Effective Strategies for Team-Based Care

The Cambridge Health Alliance
October 11, 2018
Agenda

• screening for SDOH, then what
• culture change and teams
• medical assistants and other staff engagement/ top of license and how to they dance well together?
• pharmacists
• onboard patients
• templates
• data integration and use esp for daily work
• call centers and population health
• alternative modes of communication
• innovation systems
• EPIC
• Scheduling - esp RNs
• residency interactions and context
• QI and training
• RN roles - expand to more visits?
• Group visits and BH - patient led visits
Cambridge Health Alliance

An academic public health safety net system outside of Boston

Largely public payer mix – 82%, almost all Medicaid

>50% patients speak languages other than English

190,000 primary care visits for 118,000 patients
Common Elements exhibited by 29 High-Performing Primary Care Practices

Building teams in primary care: A practical guide.
By Ghorob, Amireh, Bodenheimer, Thomas

<table>
<thead>
<tr>
<th>Characteristic</th>
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</thead>
<tbody>
<tr>
<td>1. A stable team structure</td>
</tr>
<tr>
<td>2. Colocation</td>
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<td>3. Culture shift: Share the care</td>
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<td>4. Defined roles with training and skills checks</td>
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<td>5. Standing orders/protocols</td>
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<td>6. Defined workflows and workflow mapping</td>
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<td>7. Staffing ratios adequate to facilitate new roles</td>
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<td>8. Ground rules</td>
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<tr>
<td>9. Communication: team meetings, huddles, and minute-to-minute interaction</td>
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Goals for the Session

Discuss effective strategies for creating a strong team culture

The role of each team member and how they help sustain team dynamics

Introduce the topic of ongoing staff training and individual development of all team members
In a patient-centered medical home, it is about the patient—and all the people a patient needs to support their care.

Team-based care means that everyone - from folks who register a patient to nurses - focus on the patient, not the doctor visit.

The patient-centered medical home is about the entire team contributing to the care of a patient by developing independent relationships with patients.
How Payment Methods in Healthcare Affect Care Delivery

Workflows in Fee for Service

Provider Visit (Payment based interaction)

Referral Coordinator, Pharmacist, Team Nurse, Medical Office Staff

Patient

Referral Request, Medication Refill, Acute Need, Prevention Need

Delay

PATIENT
How Payment Methods in Healthcare Affect Care Delivery

Workflow with Value Based Payments

Patient

Referral Request

Referral Coordinator

Medication Refill

Receptionist

Pharmacy Tech.

Acute Need

Team RN and/or Provider (*visit or asynchronous interaction*)

Prevention Need

Medical Office Staff

PATIENT

Cambridge Health Alliance, Union Square Family Health // Sabrina G. Lozandieu, MHA & Kirsten Meisinger, MD 2016
Creating a Strong Team Culture and Shared Purpose

Work with the Change Concepts of Practice Transformation
The role of Engaged Leadership
Strengthen our team culture
The role of Performance Improvement
Change Concepts for Practice Transformation


10 Building Blocks of High-Performing Primary Care

Role of Engaged Leadership ~ at all levels of the organization ~

Provide **visible and sustained leadership** to lead overall culture change as well as specific strategies to improve quality and spread and sustain change.

Ensure that the PCMH transformation effort has the **time and resources** needed to be successful.

Ensure that providers and other care team members have **protected time** to conduct activities beyond direct patient care that are consistent with the medical home model.

