Team Care – the most potent intervention

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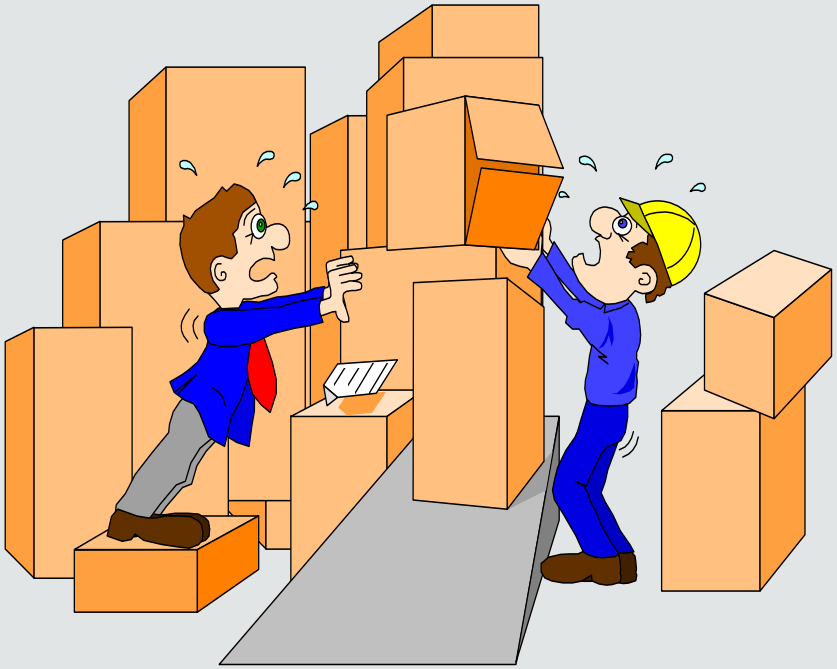
What kind of changes to practice systems improve chronic and preventive care?



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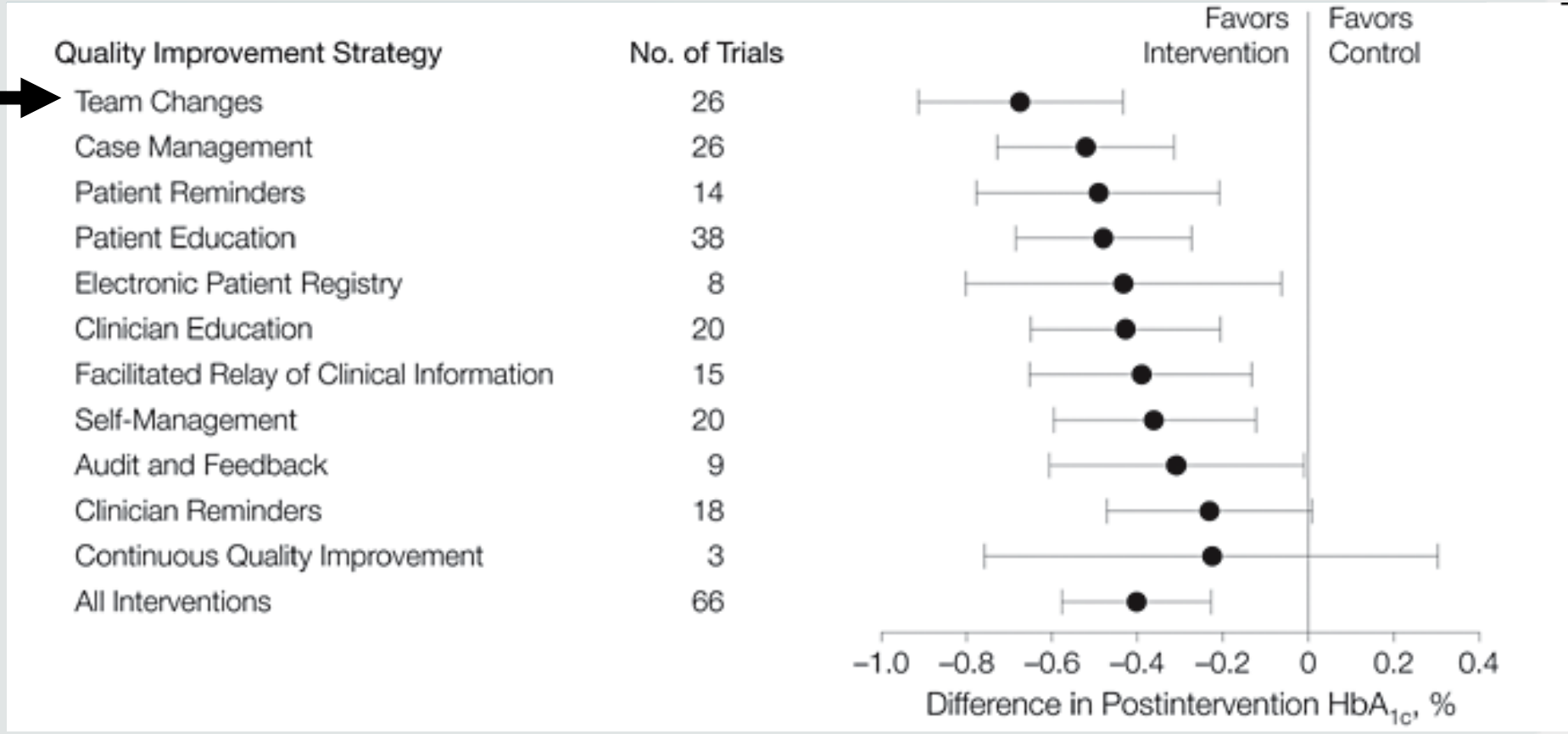
Effects of Quality Improvement Strategies for Type 2 Diabetes on Glycemic Control



