PHM INITIATIVE

CARE TEAMS AND WORKFORCE GUIDE

Population Health Management Initiative (PHMI), a California collaboration of the Department of Health Care Services, Kaiser Permanente, and community health centers.

CARE TEAMS AND WORKFORCE GUIDE EXECUTIVE SUMMARY

Why Care Teams and Workforce Matter

Recent research shows that a single primary care clinician would need 26.7 hours in a day to provide all the evidence-based preventive, chronic illness and acute care to an average panel of patients.[1] The good news is that a single clinician does not have to do it all! Team-based care — when two or more healthcare professionals work collaboratively with patients and their caregivers to accomplish shared goals[2] — can help practices to deliver high-quality primary care, leading to better health outcomes[3] and experiences for patients.[4]

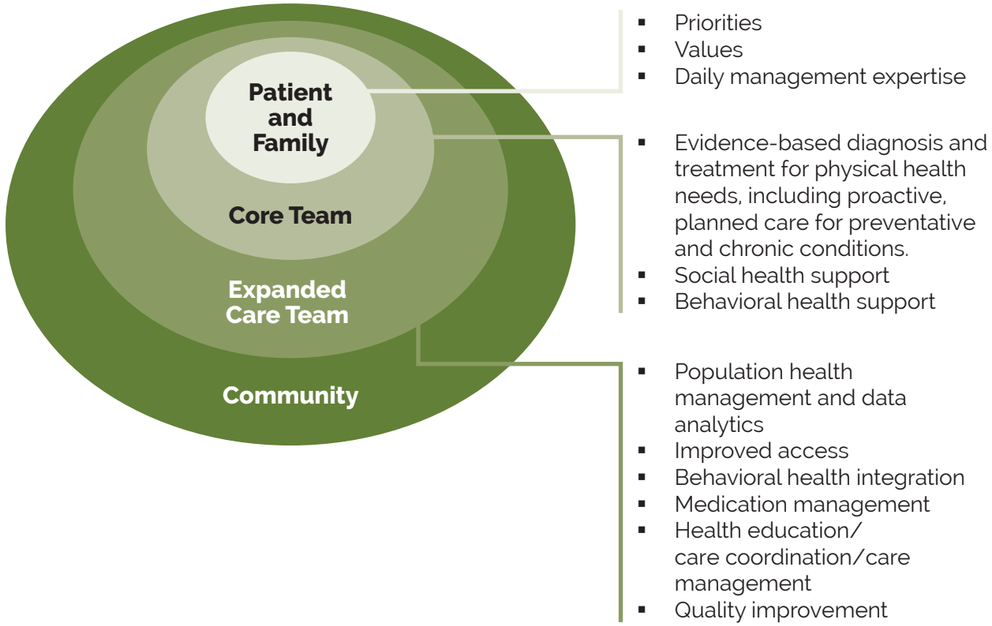
Strengthening care teams is increasingly recognized as a critical foundation for high performing primary care, with CalAIM adding community health workers and doula services as a covered benefit. Engaging nurses, behavioral health specialists, lay health workers, medical assistants and others as key partners in caring for patients increases access to behavioral health and social need services.[5] Sharing the work of primary care among a team of professionals can improve staff and clinician experience[6] — a critical consideration in this post-COVID environment when the healthcare workforce is struggling with burnout and overwork.

What the Care Teams and Workforce Guide Offers

This guide offers a practical, tested approach to building and supporting team-based care, starting with the intentional identification of a core team of people who together can provide care for most of the patient needs on their panel. Centering the cultivation of continuous healing relationships between patients, families and their care teams, the guide then shows how to build out the expanded care team to assure the functions of high performing primary care are in place. Finally, the guide offers a map for how different care team roles can help to support those functions, including licensure and full-time equivalent (FTE) considerations.

For organizations interested in going deeper, additional content on facilitating teamwork and fostering joy in work is available. Finally, the guide covers team-based care topics on the horizon, such as structuring teams for virtual care and thinking about care provision outside the walls of traditional primary care clinics.

FIGURE 1: PRIMARY CARE TEAM: CORE AND EXPANDED CARE TEAMS AND THE FUNCTIONS EACH PERFORMS.



