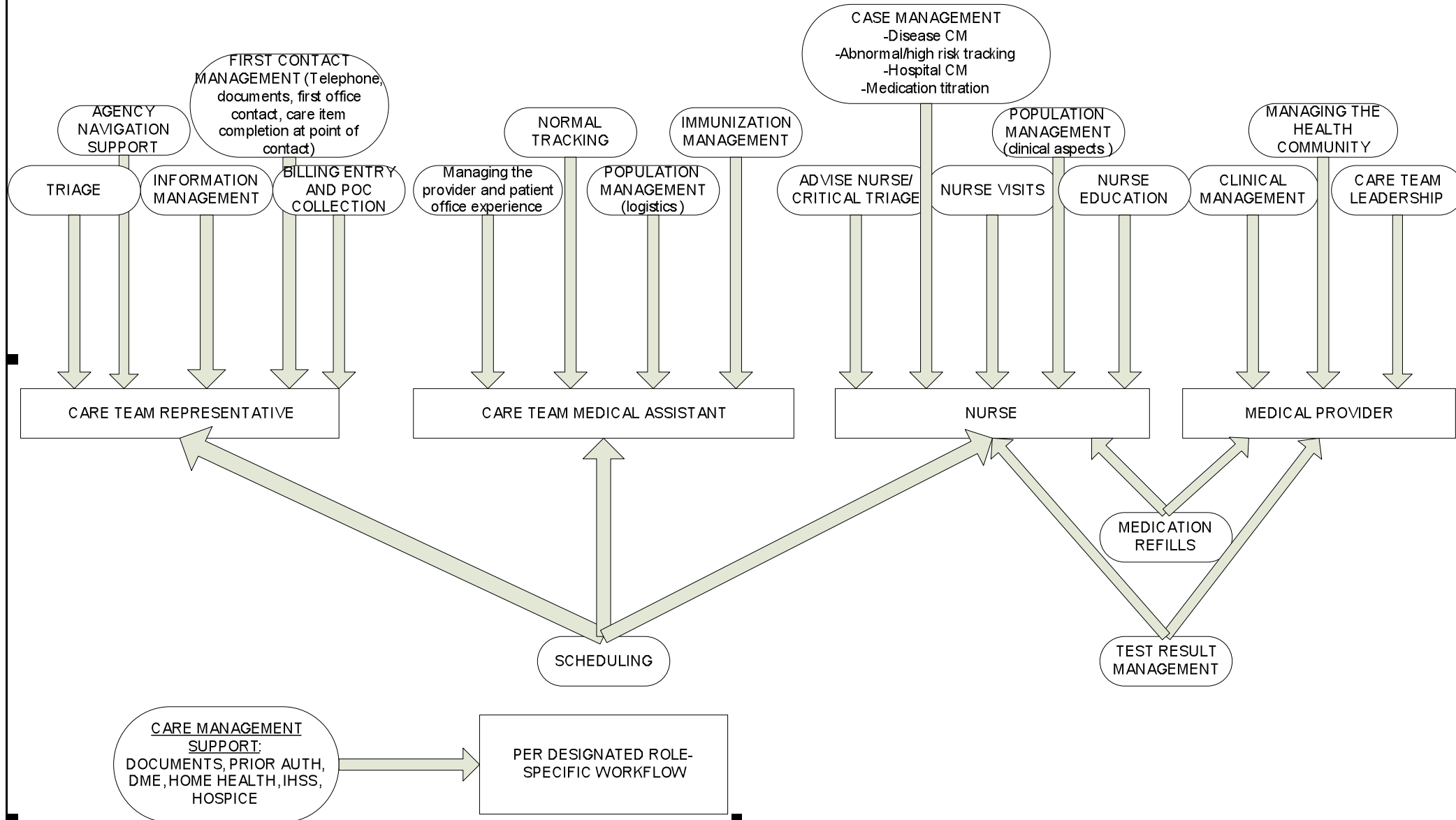
Care Team Starter Packet

I. Care Team Overview and Staffing	Page 4
- General Suggestions and Lessons Learned	Page 5
II. Care Team Staff Roles	
-Medical Provider	Page 6
-Care Team MA	Page 7-8
-Nurse Case Manager	Page 9-10
-Care Team Representative	Page 11
-Patient Navigator	Page 12
III. Care Team Meetings	Page 13-14

