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UCSF Department of Family & Community Medicine
Center for Excellence in Primary Care

Enhanced Care Teams

Population Health Learning Center
University of California Center for Excellence in Primary Care
Subject Matter Experts

Welcome

While we're waiting, please:

Rename yourself

1

Click the Participants icon

2

Hover over your name & click Rename

3

Add your name, pronouns and organization's name

Please no acronyms

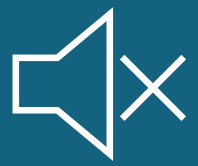
4

Click OK

If you connected to the audio using your phone

- Find your participant ID; it should be in the top left of your Zoom window
- Once you find your participant ID, press: #number# (e.g., #24321#) to connect your audio and video
- The following message should briefly appear: "You are now using your audio for your meeting"

Housekeeping Reminders



Mute

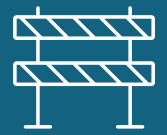
We will mute lines during the presentation to prevent background noise

Questions

Submit questions using the chat feature

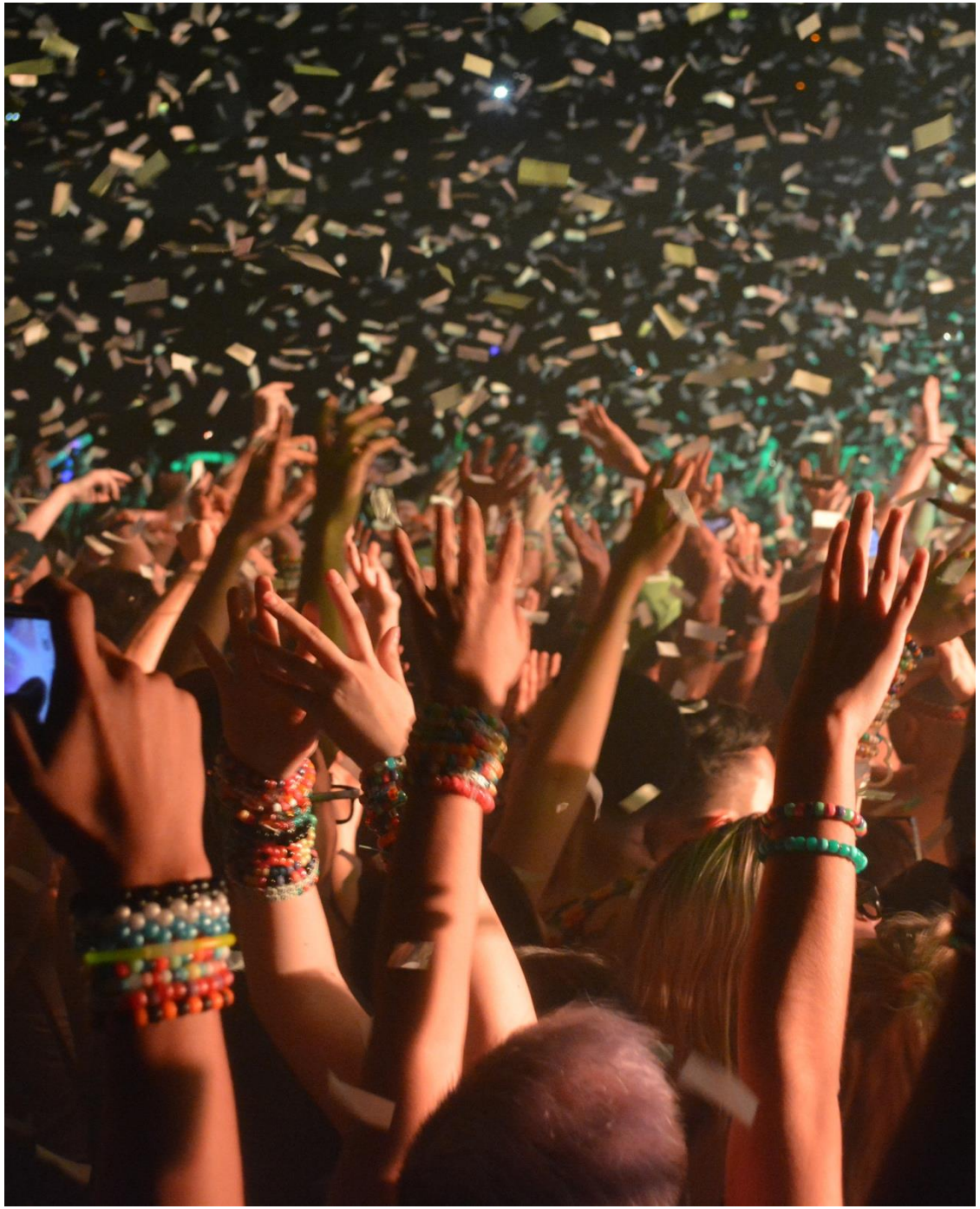
Slides + Recording

Slides and recording will be posted PopHealth+



Tech Issues

Private chat Rachel Kochhar for assistance



In the chat, please share…

- Your name
- Pronouns (if comfortable)
- Role
- Organization
- What was your first concert?

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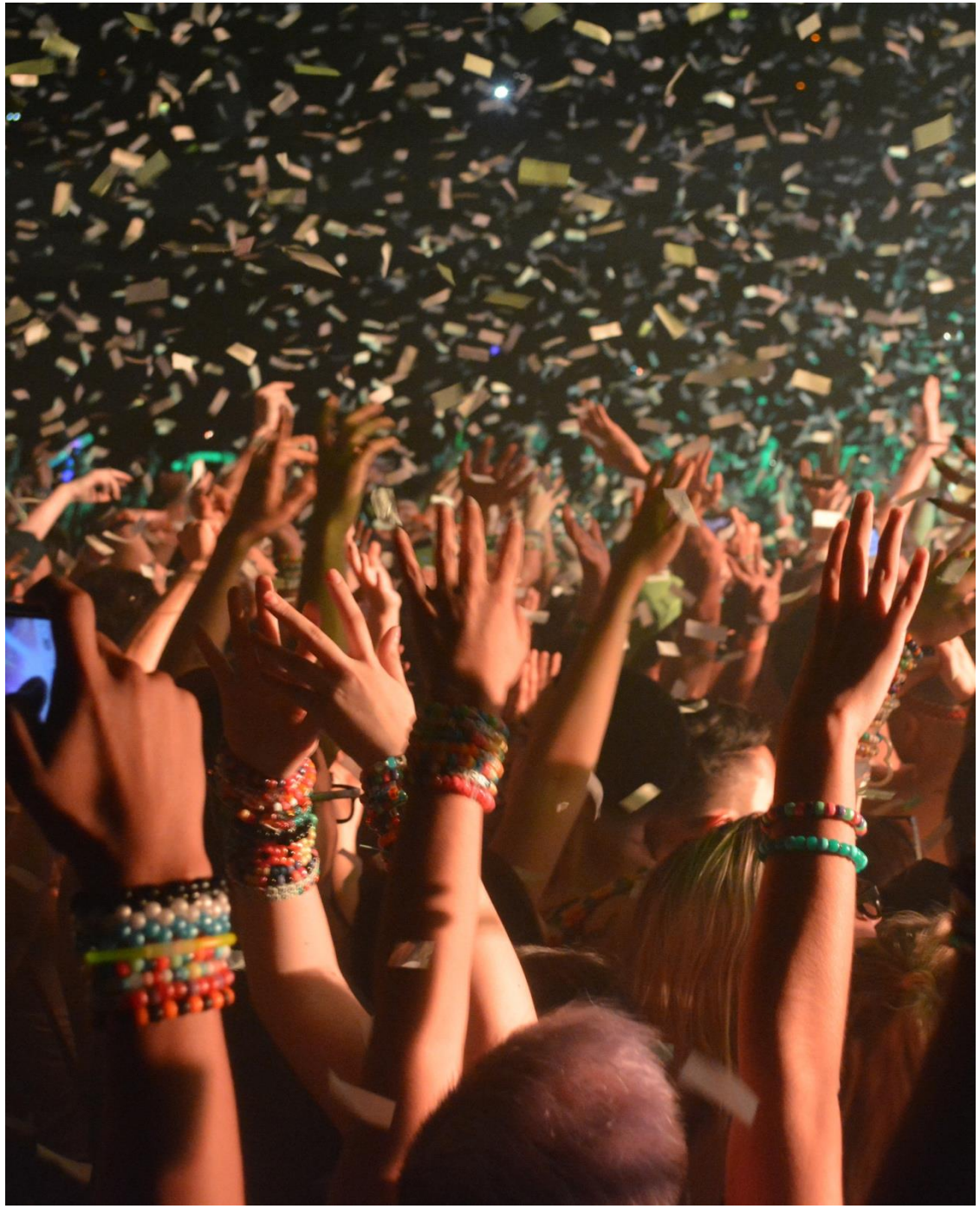

