Effective Strategies for Team-Based Care

The Cambridge Health Alliance
October 11, 2018

CHA Cambridge Health Alliance

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

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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

Table 1
The Elements of High-Performing Team-Based Care

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

Building teams in primary care: A practical guide.
By Ghorob, Amireh,Bodenheimer, Thomas
Families, Systems, & Health, Vol 33(3), Sep 2015, 182-192

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

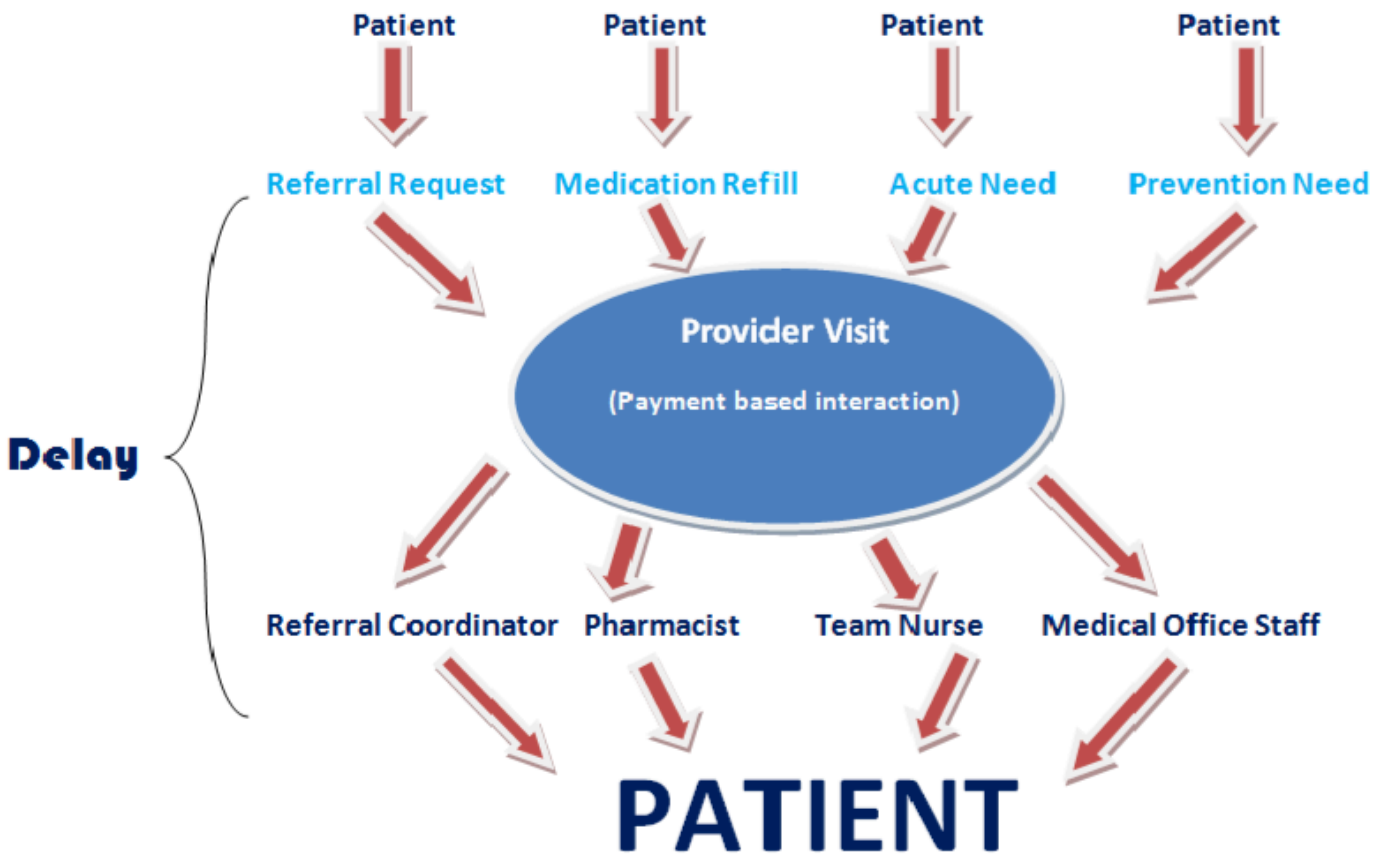
Team

In a patient-centered medical home, it is about the **patient**—and all the people a patient needs to support their care.

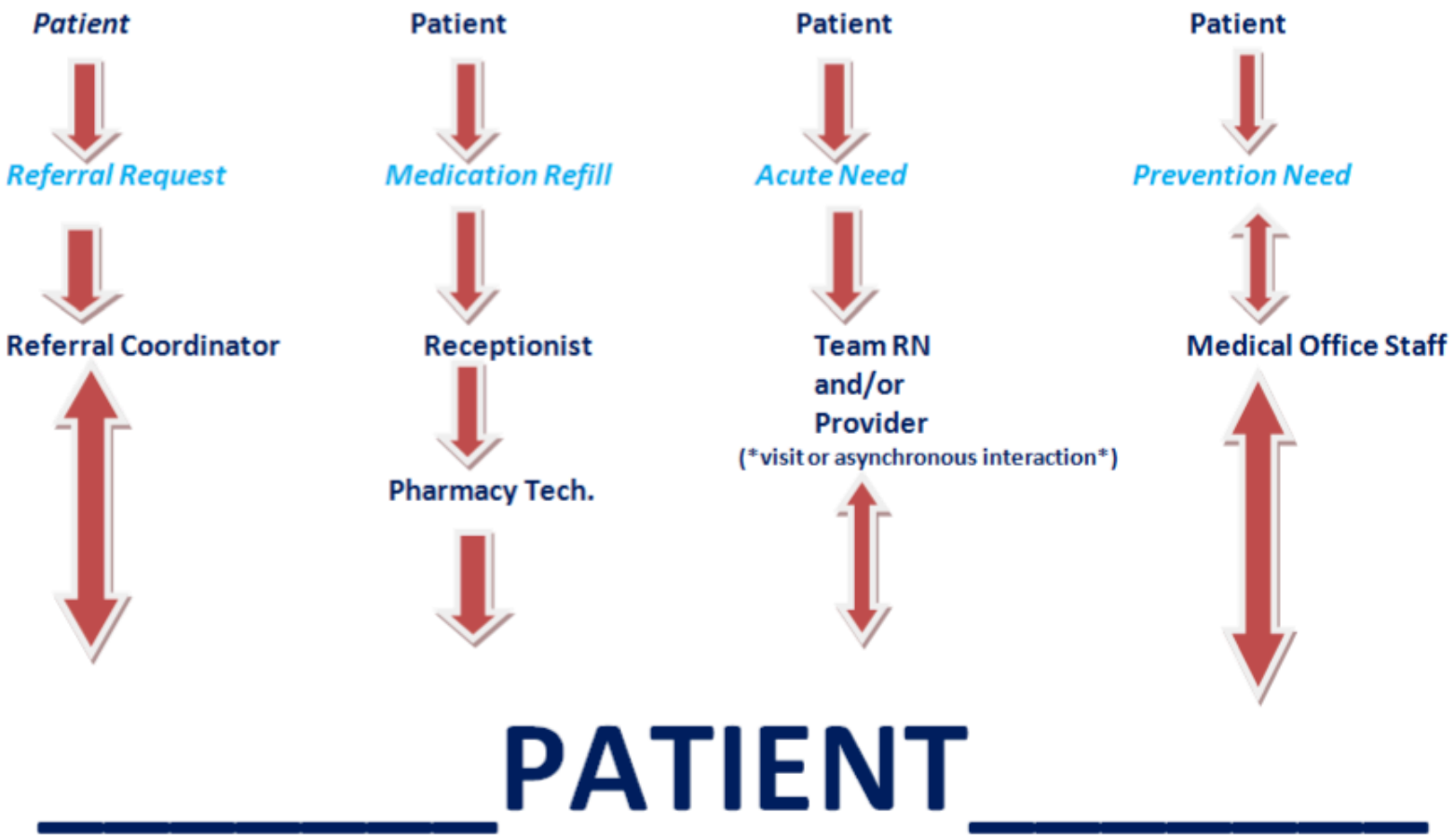
Team-based care means that everyone - from folks who register a patient to nurses - focus on the patient, not the doctor visit.