Build the **practice’s values** on creating a medical home for patients into staff **hiring and training** processes.
How to strengthen our team
~sharing the care~

Establish and provide **organizational support** for care delivery teams accountable for the patient population/panel

**Link patients** to a provider and care team so both patients and provider/care team recognize each other as partners in care

Ensure that patients are **able to see** their provider or care team whenever possible

**Define roles** and distribute tasks among care team members to reflect the skills, abilities and credentials of team members
Role of Performance Improvement

Choose and use a **formal model** for quality improvement

*Establish and monitor metrics* to evaluate improvement efforts and outcome; ensure all staff members understand the metrics for success

Ensure that patients, families, providers and care team members are **involved in quality improvement** activities

Optimize use of **health information technology**
https://www.youtube.com/watch?v=IeBznTEi_2I

https://www.youtube.com/watch?v=IeBznTEi_2I
Performance Improvement can help drive culture change

- Identify a problem
- Quantify the problem
- Identify stakeholders
- Design a workflow
- Test the workflow
- Analyze the results
- Test it again........
What do I Need to do This?
A Real Life Example: Health Care Proxy

New Workflow send to leadership

Leadership shares workflow with whole staff via email

Fully intend to discuss at meeting that week – doesn’t happen!

Medical Assistants take workflow and start using it

Request feedback over email and in person from providers

Email conversations for 1 day, workflow continuously adjusted

Final workflow presented to leadership (in writing!) 2 days later
Reaction of the Leadership Team
How we take care of our panel NOW

Panel management: “Panel manager” systematically reviews panels of patients to detect clinical quality performance gaps.

Health coaches: Health coaches give patients the knowledge, skills, and confidence to self-manage their chronic conditions.

E-mails: Coordinate with team members

Longer visits: Coordinate with specialists

Nurse care managers: Nurse care managers coordinate health care for certain high-needs groups.

Phone visits: 15-minute visit

Group visit
## Traditional Template

<table>
<thead>
<tr>
<th>Time</th>
<th>Primary care physician</th>
<th>Medical assistant 1</th>
<th>RN</th>
<th>Nurse Practitioner</th>
<th>Medical Assistant 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00</td>
<td>Patient A</td>
<td>Assist with Patient A</td>
<td>Triage</td>
<td>Patient H</td>
<td>Assist with Patient H</td>
</tr>
<tr>
<td>8:10</td>
<td>Patient B</td>
<td>Assist with Patient B</td>
<td></td>
<td>Patient I</td>
<td>Assist with Patient I</td>
</tr>
<tr>
<td>8:30</td>
<td>Patient C</td>
<td>Assist with Patient C</td>
<td></td>
<td>Patient J</td>
<td>Assist with Patient J</td>
</tr>
<tr>
<td>9:00</td>
<td>Patient D</td>
<td>Assist with Patient D</td>
<td></td>
<td>Patient K</td>
<td>Assist with Patient K</td>
</tr>
<tr>
<td>9:30</td>
<td>Patient E</td>
<td>Assist with Patient E</td>
<td></td>
<td>Patient L</td>
<td>Assist with Patient L</td>
</tr>
<tr>
<td>10:00</td>
<td>Patient F</td>
<td>Assist with Patient F</td>
<td></td>
<td>Patient M</td>
<td>Assist with Patient M</td>
</tr>
<tr>
<td>10:30</td>
<td>Patient G</td>
<td>Assist with Patient G</td>
<td></td>
<td>Patient N</td>
<td>Assist with Patient N</td>
</tr>
</tbody>
</table>

15-minute visit
### Evolving Template

<table>
<thead>
<tr>
<th>Time</th>
<th>Primary care Physician</th>
<th>Medical assistant 1</th>
<th>Team RN</th>
<th>Physician Assistant</th>
<th>Medical Assistant 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00</td>
<td></td>
<td>Huddle</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8:10</td>
<td>E-visits and phone visits</td>
<td>Panel management</td>
<td></td>
<td>Acute Patients</td>
<td></td>
</tr>
<tr>
<td>8:30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Panel management</td>
</tr>
<tr>
<td>9:00</td>
<td>Complex patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:30</td>
<td>Complex patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:00</td>
<td>Coordinate with hospitalists and specialists</td>
<td>outreach</td>
<td></td>
<td>E-visits and phone visits</td>
<td></td>
</tr>
<tr>
<td>10:30</td>
<td>Huddle with RN, NP</td>
<td></td>
<td></td>
<td>Huddle with MD</td>
<td></td>
</tr>
<tr>
<td></td>
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</table>