Continuing Education

This course meets the qualifications for **1.0 contact hours of continuing education credit for nurses** as required by the California Board of Registered Nursing, Provider #18090. The UCSF Center for Excellence in Primary Care is approved by the California Association of Marriage and Family Therapists (CAMFT) to sponsor continuing education for LMFTs, LCSWs, LPCCs, and/or LEPs. The UCSF Center for Excellence in Primary Care maintains responsibility for this program/course and its content.

This course meets the qualifications for **1.0 hours of continuing education credit for LMFTs, LCSWs, LPCCs, and/or LEPs** as required by the California Board of Behavioral Sciences, Provider #1032866.

Any activities within the program that do not have instructional time are not offered for continuing education credit. Course completion certificates will be awarded upon completion of course evaluations. Documentation must be retained by the Participant for a period of four years after the conclusion of this program.

Learning Objectives

1. Identify two benefits of enhanced team-based models of care
2. Describe approaches to prepare staff for new team-based roles
3. Name strategies to create a culture shift supportive of team-based care

Why teams in primary care?

Efficiency of practice

Improving quality of care

PRACTICE PROFILE

By Karen Nelson, Maria Pitaro, Andrew Tzellas, and Audrey Lum

PRACTICE PROFILE

Transforming The Role Of Medical Assistants In Chronic Disease Management

ORIGINAL INVESTIGATION

HEALTH CARE REFORM

Electronic Medical Record Reminders and Panel Management to Improve Primary Care of Elderly Patients

Timothy S. Loo, MD; Roger B. Davis, ScD; Lewis A. Lipsitz, MD; Julie Irish, PhD; Carol K. Bates, MD; Kathryn Agarwal, MD; Lawrence Markson, MD, MPH; Mary Beth Hamel, MD, MPH

Background: Most elderly patients do not receive recommended preventive care, acute care, and care for chronic conditions.

Methods: We conducted a controlled trial to assess the effectiveness of electronic medical record (EMR) reminders, with or without panel management, on health care proxy designation, osteoporosis screening, and influenza and pneumococcal vaccinations in patients older than 65 years. Physicians were assigned to 1 of the following 3 arms: EMR reminder, EMR reminder plus panel manager, or control. We assessed completion of recommended practices during a 1-year period.

plus panel manager arm ($P = .02$). Pneumococcal vaccine was given to 13.1% of patients in the control arm, 19.5% of the EMR reminder arm, and 25.6% of the EMR reminder plus panel manager arm ($P = .02$). Influenza vaccine was given to 46.8% of patients in the control arm, 56.5% of the EMR reminder arm, and 59.7% of the EMR reminder plus panel manager arm ($P = .002$). Results were similar when adjusted for individual physician performance in the preceding year, patient age, patient sex, years cared for by the practice, and number of visits.

