Team Based Care in Practice Transformation

Focus on Primary Care

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Transforming Clinical Practices Initiative Faculty

Continuing Education Disclosures

- Commercial support or sponsorship – None
- Speaker or planner relationships with commercial interests – None
- For CME credit or attendance certificate
  - Full session attendance + completion of online evaluation
- Evaluation link available at the end of the session

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Creating a Team Based Culture and Shared Purpose

- Working with the change concepts of team based care.
- How do we move to a team culture?
- What role does leadership have in this transition?
- Performance improvement culture change and patient centered principles form the core of this important organizational shift.

Transforming Clinical Practice Initiative

Goals for the Session

- Talk about the transition to team based care using Primary Care as the example
- Define how to move towards a performance improvement infrastructure
- Integrate tools for how to include patients as part of the team

Medical Home Transformation of Primary Care

- Integrates population health with traditional care to give high quality care
- Patient centered access to care
- Reduces waste by coordinating care
- Establishes robust teams – all of whose members have independent relationships with patients
  - This site based manner of delivering care moves patients and the medical culture towards accepting extended teams

Team Based

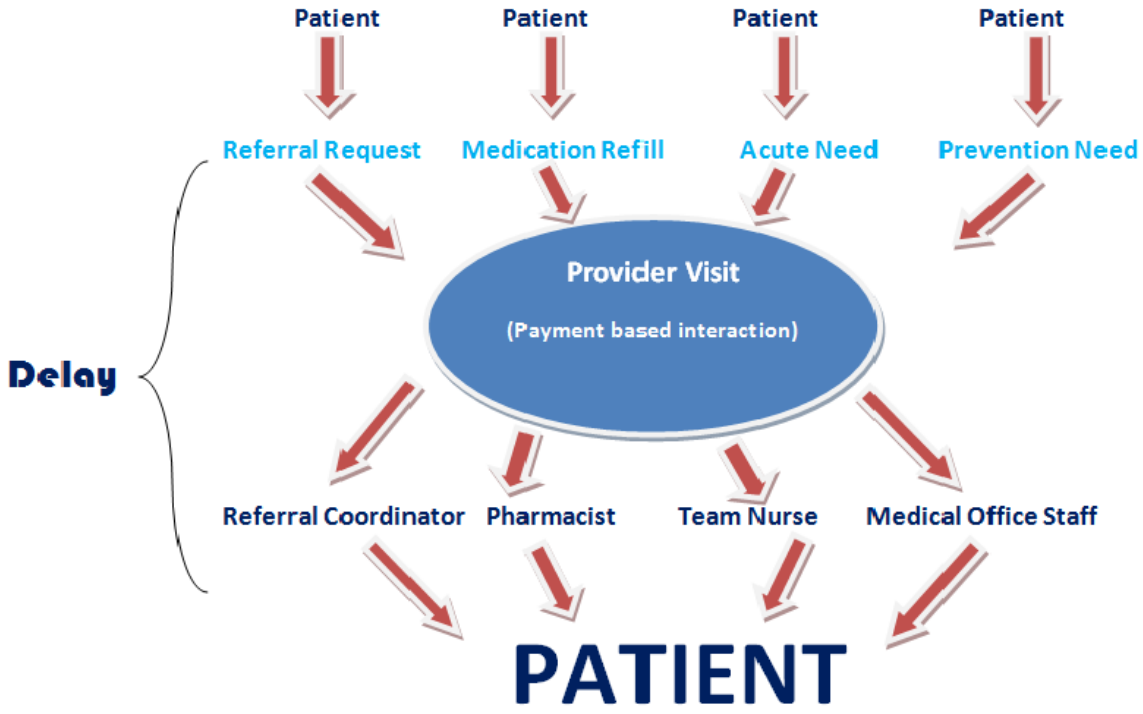
In a patient-centered medical home, it is about the **patient**—and all the people a patient needs to support their care.