*The patient-centered medical home is about the **entire team** contributing to the care of a patient by developing independent relationships with patients.*

Workflows in Fee for Service



Workflow with Value Based Payments



Creating a Strong Team Culture and Shared Purpose

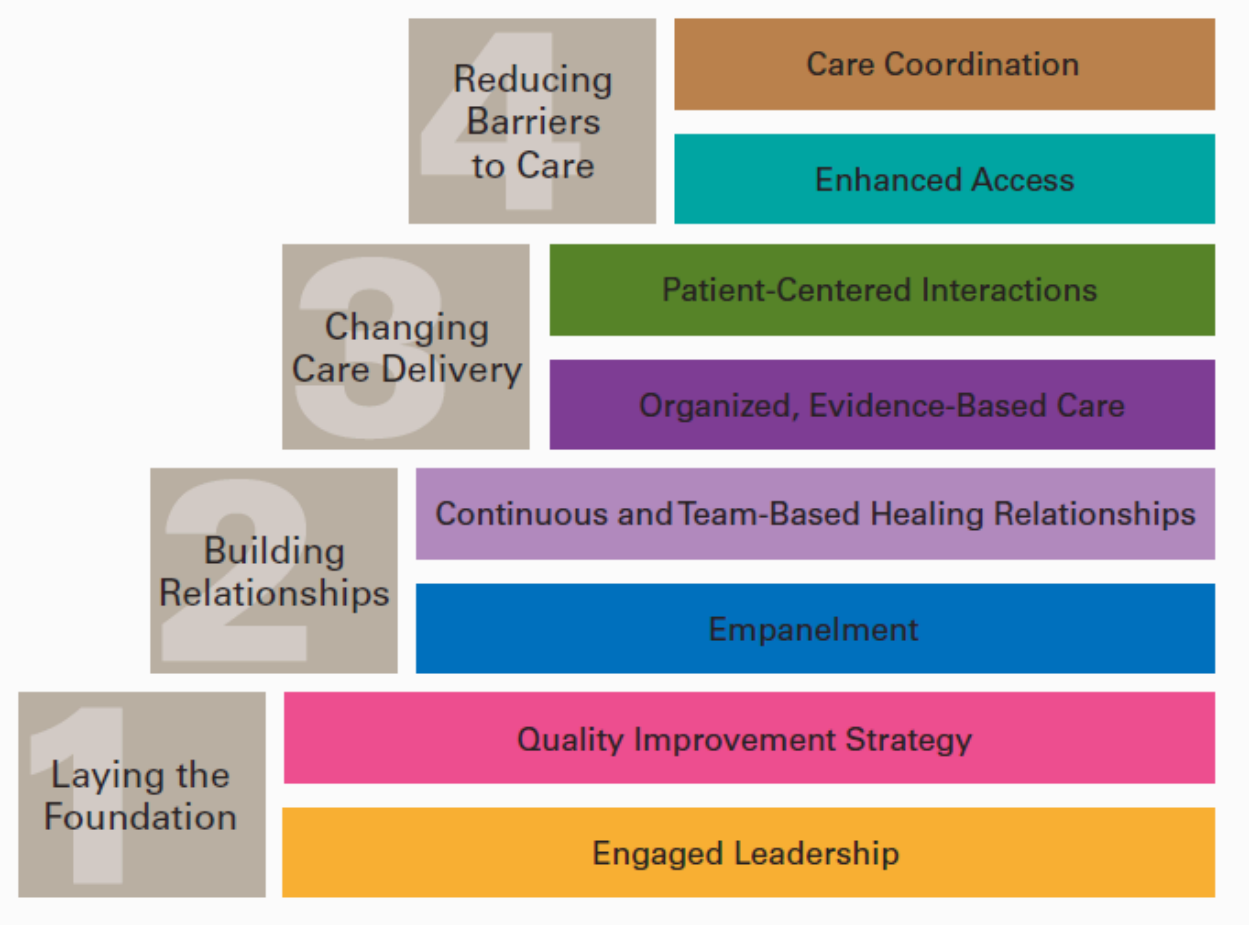
Work with the Change Concepts of Practice Transformation