Conclusions: Electronic medical record reminders alone facilitated improvement in vaccination rates and, when aug-

Harnessing skills and expertise of other care team members

FLASHBACK to the learning session in June…

Care Team Assessment

Disparity Reduction Plan

Understanding Root Causes

- Looking at your data
- Staff and patient perspectives
- Mini-Journey Mapping

Intervention

Implementation of Clinical Guidelines

Care Team Assessment & Implementation

Pre-visit Planning
(Closing the gap for people coming in for care)

Outreach
(Closing the gap for people NOT coming in for care)

Plan-Do-Study-Act

Care Team Assessment & Implementation Deep Dive

Blue Clinic is seeking to understand the roles of each team member in depression screening and follow up. Here are their results for the Care Team Assessment.

What stands out to you?

Function	Who performs this now? (Title)
Checks care gaps to determine if due for BH screening	Nobody
Administers behavioral health screening (e.g., PHQ2, PHQ9, AUDIT)	MA or provider
Addresses positive behavioral health screening (including evaluation, diagnosis, referrals, etc)	Provider
Manages "simple" behavioral health needs (e.g. mild depression or anxiety managed in primary care)	Provider
Coordinates with external MH/SUD services, including closing the loop on new referrals, coordinating ROIs	Provider or MA provide a list of resources
Conducts outreach to patients on MAT or BH registry and schedules follow-up	Nobody

Expanded duties

Care Team Role	Expanded Duties	Recommended Education/Licensure
Primary Care Provider: Physician (MD/DO), Nurse Practitioner (NP), or Physician Assistant (PA)	• Serves as Primary Care Provider (PCP) and provides direct patient care, including diagnoses and treatment for preventative, acute, and chronic health needs. • Leads and works collaboratively with the core and expanded care team to deliver whole preson care.	As per California state licensure requirements.
Medical Assistant (MA)	• Assists the PCP with direct patient care. • Manages patient flow on the day of a visit, including pre-visit and visit/room preparation. • Review and completes any overdue health maintenance or open orders. • Ensures any screenings are completed by the patient, documents results, and completes any needed follow-up. • Prepares for, attends, and participates in daily huddles and other team meetings.	As per California Certifying Board of Medical Assistants (CCBMA).
Community Health Worker (CHW)	• Is a frontline public health worker who is a trusted member or has a particularly good understanding of the community served. • Serves as a liaison between health and social services and the community to facilitate access to services and to improve the quality and cultural competence of service delivery. • Conducts outreach and provides community education, informal counseling, social support, and advocacy for moderate and high-risk	Bilingual in English and the other languages identified by the community health center (CHC). High school diploma or equivalency. Minimum two years work or

Source: https://phminitiative.com/resource/care-team-duties-and-recommended-education-and-licensure/

Care Team Assessment

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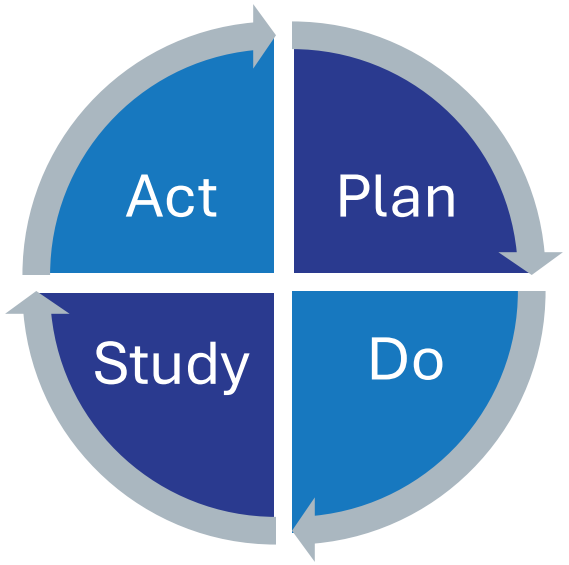
Step 2: Implementation Plan – Action Items to Optimize Care Team Model

