Teams 2.0

Getting to the Template of the Future
Introductions
- Name, organization, role
- Favorite or most recent National Park
Teams 2.0 Agenda…
### Teams 1.0: Key Attributes

#### Task Work

**Panels**
1. Empanelment
2. Teams & EHRs
3. Managing panel over time
4. Clinician/staff turnover contingency planning

**Core and expanded care teams**
1. Continuity with provider and team
2. Workforce distribution
3. Training for team-based care
4. Standing orders and protocols
5. Workflows documented
Team Work

Build a team culture
1. Shared goals, clear roles, mutual trust, effective communication
2. Building relationships with patient and family
3. Symbolic vs substantive implementation

Spread and sustaining TBC innovations
1. Career ladders
2. Standardizing vs allowing variation
3. Team-based metrics
4. Shared team productivity/access/outcomes
Refresher on 10 Building Blocks

- Foundational blocks
- Planned care
- Population health management
- Template of the future and joy in work
Where is your team-based care today?
You go to work tomorrow and the TBC 2.0 MIRACLE has happened!
Barriers to Reaching Teams 2.0

What is getting in your way?
Appoint a recorder.
Brainstorm and record barriers you see in your practice.
A different person will share the list with the group.
Do we need a break...?
What Does Team-Based Care Save and Cost?

Aggregated Outcomes from the 30 Studies

$ $ $ $ $ $ $ $ $ $ $ $ $ $ $ $ $ 21 of 23

studies that reported on cost measures found reductions in one or more measures

$ $ $ $ $ $ $ $ $ $ $ $ 23 of 25

studies that reported on utilization measures

found reductions in one or more measures

Aligning Payment and Performance: Payment reform is necessary to sustain delivery system changes, but alignment across payers is critical for health care provider buy-in
## PCPCC 2017 Meta-analysis

[https://www.pcpcc.org/initiatives/list](https://www.pcpcc.org/initiatives/list)

<table>
<thead>
<tr>
<th>Initiative</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hill Physicians Medical Group and BCBS of California ACO</td>
<td>San Ramon, CA</td>
</tr>
<tr>
<td>Delivery of Behavioral Health Services in Primary Care Using Telehealth</td>
<td>Los Angeles, CA</td>
</tr>
<tr>
<td>California Health Care Coverage Initiative (HCCI) - Bridge to Reform</td>
<td>Sacramento, CA</td>
</tr>
<tr>
<td>Aligning Forces for Quality - Humboldt University</td>
<td>Eureka, CA</td>
</tr>
<tr>
<td>Cigna Accountable Care Organization - Palo Alto Medical Foundation</td>
<td>San Francisco, CA</td>
</tr>
<tr>
<td>Anthem Blue Cross ACO Initiative</td>
<td>Woodland Hills, CA</td>
</tr>
<tr>
<td>Cigna Collaborative Accountable Care (CAC) Program - Healthcare Partners Medical Group</td>
<td>Torrance, CA</td>
</tr>
<tr>
<td>Cigna Collaborative Accountable Care (CAC) Program - Brown and Toland Physicians</td>
<td>San Francisco, CA</td>
</tr>
</tbody>
</table>

**Legend**

- **$**: Cost Savings
- **⚕**: Improved Health
- **⏰**: Improved Access
- **⏰⚕**: Increased Prevention Services
- **👍**: Improved Patient/Physician Satisfaction
- **救护车**: Fewer ED / Hospital Visits
Significant Attributes of High Value Practices

1. Decision support for evidence-based medicine

2. Risk-stratified care management

3. Careful selection of network of specialists

4. Care coordination when patient out of practice

5. Standing orders and protocols

6. Balanced compensation

Other Attributes of High Value Practices

1. Expanded access
2. Shared decision making and advanced care planning
3. Complaints are highly valued
4. Comprehensive primary care
5. Upshifted staff roles
6. Shared work spaces
7. Low overhead, space and equipment

Clinica Family Health Services TBC

- 3.4 FTEs of Provider
- 4.5 FTEs of Medical Assistant
- 1 Nurse Team Manager
- 0.5 Clinic Nurse
- 1.5 Case Manager
- 1 Behavioral Health Professional
- 2 Front Office Techs
- 1 Medical Records
- 0.5 Referral Case Manager
- 0.1 Dental Hygienist
**AHRQ Panel-Based Workforce for High Quality Care**