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.*

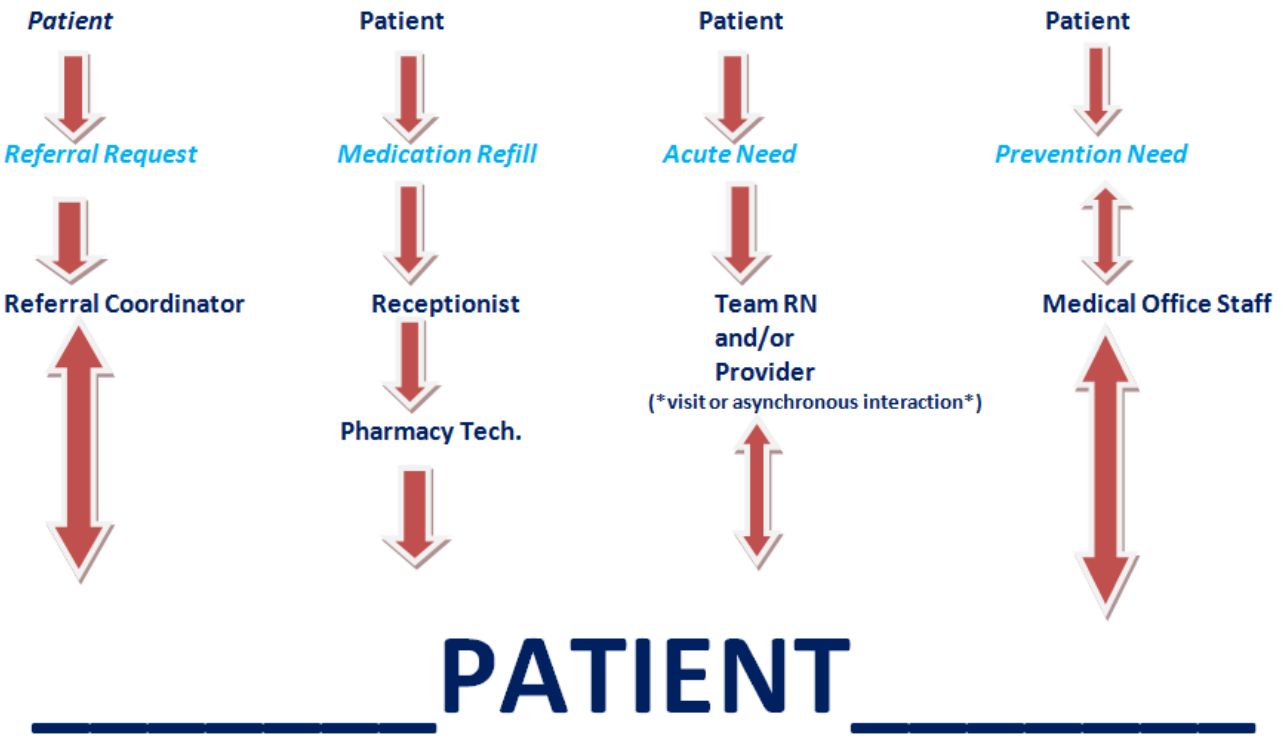
How Payment Methods in Healthcare Affect Care Delivery

Workflows in Fee for Service



How Payment Methods in Healthcare Affect Care Delivery

Workflow with Value Based Payments



Designing Teams to Fit the Work

First: Who are you?

Cambridge Health Alliance

- An academic public health safety net system outside of Boston
- Largely public payer mix – 82%, almost all Medicaid
- >50% patients speak language other than English
- 180,000 primary care visits for 102,000 patients