Equity and Practice Transformation (EPT) Payment Program
Care Team Assessment & Implementation, Adopting Clinical Guidelines, Implementing Enhanced Outreach and Engagement, Implementing Pre-Visit Planning

*To meet this milestone requirement, practices must implement **at least two NEW actions** (since the start of EPT) by **November 2025**.*

Gap Identified in Table 2	Action Taken or Planned	Team Role(s) Added or Changed	Training or Support Needed	Implementation Status (since start of EPT) ☐ Previously Implemented ☐ In Progress ☐ Planned
Checks care gaps to determine if due for screening	MAs will check care gaps	MA	Practice checking care gaps in EHR	☐ Previously Implemented ☐ In Progress ☐ Planned
Conducts outreach to patients on MAT or BH registry and schedules follow up	Stephanie (MA) will conduct follow up with patients and schedule appointment if needed	MA	Using BH registry Using script to conduct follow-up	☐ Previously Implemented ☐ In Progress ☐ Planned

Blue Clinic: PDSA



Blue Clinic decides to put on their quality improvement hat and do a small test of change.

They will work with a provider + MA team to train the MA to:

- Check the EHR for depression screening
- Administer the PHQ2 during the rooming process, and,
- If positive, administer the full PHQ9

They decide to monitor the percentage of patients with a visit during this period who are up to date with depression screening.

They will meet in 4 weeks to review their metrics.

Reflections: November 2025 Care Team Submission Template

Table 4

Implemented Action	Date of Implementation	# of Patients Impacted	Metrics Used to Evaluate Whether the Action Resulted in Improvement	Results Observed
MA will check EHR for depression screening, administer PHQ2 during rooming process, and, if positive, administer PHQ9	*9/24/2025*		*Percentage of patients with a visit during this period who are up to date with depression screening*	

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Blue Clinic: How's it going?

The MA has been doing a lot of depression screening. They have been proactively looking at the day's patients, identifying care gaps, and talking with the provider about it.

Out of 64 patients, 42 were screened (65%), which was much higher than the previous rate of 26%.

It goes so well that Blue Clinic decides to replicate it across all of their teams.

Reflections: November 2025 Care Team Submission Template

Table 4

Implemented Action	Date of Implementation	# of Patients Impacted	Metrics Used to Evaluate Whether the Action Resulted in Improvement	Results Observed
MAs will conduct behavioral health screening with all adult patients	*9/24/2025*	*42/64*	*Percentage of adult patients with a visit during this period who are up to date on depression screening*	*Intervention increased the rate of depression screening from 26% to 65%.*

