MacColl Center for Health Care Innovation

Deeper Dive on Team Roles: Part 2

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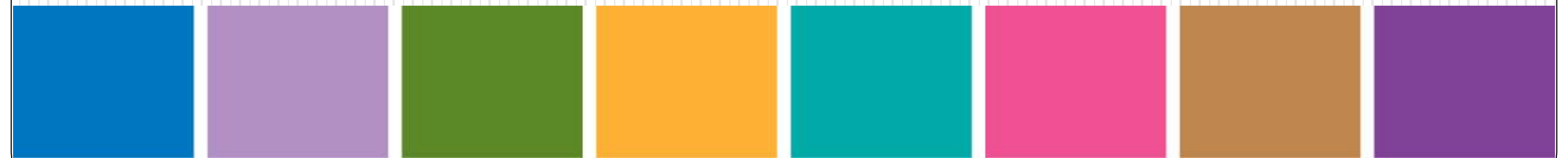

8 Change Concepts for Practice Transformation

1. Foundational Changes

   Engaged Leadership

   QI Strategy

   Empanelment

2. Changing Care Delivery

   Continuous, Team-based Healing Relationships

   Patient-Centered Interactions

   Organized, Evidence-based Care

3. Changing Patient Experience

   Enhanced Access

   Care Coordination

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Innovative Workforce Models in Health Care:

Utilizing medical assistants in expanded roles in primary care

October 25, 2012

Focus: Staff and Provider Engagement

Research

- Funded by the Hitachi Foundation
- 14 Site Visits / Case Studies
- Criteria for selection
  - Improved patient outcomes
  - Enhanced organizational efficiency
  - Career advancement for Medical Assistants (MAs)*

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Changing Roles: Medical Assistants

[At first] it was panic city around here…I was *not* happy with this.

[Now] I feel more a part of the team. I feel like I give 110%. I feel much more important.

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Medical Assistants' Concerns

- We already do too much!
- Intimidated by providers
- Lack of confidence to take on new roles
- Uncomfortable with more relational roles
- Resentful of additional responsibility
- Resentment towards peers promoted to supervisory roles
- Learning curve: EHRs

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Enhancing MA Engagement

- **Communication**—Here is where we are going and why
- **Inclusion** in planning / piloting process
- **Training and mentoring**
- **Incentives**—Recognition for effort and high achievement
- **Data**—I can see what I do makes a difference to patient outcomes

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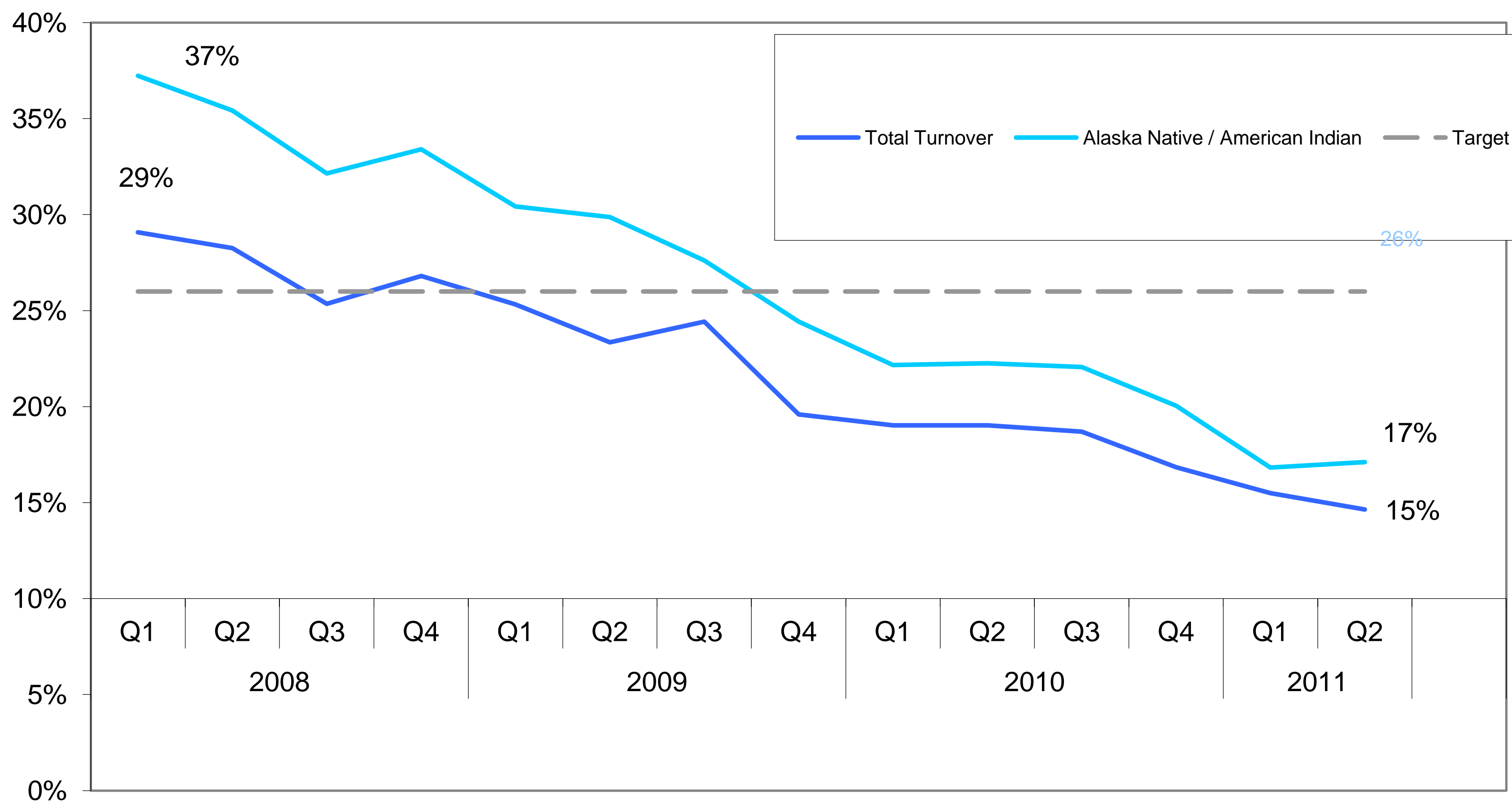
Staff Turnover—Southcentral Foundation