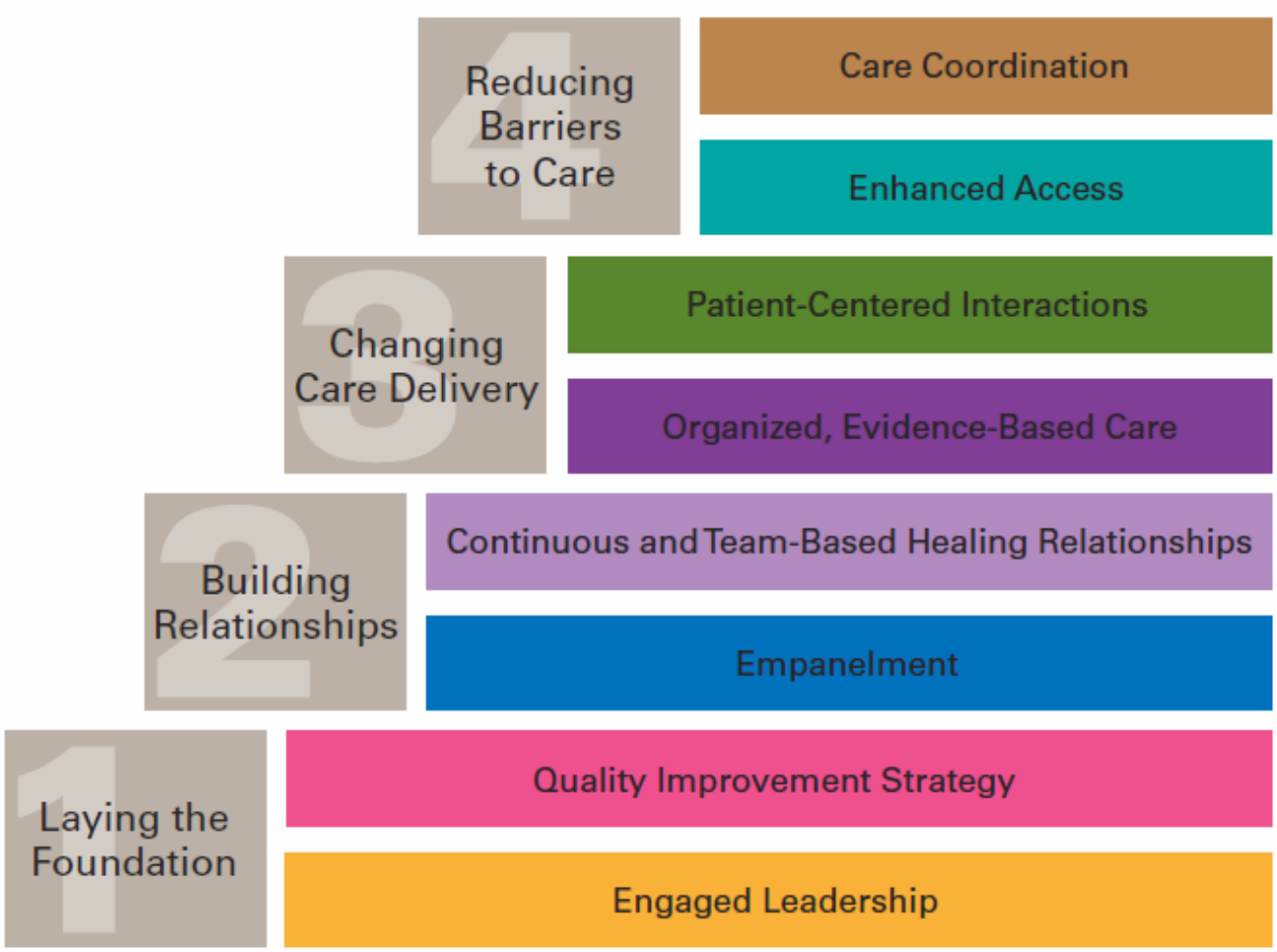
Welcome to a vibrant, caring community.

WELCOME TO

CHA

CHA Cambridge Health Alliance

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.

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

Culture Change

Performance Improvement culture change

- Non-hierarchical
- Involves everyone as an expert, including the patients!

Wait…

What is Performance Improvement?

