Building and Sustaining an Exemplary, Thriving Primary Care Team and Workforce for our Communities, our Practices, and our Country

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With acknowledgements to:

Veena Channamsetty, MD, CMO; Mary Blankson, APRN, DNP, CNO;
Tim Kearney, PhD, CBHO; Sheela Tummala, DDS, CDO; Amanda Schiessel, NCA Project Director
“Change will not come if we wait for some other person or some other time. We are the ones we’ve been waiting for. We are the change that we seek.”

—Barack Obama
Community Health Center, Inc. (CHCI) Locations and Service Sites in Connecticut

CHCI Profile
- Founding year: 1972
- Primary care hubs: 14; 204 sites
- Staff: 1,000
- Patients/year: 100,000 (est. 2017)
- Visits/year: 550,000
- Specialties: onsite psychiatry, podiatry, chiropractic
- Specialty access by e-Consult to 15 specialists

Elements of Model
- Fully integrated teams and data
- Integration of key populations
- Data driven performance
- “Wherever You Are” approach

Weitzman Institute
- QI experts; national coaches
- Project ECHO® — special populations
- Formal research and R&D
- Clinical workforce development

THREE FOUNDATIONAL PILLARS
1. Clinical Excellence
2. Research and Development
3. Training the Next Generation
# Community Health Center, Inc.

Where health care is a right, not a privilege, since 1972.

## Middletown Family Wellness Center
635 Main Street

For More Info: Visit our website! familywellness.chc1.com

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### Nat Holmes
Community Wellness & Engagement Program Coordinator HolmesN@chc1.com (607) 347-6971 ext. 3672

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<table>
<thead>
<tr>
<th></th>
<th>Mon</th>
<th>Tue</th>
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<th>Thu</th>
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<th>Sat</th>
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<tbody>
<tr>
<td>1</td>
<td>CT Strong - Young Adult Night 3:00 – 8:00pm</td>
<td>HEART/Children at HEART 6:30-8:00pm</td>
<td>Fingers and Feet 9:30 – 11:00am</td>
<td>Family Yoga 5:00-6:00pm</td>
<td>Open Playgroup 9:30-11:00am</td>
<td>Family Yoga 4:30-5:30pm</td>
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<td>8</td>
<td>Circle of Mamas – Support Group for New Moms 10:30-11:30am</td>
<td>Alons – y – French Playgroup 10:00-11:00am</td>
<td>Cantoya Cuentos 10:00-11:00am</td>
<td>Baby wearers Playgroup 10:00-12:00pm</td>
<td>Family Yoga 5:00-6:00pm</td>
<td>Open Playgroup 9:30-11:00am</td>
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<td>15</td>
<td>CT Strong - Young Adult Night 3:00 – 8:00pm</td>
<td>Kids in the Kitchen with Kim Thibeau 10:00 – 11:00am</td>
<td>Fingers and Feet 9:30 – 11:00am</td>
<td>Family Yoga 5:00-6:00pm</td>
<td>Open Playgroup 9:30-11:00am</td>
<td>Family Yoga 4:30-5:30pm</td>
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<tr>
<td>22</td>
<td>Circle of Mamas – Support Group for New Moms 10:30-11:30am</td>
<td>Parents' Time Out: Art Therapy Support Group Childcare provided 3:30-6:30pm</td>
<td>Arts Explorers 10:00-11:00am</td>
<td>Moslin' and Grooxin' with Miss Kim 10:00-11:00am</td>
<td>Family Yoga 5:00-6:00pm</td>
<td>Open Playgroup 9:30-11:00am</td>
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<tr>
<td>23</td>
<td>CT Strong - Young Adult Night 3:00 – 8:00pm</td>
<td>Parents' Time Out: Art Therapy Support Group Childcare provided 3:30-6:30pm</td>
<td>CT Strong - Young Adult Night 3:00 – 8:00pm</td>
<td>Family Yoga 5:00-6:00pm</td>
<td>Family Yoga 4:30-5:30pm</td>
<td>Infant Massage Parent-infant bonding led by a Licensed Massage Therapist 10:00-11:30am</td>
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The Weitzman Institute works to improve primary care and its delivery to medically underserved and special populations through research, innovation, and the education and training of health professionals.
Weitzman Learning Academy provides evidence-based strategies to support practice transformation and culture change through dynamic coaching and learning opportunities to address needs or goals in specific focus areas.