Nurses' Reactions

Nurses do not like people taking roles they would traditionally have.

We cannot afford to hire 40 RNs to do vital signs; RNs have enough experience and judgment to really do the higher level stuff.

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Nurses' Concerns

- MAs are not qualified to take on new roles
- MAs are not smart enough
- Expanding MA roles is a threat to RN jobs
- Expanding MA roles threatens patient safety
- Who will be responsible for training them?
- Who will supervise them?
- Miss direct patient care

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Enhancing Nurse Engagement

- Everyone working at the **top of their license**
  - RNs have valuable skills that need to be capitalized on
- **Inclusion**
  - Develop MA training materials
  - Conduct trainings and competency assessments
  - Leadership roles in quality improvement
- **No layoff policy**
  - Let staff leave by attrition if there are fewer nursing positions in the new model

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Providers' Reactions

I felt like I was on a treadmill going as fast as I could without producing many results.

One of the biggest barriers …is giving up work to the team. You feel you need to be responsible for everything, but you need to realize that other people are capable of handling some of this work.

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Providers' Concerns

- Don't want to relinquish patient education tasks
- Cannot trust staff enough to delegate
- MAs are not smart/skilled enough
- Never required to manage a team before
- Will patient care be compromised?
- Will we face legal liability?
- Hard to let go of status and privilege

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Enhancing Provider Engagement

1. **Inclusion in planning**
   1. Survey provider needs for MA skills
   2. Pilots / implementation planning
   3. Training / competency assessment
2. **Provide evidence of success**
   1. Videos / Site visits
   2. Pilots
   3. Data
3. **Physician champions**

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Increased Provider Satisfaction

Time Spent Working

0 10 20 30 40 50 60 70 80

Time you have available for your family and personal life

Degree of control you have over your schedule

Amount of time you spend working

Amount of time you spend with each patient

The volumn of my patient load or panel size is reasonable

Agregate Score

2003 Raw Score 2008 Raw Score

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Enhancing Engagement in General

1. **Build teamness**
    1. Co-location
    2. Team Huddles
2. **Support from top leadership**
3. **Everyone needs training**
    1. **Initial**
    2. **Ongoing**

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Study Team

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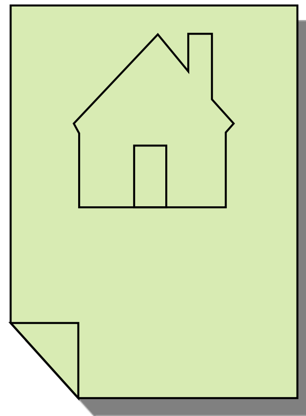
The Evolving Role of the RN in Medical Home Implementation



