Practice Transformation Curriculum for Advanced Primary Care

Facilitator's Guide to Teaching the Sessions

Session 1: Introduction to the Advanced Primary Care Model

Key Concepts:

1. There is a growing realization that primary care must be the foundation of our healthcare system in order to create a high value model of care delivery.
2. Fee for service payment has not generated or incentivized the high value practice methodologies needed at the primary care level since primary care's main function to manage populations, not individual visits.
3. Advanced primary care is an evolution of the patient-centered medical home into a population health oriented, comprehensive care delivery model.
4. Patient's trust of their primary care team is key to changing health behaviors
5. The Key Features of APC (slide 6) are the hallmarks of an advance primary care practice.

<u>Session Length</u> – 2-3 hours
Participants – ideally the entire clinic team should be participating in this session.

<u>Running the Session:</u>
This session is highly interactive. The facilitator should be a primary care physician with significant practice management experience along with reading the References in the handout to provide background information for facilitating the team discussions.

Slides 1-8: (10 min)
Present the slides and take questions to clarify them as much as possible before the team discussions

Discussion Phase: Break up your audience into working groups of 4-5 participants

Slide 9 (45 min): Have the small working groups (using the handout) answer the questions as they see it over 15 min. After that time have groups share one answer at a time to the whole audience and allow for discussion. This will likely take 30 minutes but it critical for the group develop a sense of share ownership of these answers.

Slide 10 : (30 min) - similar format, but 10 min for small group work and 20 min for sharing with larger audience.

Slide 11: (20 min) Brainstorming new ideas: full audience can do this altogether.

Slide 12: (45 min): Have the small working groups (using the handout) answer the questions as they see it over 15 min. After that time have groups share one answer at a time to the whole audience and allow for discussion.

Slide 13: (30-45 min) Use the last page of the handout to create an action plan for ideas for practice changes that the group has come up with. For this exercise, it would be best to begin to segregate your

teams into a front desk and clinic team (pods if you have them) to record items for the following key categories:

a. Access team – scheduling
b. Communications: changes to communications within the team, with patient
c. Patient services – appointment types, length, new services, etc.
d. Population Health – case management and using population data to improve compliance with screening and outcomes metrics.

We want the team to walk away with the key concepts outlined above and to begin the cultural change that is necessary for moving from FFS to a population-based payment model that encourages high value care delivery.

Session 2: Clinic Leadership Training

Key Concepts:

1. This change to population-based health will make sense to most of your providers, it will feel right.
2. Throw out the metrics you are familiar with in FFS (Cost per RVU, etc.) and begin to think in terms of cost per patient per year directly tied to access to care
3. Think through the implications of being paid, as a team, to provide care. Providers do not have to provide all of the care to improve patient's health, and the practice is paid on an enrollee basis.
4. Work to create incentives for the entire team that align with better health outcomes and better patient experience
5. Begin the process of rethinking QI, population health and patient experience metrics you will need to collect to be successful.

<u>Session Length</u> – 1.5 hours
Participants – Practice Manager, Medical Director, Lead RN, Behavioral Health providers, patient representative. Data analyst from your health record should be present if not your practice manager. Representative from your finance department in a larger group (CFO) should be present.

<u>Running the Session:</u>
This session is highly interactive to engage the group in discussion leading to action plan creation.

Slides 1-8: (15 min)
Present the slides and take questions to clarify them as much as possible before the team discussions

Discussion Phase:

Slides 8-11: Have the group spend 15 minutes per slide discussing and answering the questions.

Slide 12: (15 min) - Develop your action items using the responsibility chart in the handout.

This session is critical for the leadership to be aligned on priorities and order of the transformation work ahead. Data will be critical to assess how effective your team is in reducing the total cost of care and improve patient experience. Introducing the Starfield III Synthesis document on metrics that matter will help guide your clinic (system) to gather the right metrics that will impact outcomes.