Primary Care Team



WCHC CARE TEAM WORK FLOW



CARE TEAM STAFF OVERVIEW

CARE TEAM: The Patient/Family, Medical Provider, Care Team Medical Assistant, Care Team Representative, and RN Case Manager make up the core of the Care Team. This Care Team has a specific patient panel made up of patients who have selected the Medical Provider as their primary care provider. The size of the patient panel will be determined by the FTE of the Medical Provider, complexity of the patient's needs of the health center, and make-up of the service community.

EXTENDED CARE TEAM: Includes the Behavioral and Mental Health Team, Patient Navigator, Complimentary/Integrative Health Team, Health Educators, and Community Health Partners. These team members are not assigned to one Care Team and are available as appropriate based on the needs of the patient

CARE TEAM SUPPORT: Includes Access Coordinator, Medical Records staff, Referral Specialists, and other staff members that have significant clinical responsibilities but are not directly part of a Care Team.

GENERAL SUGGESTIONS AND LESSONS LEARNED

This will only work if there is a conscious effort to create a “Team Concept” within our approach to patient care. With that in mind, here are a few suggestions:

- **The patient is the leader of the team** and should be encouraged to voice his/her preferences or needs within their healthcare experience. “How does this affect the patient” should be asked frequently to keep the team accountable to that concept.
- The Medical Provider will be the leader in the management of the care provided for a particular panel of patients and will set the tone for how he/she prefers to deliver care to that panel. The medical provider will also need to take the lead in creating a culture that empowers all members of the team to take ownership of their role and feel valued within the team.
- Patients often suffer due to delayed or inefficient care – ask yourself “what can I do to improve the delivery and timeliness of care.” All members of the team should do as much as they are able to do within their designated role. The medical provider is the bottleneck of the team and therefore all members should try to assist in any way that would improve the provider’s ability to complete their tasks in a timely and efficient manner. Some suggestions could include improving office efficiency by setting up laptops prior to provider arrival, assisting with prep of procedures prior to the visit, filling out all parts of forms not needed to be filled out by a provider, anticipating patient alerts and ordering needed interventions per protocol, etc.
- Simply asking the provider “what can I do to help” will go a long way to relieve stress for a provider that is running late and improve patient wait times during the office visit.
- Each member of the team has a unique role within the team not easily filled by another member and will have a distinct perspective into our patient’s experience – some members of the team will have an easier time voicing that perspective but all members of the team should strive to feel comfortable as a valued member of the team.



MEDICAL PROVIDER

The medical provider is the leader of their Care Team as it cares for their patient panel. Investment in the lives of their patients within a long-term, trusting, healing relationship, offers expertise not accessible to other members of the team. They will therefore be invaluable in setting the tone for the team; triaging patient's needs and desires; establishing their preferences for patient interaction; approving algorithms for ordering laboratory tests, radiology services, and referrals for disease prevention and chronic disease management; and reinforcing the principles of the “medical home” concept with their patients.

The Care Team will help the medical provider proactively manage their patients with chronic diseases and help with disease prevention. The Medical Provider will need to be an active manager of this process for their patient panel and will need to establish the culture for their patients by educating them about the process, reinforcing the need for disease prevention and chronic disease management, and encouraging their patients to take the lead in their own healthcare.

Continued attention to clinical excellence within their practice will be critical in serving our patients well. Clinical excellence within primary healthcare includes traditional knowledge and expertise in their medical specialty but also involves attention to care that is not provided within a normal office encounter. This includes coordinating and overseeing care within the health system for complex medical problems, disease prevention and chronic disease management, patient education, critical alert follow-up, medication management, fostering relationships with consulting providers, among others. Effective use of the care teams will be critical in supporting the medical providers in providing this type of comprehensive primary healthcare.