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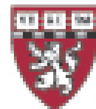

The IOM Report on the Future of Nursing – the short of it … 4 key messages

- Working to the top of the license
- Importance of educational background and new training
- Partners with the team
- Workforce planning and importance of data

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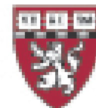

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Nurses should be the leaders of chronic care management

- Nursing *MUST* be at the table designing new and innovative care models
- Nursing across the continuum must adjust or restructure to meet the requirements of these new models
- Interdisciplinary team-based practice requires a flatter management structure that facilitates collaboration

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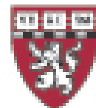

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Nursing Leadership must ensure that all nurses in these models are competent in:

- ✓ team-based care
- ✓ cross-team communication
- ✓ coordination
- ✓ collaboration
- ✓ understanding the determinants of health and well being
- ✓ patient-centered care
- ✓ knowledgeable about community resources
- ✓ infrastructure and technology

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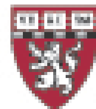
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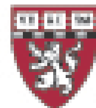
Conducting an analysis of current RN roles, tasks and daily activities will provide a baseline assessment of readiness

At our flagship site we determined that the RN role was primarily task based: telephone management, medication administration, some walk-in assessment and clerical duties



Administering a job satisfaction survey prior to implementing change is helpful in determining staff engagement and readiness – our results indicated the staff felt supported moving forward

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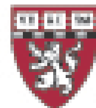

We leveraged the skillset of the nurse manager to develop a workplan to support the transition

- **By assessing the nurse schedule, time was assigned and carved out for a nurse visit schedule**
- **Protocols and policies were standardized to support autonomous practice (within State regulations)**
- **Nurses were scheduled for training**
- **Continuity of care improved due to increased access to the nurse**
- **Hired additional staffing resource (LPN) to take ownership of tasks (vaccines, etc.)**

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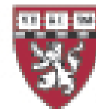
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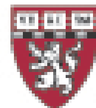
The clinic leadership must position the nurses as leaders



Defining resources for the nurses helps them coordinate patient education and care

Enhanced team based chronic and preventive care by integrating the redefined RN role with:

- Social Worker
- Clinical Pharmacist
- Nutritionist
- Planned Care Coordinator

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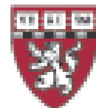
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First Initiative: Choose a high risk population

Flagship site chose Diabetes and developed workflows

- ***RN reviews Diabetic Patient List with Team Physician and uses state Risk Stratification Tool to create High Risk List***
- ***RN/Team Receptionist outreaches to High Risk Patient via phone and sets up a Nurse Visit appointment for meet and greet, assessment of needs, and determine if engageable***
- ***Or while patient is at clinic, physician does a "warm hand-off"***
- ***Nurse Visit is in collaboration with the patient to establish patient needs/goals, educational requirement, and discuss return visits***
- ***team meetings weekly with monthly break out of RN/MD/SW to discuss HR list***
- ***Nutrition, RN, Psych, Pharmacist all on site as needed***

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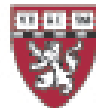

Training on patient engagement and motivational interviewing was essential for nurses to become comfortable with their new role

Unengagable

Surveillance and Tracking – Episodic attempts to engage

Potentially engagable

"Start where the patient is" – What is their goal? What is important to them? Motivational Interviewing

Patients who can and do engage

- Team Assessments
- Goal Setting
- Skill Building
- Care Coordination
- Community follow through
- Outcome Tracking
- Transition Planning to 95% level

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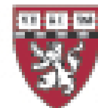
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Implementing multidisciplinary case conferences provided care guidance to the nurses

- Structured bi-monthly case conferences with RN's, diabetes nurse educator, SW, pharmacy, PCP, Nutrition
- Single case presented; the team helps the RN with any challenging or outstanding issues

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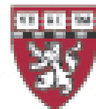

Outcomes of Diabetes Pilot

- Improved RN confidence in managing diabetes and high risk patients
- Total 140 high risk patients being cared for by 4 RNs, 100 diabetic visits over 6 months
- Improved diabetes outcomes over 6 month period:
  - -13% increase in percent of A1c levels < 7%
  - -20% decrease in percent of A1c levels > 9%
- 18% more patients engaged as active in the registry

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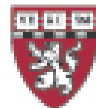
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Spreading to other CHA sites: It's about the Leadership

Management is about coping with complexity. Leadership, by contrast, is about coping with change.