(Examples of focus areas include: Implementing or Expanding a Medication Assisted Treatment Program; Integration of Behavioral Health Services; Quality Improvement Training; Practice Transformation Coaching)

Learning Methods:
- Customized coaching and consultation
- Collaborative site visits
- In-person formal training events
- Interactive virtual training sessions
- Dynamic webinars
- Learning Collaboratives

For more information contact: WeitzmanLearning@chc1.com
Community Health Center, Inc.  Where health care is a right, not a privilege, since 1972.

The newly-elected officers of the Board of Directors of Community Action for Greater Middletown gathered this week at CAAM’s East Main Street offices. They are (left to right) executive secretary Edith Barnes, president Munsell, vice president Michael Young, and treasurer Eugene Shaw.
Where Are We Now in Healthcare?

- Post ACA, far greater access to primary care than before through expansions in Medicaid, FQHCs, new investments in rural health, but not equitably distributed or universally accessible

- Social determinants of health receive far greater attention, but huge gaps exist in resolving them

- New focus on population health and value-based care, which are not the same thing but both strive for improved health outcomes and provide some resources to get there
Difficulties with finding, attracting, retaining staff with the required skills sets, specialties, and disciplines

Reported burnout of providers across primary care as well as other specialties

Continued dominant mode of fee for service, particularly in FQHCs but some transition to value-based payments, risk arrangements, and ACOs

Yet we have resources, frameworks, models, and innovations that we have never had before at our disposal!

How do we build, strengthen, and fortify our teams going forward to experience the joy of helping people attain their optimum health as a fundamental human right and social goal?
Where Are Federal Priorities?

- New support for targeted investments in rural communities, workforce development and training, and particularly strategies to address OUD.

- Federal focus on ending the HIV epidemic and impacting maternal-infant mortality.

- From CMS/CMMI, new focus on virtual care/telehealth, primary care payment models focused on value based care and incentives, addressing the seriously ill in primary care, and addressing behavioral health and OUD.
How Are We Transforming Our Practices?

- Increasing our focus on training and education to a model of high performing primary care, with team-based care as a central component
- Emphasizing training and education to for every member of the team, not just some members of the team
- Addressing the highest risk/vulnerable among us with special initiatives and interventions
- Recognizing the off-stage players as well as the on-stage players
- Using data, quality improvement, and continuing learning to drive transformation
- Capturing the power of telehealth at all points on the continuum
Moving from Surviving to Thriving

Intensive, formal, supported preparation, and transition from education to practice in primary care with undeserved and key populations for everyone on the team

- Postgraduate residency and fellowship for PCPs in FQHCs
- DEU (dedicated education units) for RNs in primary care
- Medical assistant training based on Bodenheimer principles
- Clinical Psychologist residency training and LCSW/LPC practicums in integrated settings
- Clinical Pharmacist training in primary care
Moving from Surviving to Thriving

- Supportive design, team and leadership
  - Relational skills for all team members
  - On-site leadership/Integrated team-based clinical leadership
  - Physical design that supports pods and social interaction between team
  - Clear workflows, processes, “playbooks”
  - Just-in-time delivery of data through dashboards, alerts, and transitions of patients
  - Agreed upon principles for managing disruptions and upsetting events
Benefits matter at all levels of staff

- Paid maternity leave/paternity leave
- Tuition reimbursement
- Support with loan repayment
- Celebrations and recognitions
- Entry level wages and livable wage, not minimum wage
- Possible job shares? Remote work arrangements?
- Career pathways and advancement—*for everyone*
Moving from Surviving to Thriving

- Consider after hours contracted telephonic nurse triage system to reduce frequency of on-call responsibilities

- Consider investment in workplace wellness programs, from chair massage to incentives for walking, breathing, meditation

- Consider strengthening feedback loop to leadership when local environmental issues are not resolving in timely way

- *What matters to your teams? Have you asked?*
Why Primary Care Teams?

