Working at “Top of License”
How do you reallocate work among a team?

January 28, 2015
We Want To Hear From You!

Type questions into the Questions Pane at any time during this presentation.
Patient-Centered Primary Care Institute

Online Modules
Webinars
Website
Learning Collaboratives
Trainings
TA Network
PCPCH Model of Care

Oregon’s PCPCH Model is defined by six core attributes, each with specific standards and measures

- **Access to Care**  “Health care team, be there when we need you”
- **Accountability**  “Take responsibility for making sure we receive the best possible health care”
- **Comprehensive Whole Person Care**  “Provide or help us get the health care, information and services we need”
- **Continuity**  “Be our partner over time in caring for us”
- **Coordination and Integration**  “Help us navigate the health care system to get the care we need in a safe and timely way”
- **Person and Family Centered Care**  “Recognize that we are the most important part of the care team - and that we are ultimately responsible for our overall health and wellness”

Learn more: http://primarycarehome.oregon.gov
Introduce Presenter

Elicia Miller, RN, BSN, PHN
Primary Care Innovation Specialist, Lead
Care Oregon
Stories from MA Perspective:

Scott Zahlmann, MA, EMT-P
Population Health Supervisor
CareOregon
Objectives:

• Define boundaries around “top of license” work allocation
• Explore the challenges associated with reallocating and changing work among the team
• Discuss leadership strategies for anticipating and responding to changes
• Review concrete tools and activities that can be used to address this challenge
Basic Medical Home Concepts

- Engaged Leadership
- Empanelment
- Care Team Development
- Care Coordination
- Strategic Use of Data
Basic Medical Home Concepts

- Engaged Leadership
- Empanelment
- Care Team Development
- Strategic Use of Data
Traditional Methods of Managing Workflow

Source: Southcentral Foundation

Situation “A”
Time Needed Today to Meet Patient Needs:

- Preventive Care: 7.4 hours
- Evidence Based Care: 10.6 hours

Team-Based Care

• Care Team may include:
  – Provider
  – MA
  – RN Care Coordinator
  – Panel Manager
  – Front Desk
  – Pharmacist...Behaviorist...Medical Records...

• Using each care team member at the “top” of their license or skill set
Parallel Work Flow Redesign

Source: Southcentral Foundation

Situation “B”
POLL:

- On a scale of 1-10 where do you think your clinic currently is?

1. Work not well distributed across diversity of team members.

10. High Functioning Teams with work well distributed across roles.
What Do We Do With All This Work??
Use your team members!!
How Do We Do This??
How To Use Your Team Members:

• **With staff**, assess current work being done as well as work that still needs to be done?

• Is the most appropriate staff member doing the work?
  – Is your RN on the phone all day or doing high-level RN visits?
  – Are the providers hunting down medical records?

• Involve Staff in reallocation of work

• Encourage thinking outside of the box problem solving
Some Tools We have Found Helpful in the Past:
## Reassignment of Work:

<table>
<thead>
<tr>
<th>Work:</th>
<th>Role Doing this work currently:</th>
<th>Have to Do It:</th>
<th>Other Team Members That Could:</th>
<th>What Need To Achieve Change:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Order standard DM follow-up labs.</td>
<td>Provider</td>
<td>No</td>
<td>MA, RN, Lab Tech, Front Desk</td>
<td>Training, protocols,</td>
</tr>
<tr>
<td>Weight management Education</td>
<td>Provider, RN</td>
<td>No</td>
<td>MA, Community Health Worker,</td>
<td>Training, monitoring,</td>
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<td></td>
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<td>protocols, clear expectations</td>
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<tr>
<td>Triage</td>
<td>RN</td>
<td>Yes</td>
<td>LPN (?)</td>
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</tr>
<tr>
<td>Take phone message for provider</td>
<td>?</td>
<td></td>
<td>Front desk, medical records,</td>
<td>Protocols, training,</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>MA, panel manager</td>
<td>expectations</td>
</tr>
</tbody>
</table>
Your current role on the team: __________________________

