Topic Area	Question	Person Who Asked	Person Who Responded	Responses Shared	Resource Description	Resources Link
Outreach	Has anyone struggled or have experience with population health outreach with clinical staff?		Linda D'Agati, **Open Door**	Teams are so impacted by the needs of patients during the day-to-day that there isn't much time to do the outreach for preventive services. Doing outreach at a smaller site is much more doable (and easier to squeeze in between tasks). Most of our staff members enjoy the outreach/QI work. Once people are trained and see the results, they are up for it. Outreach staff do bi-weekly check-ins with QI staff to discuss best practices and scripts. The people are FTE in QI dept are mostly MAs that can't work the floor full time anymore, so it's not a career ladder.	Compentency Assessement by Clinic Role from Clinica Family Health (useful for thinking about career ladders)	https://www.careinnovations.org/wp-content/uploads/5.-Competency-Assessments_CP3-Toolkit.pdf
			Carolyn Shepherd, **Clinica Family Health**	There were many ladders that allowed staff to move up if they met certain competencies. For example, when front desk staff got to relate with patients beside just checking them in at the front staff, they enjoyed it more.		
			Nancy Yu, **NEMS**	We have a Patient Health Coach (similar to navigators), who will graduate to become MA 1 and MA 2. We have RNs who become nursing team leads.		
			Deizel Sarte, **North County**	We have centralized all outreach staff. There's minimal outreach happening from the clinic sites.		
MA Roles	Do you have unionized support staff? (In response to Linda) If you're not paying them any differently, how do you reconcile the fact that certain MAs have additional tasks added to their duties?	Christine Park, **NEVHC**	Linda D'Agati, **Open Door**	All MA should have outreach work as part of the tasks that they do. A lot of the MA outreach work includes "you need to come in and get this lab."		
			Bonnie Trinclisti, **Native American Health Center**	We have changed the MA positions who are unionized by reviewing the job descriptions when the union contract was re-negotiated. Their reps have an opportunity to give feedback prior to the JD change and the contract ratification.		
CPT codes for Chronic Care Management (CCM)	(To Lynette and larger group) Do you have any suggestions for the CPT codes that would be eligible for chronic care management? We currently have non face to face visit that you can bill up to 20 minutes each month for Medi-Care patients. Looking for ICT10 diagnoses that qualify for claims for CCM.	Nancy Yu, **NEMS**	Lynette Harris, **San Ysidro**	I'm not sure which CPT codes to use, but I can find out.	Chronic Care Management Codes	**Chronic Care Management Services Changes for 2017 from CMS:** https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagementServicesChanges2017.pdf
			Christine Park, **NEVHC**	CPT codes: Medicare care coordination codes are G9001, G9005, G9006, G9007, G9008		**Chronic Care Management Codes Toolkit from ACP:** https://www.acponline.org/system/files/documents/running_practice/payment_coding/medicare/chronic_care_management_toolkit.pdf
Social Worker Roles	What are your thoughts on having a social worker on the care team?	Lynette Harris, **San Ysidro**	Christine Park, **NEVHC**	We have LCSWs and LC Family and Marriage Therapists (the latter may start billing at the end of this month). We do warm handoffs from medical providers to BH providers. Currently trying to set boundaries about when medical providers can pull in BH providers. Just hired a psychiatric mental health nurse practitioner who can take referrals from BH providers to psychiatric medication management and take referrals from medical providers for patients who have failed 1st or 2nd line medication.		**Harvard SW job description available on line at:** http://improvingprimarycare.org/team/behavioral-health-specialist Clinica Social Worker Job description here.
			Carolyn Shepherd, **Clinica Family Health**	Clinica has a social worker (1 SW: 3.4 FTE clinica providers). SW is responsible for patients with high acuity and BH issues with high PQ9 score. Patients with lower PQ9 score are seen by a case manager, who are also on the team. They divided based on acuity of BH issues. SWs have open schedules during the day and see 2-4 patients a day for therapy sessions; the rest of the day are dedicated to seeing patients with care team. First month of SW was slow, but they are now a key.		
			Cynthia Musto, **NEMS**	We have both LSW and Psychiatric (in a very limited time slot).		
			Deizel Sarte, **North County**	We use a LCSW within our primary care clinics and is part of our integrated behavioral health program.		
			Bonnie Trinclisti, **Native American Health Center**	Every patient gets assessed by PHQ2/9 and any positives by MA or NP gets offered Warm Hnd Off for counselling same day--we have had great success with this.		