- Improved clinical outcomes
- Improved support for complex patients
- Better patient access and experience
- Reduced burnout
- Become a high value PCMH
“Lower burnout may be achieved by medical home models that are appropriately staffed, emphasize participatory decision making, and increase the proportion of time team members spend working to the top of their competency level.”
Integration

- Hygiene
- Restorative Care
- Integrated Fluoride Treatments
- Bring in BH Provider for Anxiety/Trauma Issues

- Medical Follow-up
- Integrated Meetings
- Huddles
- Substance Abuse Services (including MAT)

- Therapist
- Psychiatry
- Individual Appointments
- Consultation
- Curb-sides
- Groups
- WHOs
- Substance Abuse Services (including MAT)

- Transitional Care
- Education
- Monitoring
- MI/Coaching
- Panel Management
The Components of Integration

- Evaluation
- Training
- Workflow/Processes
- Facilities/Systems
- Leadership Structure
Leveraging the Core Care Team
“Core” and “Extended” Team Members

**Core** = individuals on a team that work with a specific primary care provider caring for a defined population of patients

**Extended** = practice staff who have an ongoing professional relationship with the core team and who provide services to any patient of the practice or specific sub-populations
The Interdisciplinary Team

- **POD design**
  - 2 Medical Providers
  - 1 Registered Nurse
  - 2 Medical Assistants
  - 1 Behavioral Health Clinician
  - Extended members: podiatrist, dietician, Pharm-D, chiropractor, CDE, CHW
  - Students/Trainees
Shared Communication Among the Team
Support of the Clinician

- Clinical Leader/Responsible

- Clinical Management
  - Support planned care
  - Evidence-based care delivery
  - Care coordinate with team

- Empower the Team

- Leverage the Team

- Engage in the Team
High-Performing Primary Care

Ten Building Blocks of High-Performing Primary Care

1. Engaged leadership
2. Data-driven improvement
3. Empanelment
4. Team-based care
5. Patient-team partnership
6. Population management
7. Continuity of care
8. Prompt access to care
9. Comprehensive-ness and care coordination
10. Template of the future

Panel Management
Patient Education
Health Coaching
Care Coordination
Patient Navigation
Interprofessional Team
Medical Assistants

- The role of the Medical Assistant (MA) has continued to advance to include functions including care coordination, patient navigation, health coaching, population health and more. (Ladden 2018)

- Job growth expected to be 29% between 2016 and 2026 (U.S. Department of Labor)

- Education and training and scope vary widely across the country with new models emerging
The Role of the Medical Assistant

- Proactive Planned Care
- Delegated Ordering
- Panel Management
- Patient Navigation
- Health coaching
- Retinal camera exams
- QI/Microsystem role
Domains of RN Practice

- Primary care RNs build capacity to care for patients in the panel and enhance care quality
- Primary care RNs perform complex care management, chronic disease management, engage in primary and secondary prevention and health promotion
- Primary care RNs see patients independently and under standing orders and delegated order sets
- May take the lead in Medicare Annual Wellness Visits
One in five individuals in America has a mental health issue

Many of the health issues we address in primary care also have a behavioral health component

We need a strategy for both in-reach and outreach

We need both therapists and psychiatric medical providers

Our patients benefit from both individual and group treatment

Warm hand-offs from primary care to behavioral health increase the chance of a successful referral
Pharmacists

- Pharmacists who are co-located with primary care delivered favorable results with respect to chronic disease management and evidence-based use of medications in about 50% of studies reviewed. (Tan, Stewart, et al 2014)

- “Primary care providers believe that comprehensive medication management improves their work life.” (Funk KA, et al. J Am Board Fam Med. 2019 Jul-Aug)

- Clinical pharmacist can be invaluable in efforts to achieve performance targets in value-based care contracts
Meeting the Need for Just In Time Care
Adding Urgent Care Clinic/Providers to our Team
New Team Players

- Population health team, direct and indirect
  - Population health RN, Pop health data specialist, Community Health Worker, outreach workers
  - Integrated care meeting coordinator for high risk/need/complex patients
  - Business intelligence/data analyst(s)
  - 24-hour RN triage, education, and advice line
  - “Patient Ping” just in time data on patient transitions
  - Process redesign and improvement coaches
Goals of Population Health Department

① Improve patient outcomes by every means possible
② Increase purposeful spending and reduce wasteful spending
③ Secure appropriate reimbursement from value-based work
Novo—Managing the Patient Relationship