JAMA. 2006;296:427-440.

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What do they mean by Team Changes?

Changes to the structure or organization of the primary health care team, defined as present if any of the following applied:

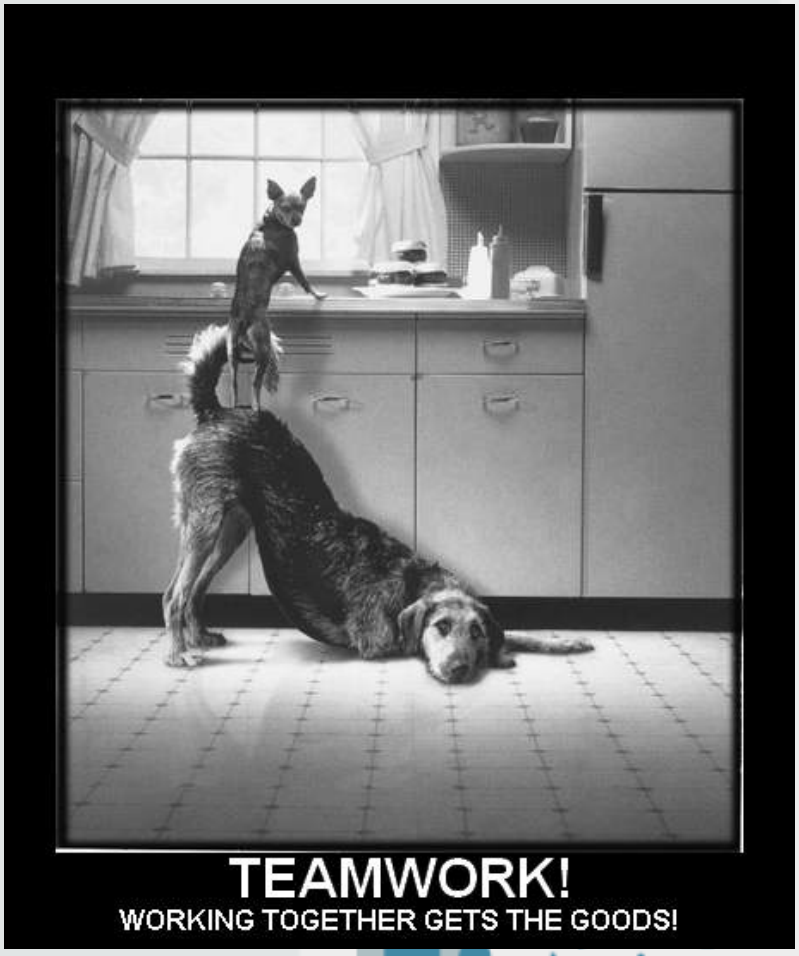
- Adding a team member or "shared care,"

- Use of multidisciplinary teams, ie, active participation of professionals from more than 1 discipline (eg, medicine, nursing, pharmacy, nutrition) in the primary, ongoing management of patients.