Who Needs to Be Involved in the Work

Reimagining care teams effects everyone in the practice, as it impacts care delivery, communication, culture and budgets. Critical leadership roles needed to support an organization's approach include:

- Clinical leadership like a chief medical officer to design and support care team changes, including changes to clinical schedules and coverage arrangements.
- Financial leadership like a chief financial officer to examine revenue and expense implications of modifying, adding or removing care team roles.

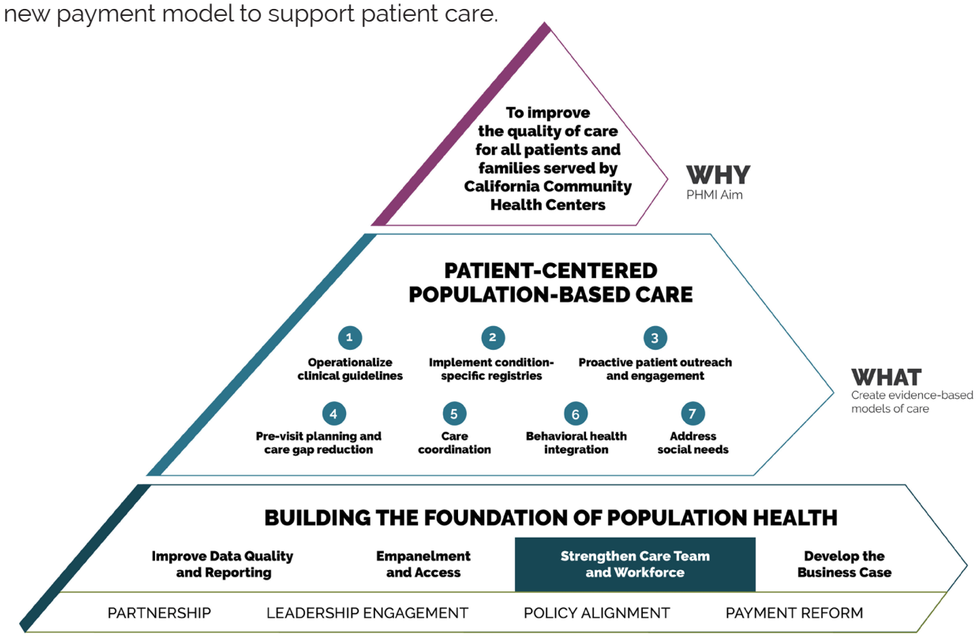
- Quality improvement leadership like a director of quality improvement (QI) to support cultural changes and reimagine how teams work, including fostering communication and trust.

In addition to strong, aligned leadership, care team members themselves must be part of any effort to redesign care teams. Clinicians, nurses, community health workers and behavioral health providers know the needs of their patients best and have critical insights into how current role and task distribution works or doesn't. Care team redesign means changing what people are asked to do each day. Involving staff and clinicians in design and decision-making about their work is critical to get the best ideas and create lasting change.

When to Use the Care Teams and Workforce Guide

Care teams and workforce is a critical foundation for patient-centered population-based care.

This guide is the third in the "Building the Foundation" series of implementation guides. Care teams and workforce is a critical foundation for patient-centered population-based care. As you get started with care teams, the Business Case Guide can help model the revenue and expense implications of any choices to add or redeploy staff or shift to a new payment model to support patient care.



Advancing Equity through Care Teams and Workforce

Health equity—the principle that each person has an opportunity to be as healthy as possible—is enhanced by improving access to the conditions and resources that support health.[7] Working as part of the Population Health Management Initiative (PHMI), practices can contribute to improving health and reducing disparities as they build their care teams by:

- Prioritizing lived experience during hiring and recruitment. CalAIM's expanded coverage of community health services, for example, may enable practices to recruit staff to do more to understand and address health-related social needs that impact patients who have been economically disadvantaged by our systems.
- Exploring racial, ethnic and cultural concordance between clinicians and patients, as well as preferences as they relate to sexual orientation and gender identity, are potentially powerful considerations for improving health[8], and considering these dynamics when structuring patient panels and care teams.
- Thinking about how power and expertise is shared among staff, clinicians, and patients and their families, including building psychologically safe environments and practicing shared decision making.
- Supporting teams' skills and abilities to address the needs of subpopulations of patients attending to their specific care needs and structural barriers to health, including tailoring interventions to address root causes of disparities.