Session 3: Reception and Scheduling Team Training

Key Concepts:

1. Your team's overarching goal is to create great access for your patients.
2. Having around 30% of your appointments open at the beginning of the day will create the capacity to both urgent and routine add-ons into the schedule.
3. Simplifying appointment types and having longer visits can allow patients to be managed more comprehensively.
4. The transition from your old scheduling model will take several months AND patients will need to be reassured that getting same day appointments is very likely once the transition is complete.
5. Your metrics will be determined by your team and the clinic leadership – expect to track your progress and patient experience data on how well we are serving their needs.

<u>Session Length</u> – 1.5-2 hours.
Participants – Practice Manager, Medical Director, Scheduling staff, reception staff, Clinic RN (triage).

<u>Running the Session:</u>
This session is highly interactive to engage the group in discussion leading to action plan creation.

Slides 1-3: (5 min)
Present the slides and take questions to clarify them as much as possible before the team discussions

Discussion Phase: Have the group spend 15 minutes discussing and answering the questions on each slide.

Slides 4: Work through the list of questions. Take notes to fill in your action plan at the end of the session.

Slide 5: Review your current appointment types and length. If you are going to be adding new types (i.e. longer procedures or even just longer visits), look at the downstream effects on access and how to mitigate the impact of those changes.

Slide 6: Examine your communications workflow – who reviews incoming messages of various types, how is that work cue handled, especially that with your new payment model, more care can be delivered through your patient portal.

Slide 7: Enrollment process for patient on a comprehensive PMPM plan needs to be shared and understood by all of the staff. Often clinics will have a mix of FFS and PMPM patient panels and the latter are entitled to addition services due to their payment model.

Slide 8: Team communications – look carefully at how your team communications are working – where are the weak points and how can you create the space to allow them to improve?

Slide 9: (10-15 min) - Develop your action items using the responsibility chart in the handout.

This session is critical for the scheduling team to shift from strategies that often were designed to "protect" the provider's schedules to strategies that ensure timely access to care. Managing patients

via the patient portal and by phone is now encouraged, as well as utilizing your RN and MA's to complete some care tasks, so more of the team can be part of patient care delivery without booking an appointment with a clinician. Here is where communications are key to ensure quality is maintained in the care delivered.

Session 4: Medical Assistant and Clinic Nurse Training

Key Concepts:

1. These team members can carry out certain population health activities independently of providers
2. Maximizing the work of both the MA and RN's within the scope of their license can improve access and manage acute and chronic problems with supervision of the clinical providers.
3. Pre-visit preparation and systematic patient outreach can significantly improve patient screening compliance and reaching disease specific metrics.
4. Performing team huddles once or twice daily will improve team communications and efficiency with visits.

Session Length – 1.5-2 hours.
Participants – Practice Manager, Medical Director, Medical Assistants, Clinic RN (triage).

Running the Session:
This session is highly interactive to engage the group in discussion leading to action plan creation.

Slides 1-7: (15min)
Present the slides and take questions to clarify them as much as possible before the team discussions

Discussion Phase: Have the group spend 15 minutes discussing and answering the questions on each slide.

Slides 8: Work through the list of questions on the handout. Take notes to fill in your action plan at the end of the session.

The first portion of the handout and Slide 8 focus on the team's communications. It is important to develop a culture of safety (trust, proactive support of others) within the nursing team and between them and the providers. The RN and MA's can manage a great deal of the patient communications and with training can improve the turn around time. Regular feedback on how communications are being managed can help keep all members of the clinical team moving through messages cleanly. Since patients can actually be managed to a high degree using the patient portal (i.e. MyChart), a clear understanding of how to manage those messages that could replace a patient visit which is vital to improving access.

Slide 9: This will give your opportunity to work on creating and improving your daily huddle process. Having a full team huddle then a twice a day Provider-MA huddle is ideal. (See the AMA Team Huddle reference). Dissect how things are working in your team and how well pre-visit prep is going. It would be best to set up quarterly QI meetings and projects to improve how your huddle and communications are going.

The last part of the handout focuses on the additional roles that a new payment model allows for in care delivery. It is important to expand and define the scope of work of these team members and having visits with patients in alternative ways will allow for more time for patients who need to be evaluated face to face.