30 patients are seen or contacted in the first 3 hours of the day.
Define and Design the Team

- Provider, MA, RN, PA, Receptionist, LPN
- Non-hierarchical
- Involves everyone as an expert, including the patients!
- Co-Location ideal
- Well defined workflows: Pre-visit, During Visit, Between Visit

This is what a day looks like without team support:

<table>
<thead>
<tr>
<th>Care Type</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care</td>
<td>4.6 hours/day</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>7.4 hours/day</td>
</tr>
<tr>
<td>Chronic Care</td>
<td>10.6 hours/day</td>
</tr>
</tbody>
</table>

22.6 Hours/day

This is the amount of time required to take perfect care of ONE patient!

In 15 minutes? By a single provider?

Redesigning Care Delivery:

<table>
<thead>
<tr>
<th>Previsit</th>
<th>Visit</th>
<th>Between visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>The time of recognized need or risk by system or time of patient contact to check-in</td>
<td>Time of check-in to departure from health center</td>
<td>Completion of visit plans/actions to previsit</td>
</tr>
<tr>
<td>Care team plans for the encounter</td>
<td>Patient’s encounter with clinician and care team</td>
<td>Care management</td>
</tr>
</tbody>
</table>

**Note:**

- Previsit: The time of recognized need or risk by system or time of patient contact to check-in.
- Visit: Time of check-in to departure from health center.
- Between visit: Completion of visit plans/actions to previsit and Care management.
Communication

Every idea matters
Don’t criticize
Combine and build on ideas of others
Creating opportunities for team communication throughout the day

• Huddles
• Co-location
• Structured team meetings
The Cambridge Health Alliance Team Model of Care: Role Definition

Panel Provider – panel composition created around their skill set

Practice Support Provider – shares the panel with the panel provider, team support

RN – chronic disease management and patient education, triage

LPN – vaccines, ER follow up, treatments, pharmacy calls, calls patients with results and f/u

Medical Assistant – flow manager, key to in-reach and outreach

Receptionist – primary access to the services, key to in-reach and outreach, directs electronic medical record flow

Patient – works with the practice on the improvement team
Extended Care Team

Shared team members at the practice level
- Referral Coordinator
- Integrated Behavioral Health (Care Partner, Therapist and MD)
- Regional Family Planning
- Complex Care (Nurse and Social Worker)
- Pharmacist
- Nutrition
- Panel Manager (Planned Care Coordinator)

Other Resources:
- Central refill process through the OP pharmacy

System wide team members
- Central Complex Care Team (Social Worker and CHW)
- Hospice/Palliative Care Team
- Visiting Nurse/SNF/Aging agencies
- Community Mental Health
- Specialty Partners (econsults, chart reviews, televisits)

Patient Team Members
- Patient Partners - two per practice
- Patient Family Advisory Councils
Patient

- Practice Medical Receptionists
- Complex Care Management Team
- Behavioral Health Integration Team
- RN
- Team MA
- Community Health Worker
- Nutritionist
- Pharmacist
- Primary Care Provider
- Planned Care Coordinator
Designing the Core Team: Receptionist
Role of the Receptionist

First impression of care - sets the tone for the whole visit
Initiates the care someone receives with contact information, patient portal initiation, screenings for the visit
Previsit work done ahead of time or at the time of the visit if same day
Care coordination for the visit and after the visit - person to person and over the phone with calls
Professionalization of this role is essential to the patient experience!
Receptionist Previsit work

Review of Health Maintenance and appropriate forms pre-printed and put in folder
  eg. Social Determinants of Health screenings
Insurance verification
Altering time of visit or appointment notes based on inreach
  (add the well child to a visit for ear check)
check on mychart status and any missing information in the chart
Receptionist Care Coordination

Patient facing
read patients the results from letters in the chart
send a copy, manage form requests
utilities letters
transportation approvals