*Internal Rules Engine takes into account:

- No show hx
- Panel size management
- Age restrictions
- Specialties
- PCMH+ risk scores
- ED visits
- Load balances longer appointment types, i.e., physicals and initials
Training Providers to a New Model of Care

Weekly, distance, case-based learning with a team of experts to focus on patients with chronic pain, HIV, Hepatitis C, OUD, complex pediatrics, behavioral health, and more.
Beyond the Team—Support for Providers

- Access to Experts
  - Using Project ECHO and eConsults to tackle “Hot Spots”
  - CME Support
  - Faculty Leadership Development

- Opportunity for Teaching
  - Dedicated, teaching time (precepting)

- Opportunity for Research
  - Weitzman Institute
  - Quality Improvement/Microsystems
Training the Next Generation—
What’s Available in FQHCs?

- Postgraduate NP Residency Programs
- Postdoctoral Clinical Psychology Residency Programs
- National Institute for Medical Assistant Advancement (NIMAA)
- Teaching Health Centers (medical residencies)
- Teaching Health Centers (dental residencies)
- Dedicated Education Units for RNs
- Administrative Fellowships
A Growing Shortage of PCPs

Growing Ranks of Advanced Practice Clinicians—Implications for the Physician Workforce
David Auerbach, Douglas Staiger, and Peter Buerhaus

“Two thirds of the health care providers joining the U.S. workforce by 2030 will be nurse practitioners (NPs) or physician assistants (PAs). The large influx will have its greatest effect in primary care where fewer physicians are choosing primary care.”
—The New England Journal of Medicine
June 2018

Estimates of primary care physician shortage of 21,000-50,000 by 2032
AMA, 2019

Rural and Nonrural Primary Care Physician Practices Increasingly Rely on Nurse Practitioners

“By 2016, NPs constituted 25.2 percent of providers in rural and 23 percent in nonrural practices.”
—Health Affairs
June 2018
Growth and Spread of Postgraduate NP Training Programs
Growth and Spread of Postgraduate NP Training Programs

Primary Care Nurse Practitioner Postgraduate Training Program Sites Across the Country

- 71 currently operational postgraduate NP residency and fellowship training programs
- Nationally, over 500 primary care NP Residency and Fellowship graduates—and growing!

Nurse Practitioner (NP) Postgraduate Training Programs

ARIZONA
- 2019: El Rio Health Center, Tucson

ALABAMA
- 2018: Cahaba Medical Care Foundation, Centreville

CALIFORNIA
- 2011: Glide Health Services and UCSF/UCLA NP Residency*, San Francisco
- 2012: San Francisco VA Medical Center, San Francisco
- 2012: Santa Rosa Community Health Centers, Santa Rosa
- 2015: Leflore Medical Care, Berkeley
- 2015: Shasta Community Health Center, Redding
- 2016: Open Door Community Health Center, Aracata
- 2016: Greater Los Angeles VA Medical Center, Los Angeles
- 2017: Aetna Community Health Center, Lemoore
- 2017: Asian Health Services, Oakland
- 2018: Clinicas de Salud del Pueblo (Brawley 2018), Health Right 360 (Lyton Martin Health Services), San Francisco
- 2018: Petaluma Health Center, Inc., Petaluma
- 2019: Clinicas de Salud, El Centro

COLORADO
- 2015: Peak Vista Community Health Centers, Colorado Springs

CONNECTICUT
- 2007: Community Health Center, Inc., Middletown
- 2011: VA Connecticut Healthcare System, West Haven

DELAWARE
- 2017: Christiana Care, Wilmington

FLORIDA
- 2016: West Kendall Baptist Hospital, Miami
- 2016: Baycare Health System, South Bay

HAWAII
- 2015: Waiakea Coast Comprehensive Health Center, Waiakea

IDAHO
- 2012: Boise VA Medical Center, Boise

ILLINOIS
- 2016: OSF Healthcare, Peoria
- 2019: Esperanza Health Centers, Chicago

INDIANA
- 2016: HealthLinc, Valparaiso

MAINE
- 2011: Penobscot Community Health Care*, Bangor

MASSACHUSETTS
- 2016: Reliant Medical Group, Leominster
- 2019: Baystate High Street Health Center, Springfield
- 2019: Harbor Health, Mattapan
- 2019: Holyoke Health Center, Holyoke
- 2019: Northshore Community Health Center, Salem