The role of Engaged Leadership

Strengthen our team culture

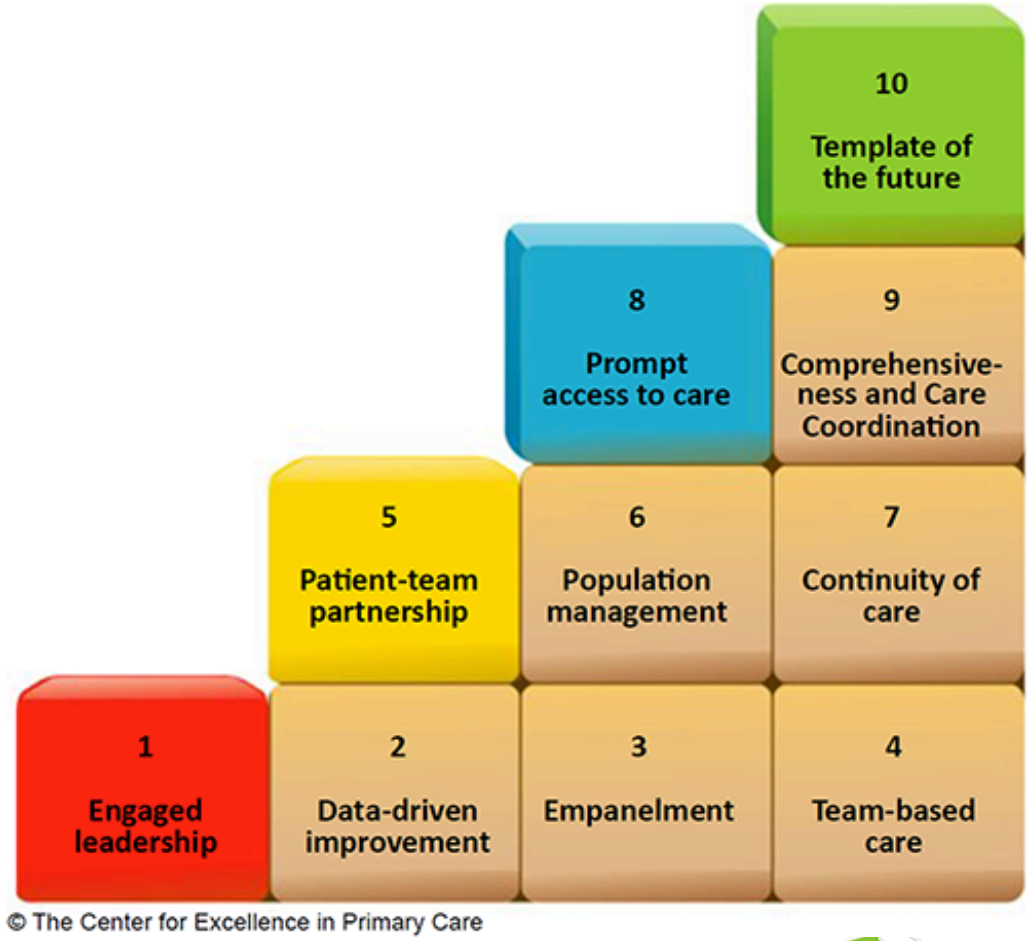
The role of Performance Improvement

Change Concepts for Practice Transformation



Wagner EH, Coleman K, Reid RJ, Phillips K, Abrams MK, Sugarman JR. The Changes Involved in Patient-Centered Medical Home Transformation. *Primary Care: Clinics in Office Practice.* 2012; 39:241-259.

10 Building Blocks of High-Performing Primary Care



Thomas Bodenheimer, MD, Amireh Ghorob, MPH, Rachel Willard-Grace, MPH and Kevin Grumbach, MD. The 10 building blocks of high-performing primary care. Ann Fam Med 2014;12:166-71.

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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

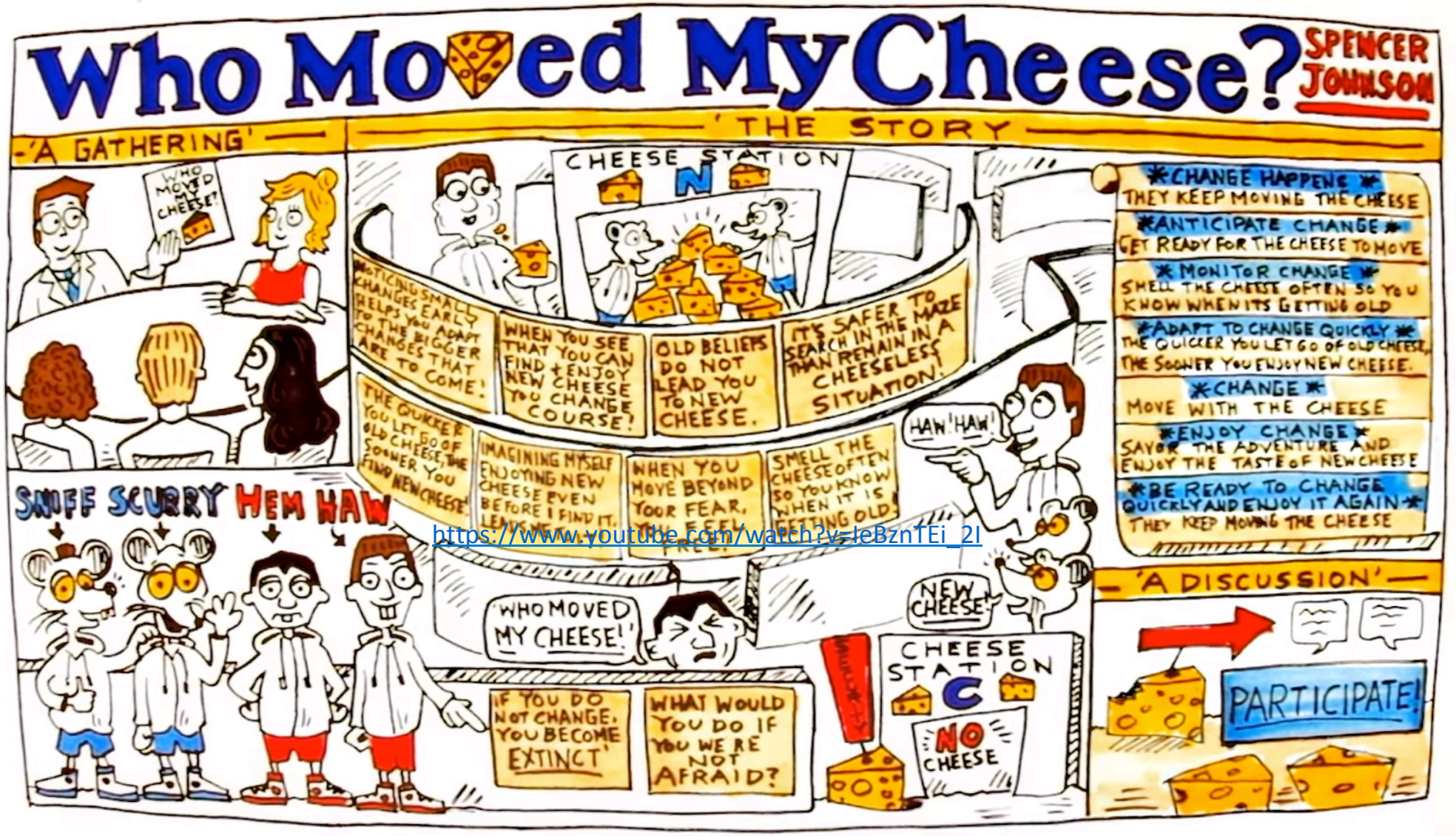
Link patients to a provider and care team so both patients and provider/care team recognize each other as partners in care