Finally, the Medical Provider will be the leader of their care team meetings and will set the tone for discussion about the patients in their panel and guide the management decisions within the meetings. They will actively participate in quality oversight within their clinical practice and regarding data entry and outcome reporting.



CARE TEAM MEDICAL ASSISTANT

The Care Team Medical Assistant plays a critical role in providing excellent clinical care. Our ability to proactively care for our patient's chronic illness and help prevent disease will depend in large part on the role of the Care Team Medical Assistant within the Care Team.

The Care Team Medical Assistant will serve as an extension of the Medical Provider and will have an opportunity to invest and develop a long-term relationship with patients in their own patient panel. Understanding the particular style and preferences of the Medical Provider within the Care Team will be important in creating a common voice and facilitate confidence in the care provided to their patients. Patients within your Care Team panel will see the Care Team MA as an integral role in their health.

In addition to the important clinical tasks routinely assigned to the medical assistant, the Care Team MA has a number of distinct roles

1) Managing the office experience for the Medical Provider. Partnering with the Medical Provider in serving patients can transform the Provider's day and will ultimately enhance the patient's experience. Being adequately prepared for the day, anticipating provider needs, overseeing office and room supplies, taking responsibility for patient office flow, helping manage the Provider's time, assisting with appropriate patient scheduling are some examples of opportunities that the CTMA can enhance the Medical Provider's attention and care of their patients.

2) Managing the office experience for the Patient. "Customer Service". The Care Team MA will set the tone for the office visit. Every interaction is an opportunity for investment into the "first name" relationship that we want to establish with our patients. Presenting in a professional manner, greeting patients with a smile, looking for opportunities to convey empathy, communicating expected waiting times, respecting patient privacy, being available to help guide patients through the health center, being aware of patient's schedules, will help improve the patient's experience in the office and help lay a foundation of trust and respect.

3) Managing population management logistics: The Care Team MA will manage the logistics involved in helping our patients manage their health and chronic illness. The logistics primarily involves encouraging patients to get recommended labs, DI, and referrals; follow through with scheduled office

visits, specialty care and education; completing recommended procedures such as depression screening and Diabetic foot exams.

4) Care Management Support logistics: The Care Team MA will manage the logistics of completing needed Care Management Support tasks. This includes managing the logistics associated with prior authorizations, medical supplies, DI/Lab orders, patient education materials, setting up for special projects and group visits, medical records needs, or disability forms. Managing logistics could include retrieving appropriate forms and filling out demographics or basic clinical information, calling appropriate health facilities, faxing orders, etc. This will not include entering complex clinical information which will be completed by the Nurse Case Manager or Medical Provider.



NURSE CASE MANAGER

The Nurse Case Manager will play an invaluable role in helping patients manage their diseases effectively and navigate appropriately through the fragmented and complicated medical system.

The Nurse Case Manager is the clinical manager of the Care Team and has a unique ability to understand and empathize with all members of the team. “Managing” the team, therefore, will naturally fall on the Nurse Case Manager and will have an impact on the teams ability to work effectively to support their patients and families throughout their health journey.

The Nurse Case Manager’s training allows for more complex clinical reasoning that departs from specific workflows or clinical algorithms. The ability to work through specific issues that affect an individual patient and make appropriate decisions is an important skill that the Nurse Case Manager brings. Furthermore, the Nurse Case Manager will need to gain skills in motivational interviewing, boundary setting, active listening, and team management to be successful in this role.

Then Nurse Case Manager will primarily work in the following areas: (1) clinical advice and triage; (2) nurse level care management support including medication refills, document management, lab triage and management, abnormal or critical clinical triage; (3) population management; (4) health education; (5) complex case management including chronic disease case management, critical diagnosis care coordination, transition care management, high risk clinical tracking, complex medication management, and system utilization.