MINNESOTA
- 2019: Health Partners Institute, Minneapolis

MISSISSIPPI
- 2015: North Mississippi Medical Center Clinic, Tupelo

MISSOURI

NEW HAMPSHIRE
- 2017: Lamprey Health Care, Newmarket

NEW JERSEY
- 2018: Henry Austin Health Center, Trenton

NEW YORK
- 2015: Morris Heights Health Center*, Bronx
- 2015: Community Health Care Network, New York
- 2016: Highland Family Medicine, Rochester
- 2017: The Institute of Family Health, Bronx
- 2017: HHC Care, Jeannette J. Phillips Health Center at Peekskill, Peekskill
- 2018: Wyckoff Heights Medical Center, Brooklyn
- 2019: The Jewish Board, New York
- 2019: Urban Health, Bronx

NORTH CAROLINA
- 2016: The Western North Carolina Community Health Services, Asheville
- 2016: The Center for Advanced Practice—Atrium Health, Charlotte
- 2016: University of Rochester, Rochester

OHIO
- 2013: Louis Stokes Cleveland VA Medical Center, Cleveland
- 2019: Nationwide Children’s Hospital, Columbus

OREGON
- 2015: PeaceHealth, Eugene
- 2016: Yakima Valley Farmers Workers Clinic, Salem

PENNSYLVANIA
- 2012: Puentes de Salud, Philadelphia
- 2019: Lancaster Health Center, Lancaster

RHODE ISLAND
- 2015: Thedermist Health Center, Woonsocket
- 2019: Providence Community Health Center, Providence

SOUTH CAROLINA
- 2016: Lexington Medical Center, West Columbia
- 2017: Spartanburg Regional Healthcare System, Spartanburg

TENNESSEE
- 2019: Johnson City Community Health Center, Johnson City

TEXAS
- 2017: CommunityCare and the University of Texas at Austin School of Nursing, Austin

VIRGINIA
- 2016: Bon Secours Richmond Health System, Midlothian

WASHINGTON
- 2012: Community Health Care, Tacoma
- 2013: VA Puget Sound Health Care System, Seattle
- 2014: Columbia Basin Health Association*, Othello
- 2014: International Community Health Services, Seattle
- 2014: Yakima Valley Farm Workers Clinic, Yakima
- 2015: The Everett Clinic, Everett
- 2015: Primary Care Advanced Practice Fellowship—MultiCare Health System, Puyallup
- 2015: Sea Mar Community Health Centers, Seattle
- 2017: CHS Health, Spokane
- 2018: Seattle Children’s Hospital, Seattle
- 2019: Peninsula Community Health Services, Bremerton

U.S. Department of Veterans Affairs Centers of Excellence in Primary Care Education (CoEPE)
Primary Care Nurse Practitioner (NP) Postgraduate Residencies

CALIFORNIA: Los Angeles; San Francisco

CONNECTICUT: West Haven

IDAHO: Boise

OHIO: Cleveland

WASHINGTON: Seattle

*Not currently active
The NIMAA Vision and Opportunity

NIMAA Students

- Trained for team-based primary care; gateway to health
- Participate in caring for the underserved
- Learn online in parallel with clinical experience
- Learn from national experts/evidence-based approach
- Receive assistance in finding a job; start with your externship site
- Pay an affordable tuition: $6,000 for 7 month program
Training the Next Generation—
All the Professions!
The Virtualization of Primary Care

- Virtual primary care is just one point on the telehealth continuum, a continuum which includes face to face, real time communication via video, email, or phone in the context of an established or random relationship.

- It raises the question:

  *Can only primary care services be delivered virtually, or can a primary care relationship be developed in which those services can be delivered?*

- Change is afoot. And it offers opportunities, just like the retail clinics did 15 years ago.
Leadership circles
Emerging leaders circles
Opportunity to lead in professional organizations
Coaches and clinical champions
PIs and Project Leads
Preceptors for health professions students/trainees
Faculty for ECHO
Clinical leadership/supervisory/roles
Opportunities to teach, write, precept, consult, research, lead, coach, organize, develop

Creating Platforms of Growth for Our Teams