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

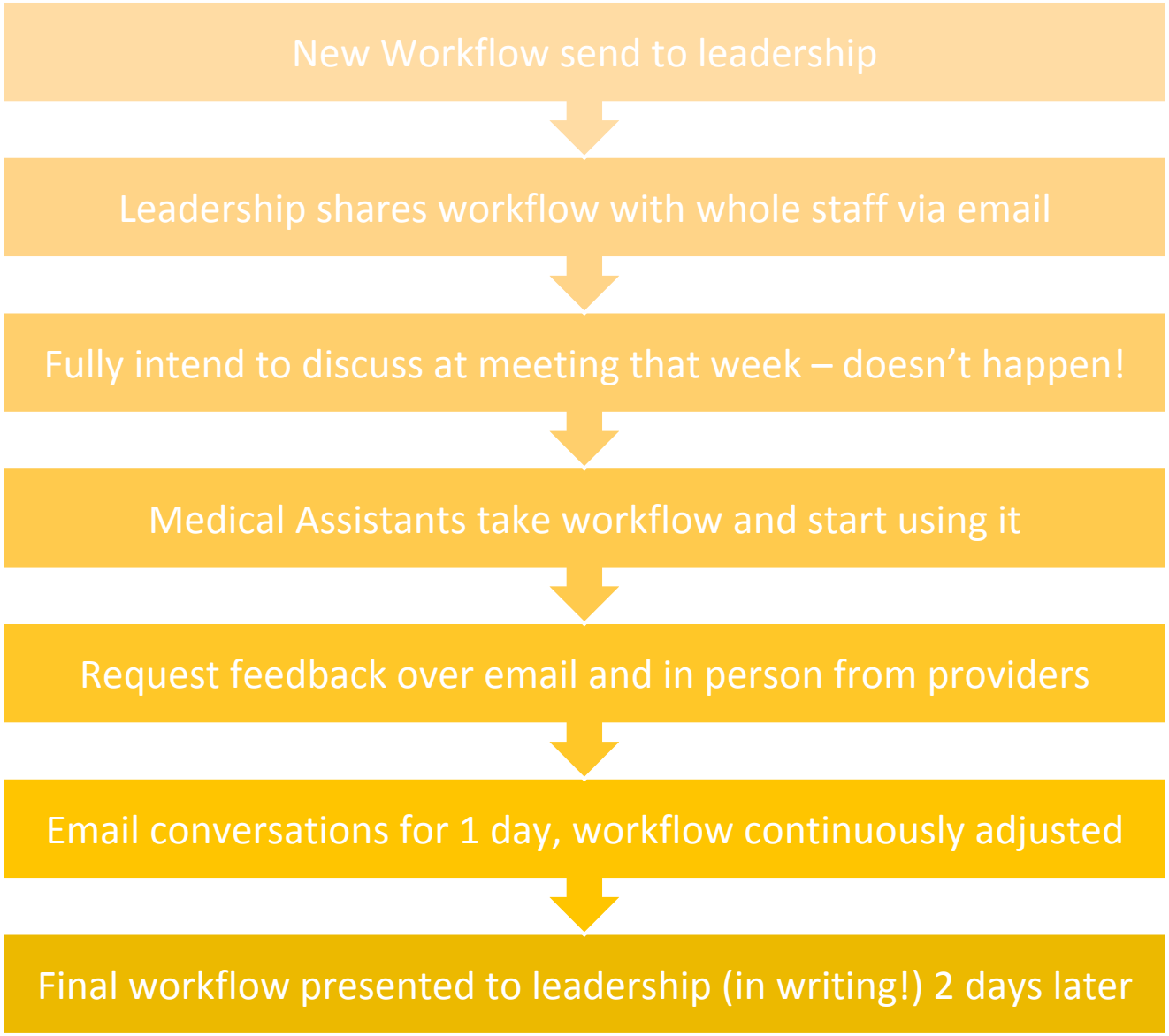
Test the workflow

Analyze the results

Test it again……..

What do I Need to do This?

A Real Life Example: Health Care Proxy



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.

Phone visits

E-mails

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

Longer visits

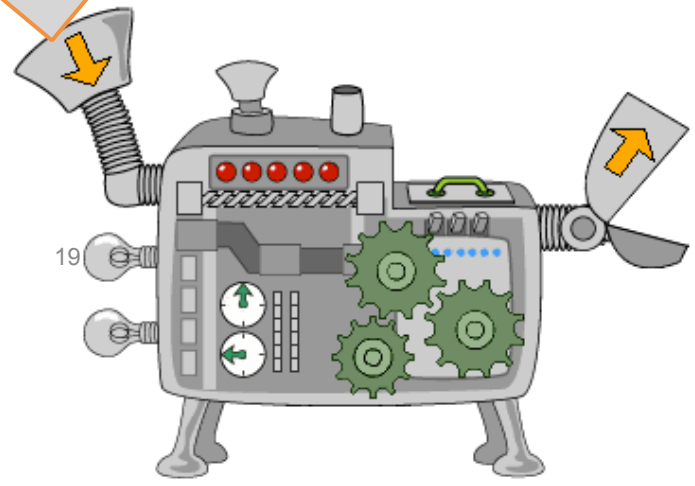
Coordinate with team members

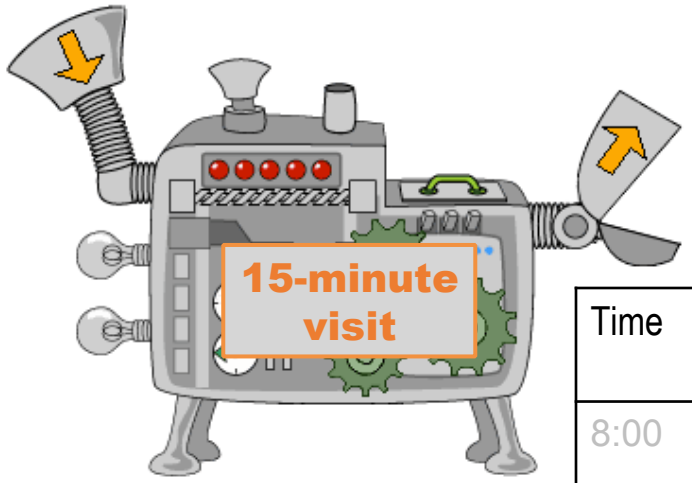
Coordinate with specialists

15-minute visit

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

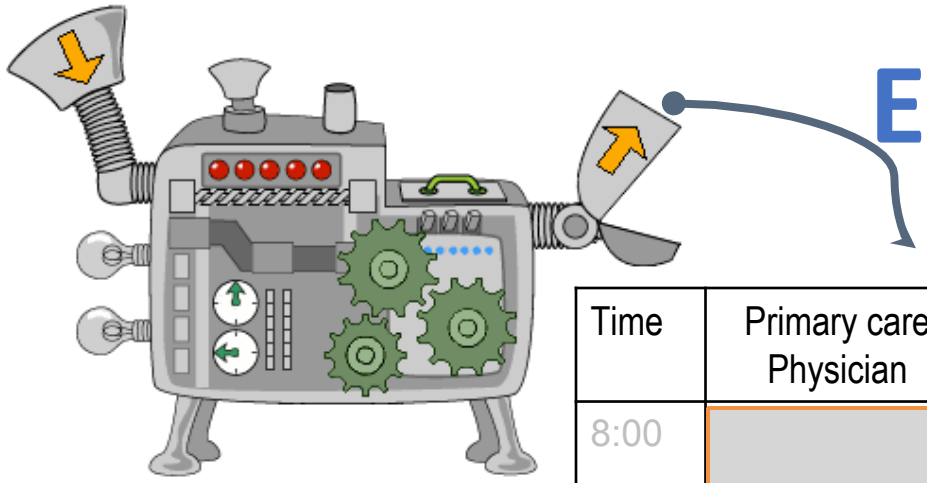
Group visit





Traditional Template

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



Evolving Template

Time	Primary care Physician	Medical assistant 1	Team RN	Physician Assistant	Medical Assistant 2
8:00	Huddle				
8:10	E-visits and phone visits	Panel manage-ment	RN Care manage-ment	Acute Patients	
8:30					
9:00	Complex patient				
9:30	Complex patient			E-visits and phone visits	Panel manage-ment
10:00	Coordinate with hospitalists and specialists	outreach			
10:30	Huddle with RN, NP		Huddle with MD		

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

Real-world solutions to enhance practice effectiveness - STEPS Forward. (n.d.). Retrieved February 08, 2018, from https://www.stepsforward.org/

This is what a day looks like without team support:

Acute Care	4.6 hours/day
Preventive Care	7.4 hours/day
Chronic Care	10.6 hours/day

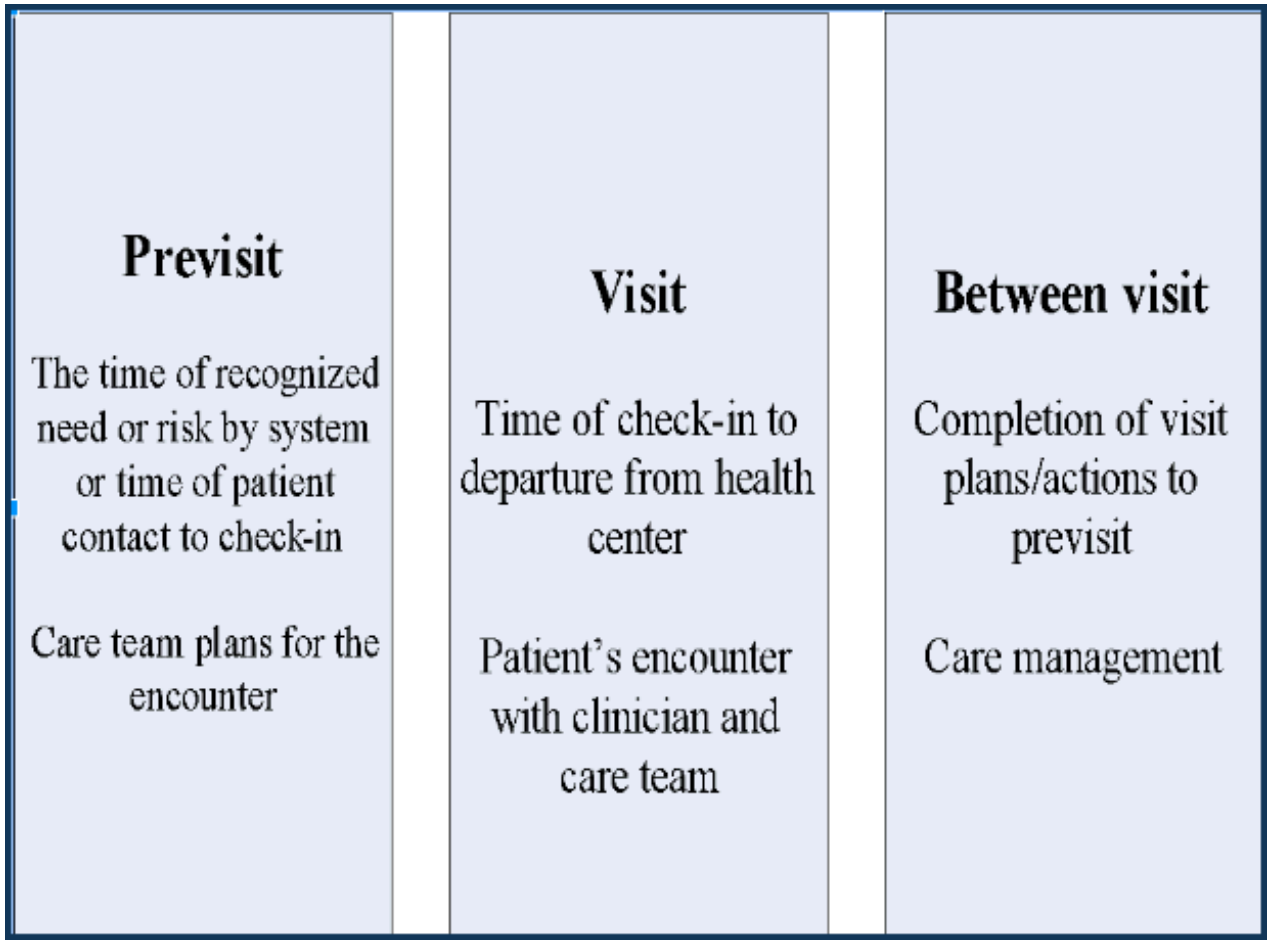
22.6 Hours/day

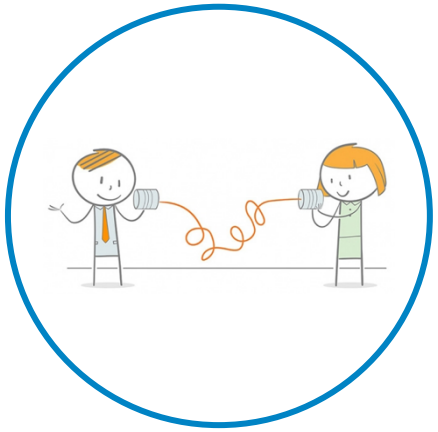
This is the amount of time required to take perfect care of ONE patient!

In 15 minutes? By a single provider?

N Engl J Med 2003; 348:2635-45

Redesigning Care Delivery:





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

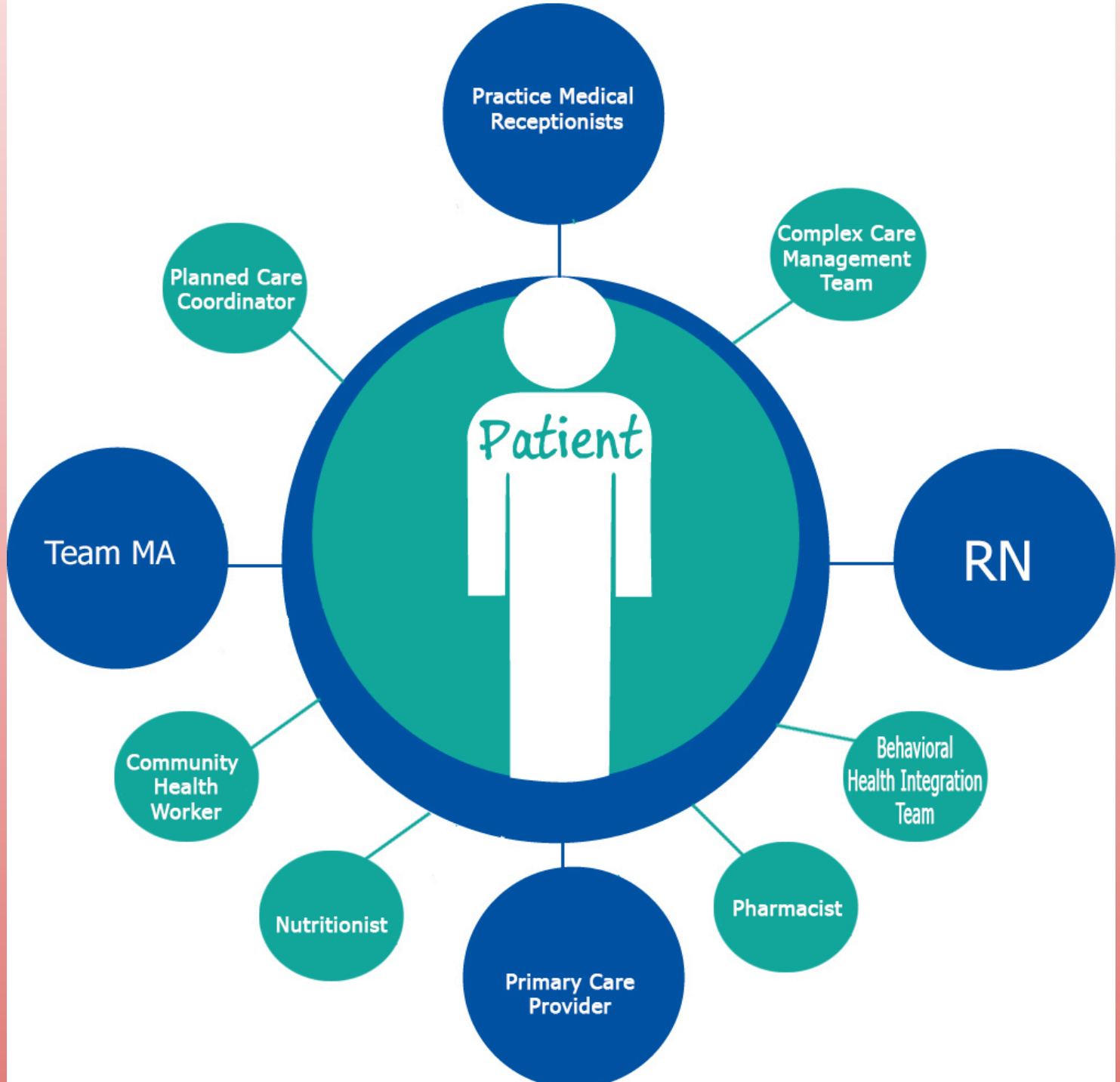
Community Mental Health

Specialty Partners (econsults, chart reviews, televisits)

Patient Team Members

Patient Partners - two per practice

Patient Family Advisory Councils


Practice Medical Receptionists
Complex Care Management Team
Planned Care Coordinator
Patient
Team MA
RN
Community Health Worker
Behavioral Health Integration Team
Nutritionist
Primary Care Provider
Pharmacist

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Team Sabia

Patrick Sabia, MD
- Sees people of all ages
- Pregnancy Care

Susan Gesing, RN
Registered Nurse
- Health & Medication questions
- Chronic Disease Management

Mirna Mejia
Medical Assistant
- Lab tests
- Mammograms and ultrasound appointments

Silvia Hamilton
Medical Receptionist
- Appointments
- Letters

Team Hall

Lara Hall, MD
- Sees people of all ages
- Pregnancy Care

Mary Hart, RN
Registered Nurse
- Health & Medication questions
- Chronic Disease Management

Elizaria Cabral
Medical Assistant
- Lab tests
- Mammograms and ultrasound appointments

April Johnson
Medical Receptionist
- Appointments
- Letters

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HARVARD MEDICAL SCHOOL TEACHING AFFILIATE

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

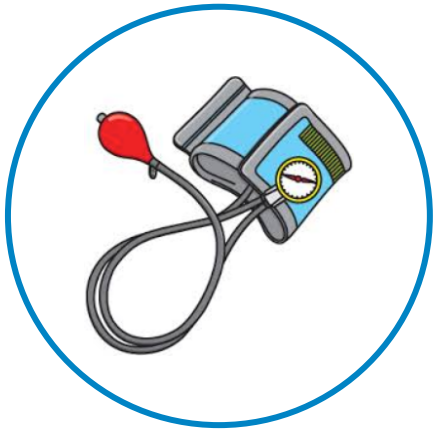
transportation approvals

Internal

faxes/media/scanning

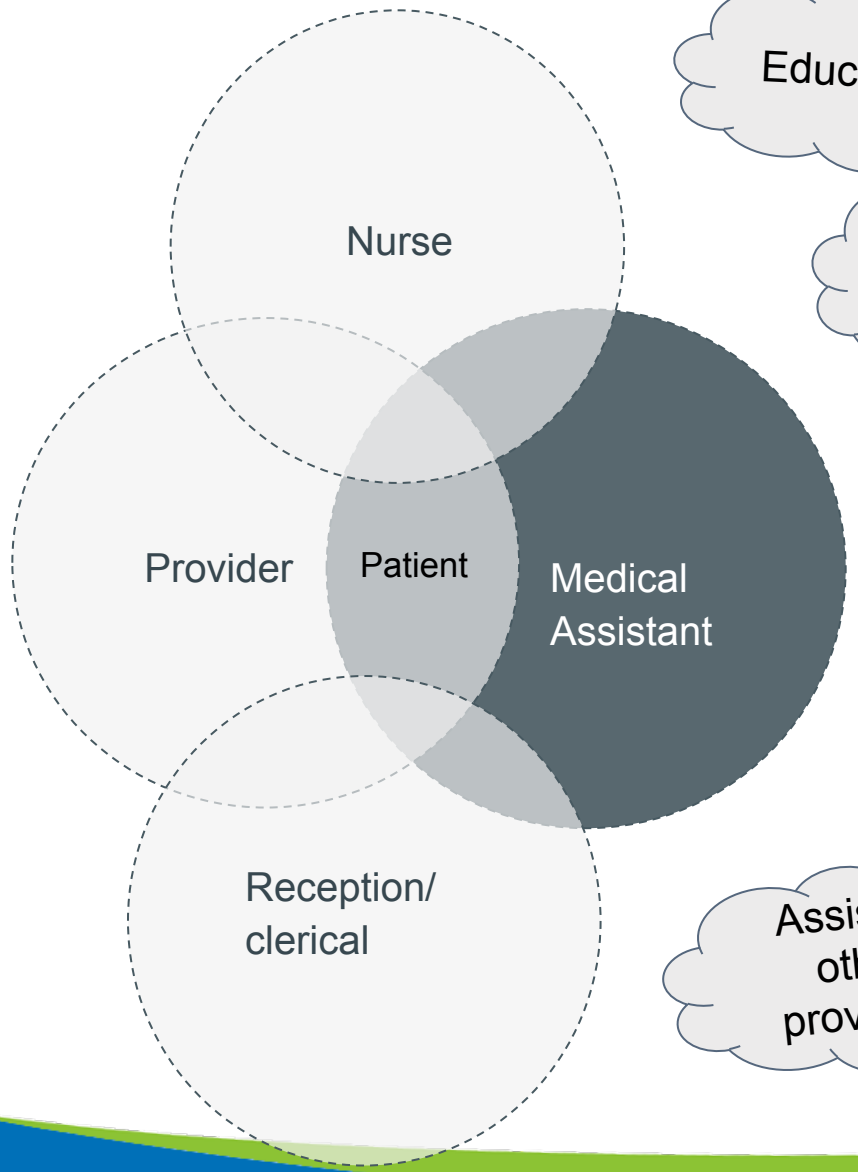
outreach - Well child appointments, Pap smear appointments

Attribution and panel management



Designing the Core Team: Medical Assistant

"Yes, you can take your earrings off if you think that would help."