<table>
<thead>
<tr>
<th>Patient Centered Primary Care Home Team Tasks</th>
<th>Priority Task</th>
<th>Your Role Now</th>
<th>If no, whose role?</th>
<th>Your Comfort Level Now</th>
<th>Would Like to Continue or Start Doing</th>
<th>Training or Organizational Change Needed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being a Team</td>
<td>Yes No</td>
<td>Yes No</td>
<td>High Med/Low</td>
<td>Yes No</td>
<td>Yes No</td>
<td>Yes No</td>
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<tr>
<td>Develop agenda for team meetings</td>
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<td>Lead team meeting</td>
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<td>Attend team meeting</td>
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<tr>
<td>Record decisions of team meeting and track follow up</td>
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<tr>
<td>Participates in huddle to review needs of scheduled patients</td>
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<tr>
<td>Proactive Work</td>
<td>Yes No</td>
<td>Yes No</td>
<td>High Med/Low</td>
<td>Yes No</td>
<td>Yes No</td>
<td>Yes No</td>
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<tr>
<td>Pre-visit chart review for gaps in care before patient visits</td>
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<tr>
<td>Pre-visit chart review for gaps in care for same day visits</td>
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<tr>
<td>Create paper checklist of gaps in care for provider visit (optional)</td>
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<td>Identify patients without a recent visit for gaps in care</td>
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<td>Outreach to patients not seen for gaps in care</td>
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<td>Contacts patients (via telephone calls, reminder letters, and/or emails) to remind them of appointments</td>
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<tr>
<td>Visit Based Work</td>
<td>Yes No</td>
<td>Yes No</td>
<td>High Med/Low</td>
<td>Yes No</td>
<td>Yes No</td>
<td>Yes No</td>
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<tr>
<td>Review schedule to define needs for patient visit</td>
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<tr>
<td>Gathers documents related to visit (eg. ED records)</td>
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<td>Rooms patients and performs established screenings</td>
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<td>Medication verification and reconciliation</td>
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<td>Creates after visit summary (AVS)</td>
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<tr>
<td>Reviews AVS with patient at discharge</td>
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<td>Generates referrals</td>
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<td>Generates referral authorization requests/schedules referrals</td>
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<tr>
<td>Checks and restocks rooms for supplies/equipment</td>
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<tr>
<td>Follow Up Work</td>
<td>Yes No</td>
<td>Yes No</td>
<td>High Med/Low</td>
<td>Yes No</td>
<td>Yes No</td>
<td>Yes No</td>
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<tr>
<td>Calls patients for ED follow up</td>
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<td>Calls patients for hospital follow up</td>
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<td>Receives refill requests</td>
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<tr>
<td>Authorizes refill requests</td>
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<td>Tracks referrals for completion</td>
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<td>Schedules patients for visits</td>
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<tr>
<td>Reactive Work</td>
<td>Yes No</td>
<td>Yes No</td>
<td>High Med/Low</td>
<td>Yes No</td>
<td>Yes No</td>
<td>Yes No</td>
</tr>
<tr>
<td>Answers calls from team patients about health concerns</td>
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<tr>
<td>Answers calls from patients about administrative issues (forms, authorizations, etc)</td>
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</tr>
</tbody>
</table>

Adapted from UW Impact Program
## Examples of Extremes

<table>
<thead>
<tr>
<th>Collaborative Care Tasks</th>
<th>On the Team: Responsible for the Panel</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Staff1</td>
</tr>
<tr>
<td></td>
<td>PCP</td>
</tr>
<tr>
<td><strong>Being a Team</strong></td>
<td></td>
</tr>
<tr>
<td>Develop agenda for team meetings</td>
<td>X</td>
</tr>
<tr>
<td>Lead team meeting</td>
<td>X</td>
</tr>
<tr>
<td>Attend team meetings</td>
<td>X</td>
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<td>X</td>
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<tr>
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<td>X</td>
</tr>
<tr>
<td>Create paper checklist of gaps in care for provider visit (optional)</td>
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<td>X</td>
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<tr>
<td><strong>Visit Based Work</strong></td>
<td></td>
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</tbody>
</table>
“Share The Care” Before:
### “Share The Care” After:

<table>
<thead>
<tr>
<th>PRIMARY CARE PROVIDER</th>
<th>REGISTERED NURSE</th>
<th>MEDICAL ASSISTANT/LICENSED PRACTICAL NURSE</th>
<th>FRONT OFFICE</th>
<th>NOBODY</th>
<th>OTHER</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evaluate knee, recurring headaches</td>
<td>Take initial patient history using EHR template</td>
<td>Insure patient of abnormal lab tests</td>
<td>Control patients in community resources</td>
<td></td>
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<tr>
<td>Management of adult patients with hypertension</td>
<td>Warfarin management (anti coagulation)</td>
<td>Lead daily huddle</td>
<td>Keep track daily of missed and cancel appointments</td>
<td></td>
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<tr>
<td>Talk with patient about treatment options for prostate cancer</td>
<td>Refill high blood pressure medications for patients with well-controlled hypertension</td>
<td>Perform Diabetes foot exams</td>
<td>Identify people who need influenza immunizations and administer those immunizations by protocol</td>
<td></td>
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</tr>
<tr>
<td>Medication reconciliation for patient with 4+ meds</td>
<td>Treat uncomplicated urinary tract infections</td>
<td>Under Menopause for women 50-75 years of age</td>
<td>Review lab results to separate normal from abnormalities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medication reconciliation for diabetes patients with 2 meds</td>
<td>Manage referrals for chronic pain patients taking opioids</td>
<td>Refill patients of normal lab tests</td>
<td>Use protocols to squeeze in same-day patients</td>
<td></td>
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</tr>
<tr>
<td>Discuss CRC screening options with patient</td>
<td></td>
<td>Find patients outside for LDL and order labs</td>
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</tbody>
</table>