Nurse will have a patient panel or caseload that will include patients who are not able to manage their chronic disease effectively. This could include Diabetics with chronically abnormal HgA1c's, complications from their Diabetes that make it difficult to manage their disease, difficult social or economic stressors that present road blocks to care, or their complexity of illness requires extra support to improve outcomes. Nursing staff will have authority to utilize staff resources; refer to appropriate medical care or support services; schedule needed appointments, labs, or preventative services; adjust medication based on clinical algorithms given by medical providers; assess patients for co-morbid risks including depression, addiction, poly-pharmacy, etc. and refer to needed care when appropriate; refill routine medications; and oversee the care within the clinic for these patients. Certain alerts such as

abnormal Pap or Mammogram result, or new diagnosis of cancer could automatically trigger a referral to nurse case manager to ensure proper access to needed resources.

Nursing staff will contact patients who were recently hospitalized or discharged from a skilled nursing facility to ensure safe and effective transition into the outpatient setting. Patient charts for patients seen at emergency services will be reviewed and managed if needed including helping patients utilize medical resources appropriately.

Appropriate caseload for this position will be evaluated over time and is currently at 1:1 provider : RN FTE.

The Nurse Case Manager will be present at care team management meetings and will be invaluable in offering clinical insight and suggestions for the care team as they serve their patient panel.



CARE TEAM REPRESENTATIVE

The Care Team Representatives play a critical role in providing excellence in the care of patients at the Sebastopol Community Health Center. Providing a familiar, safe, and culturally sensitive medical home for our patients will require a health care team that clearly understands their individual roles and values and assists other members of the team.

The Care Team Representative will likely be the first person that a patient will talk to when accessing the health center and will therefore play a vital role in making our patients feel supported and welcome. Developing skills in listening and communication, as well as showing empathy and sincere interest for our patient's needs, are crucial in their role. They will assist patients in effectively navigating through the system and will play a leadership role in helping the care team understand ways in which the system can better serve the needs of our patients.

Attention to the immediate relational needs of the patient and making the patient feel supported and welcome are the most important responsibilities of the Care Team Representative. Other responsibilities include expertise in using the scheduling and telephone message system, helping patients see their medical provider in a timely manner, and assisting in communication with other medical facilities. Furthermore, the Care Team Representative will help manage information entry into the electronic health record and will also provide counsel for patients in accessing eligible programs such as sliding scale, MediCal, Family PACT, and CDP. Finally, the Care Team Representative will assist in population management tasks for their assigned patient population.



PATIENT NAVIGATOR

The Patient Navigator will play an important role in assisting patients make lasting behavioral changes, understand available community health resources, and achieve success in meeting their self-management goals. The Patient Navigator is specifically trained in techniques to improve patient engagement such as motivational interviewing, goal setting, and active/ empathetic listening.

The ability of the Medical Provider, Nurse Case Manager, or Mental Health staff to establish a trusting, fruitful environment to engage patients around self-management and goal setting will be an important part of the success of the Patient Navigator. Furthermore, transferring earned trust to the Patient Navigator will improve the success of any interaction with the patient.

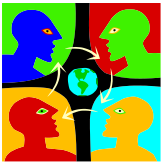
The Patient Navigator will focus on helping patients set realistic, specific, achievable goals. This could include clarifying a goal broadly outlined by the patient and other Care Team staff or engaging patients to establish an initial goal. Follow up contact to encourage and coach patients in meeting their goals will be an important part of this role.

The Patient Navigator acts as a resource for patients and staff in maintaining knowledge of available health resources and supporting patients in making a meaningful connection with health partners. The Patient Navigator will participate in the creation, implementation and maintenance of a web-based resource database for Patient Navigator and Care Team use within the agency.

The Patient Navigator participates in Care Team Huddles and offers role-based expertise when appropriate, anticipates potential Patient Navigator encounter during office visit, and coordinates timing of follow-up consultation with the patient's Care Team.

The Patient Navigator will also participate in case conferences as appropriate, provide resources and referrals for patients interested in alternative or complimentary therapy, and participate in home-based care as needed.