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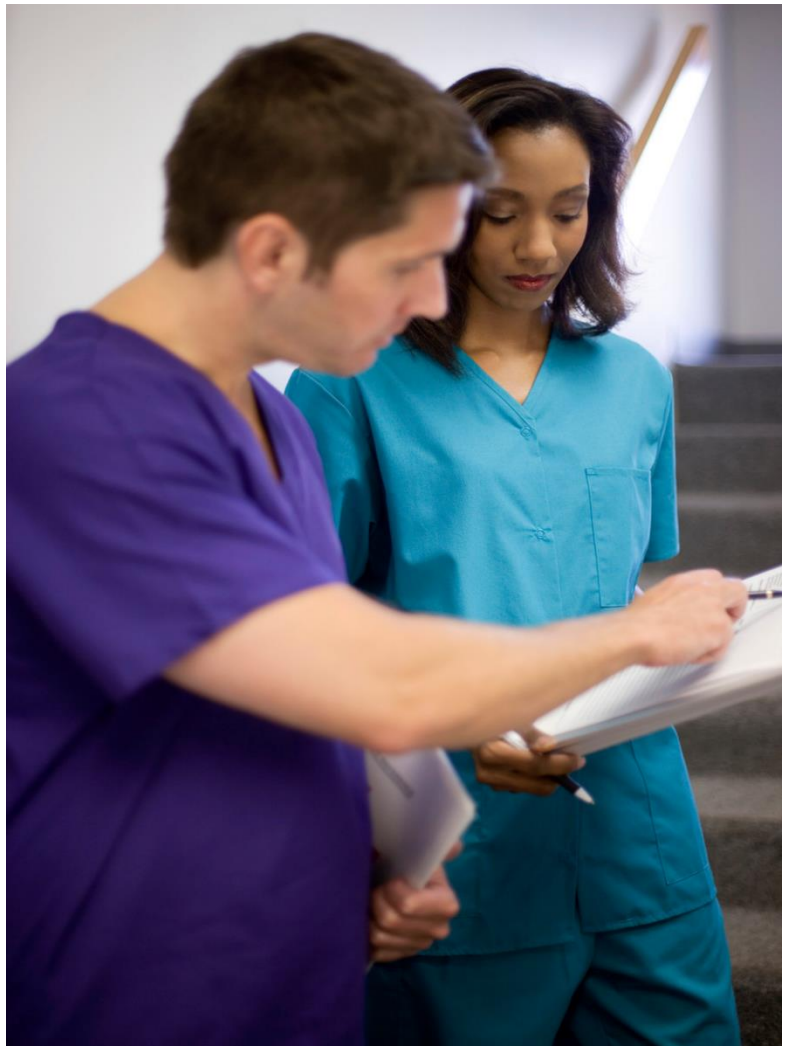
Blue Clinic: Scaling Up



You introduce the idea of a depression screening at your clinic's team meeting. An MA says, "I just don't think I should be the person to ask about depression. I think that should be the doctor's job."

- What might be factors in the MA's discomfort?
- How might we respond?
- What about providers?

Skills + Confidence

What do the MAs need in terms of…

- Skills

- Resources

- Workflows

- Communication

Thinking about skills and confidence

Knowledge

- Why is this important?
- What questions would the person need to be able to answer?
- How do they need to document work?

Confidence

- What is new, unfamiliar and needs to be practiced?
- What support will people need from their supervisors? Their provider partners?
- How will we check in with staff?

Staff Empowerment: Building skills and confidence

Foster the culture

- Establish a culture of mental health screening as an important part of health

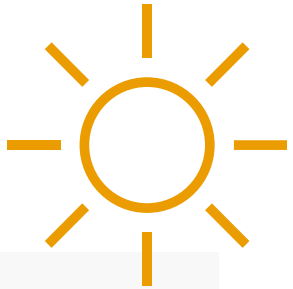
Develop clear protocols & scripts

- “We ask all our patients these questions every year to help us take better care of your health.”
- Interdisciplinary input
- Roles + responsibilities

Provide opportunities for practice

- Dedicate time for staff training & roleplays
- Helpful for staff to have sample phrases on how to introduce/explain screening

San Francisco Health Network – How to talk about it



- **Developed and practiced FAQs**
  - Why is depression screening important?
  - What do you say if someone says, “Why are you asking me about that? That's not why I came in.”
  - What other questions would you want them to be able to answer on the spot?
- **Referring back to the provider**
  - How do you practice referring other questions to the provider and alerting the provider that the patient has questions?
- **Follow-up:** Is follow-up needed?

San Francisco Health Network – Behavioral Health Vital Signs

San Francisco Health Network
Primary Care

Label

Behavioral Health Vital Signs

Your relationships and experiences affect your health and well-being.
Please tell us whether you are experiencing any of these challenges.
We are here to support and help you!