### Average US Adult Model (10,000)

<table>
<thead>
<tr>
<th>Function</th>
<th>FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned, Evidence-based Care (PCP)</td>
<td>8 (6 MD &amp; 2 NP)</td>
</tr>
<tr>
<td>Planned, Evidence-based Care (RN)</td>
<td>1.5 RN</td>
</tr>
<tr>
<td>Planned, Evidence-based Care (MA)</td>
<td>9 (MA or LVN/LPN)</td>
</tr>
<tr>
<td>Complex Care Management</td>
<td>2.5 RN</td>
</tr>
<tr>
<td>Behavioral Health Integration</td>
<td>2.5 LCSW</td>
</tr>
<tr>
<td>Reception, intake, etc.</td>
<td>8 Clerks</td>
</tr>
<tr>
<td>Medication Management</td>
<td>1 Pharmacist</td>
</tr>
<tr>
<td>QI and Optimizing HIT (Leadership)</td>
<td>.3 FTE MD/DO for leadership</td>
</tr>
<tr>
<td>Population Health (Leadership)</td>
<td>.5 FTE RN for leadership</td>
</tr>
<tr>
<td>Self Management Support</td>
<td>1.5 FTE - Health coach role (MA, Care manager)</td>
</tr>
<tr>
<td><strong>Total Staff</strong></td>
<td><strong>36.8</strong></td>
</tr>
</tbody>
</table>
### Cost of Primary Care Models

<table>
<thead>
<tr>
<th>Model</th>
<th>Index Model</th>
<th>High Geriatric and/or High MCCs Model</th>
<th>Rural Model</th>
<th>High Social Need Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Compensation Level</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
<td>Medium</td>
</tr>
<tr>
<td>Patient Cohort Size</td>
<td>10,000</td>
<td>10,000</td>
<td>5,000</td>
<td>10,000</td>
</tr>
<tr>
<td>Total FTE Per Year</td>
<td>36.8</td>
<td>52.3</td>
<td>22.3</td>
<td>50.3</td>
</tr>
<tr>
<td>Total Staffing Cost Per Year</td>
<td>$3,411,000</td>
<td>$4,795,000</td>
<td>$1,773,000</td>
<td>$4,217,000</td>
</tr>
<tr>
<td>General Operating Cost Per Year (1,2)</td>
<td>$1,767,000</td>
<td>$2,651,000</td>
<td>$884,000</td>
<td>$2,209,000</td>
</tr>
<tr>
<td>Business Operating Staffing Cost Per Year (1,3)</td>
<td>$188,000</td>
<td>$282,000</td>
<td>$94,000</td>
<td>$235,000</td>
</tr>
<tr>
<td>Total Cost Per Year</td>
<td>$5,366,000</td>
<td>$7,728,000</td>
<td>$2,751,000</td>
<td>$6,661,000</td>
</tr>
<tr>
<td>Total Cost Per Patient Per Month</td>
<td>$45 ($37-$57)</td>
<td>$64 ($53-$82)</td>
<td>$46 ($38-$58)</td>
<td>$56 ($45-$71)</td>
</tr>
</tbody>
</table>

1. Other Overhead and Operating Costs are derived from the number of PCPs. Note that this model counts NPs as physicians for the purpose of overhead staffing.
2. General Operating Costs are costs for the following items (excluding staffing costs): Information Technology, Drug Supply, Medical and Surgical Supply, Building and Occupancy, Building Depreciation, Furniture and Equipment, Furniture and Equipment Depreciation, Administrative Supplies Services, Professional Liability Insurance, Other Insurance Premiums, Legal Fees, Consulting Fees, Outside Professional Fees, Promotion and Marketing, Clinical Laboratory Radiology and Imaging, ancillary services, Billing and collections services, Management fees paid to KSO, Miscellaneous Operating Cost allocated to practice from parent organization.
3. Business Operations Staffing Cost pertains to the cost for the following positions: General Administrative, Patient Accounting, General Accounting, Managed Care Administrative, Information Technology, Housekeeping Maintenance and Security.
Reimbursement for TBC 2.0 Services

• Chronic Care Management-CCM Codes
  https://www.cms.gov/Center/Provider-Type/Federally-Qualified-Health-Centers-_FQHC-Center.html

• Certified Diabetes Educator
  https://www.diabeteseducator.org/practice/ask-the-expert

• BHI Collaborative Care Model CoCM

• Clinical Pharmacists Medication Therapy Management Services MTMS
  http://www.pstac.org/services/mtms-codes.html
Measuring Team-Based Care 2.0

http://clinicalmicrosystem.org/knowledge-center/

Improving Microsystems

It’s just like patient care

- To improve a patient’s health status ... a clinician assesses, diagnoses, treats, and follows-up based on biomedical science, patient preferences, and their outcomes.

- To improve a microsystem’s “health” status ... an interdisciplinary group assesses, diagnoses, treats, and follow-ups based on improvement science and performance feedback.