Education

Reminder calls

Assisting patients

Specialty Appointments/ Referrals

Pre-visit plan for next day

Outreach

POC testing

The Unexpected

EKG

Rooming the next patient

Records

Ordering supplies

Preparing for next patient

Stocking rooms

Data Entry

Assisting other providers

Communicating with other team members/ extended team members

Coverage

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

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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

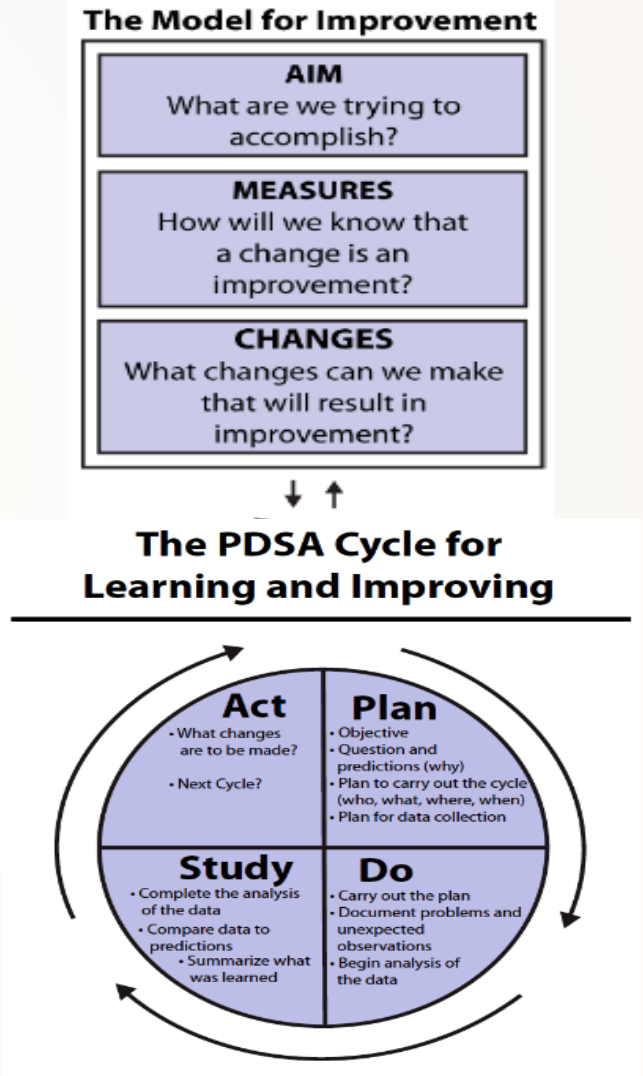
Continue to use all staff meetings as a venue for PI and QI to keep the culture alive

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



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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

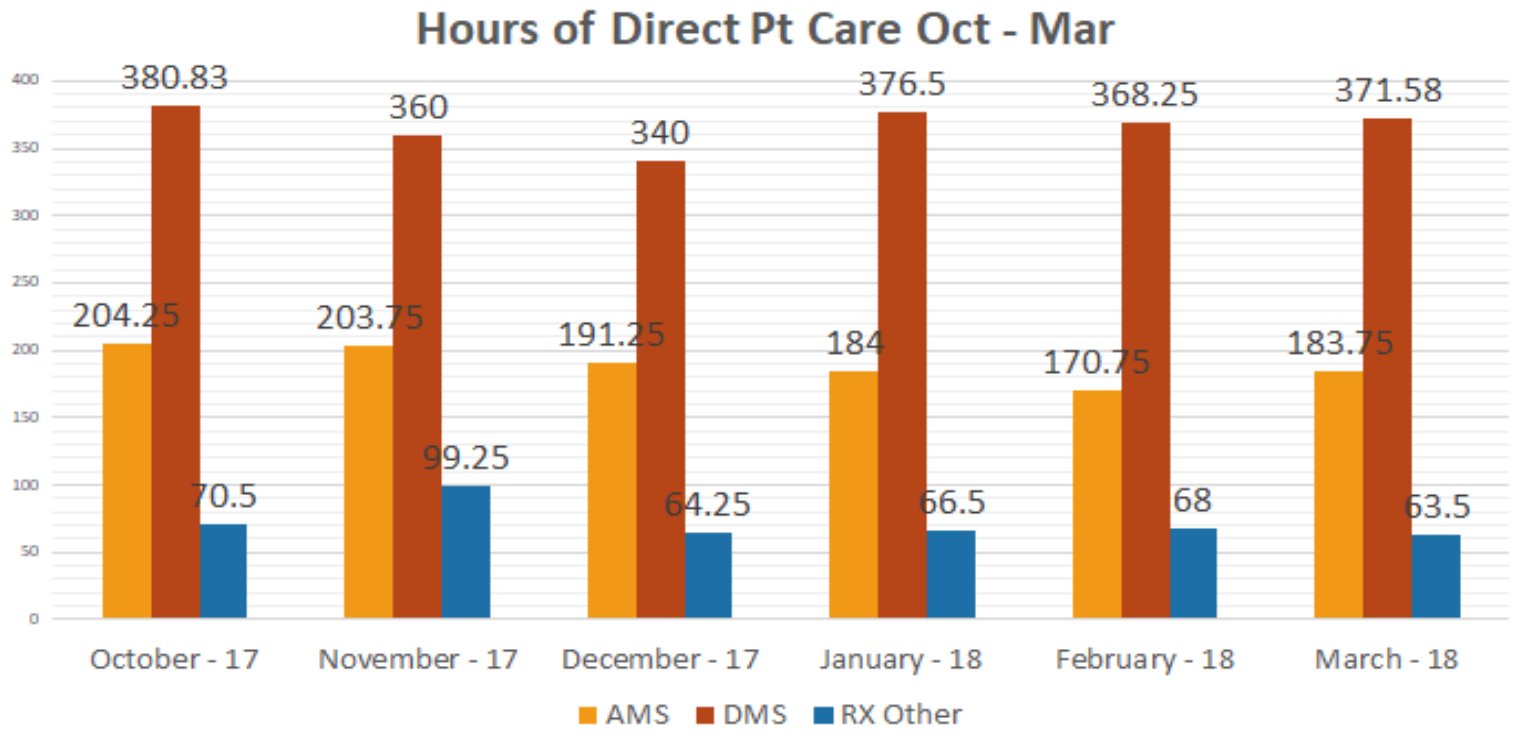
Role of the Pharmacist on the team involves working with each team on their patients not at goal for DM, HTN or COPD