Internal
faxes/media/scanning
outreach - Well child appointments, Pap smear appointments
Attribution and panel management
Designing the Core Team: Medical Assistant
Medical Assistant

Provider

Patient

Reception/clerical

Nurse

Education

Reminder calls

Assisting patients

POC testing

Specialty Appointments/Referrals

Outreach

Preparing for next patient

Rooming the next patient

Records

Ordering supplies

EKG

Data Entry

Coverage

The Unexpected

Preparing for next patient

Assisting other providers

Communicating with other team members/extended team members

Pre-visit plan for next day

Assisting other providers

Reminder calls

Communicating with other team members/extended team members

Rooming the next patient

Assisting patients

EKG

Data Entry

Coverage

The Unexpected
Medical Assistant and Provider relationship

Communication
Interdependent
Prepared
Trust
Well defined roles/expectations
Acknowledgement
Radar - master of flow in the office
Before the Session

Huddle/Pre-visit work

○ Ideally done in a variety of ways
○ Checklist
○ Document and Communicate!
○ Anticipate and plan for the unexpected

Get ready

○ Rooms, special procedures
MA: During the Session/Visit

Responsible for the flow of the day

Review huddle notes

Special room set-up

Rooming/Vital Signs

Lab/POC

Screenings/Teaching (ie: IFOB directions, Mammo, Colonoscopies, Goal setting)
Designing the Core Team: Nursing
Role of Nursing

**Patient facing**
RNs are chronic disease management leader: panels include everyone not at goal or with abnormal screening test (Pap, PSA etc.)

Triage (RN)
Walk-ins (LPN or RN)
Hospitalization follow ups (48 hr phone call, visit within 7 days - RN)
ER follow up (LPN)
Role of Nursing

Team facing

Supervise the MAs and same day visits/appointments (LPN and RNs)

Call patients when a conversation is required (team calls when it is a “tell”)

Work with practice support role for things “as they come up” (VNA, coordination with outside specialists etc.)
Practice Support Provider Role

PAs or NPs, too expensive to have MD/DO
media/problem list management
works with RN on day to day issues on behalf of the team
acute care
hospital follow up/social rounding
attends planned care meetings
7 sessions of patient care time
Other conceptions of team

PI teams when the site gets too big to just have everyone be the PI team

Continue to use all staff meetings as a venue for PI and QI to keep the culture alive
  delicate balance between empowerment and getting lost in the weeds

Leadership structures - need to support that team too!
Practice Improvement Teams (PITs)

Clinic based, multidisciplinary performance improvement teams
Each PIT is partnered with two patients
Mandate to pursue improvement initiatives at a site level
Led by staff, one site leader and a coach
PITs trained in IHI’s model of improvement
Monthly to bi-weekly meetings attended by all members
Daily Huddle & Staff Meetings

**Daily Leadership Huddle**

- Develop and pilot clinic specific workflows
- Provide guidance to daily team assignment and problem solve early (and often!)
- Often only 10 minutes
- Often moved to electronic format once a leadership team is “in the swim”

**Staff Meetings**

- Review site performance
- Transparency
- Workflow development
  - maintains the culture of performance improvement
  - Highlight teams that have perform exceptionally well
  - Discuss ways to leverage tactics across all other care teams
Highlight on Chronic Disease Management

Role of the Pharmacist on the team involves working with each team on their patients not at goal for DM, HTN or COPD.

One hour initial appointments with extensive patient education around medication and disease management.

DM and HTN policies and protocols in place, visits billed and co-signed by PCP.

COPD rescue pack protocol.
Diabetes, Anticoagulation, HTN, COPD
Results

Diabetes A1c Control (Age 18-75 with A1c < 8%)

↑ 27.3%
Hypertension control results

Blood Pressure Control in Diabetics (Age 18-75)

Before Pharmacotherapy Visit (Baseline): 70%

Most Recent Lab: 74.10%

↑ 4.1%
¿QUESTIONS?