It's Actually Quite Simple…

Identify a problem

Quantify the problem

Identify stakeholders

Design a workflow

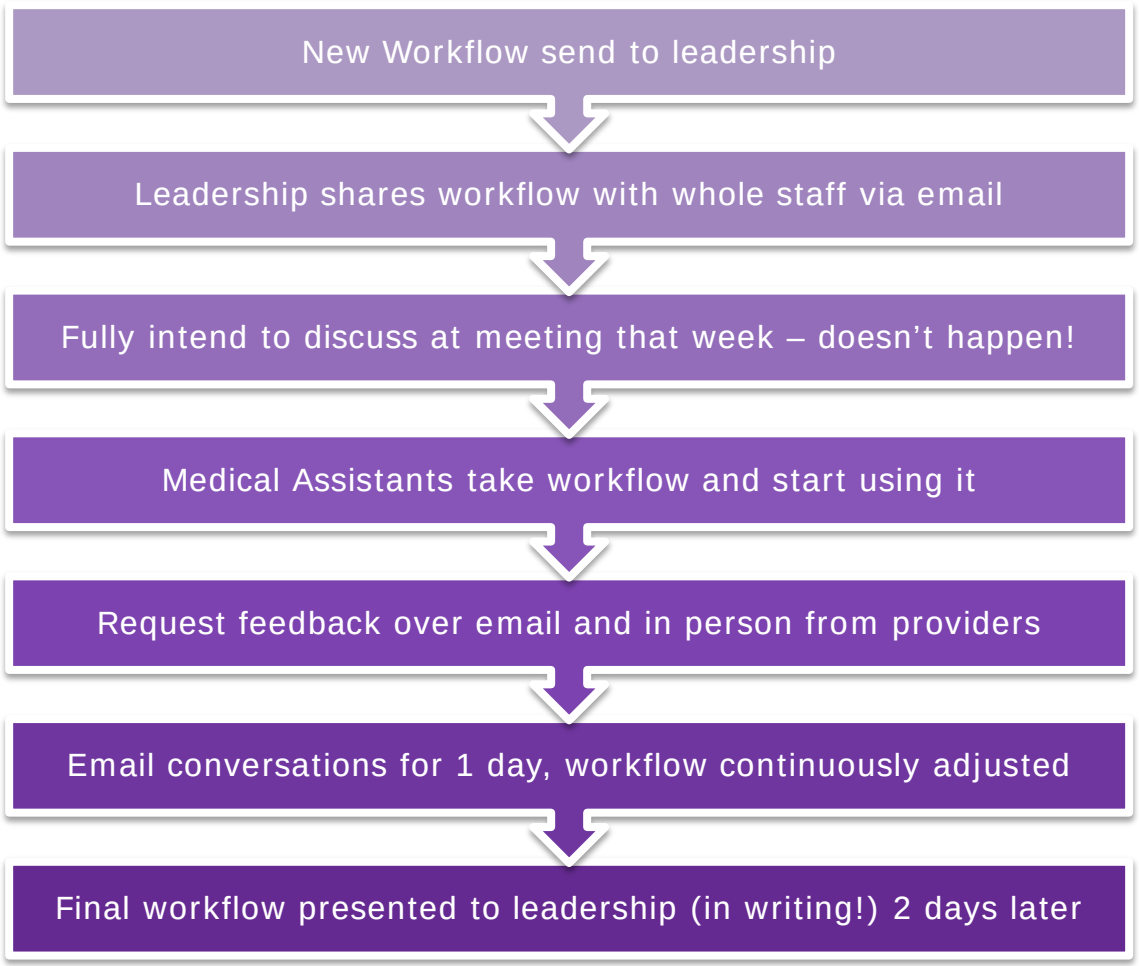
Test the workflow

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

Who Does This Work?

TEAMS


Patricia

Designing Teams to Fit the Work

Next: What work are you doing?

The Vast Majority of Cases of Chronic Disease Could Be Better Prevented or Managed

The World Health Organization (WHO) estimates that…

- At least **80%** of all heart disease, stroke, and type 2 diabetes, and
- More than **40%** of cancer

would be prevented if only Americans were to do three things:

- ✓ **Stop smoking**
- ✓ **Start eating healthy**
- ✓ **Get in shape**

http://www.fightchronicdisease.org/

This Is What We Do Now

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 doctor?