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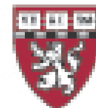
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John P. Kotter
BEST OF HBR
What Leaders Really Do

- **Nursing Leadership focus is essential for success**
- **Nurse Managers are now in monthly training to learn how to spread the knowledge**
- **Nurse Managers are visible at the site and assessing staff performance**
- **Nurse Manager must be the coach**
- **Nurses cannot independently determine that staffing does not support chronic disease management**

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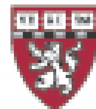
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Our next step is to leverage a whole person, team-based approach to care management

The Community

Patient's Life

Complex Care Management Team for top 5% - RN, SW + CHW

Medical Needs
Nurse Care Manager

Psycho-Social
Social Worker
Case Worker

Planned Care Team – 95%

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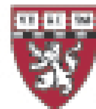

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Clinical Pharmacy in the Medical Home

Ann Turner, MD, Medical Director
Sarah Hilbert Deines, Pharm.D., Clinical Pharmacist
October 2012

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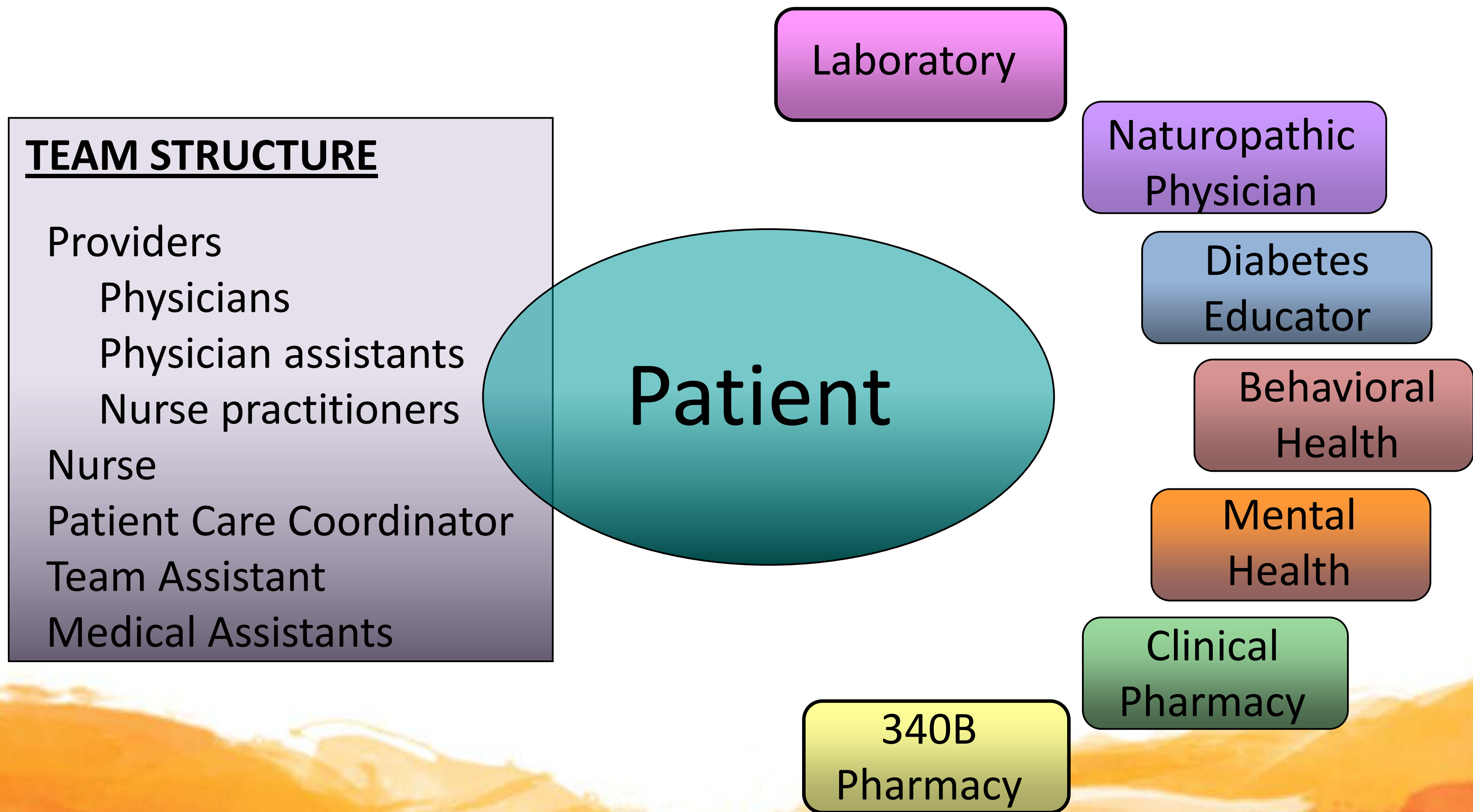
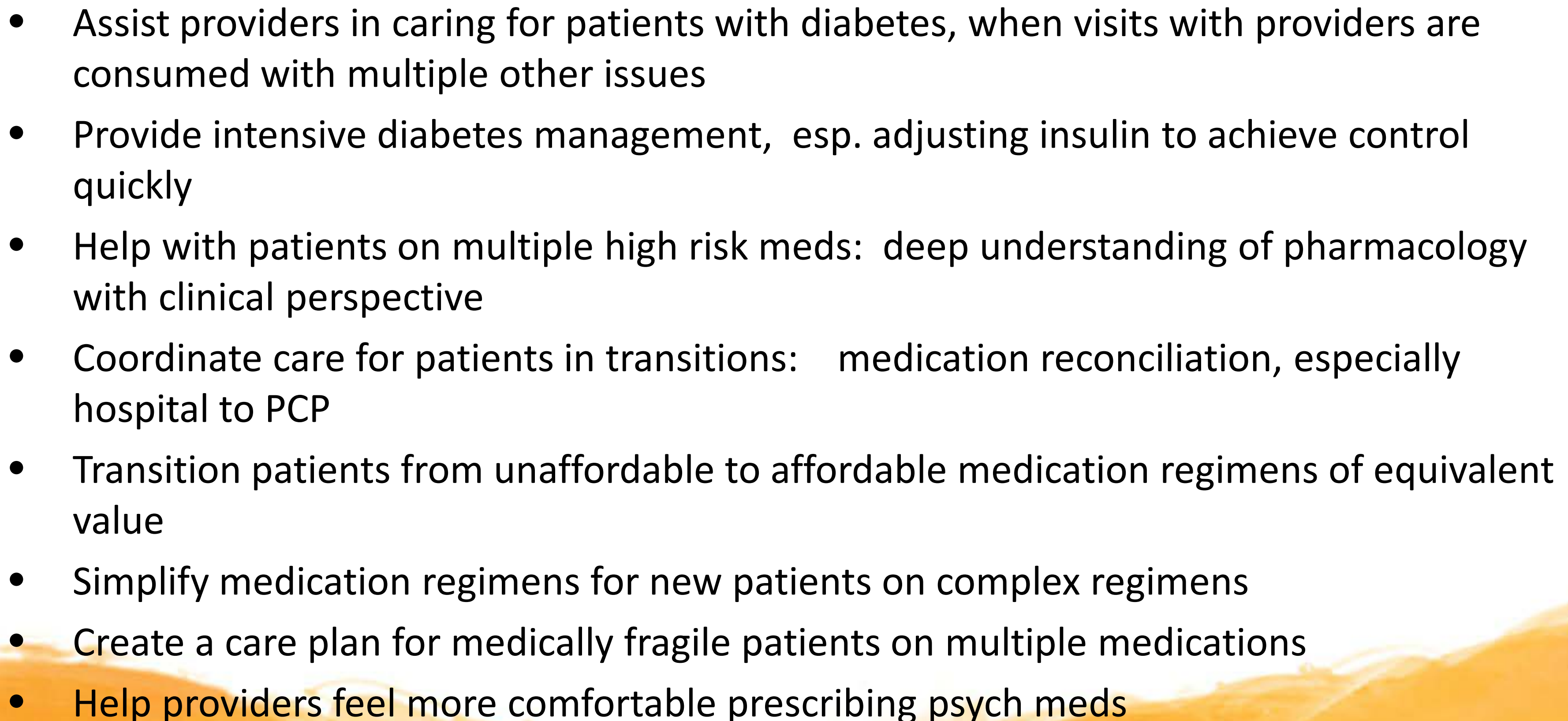
- Federally Qualified Health Cetner
- 4 PC clinics and 3 school based health centers
- Located west and southwest of Portland, Oregon
- ~35,000 Patients