The Patient Navigator will not provide long-term behavioral therapy or provide comprehensive health education but will enhance the effectiveness of these services and give needed additional coaching and encouragement.



MEETINGS

DAILY HUDDLES: The Care Team Medical Assistant, FO Representative, RN Care Manager, and Medical provider will meet for 15 minutes at the beginning of the day to discuss issues related to the patients scheduled that day, ongoing population management tasks, or other pertinent items.

- This works best if the meeting can start 20 minutes prior to the first scheduled patient allowing the CTMA to finish the meeting and room the first patient. (Arriving early also sets the tone for an organized and timely day)

- The CTMA will perform an overview of the following days schedule to “prep the chart” and ensure appropriate lab results, patient documents or diagnostic imaging reports are in the chart or printed out for the patient. This also allows the MA to review needed “Alerts” which can be considered during the huddle or ordered prior to the visit.

- The FO Representative performs a robust call for confirmation to ensure the patient is aware of the scheduled visit, inquires further about the patient’s reason for the visit, updates insurance information, asks the patient to bring in all medications, asks if the patient has been to another facility for care to retrieve needed records, etc. The FO Representative’s participation is an important voice in the team huddle to improve the quality and efficiency of the office experience.

- The RN Care Manager will add a management perspective to the day, update the provider on potential care items that are pending or need insight, and coordinate logistics or communication items to the team to convey during the office visit. The huddle is an important time to plan strategically for potential assistance by the RN for high risk patients or patients that may need care management. The provider and RN will also spend a short time discussing the RN’s plan for the day and clarify any pending questions or outstanding issues.

- It helps if the provider can review the patients previous note during the huddle and “think aloud” about what they are expecting which can spur on opportunities to improve teamwork and coordination of the patient’s office experience.

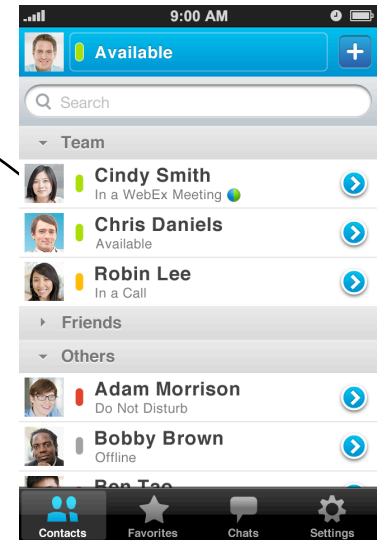
- Having the Patient Navigator or Mental Health team at the huddle or available for coordination is best practice and will enhance the success of the team’s ability to provide comprehensive care to the patient during their office experience.

MONTHLY CARE MANAGEMENT MEETINGS: This meeting should be attended by all members of the Care Team including the Medical Provider, Care Team Medical Assistant, Care Team Representative, and Nurse Case Manager. The meeting will be led by the Medical Provider and is designed to focus on improving care for the patients in their patient panel. This may include discussion about provider style or preferences of care, case management discussion about particular patients, coordinating resources for the panel or specific patients, etc. This meeting also offers opportunity for quality oversight - including data entry, billing, clinical outcomes, and new quality initiatives, among others. It also offers a place to improve care through PDSA projects within the context of a clinical team. Each team would have the opportunity to continually improve their care delivery through these projects and lessons learned could be passed on to other teams during their care management meetings. Finally, these team meetings allow agency wide initiatives and policies to be standardized and adopted, again, within the context of a clinical team.

CASE CONFERENCE: Complex case management and high risk case management requires strategic discussions among appropriate members of the team to ensure an organized approach to health management. All members of the team, including patients, care givers, specialist partners, and community partners may be involved in individual case conference and will be organized by the Nurse Case Manager or High Risk Case Management team.



WebEx Connect



Improving Communication in Primary Care

Care Team Relational Collaboration

Transfer of Trust (warm hand-off)

Real Time Decision Support

Community Collaboration

Remote Care

Real-Time Specialty Collaboration

"Share the Visit" Care Circle Collaboration