1. In the last 2 weeks, have you been bothered by:			
Little interest or pleasure in doing things?	**Yes**	**No**	**Skip**
Feeling down, depressed, or hopeless?	**Yes**	**No**	**Skip**
2. Alcohol use (a drink is a 12-ounce beer, 5-ounce wine, or 1.5-ounce hard liquor)			
How many times in the past year have you had (Men 5 or more; Women 4 or more) drinks in a day?	**1 or more**	**None**	**Skip**
3. How many times in the past year have you used a recreational drug or used a prescription medication for non-medical reasons?	**1 or more**	**None**	**Skip**
4. In the past year, has your partner or someone else hurt, hit, threatened you, or made you feel afraid?	**Yes**	**No**	**Skip**
5. Has your partner or someone else ever hurt, hit, threatened you, or made you feel afraid?	**Yes**	**No**	**Skip**

Please check the boxes below for any that you have tried in the past 30 days as a way to cope or feel better:

- ☐ Spending time with supportive friends and family
- ☐ Helping others

https://catalyst.nejm.org/doi/full/10.1056/CAT.19.0697

San Francisco Health Network – Behavioral Health Vital Signs

- MEA or clerical staff see EHR "global alert" for patients due for BHVS
- MEA or clerical staff provide patient with paper or verbal administration of BHVS
- Patient completes BHVS (may skip questions)
- MEA enters patient responses in BHVS template in EHR

PHQ2 positive	MEA gives patient PHQ9 and enters results in EHR patient visit note	PCP facilitates "warm hand off" to PCBH (PHQ9 results guide response by PCP and BHCs)
Alcohol or substance use question positive	MEA pulls 10-item DAST and/or AUDIT-C templates into EHR patient visit note	PCP facilitates "warm hand off" to PCBH
IPV question(s) positive	MEA pulls more detailed IPV template into EHR patient visit note	PCP facilitates "warm hand off" to PCBH and/or ARISE IPV Advocate

https://catalyst.nejm.org/doi/full/10.1056/CAT.19.0697

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What is a standing order?

A protocol approved by the medical and administrative leadership of a healthcare facility that empowers RNs, medical assistants, or other team members to provide a specific service to appropriate patients.

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Blue Clinic Checking In

It is the first week of our depression screening intervention, and we have problems!

- Some people are not offering the depression screening at all
- Others are offering it multiple times

What do you think is going on?

Diagnosing "things not working"

- Skills

- Resources

- Workflows

- Communication

Blue Clinic, continued

When they check in with the other teams they hear:

"No, I don't do it. My provider prefers to do it."

"My MA doesn't know what she's doing."

What do you think is going on?

Blue Clinic Update…

Checking in with our team helped us realize that people did not have shared expectations.

What we need is a set time to check in with one another to ensure that we are all on the same page.

We have added this check-in to our morning huddle agenda, and communication has improved!

Watch for an upcoming e-learning module on huddles!