Roles & Standing Orders re: Chronic disease management	How do teams work to address chronic disease management? Example of roles responsibilities. Which team members work off of standing orders?	Louis Guitron, **LA LGBT Center**			Cambridge Health Alliance Team guide pgs 7-11 and from 17-27.	https://www.samhsa.gov/sites/default/files/programs_campaigns/samhsa_hrsa/team-based-care-implementation.pdf
Nurse Roles	Can you talk more about the integration of the RN on the team? What is the differene bewteen nurse team manager and clinic nurse role?	Lucretia Maas, **Communicare**	Carolyn Shepherd, **Clinica Family Health**	Clinica has a half time clinic nurse (helps care for patients coming in to be seen, does visits with clinicians) and a pod nurse (responsible for care management and outreach to high acuity patients, does "foot visits" and seeing patients on their own by standing order for presenting complaints and consult with PCP if needed).	One example: Serve the People Integrated RN's into care teams.	https://www.careinnovations.org/wp-content/uploads/2017/10/Spreading_Innovations_2016_Team_STP.pdf
Nurse Roles	Anyone using nurses in similar way?	Lucretia Maas, **Communicare**	Linda D'Agati, **Open Door**	All care teams have nurses who are involved with providing visits based on protocol, eg, acute services, and are included in running hypertension and diabetes education and haven't yet gotten them to start administering medications. Sometimes, nurses will bill their visit depending on the payer, we have a lot of commericla payers. If they're seeing an FQHC-billable visit, they bring in care team provider, who reviews care plan with patient. They also have panels of patients that they follow (eg, food, therapy, HIV case management). We push providers to allow nurses to do what they need to do.		
Standing Orders	Can we hear more about which teams work off of standing orders and which standing orders are in place?	Lynette Harris, **San Ysidro**	Bonnie Trinclisti, **Native American Health Center**	Every patient gets assessed by PAHQ29 and any positives by an MA or MP get warm handoff for counseling from the same day. Great success with this!	Examples of standing orders from Clinica Family Health, West County and Petaluma Health Center as well as tips for developing standing orders.	**Visit this link and click on "Set Examples" and "Protocols" to download examples:** https://www.careinnovations.org/resources/cp3-population-health-toolkit/ **Tips on developing standing orders:** https://www.careinnovations.org/wp-content/uploads/8_Standing_Orders_CP3_Toolkit.pdf
			Tam Nguyen, **Tri-City Health Center**	We use the Collaborative Care Model from AIMS developed at University of Washington. We have psychologists, social workers, care coordinators and consulting psychiatrists. Care coordinators complete warm connections and connect directly with BH Provider for acute BH needs or crisis assessment and treatment.		
			Cathy Sakansky, **North County**	We have an internal registry interfaced with our electronic records that is home grown which is updated nightly. This system creates a summary of opportunities for health prevention and/or chronic management that we name the "cheat sheets" that are shared in the daily huddles with the care teams. These provide the knowledge of implementing standing orders and/or filling gaps of care which can be fulfilled with the health care team/provider as defined by the top of their license.		

			NEVHC	We use i2i Tracks to track preventive measures specific to age or chronic disease. Medical assistants use the i2i Tracks summary sheet when scrubbing charts the day before the visit. They use standing orders to order the labs, schedule mammograms, give FIT kits to patients. Family Medicine Care Coordinators and a centralized QI team runs lists of patients that need FIT tests or retinal photos, and contacts patients to bring them in.		
Population Health Tools: i2iTracks	What is i2i?	Casey McChesney, **Santa Rosa Community Health**	Robert Veliz, **NEVHC**	*i2iTracks is a population health system	CCI hosted webinar series for our PHASE program on i2i, you can access this along with tools, or visit i2i's website.	**More information about i2iTracks:** https://www.i2ipophealth.com/solutions/ **Webinar Link:** https://www.careinnovations.org/resources/actionable-phase-tools-i2itracks/
			Christine Park, **NEVHC**	*It's a pop health software that grabs data from our EHR used for referral tracking and population health management. Running lists.		
ADDITIONAL QUESTIONS & TOPICS TO ADDRESS						
Change management (re: administration)	I would like to move our staff to this new model but how do I get Administration to not think of RN as floor supervisors unless we hire new staff to see patients on a productivity model.	Cynthia Musto, **NEMS**				
Change management (re: roles and staff buy-in)	I would like to hear more about changing roles and implementing the changes especially in clinics where the longstanding employees whose roles need to change due to growth in our agency	Bonnie Trinclisti, **Native American Health Center**			This website is a guide that provides step-by-step direction on how to establish high-functioning teams and implement new functions essential to team-based care.	http://improvingprimarycare.org/getting-started
Job descriptions	More detail on Models and actual job descriptions and roles. ie. Nurse vs Pod RN at La Clinica	Melinda Carroll, **Chapa-De**			Position descriptions for a range of clinic staff, including administration/operations, behavioral health, case managers, and providers from Clinica Family Health.	https://www.careinnovations.org/wp-content/uploads/4.-Job-Description-Examples_CP3-Toolkit.pdf http://improvingprimarycare.org/team/registered-nurse-rn
PHLN teams' care team configurations	I'd like to see all PHLN participant's care team configuration including their panel sizes and # visits per day.	Linda D'Agati, **Open Door**				
RN Roles	NEVHC would like to learn more about the RN's role. Our RN's are having trouble with bandwidth: supervising staff, ensuring skills competency, care coordination, and triaging patients in person as well as through fax (discharge reports, med refills) and about RNs as floor supervisors	Christine Park, **NEVHC**			Position descriptions for a range of clinic staff, including administration/operations, behavioral health, case managers, and providers from Clinica Family Health.	https://www.careinnovations.org/wp-content/uploads/4.-Job-Description-Examples_CP3-Toolkit.pdf http://improvingprimarycare.org/team/registered-nurse-rn