- **Depression screening and follow-up**
- **Help patients make plans to increase physical activity or remind to take medications**
Primary Care
Population Health Strategies

1. Panel Management
   - Registries
   - Gaps in Care Outreach
   - Planned Visits

2. Care Management for Chronic Disease
   - Self Management Support
   - Medication Management
   - Care Coordination
   - Patient Education
   - Patient Activation

3. Complex Case Management for high risk/cost patients
   - Complex Care Coordination
   - Problem Solving
   - Linking with Community Resources
   - Empowerment and Education
   - Transitional Care (post hosp/ED)

Applies to entire population
First stage

Builds on existing panel management work. Applies to subset of population.
RN and CHW Roles Within the Continuum of Care

**Clinical Case Management:** RN
- Clinical monitoring
- Medication management
- Logistical
- Self-management support

**Clinical Follow-up Care:** RN or Health Navigator
- Logistical
- Self-Management Support (Health Navigator under supervision of RN)

**Care Coordination:** Health Navigator
- Transportation assistance
- Social Services resource connection
- “Barrier-Busting”
- Phone calls
- Work with Referral Specialist
- Assistance filling out paperwork and documents
- Chart review to assess need (under supervision of RN)

Adapted from MacColl Institute for Healthcare Innovation, Group Health Research Institute 2011
Level of Care Matrix

Community Health Worker

Low Risk
- Oral medications
- Stable or no insulin
- Hgb A1c <7
- None or stable comorbidities

Moderate Risk
- Stable insulin dosing
- Hgb A1c <8
- Unstable housing
- Food insecurity
- Limited English proficiency
- Unemployment
- Social isolation
- Transportation barriers
- Medical or mental health condition that has potential to put client's health at risk

High Risk
- Hgb A1c >8
- High insulin dose
- Adjusting insulin dose
- Unstable co-morbidities
- New diagnosis
- Mental health concerns
- Substance abuse

RN Care Coordinator
Top Of License Work:
What is Top of License Work?

<table>
<thead>
<tr>
<th>RN</th>
<th>LPN</th>
<th>MA</th>
</tr>
</thead>
</table>
| 2(a)Conduct initial and ongoing comprehensive and focused nursing assessments of the health status of clients  
2(b)Document nursing diagnostic statements  
2(c)Develop and coordinate a comprehensive and/or focused plan of nursing care  
2(d)Implement the plan of care  
2(e)Evaluate the plan of care | 2(a)Conduct initial and ongoing focused nursing assessments of the health status of clients  
2(b)Document nursing diagnostic statements  
2(c)Contribute to development of comprehensive plan of care and develops focused plan of nursing care  
2(d)Implement the plan of care  
2(e)Evaluate the plan of care | Collects data and reports observations to contribute to the development and execution of the client plan of care. |

*Interpretation based on Oregon State Board of Nursing*
Development of Protocols for Focused Nursing Visits:

• **Standing orders and protocols:** “may be used to authorize administration of medication or provision of a prescription to an individual patient ("patient specific protocols") or for an individual condition ("condition specific protocols") Oregon Board of Nursing, *Sentinel*, vol.30, no.2, June 2011

• **Designing a strong nursing visit:**
Lead The Change...
Even if it Just Means Being There

Be the kind of leader that you would follow.
Leadership Strategies

• Collaboration with staff for the process

• Why is this important to the clinic staff?

• Identify clinical leaders
  – MA, Front Desk, RN, Panel Manager, provider
What Infrastructure Can Ease Transition:

- Support from senior leadership
- Role definition/ transformation
- Commitment to all team members working at top of skill or licensure
- Standard workflows developed
- Inclusion of team members not typically thought of as team members:
  - Medical records
  - Referral coordinator
Assess Infrastructure Needs

• Be prepared to support the work:
  – Written and agreed upon protocols for staff
    • MA’s performing diabetic foot exams
  – Standard care guidelines
    • Hypertension recall standards
  – Training
    • Scripting for front desk staff for scheduling appointment
    • Upskilling community outreach workers
    • RN training for new role (changing from phone triage to visits)
  – Incorporate commitment into all aspects of hiring process
    • Position Descriptions
    • Additional set of “soft” skills
A Culture Shift Across the Organization

• Patient centeredness
  – Patient runs the show

• Commitment to model
  – There will be rough times

• Trust between team members
  – Knowing that the work will get done

• Communication between team members

• Buy-in at every level
What Questions Do You Have?

Type questions into the **Questions Pane** at any time during this presentation.
Please Complete the Post-Webinar Survey!