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

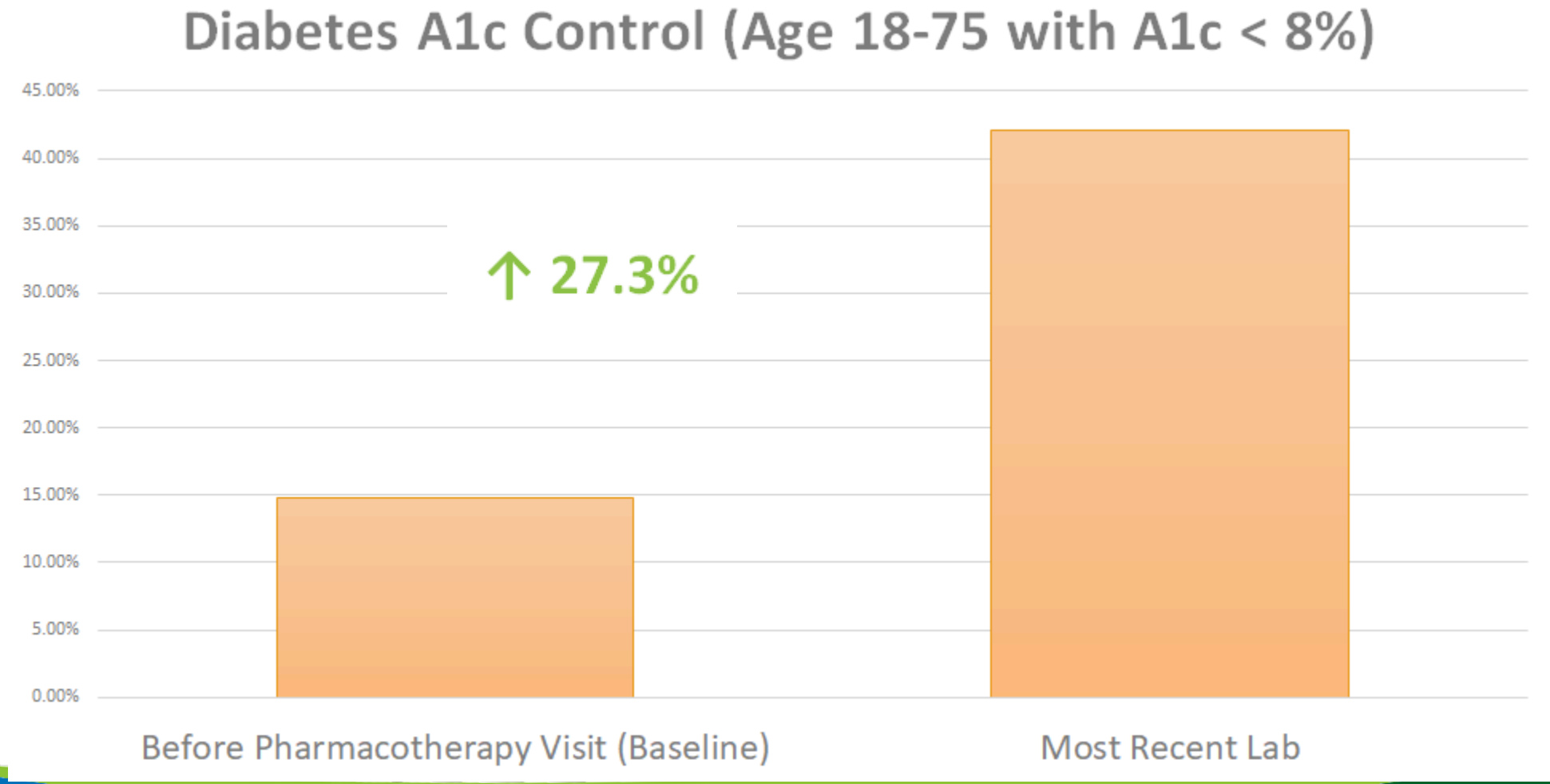
DM and HTN policies and protocols in place, visits billed and co-signed by PCP

COPD rescue pack protocol

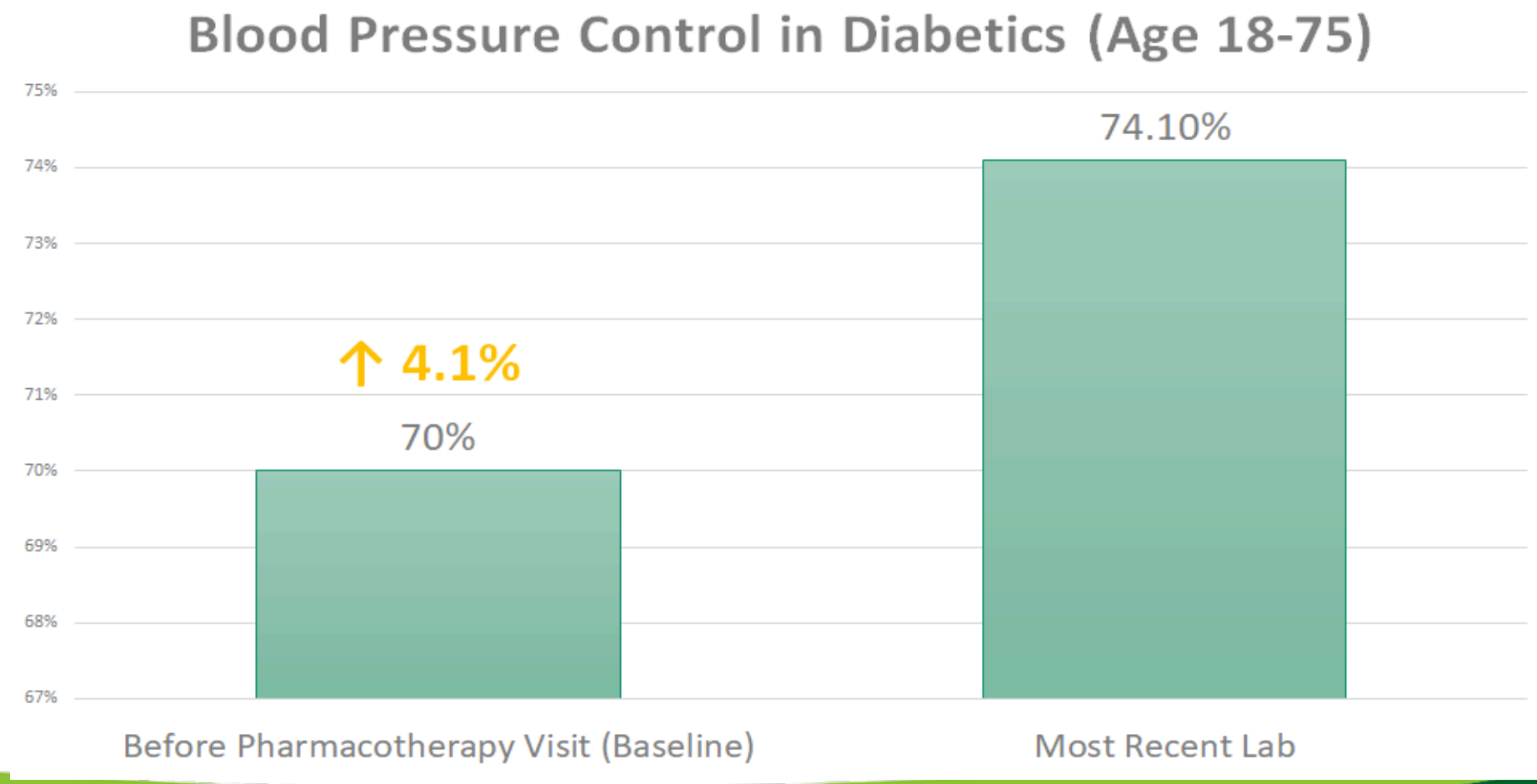
Diabetes, Anticoagulation, HTN, COPD



Results


Diabetes A1c Control (Age 18-75 with A1c < 8%)
45.00%
40.00%
35.00%
30.00%
25.00%
20.00%
15.00%
10.00%
5.00%
0.00%
↑ 27.3%
Before Pharmacotherapy Visit (Baseline)
Most Recent Lab

Hypertension control results



¿QUESTIONS?