Redesigning Care Delivery

Care is no longer based primarily on visits

Previsit	Visit	Post-visit	Between visit
The time of recognized need or risk by system or time of patient contact to check-in Care team plans for the encounter	Time of check-in to departure from health center Patient's encounter with clinician and care team	Departure to completion of visit plans/actions	Completion of visit plans/actions to previsit Care management

There Are Many Roads…

- Form follows function: who is around to help with the work?
- Teams need leadership direction and support but can grow organically (especially important when there are economic constraints)
- Functions and roles of teams members change over time based on staffing and need
- Role definition has to be well defined so there is no duplication of work

The Cambridge Health Alliance Team Model of Care: Role Definition

Panel Provider – panel composition created around their skill set

Non-Panel Provider – shares the panel with the panel provider, team support

RN– chronic disease management and patient education, triage

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

MA – 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


Cambridge Health Alliance
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
Cambridge Health Alliance
HARVARD MEDICAL SCHOOL TEACHING AFFILIATE

Extended Team

Shared team members at the practice level

- **Referral Coordinator**
- **Integrated Behavioral Health** - Care Partner, Therapist and MD

Regional team members

- **Complex Care** - Nurse, Social Worker team manage 150 patients
- **Pharmacist** - visits for medication compliance, reconciliation and chronic disease management and education
- **Panel Manager** (Planned Care Coordinator)

System wide team members

- **Central Complex Care Team** (Social Worker and CHW)
- **Hospice / Palliative Care Team**
- **Visiting Nurse / SNF / Aging Agencies**
- **Community Mental Health**

Care Coordination Is Everyone's Job!

Patients have visits with multiple team members in one day

Who facilitates that?

Receptionist schedules so it can actually happen!

Medical Assistant makes the flow happen

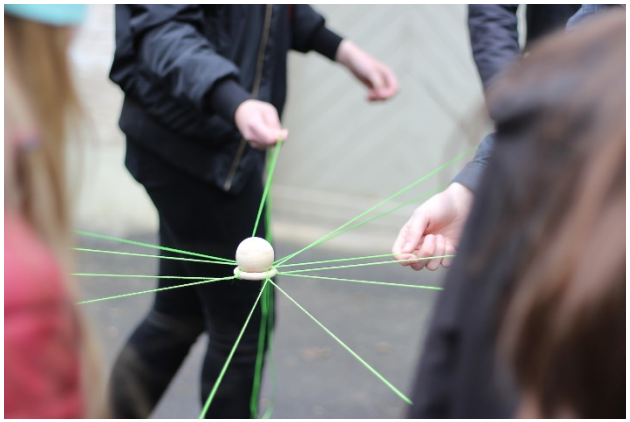
How does it look?

Pharmacy – RN co-visit: pharmacist does 30 min with warm handoff to team RN

RN – provider co-visit: RN does 1 hr. teaching and makes plan with patient before provider visit

Nursing: LPN does immunizations before provider visit

Behavioral Health co-visit with anyone – warm handoff in either direction, same day scheduling commonplace



Care Coordination is Everyone's Job! Outreach

Patients most at risk with "hand offs" and when travel between parts of the system (consults, ER , Hospitalizations, testing)

Provider calls the Emergency Room when sending a patient there to coordinate care

Emergency Room visit follow up calls by team LPN

Post Hospital Discharge visits with team within 1 week and telephone call from RN within 48 hours