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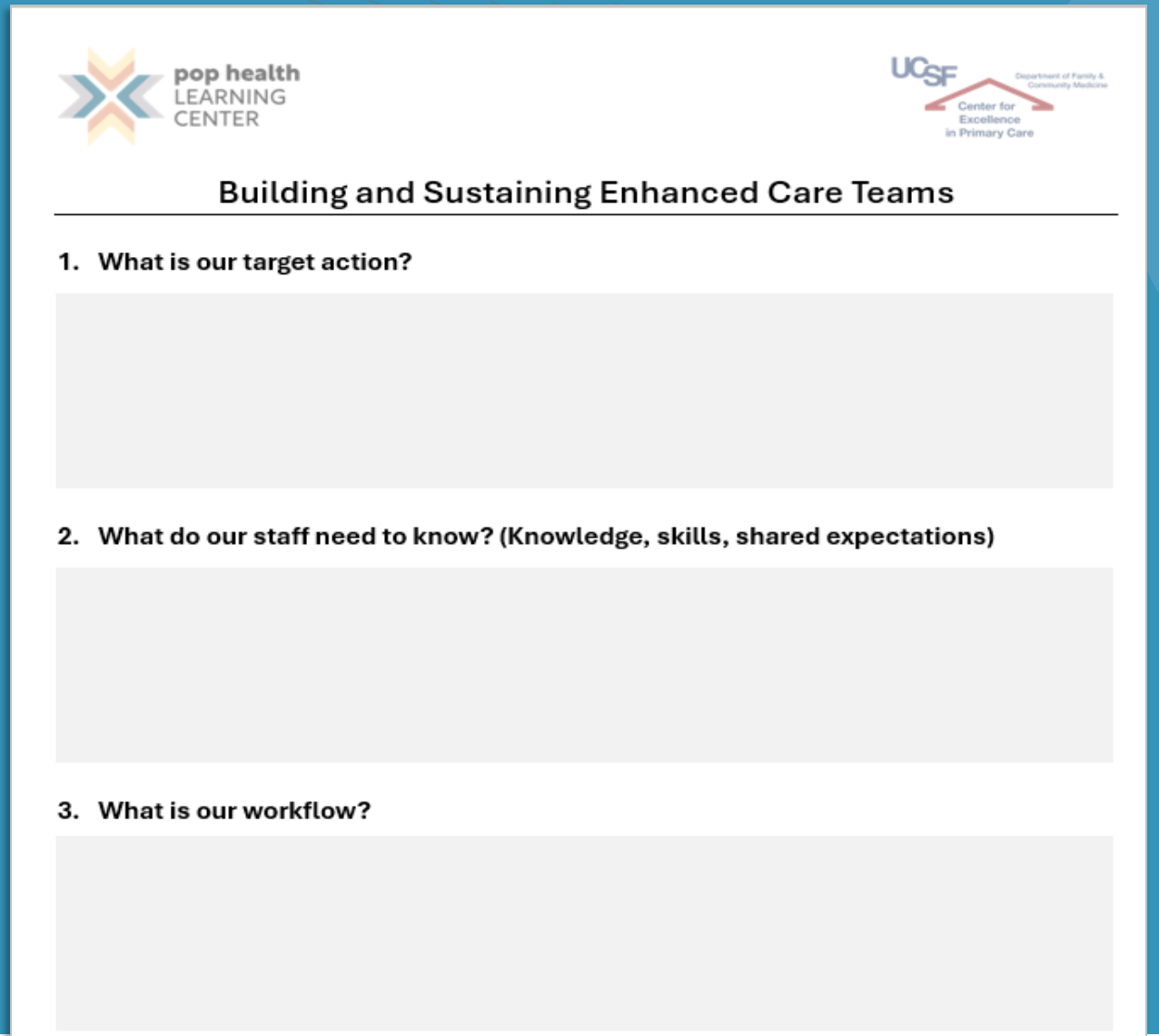
Breakout groups: Create your plan

Working with your team, draft a plan…

Think about:

- Knowledge, skills, shared expectations
- Workflow
- Resources
- Communication



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Building and Sustaining Enhanced Care Teams

1. **What is our target action?**

2. **What do our staff need to know? (Knowledge, skills, shared expectations)**

3. **What is our workflow?**

Breakout: Building and Sustaining Enhanced Care Teams

1. What is our target action?
2. What do our staff need to know? (Knowledge, skills, shared expectations)
3. What is our workflow?
4. What resources do staff need?
5. How will we communicate with one another?

Debrief

What is one takeaway from the breakout?

Questions, comments, observations

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Resources

- Workflow Mapping: https://cepc.ucsf.edu/sites/cepc.ucsf.edu/files/Overview_workflow_mapping_14-0602.pdf

- Population Health Management Initiative (PHMI): Core Teams and Workforce Guide:

  https://phminitiative.com/resource/care-teams-and-workforce-guide/#introduction

- Resource 1: Core and Expanded Care Teams Functions, Team Members and Roles

  https://phminitiative.com/resource/care-team-duties-and-recommended-education-and-licensure/

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Thank You!