Session 5: Medical Provider Training

Key Concepts:

1. Moving away from FFS and RVU based income creates a whole new set of incentives that will make your work more meaningful.
2. Your work will be assessed on patient-oriented outcomes and access not volume.
3. Expect a cultural change that will need to permeate many of your processes to be successful in transitioning to value based payment.
4. Management of complex and chronic conditions will be much of your focus, while your team can help take care of minor illness and caring for patients outside of FTF appointments.

Session Length – 2.75-3 hours.
Participants – Practice Manager, Medical Director, Clinical Providers

Running the Session:
This session is highly interactive to engage the group in discussion leading to action plan creation.

Slides 1-7: (15min)
Walk through the slides which will lay out the main features of advanced primary care and how office visits can be redesigned to help manage your time better and begin the process of rethinking the culture of care delivery in your clinic.

Slide 9: Case #1 – Anti-coagulation Visit (15 min)
Discuss the questions on the slide – take notes for future use.

Slide 10: Case #2 – Diabetes management (15 min)
Discuss the questions on the slide – take notes for future use.
Consider other diagnoses that could have similar management via phone or electronic portal.

Slide 11: Procedures (15 min)
Review and discuss the questions.

Slide 12: Documentation redesign (20 min)
Review and discuss these questions. Your team may want to set up a task force for documentation – creating new patient oriented notes, not insurance payer oriented notes.

Slide 13-14 - Access and accountability
Discuss and review slides (30 min)

Slide 15 – Metrics Discussion (30 min)
Here again, selecting a task force to work on this over time will be important.

Slide 16 – Panel and Management (20 min)
Begin your discussion on how to you can use your team, especially your case managers, to identify and manage your most complex patients.

Develop your action plan from the discussions above (20 Min)

Session 6: Integrated Care Management Training

Key Concepts:

1. The care management nurses are a critical part of your management of complex patients
2. Frequent contact between your CM nurses with your PCP's is essential and creating protected time for rounding enhances their team dynamic
3. Care managers can extend and enhance your care plans for patients beyond what you can do in an office visit.
4. Many patients requiring care management are medically, socially and psychologically complicated – do not forget that this mix results in poor compliance in many cases

Session Length – 1.5 hours.
Participants – Practice Manager, Medical Director, Care managers/Navigators and/health coaches, medical providers, behavioral health providers.

Running the Session:
This session is highly interactive to engage the group in discussion leading to action plan creation.

Slides 1-8: (20 min)

Slide 9: Using the handout the session, work through the questions.

Team Dynamics: (30-45 min)
Look carefully at how the providers are responding to and interacting with the care managers. Are there trust issues on either side? Is there open dialog and education about what is needed for patients and overcome patient barriers?

Action Plan (30 min)
Develop a plan for check-ins for the care managers with each provider.

Population Heath
Develop a plan for how to manage the population health tasks your clinic will need to master over time:

1. Identification of high risk or rising risk patient for proactive outreach
2. Tracking of hospital and ED discharges, frequent users reports.
3. Advanced directive completion reports
4. Preventive maintenance reports with outreach to encourage completion of needed screening and immunizations.

Who will gather the reports, which patients will the care manager take on for most of these tasks and who on the clinical team will be managing lower risk patients on the panel?

Session 7: Integrated Behavioral Health Training

Key Concepts:

1. Behavioral health provider can provide a very high value adjunct to your team's care
2. Having in-house psychological support allows for a higher degree of access for patients in need.
3. Warm hand-offs will enhance patient compliance with recommendations to seek counseling.
4. Many patients requiring care management are medically, socially and psychologically complicated – do not forget that this mix results in poor compliance in many cases

Session Length – 65 min.
Participants – Practice Manager, Medical Director, behavioral health providers, care management nurse, clinic nurse.

Running the Session:
This session is highly interactive to engage the group in discussion leading to action plan creation.

Slides 1-6: (15 min)
Re-imagine how providing counseling could be different with a salaried psychologist who no longer has to create a care plan based on billing for visits or time, but instead what would be the optimal frequency of visits. Seek out reactions to the bullet points on the slides.

Slide 7 – Discussion (40 min):
Work through the questions on your handout and as answers arise, develop next steps for your action plan. Pay close attention to the multiple levels at which your behavioral science providers will interact with the team (nursing staff, medical providers, population health data analyst).