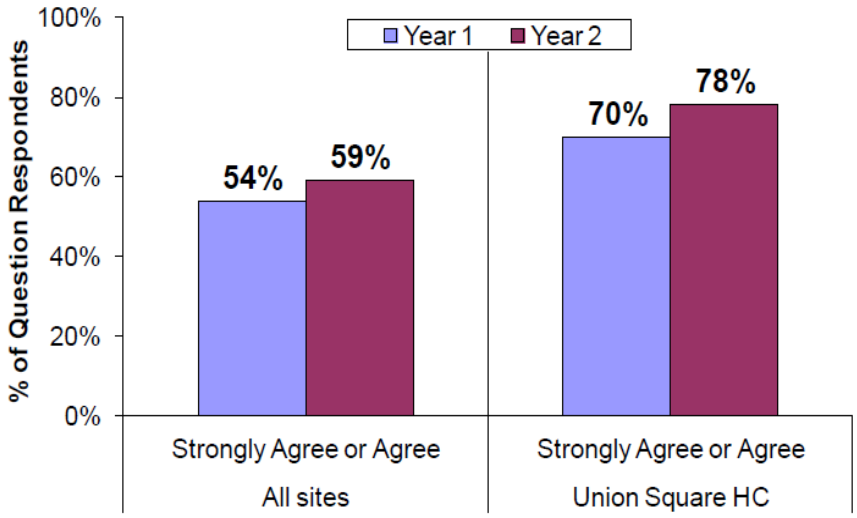
Integrated system of sharing visit notes (ER, consults, admissions)

Measures of Success: Work Environment

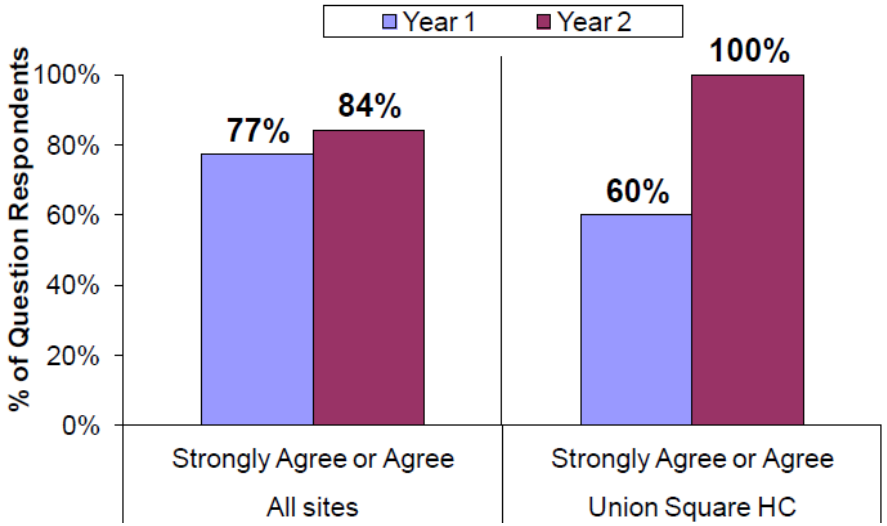
- Patients most at risk with “hand offs” and when travel between parts of the system (consults, ER, Hospitalizations, testing)
- Provider calls the Emergency Room when sending a patient there to coordinate care
- Emergency Room visit follow up calls by team LPN
- Post Hospital Discharge visits with team within 1 week and telephone call from RN within 48 hours
- Integrated system of sharing visit notes (ER, consults, admissions)

What You Can Expect to See (and Fast!)

Q161: Employees in my team report a strong sense of connection to their work

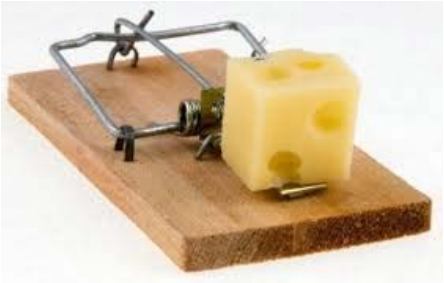


Q17a: I am treated with respect every day by everyone that works in this practice