Summary of Key Activities

The key activities covered in this guide include:

1. Develop and test a core care team structure.
2. Identify gaps in staffing and decide how to address them.
3. Engage patients.
4. Leverage teams to lead continuous improvements.

After working through the key activities above, you will be able to:

- Define and establish a core care team incorporating team-based care principles.
- Assure that care teams know their patient panels (applies only if the practice is also working on empanelment or has it in place).
- Assure that patients know their care team.
- Build expanded care team functions that incorporate team-based care principles.

Additional content is available for practices interested in going deeper and exploring what's on the horizon.

Tools and Resources

These tools were developed for PHMI and can also be used by a wide range of primary care practices. They are open-source: we encourage you to take these tools and adapt them to best meet the needs of your organization and the communities you serve.

Resource	Description
Care Team and Workforce Resource 1: Core and Expanded Care Team Functions, Team Members and Roles	This tool provides an overview of the functions that high-performing primary care practices deliver reliably and proposes a potential array and FTE of team members to do so. Different teams will adjust these roles and FTE to fit their context.
Care Team and Workforce Resource 2: Care Team Duties and Recommended Education and Licensure	This tool is a companion to Resource 1 and offers more detail about the activities each care team member performs, along with recommended education and licensure.
Care Team and Workforce Resource 3: Role of the Pharmacist in the Care Team	This resource offers a deeper dive into the role of the clinical pharmacist and how they contribute to delivering high-quality primary care.
Care Team and Workforce Resource 4: Daily Huddles Overview and Process	This guide for organizing daily huddles supports one of the ways teams can work together to communicate and manage care.
Care Team and Workforce Resource 5: CalAIM Guidance for New Covered Services	These documents from the state outline the new community health worker and doula requirements from CalAIM. View guidelines for community health workers View guidelines for doulas
Care Team and Workforce Resource 6: Workflow Examples	This document provides common workflows for pre-visit planning, proactive outreach and engagement, among other activities to jumpstart your thinking.

Contacts for Support

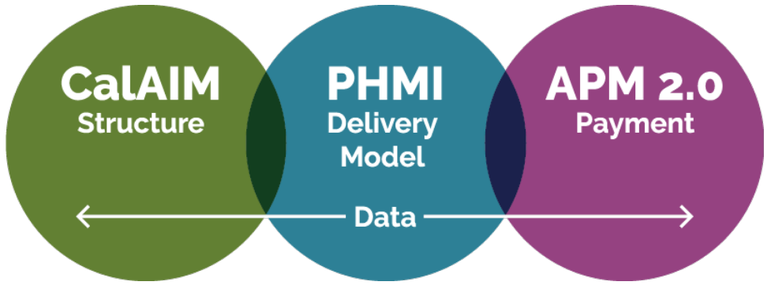
If you are part of PHMI, contact your coach. If you are part of Equity and Practice Transformation (EPT), visit the EPT website or contact your managed care plan. Otherwise, reach out to us at phm_initiative@kp.org

About PHMI

Community health centers, Regional Associations of California (RAC), California Primary Care Association (CPCA), Department of Health Care Services (DHCS), and Kaiser Permanente are partnering to transform care for Medi-Cal beneficiaries. Together, we are working to advance population health management capabilities in order to eliminate health disparities and improve the health of people and communities.

Through collaborative design with community health centers and the support of Kaiser Permanente, PHMI is aligning with CalAIM and APM 2.0 to:

- Focus on shared priority measures and populations, including children, pregnant people, people with behavioral health conditions, and adults living with chronic conditions and preventive care needs.
- Engage resources and expertise to create population health management solutions that work.
- Invest in technology solutions to improve data capabilities.



ENDNOTES

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6 Willard-Grace R, Hessler D, Rogers E, Dube K, Bodenheimer T, Grumbach K. Team structure and culture are associated with lower burnout in primary care. J Am Board Fam Med. 2014;27(2):229-38.

7 Advancing Health Equity. Defining Health Equity Chicago: Advancing Health Equity; [July 10, 2013]. Available from: https://advancinghealthequity.org/roadmap-to-ahe/.

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