Medical Home Model at VGMHC



Provider Perspective of Clinical Pharmacy



- Assist providers in caring for patients with diabetes, when visits with providers are consumed with multiple other issues
- Provide intensive diabetes management, esp. adjusting insulin to achieve control quickly
- Help with patients on multiple high risk meds: deep understanding of pharmacology with clinical perspective
- Coordinate care for patients in transitions: medication reconciliation, especially hospital to PCP
- Transition patients from unaffordable to affordable medication regimens of equivalent value
- Simplify medication regimens for new patients on complex regimens
- Create a care plan for medically fragile patients on multiple medications
- Help providers feel more comfortable prescribing psych meds

Clinical Pharmacy Services (CPS)

- 2008- School of Pharmacy faculty member
- 2009- HRSA grant
  - Clinical Pharmacy Team
    - Clinical pharmacist
    - Clinical pharmacy technician
- 2012- School of Pharmacy partnership
    - Psychiatric clinical pharmacist

Clinical Pharmacy Services

- Collaborative Drug Therapy Management
  - Initiate, change & discontinue therapy under protocols
    - Type 2 Diabetes, Hypertension, Hyperlipidemia
- Medication review and reconciliation
  - Complex patients, multiple comorbidities, polypharmacy
  - Emergency room and hospitalization follow-up
  - New patients or those with barriers to medication access
- Provider and nurse education
- Committee involvement
  - Pharmacy and Therapeutics Committee
  - Controlled Substance Oversight Committee

HRSA Collaborative

- Health Resources and Services Administration (HRSA)
- Patient Safety and Clinical Pharmacy Services (PSPC)
  - Fourth year of participation in the collaborative
  - Supports initiating Clinical Pharmacy Services (CPS)
  - Regional and National Coaching
  - Reporting of clinical pharmacy outcomes
  - Compilation of impact of CPS on a national level

Clinical Pharmacy Services

- Provider acceptance of the service
  - Initial adoption
    - Identify population with the highest need
    - Small trial with one PCP to build understanding of pharmacy role
    - Expansion once confidence in service is established
  - Optional service, accessed by internal referral
  - Variable utilization depending on provider preference
  - New provider orientation includes information about CPS

Clinic Resource Utilization

- How best to use each role?
  - Example: Diabetes management
    - Certified Diabetes Educator
    - Behavioral Health Provider
    - Naturopathic physician- nutrition classes and consultation
    - Nurse Care Management
    - Clinical Pharmacy Services

Initiating Clinical Pharmacy Services

- Funding
  - 340B pharmacy
    - Starting pharmacy to fund CPS
    - Using existing pharmacy staff in new ways
  - Insurance reimbursement for services (barrier)
- Partnership with Schools of Pharmacy
  - Pharmacy faculty practice sites

Patient visits

- Prior to Clinical Pharmacy Visit
  - Referral and “Warm hand-off” from PCP
- Pharmacist Visit
  - Medication reconciliation
  - Identify knowledge deficits about diseases & medications
  - Adjust therapy
  - Coordinate care with pharmacy, PCP, team, and specialists
- CPS visits do not replace PCP visits

Outcomes data

- 2011 Diabetes outcomes with CPS
  - Average A1c decreased from 10.6% to 8.6%
  - Improvement was seen in 86% of patients
  - Patients achieving goal A1c, blood pressure and LDL were referred back to their health care team for ongoing chronic disease management

Expansion of pharmacy services

- Future Plans
  - One clinical pharmacist per site
  - Additional partnerships with Schools of Pharmacy
- Barriers: Funding

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Questions?

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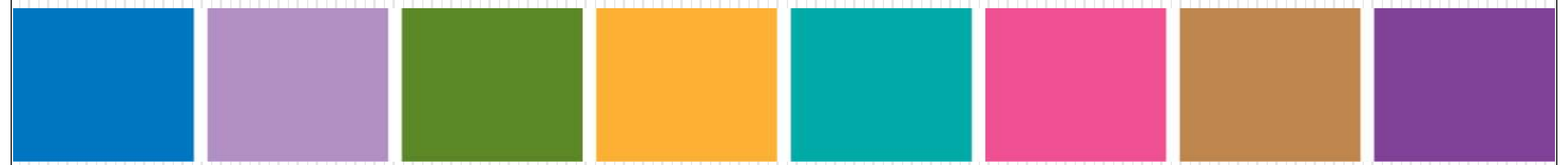
Q & A



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