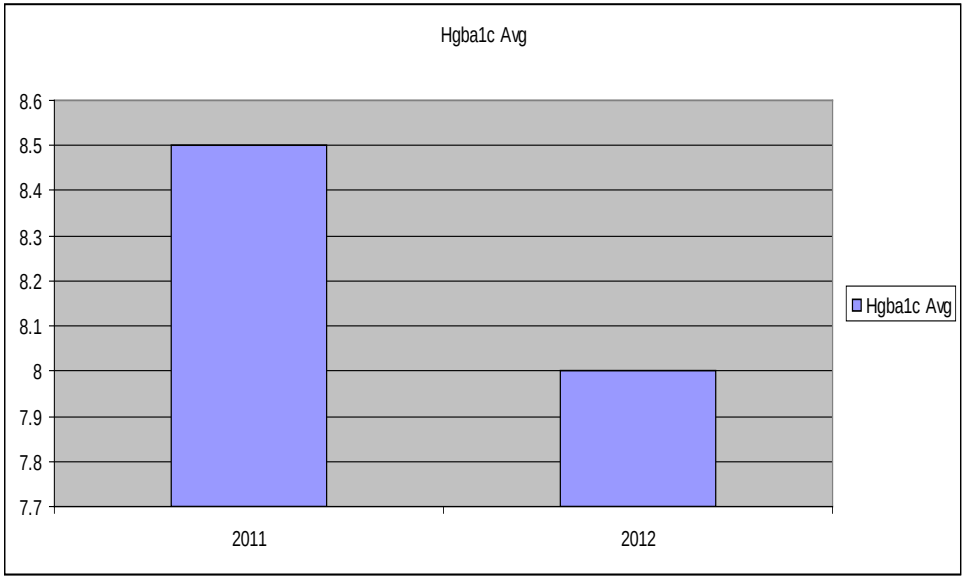
Traps

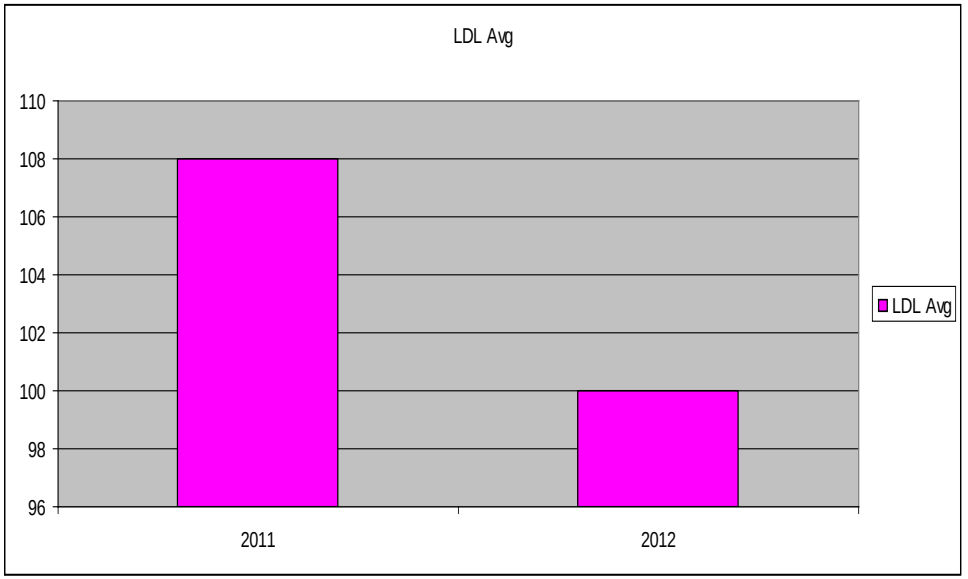
- Important for people to own the work
  - Clear communication, role definition, empowerment
- Important to preserve a sense of teamwork across care teams
  - Vacations, sick days, etc.
- Appropriate prospective staffing and scheduling really matters
- Personality management
  - Help each person to succeed