Slide from Marjorie Godfrey, MS, RN IHI IDCOP 2015
<table>
<thead>
<tr>
<th>Team Stage Question</th>
<th>Traditional Care</th>
<th>Developing Care Team</th>
<th>Advanced Care Team</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Staff other than PCPs...</td>
<td>Are primarily tasked with managing patient flow and triage.</td>
<td>Provide some clinical services, such as assessment or self-management support.</td>
<td>Perform key clinical service roles that match their abilities and credentials.</td>
</tr>
<tr>
<td>2. Medical Assistants...</td>
<td>Mostly take vitals and room patients.</td>
<td>Perform a few clinical tasks beyond rooming patients, such as reviewing medication lists or administering PHQ-9s.</td>
<td>Collaborate with the provider in managing the panel and play a major role in providing preventive services and services to chronically-ill patients, such as self-management coaching or follow-up phone calls.</td>
</tr>
<tr>
<td>3. Laypersons (e.g., front desk staff, community health workers)...</td>
<td>Are not involved in clinical care.</td>
<td>Mostly provide non-clinical patient-facing services such as reception or referral management.</td>
<td>Provide self-management coaching, coordinate care, help patients navigate the healthcare system, and/or access community services.</td>
</tr>
<tr>
<td>4. The practice...</td>
<td>Does not have an organized approach to identify or meet the training needs of providers and other staff.</td>
<td>Routinely assesses training needs and encourages on-the-job training for staff.</td>
<td>Routinely assesses training needs, ensures that staff are appropriately trained for their roles and responsibilities, and provides cross training to ensure the patient needs are consistently met.</td>
</tr>
<tr>
<td>5. Standing orders that can be acted on by non-independent providers under protocol...</td>
<td>Do not exist.</td>
<td>Have been developed for some conditions.</td>
<td>Have been developed for many conditions and are used extensively.</td>
</tr>
<tr>
<td>6. Workflows for clinical teams...</td>
<td>Have not been documented and/or are different for each person or team.</td>
<td>Have been documented, but are not used to standardize workflows across the practice.</td>
<td>Have been documented, are utilized to standardize workflows, and are evaluated and modified on a regular basis.</td>
</tr>
</tbody>
</table>

How are you doing?

Adapted from [http://improvingprimarycare.org/assessment/full](http://improvingprimarycare.org/assessment/full) MacColl Center for Health Innovation, Group Health Research Institute, 2015, v 1.1
Relational Model of Organizational Change

**Structural Interventions**
- Select & Train for Teamwork
- Shared Accountability & Rewards
- Shared Conflict Resolution
- Leader & Supervisor Roles
- Boundary Spanner Roles
- Team Meetings
- Shared Protocols
- Shared Information Systems

**Relational Interventions**
- Create Safe Space
- Relational Assessment
- Humble Inquiry/Coaching

**Relational Coordination**
- Frequent Communication
- Timely Problem Solving
- Accurate Shared Knowledge
- Mutual Respect

**Performance Outcomes**
- Quality & Safety
- Efficiency & Finance
- Client Engagement
- Worker Engagement
- Learning & Innovation

**Work Process Interventions**
- Assess Current State
- Identify Desired State
- Experiment to Close the Gap
Improving Healthcare Through Relationships

### 7 Dimensions of Relational Coordination

<table>
<thead>
<tr>
<th>Seven RC Dimensions</th>
<th>Survey Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Frequent communication</td>
<td>How <em>frequently</em> do people in each of these groups communicate with you about the work that we do together?</td>
</tr>
<tr>
<td>2. Timely communication</td>
<td>How <em>timely</em> is their communication with you about the work that we do together?</td>
</tr>
<tr>
<td>3. Accurate communication</td>
<td>How <em>accurate</em> is their communication with you about the work that we do together?</td>
</tr>
<tr>
<td>4. Problem solving</td>
<td>When there is a problem in the work that we do together, do people in these groups <em>blame others</em> or try to <em>solve the problem</em>?</td>
</tr>
<tr>
<td>communication</td>
<td></td>
</tr>
<tr>
<td>5. Shared goals</td>
<td>Do people in these groups <em>share your goals</em> for the work that we do together?</td>
</tr>
<tr>
<td>6. Shared knowledge</td>
<td>Do people in these groups <em>know about the work</em> you do in the work that we do together?</td>
</tr>
<tr>
<td>7. Mutual respect</td>
<td>Do people in these groups <em>respect the work</em> you do in the work that we do together?</td>
</tr>
</tbody>
</table>

**Scoring: Between and Within Groups**

- 5 = Always, Completely
- 4 = Often, A lot
- 3 = Occasionally, Somewhat
- 2 = Rarely, A little
- 1 = Never, Not at all

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Teamwork Tools

Study of validated tools to assess teamwork:

Other: TeamSTEPPS
https://www.ahrq.gov/teamstepps/index.html
Thank you... carolynmshepherd@gmail.com