Slide 8 – complete the action plan for your team (10 min)

Session 8: Ancillary Support for Integrated Care

Key Concepts:

1. Depending on the size of your clinic and referral patterns, adding PT, social work, referral coordinator and pharmacy support may be very cost effective.
2. Each of these skill sets, in a value-based model, can improve outcomes and address needs that are common to primary care patients but are costly in the FFS model.
3. Warm hand-offs will enhance patient compliance with recommendations and treatment plans.
4. Support needs can be tailored by the demand – starting with part of an FTE for these positions until actual workload is determined. Salaried and incentivized positions would be recommended.

Session Length – 60 min.
Participants – Practice Manager, Medical Director, behavioral health providers, care management nurse, clinic nurse.

Running the Session:
This session is highly interactive to engage the group in discussion leading to action plan creation.

Slides 1-5: (15 min)
Introduce the notion of adding on these common needs of patients into your clinic model.

Slide 6: (15 min)
These questions will need some pre-work done before the session. You will need to know how much time your team is investing in refill management and also the number of PT referrals (and ideally sessions) are generated weekly in your clinic. Total cost of PT services would be a helpful data point to have in your discussion.

Slide 7: (15 min)
Discuss as a team these question regarding social work service support and the idea of bringing on health coaches for your highest risk patients. These positions can off load significant pieces of work from your care management RN's which will enable them to manage more patients.

Slide 8-9: (15 min)
From the past 45 min of discussions, it there a need for any of these positions internally or can you subcontract out for the same services? Do you have candidates in your community who could be hired in? Space issues? Develop a prioritized action plan on what your clinic manager can work on next to move this forward.

Session 9: Metrics and Quality Improvement

Key Concepts:

1. Moving away from FFS and RVU based income creates a whole new set of incentives and metrics that focus more on outcomes and less on throughput
2. Patient outcome and experience oriented metrics are more accurate reflections of high value care then disease specific data points.
3. Develop a culture of innovation using QI and PDSA cycles to generate ideas and test them.
4. Develop a regular reporting plan to the team on how your clinic is doing on PCPCM metrics and on outcomes of your QI work.

Session Length – 1.75 hours.
Participants – Practice Manager, Medical Director, Clinical Providers, Clinic RN, Care Managers
Pre-reading: **Etz RS, Zyzanski SJ, Gonzalez MM, Reves SR, O'Neal JP, Stange KC.**
Ann Fam Med. 2019 May;17(3):221-230. Plus the supplemental tables.

Running the Session:
This session is highly interactive to engage the group in discussion leading to action plan creation. It is important that the members of this session complete the pre-reading (PDF's included).

Slides 1-7: (30min)
Review the slides, discuss questions that arise. What capacity do you have to change your patient experience survey tool and how quickly and you get data back? Also, what metrics (Slide 7) do you currently get back in your clinic reports and which one's do you need to get from payers/TPA's.

Slides 8-10 (45 min)
Discuss your current QI efforts and see which ones truly are important to maintain. Based on the work from other session, including those action plans, outline a new set of QI ideas and prioritize them as a team. Identify some population health based QI projects if possible.

Slide 11 : (30 min)
Develop your project list for the next year and assign responsibility for carrying out those projects. Clearly identify the data you will need to collect so you can ensure that you can see the impact of your team's interventions.

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References:

A. The EPA's for Family Medicine: https://www.afmrd.org/page/epa

B. Shared Principles of Primary Care: https://www.pcpcc.org/about/shared-principles

C. Advanced Primary Care:

1. Role of FM: The future role of the family physician in the United States: a rigorous exercise in definition. Phillips RL Jr, Brundgardt S, Lesko SE, Kittle N, Marker JE, Tuggy ML, Lefevre ML, Borkan JM, Degruy FV, Loomis GA, Krug N. Ann Fam Med. 2014 May-Jun;12(3):250-5
2. The Revolution
   - A. Ellner AL, **Phillips** RS. The Coming Primary Care Revolution J Gen Intern Med. 2017 Apr;32(4):380-386
3. In ACO's: https://www.pcpcc.org/resource/evidence2018
4. Components related to delivery and payment :
   - A. Comprehensiveness : Bazemore A, Petterson S, Peterson LD, Philips RL. More Comprehensive Care Among Family Physicians is Associated with Lower Costs and Fewer Hospitalizations. The Annals of Family Medicine. 2015; 13(3):206-13.
   - B. Increased Investment: Phillips RL, Bazemore AW. Primary care and why it matters for U.S. health system reform. Health Aff (Millwood). 2010;29(5):806-810.
   - C. Teams in Primary Care: Mitchell, P., Wynia, M., Golden, R., McNellis, B., Okun, S., Webb, C. E., Von Kohorn, I. (2012). Core principles & values of effective team-based health care. Washington, DC: Institute of Medicine.
   - D. Sinsky CA, Willard-Grace R, Schutzbank AM, Sinsky TA, Margolius D, Bodenheimer T. In search of joy in practice: a report of 23 high-functioning primary care practices. Ann Fam Med. 2013 May-Jun; 11(3):272-8.
   - E. Wen, J., & Schulman, K. A. (2014). Can Team-Based Care Improve Patient Satisfaction? A Systematic Review of Randomized Controlled Trials. PLoS ONE, 9(7), e100603.
   - F. Weaver, S. J., Dy S.M. , and Rosen M.A. (2014)"Team-Training in Healthcare: A Narrative Synthesis of the Literature." BMJ Quality & Safety 23(5): 359–72
   - G. Patient Engagement: – https://www.aafp.org/fpm/2015/0700/p22.pdf -Patient Advisory Councils
   - H. Advanced Access-Scheduling:
     Shuster, M. Advanced-access scheduling in primary care.
     JAMA :2003, Vol.290(3), p.332-4
     Murray, M., Berwick, D. Advanced access: reducing waiting and delays in primary care.
     JAMA : 2003, Vol.289(8), p.1035-1040

D. Behavioral Health Integration:

   - A. Gilbody, S., Bower, P., Fletcher, J., Richards, D., & Sutton, A. J. (2006). Collaborative care for depression: a cumulative meta-analysis and review of longer-term outcomes. Archives of Internal Medicine, 166(21), 2314–2321.

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B. Kathol RG, DeGruy F, Rollman BL. Value-based financially sustainable behavioral health components in patient-centered medical homes. Ann Fam Med. 2014;12(2):172-5.
C. Wallace NT, Cohen DJ, Gunn R, et al. Start-up and ongoing practice expenses of behavioral health and primary care integration interventions in the Advancing Care Together (ACT) program. J Am Board Fam Med. 2015;28 Suppl 1:S86-97.

E. Care Management and the Care Team:

A. Bielaszka-DuVernay, C. (2011). Vermont's blueprint for medical homes, community health teams, and better health at lower cost. Health Affairs 30(3):383-386.

F. Health coaches:

A. Adelman AM[1], Graybill M. Integrating a health coach into primary care: reflections from the Penn state ambulatory research network. Ann Fam Med. 2005 Jul-Aug;3 Suppl 2:S33-5.

G. Community Health Workers

A. Hartzler AL[1], Tuzzio L[2], Hsu C[2], Wagner EH[2]. Roles and Functions of Community Health Workers in Primary Care. Ann Fam Med. 2018 May;16(3):240-245

H. PT:

A. Freburger J, Samannaaz K, Timothy S, Carey Primary Care Physician Referral to Physical Therapy for Musculoskeletal Conditions, 2003-2014. Journal of general internal medicine : JGIM. , 2018, Vol.33(6), p.801-803
B. R. Speerin, H. Slater, L. Li, *et al.* Moving from evidence to practice: models of care for the prevention and management of musculoskeletal conditionsBest Pract Res Clin Rheumatol, 28 (2014), pp. 479-515

I. Quality Improvement in a Team Model:

A. Buljac-Samardzic, M., Dekker-van Doorn,C , Van Wijngaarden J., Van Wijk, K. "Interventions to Improve Team Effectiveness: A Systematic Review." Health Policy 94, no. 3 (March 2010): 183–95.