1 Year Results

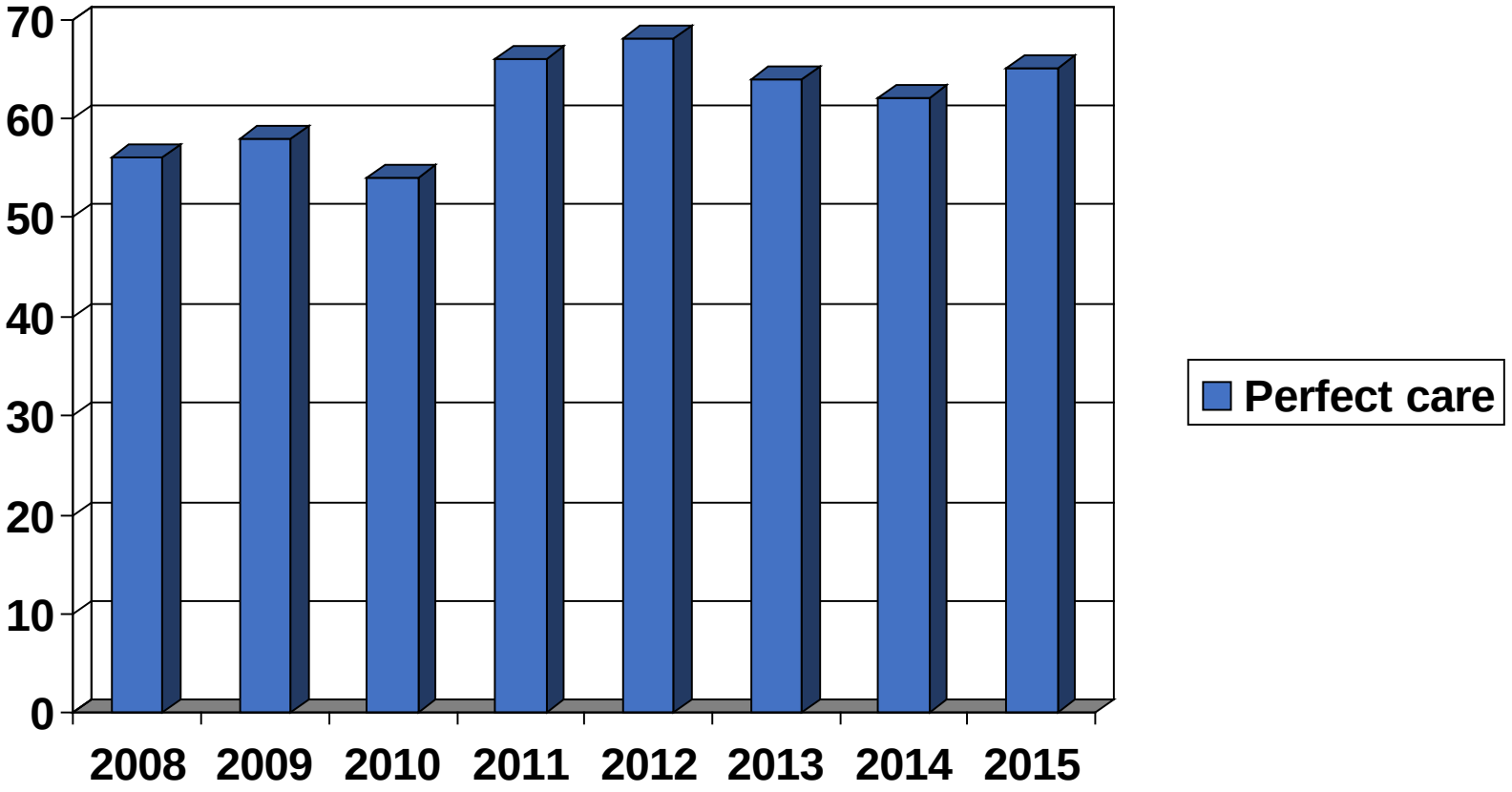
RNs have taken on direct patient education for high-risk patients, especially those with diabetes.





Diabetes “Perfect Care”

Outcomes – the long term



“Teams can work if your whole team loves the patient as much as you do.” - *Lucy Candib, MD*

Continuing Education Certificate

For CME credit or attendance certificate –

Full-session attendance and completion of on-line evaluation:

https://www.surveygizmo.com/s3/4125544/January-17-2018-Team-Based-Care-in-Practice-Transformation

OR

http://bit.ly/2mAaqHN

Thank you!