- Expansion or revision of professional roles

Team Care

- **Recognize the MD can't do it all**
  Ostbye et al.* estimate that it would take 10.6 hrs/working day to deliver all evidence-based care for chronic conditions
- **Build an effective clinical team**
  www.teammeasure.org
- **Define roles and tasks and distribute them among the team members.**



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Organizing for Team Care

Tasks

- **Determined by guidelines**

  Review registry
  Diabetic foot exam
  Peak flow measurement
  Administering the PHQ-9
  Review self-management goals
  Follow-up phone calls

Roles

- **Population manager**
  maintains registry, calls patients, performance measurement
- **Care manager**
  provides more intensive management/follow-up for selected patients
- **Self-management Coach**
  provides SM assistance

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Roles Relate to Patient Needs

Patient Needs	Practice Roles
Drug therapy that gets them safely to the therapeutic target	Medication Management
Effective self-management support	Self-management Support
Preventive interventions at recommended time	Population Management
Follow-up tailored to severity	Care Management
Coordinated specialty or community services	Care Coordination

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Self-management Support

- Organize and train team members to provide self-management support and counseling
- Increasingly teams looking to Mas and others.

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Population Management

Population management

- Maintain a database (Registry) that includes key information on important patient groups within a practice population.
- Monitor the database to identify and reach out to those needing service.

Medication Management

- Many chronic conditions treated by stepped care protocols that increase treatment intensity to reach goal.
- Clinical Inertia – Treatment is often not changed in visits with individuals not achieving therapeutic goals.
- **Medication Management – Nurses or other care managers initiate and monitor, by telephone or brief visit, medication adjustment in patients not at goal. Requires agreement on and use of evidence-based protocols.**

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Follow-up/Care Management

Care Management - The provision of monitoring, clinical management, and self-management support to selected patients.

- Usually provided by a nurse or other health professional who can provide all functions.
- Monitoring and self-management support can be provided by other trained staff.

Care Coordination

- Developing linkages and agreements with specialists and community resources
- Helping patients access outside resources
- Assuring timely flow of relevant information to and from referral sources

What have successful teams done to implement the CCM?

- **Plan and organize their visits with chronically ill patients**

  a) Prior to visit, huddle to review registry data to identify needed services

  b) Organize team to provide those services

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Care Teams @ La Casa-Quigg Newton Clinic

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Denver Health
January 12, 2010

WHY Care Teams?

- Support staff not as engaged as they could be/should be/want to be in patient care
- Clerical staff willing to 'do more'
- Providers were not receiving help with desk top management work
- Patient care not coordinated in an efficient manner
- If multiple staff members 'know' the patient, care is better for patient
- Incredible amount of WASTE

How did we get here?

- Dyads (***Provider + MA***) present since 2001
- 2005 Agency adopts LEAN tools for process improvement. Leading to process improvement efforts at the clinic level through RIE (Rapid Improvement Event) process. Culture of "Continuous Improvement"
- Triad (***Provider + MA + Clerk***) in 2007 with the main goal to improve communication between MA and clerk
- 2008 RIE on "Roles" of each staff member defined and reassigned
- 2009 Medical Home Initiative for CHC's. RIE 6/09 development of the Quartet (***Provider + MA + Clerk + RN)***

Who's on the team and what do they do?

- Provider + MA + Clerk + RN

Clerk
- Answer Voice Mail
- Prefill Forms
- Sort Paper Work from Box
- Set Up Future T.V.
- Prepare T.V. Encounter
- Ask HCP for help
- Rosa duties
- Clinic/provider Stamp
- Registry Management
- Schedule Pt visits
- Consider pt for TV
- Billing

MA
- Answer Voice Mail
- Prefill Forms
- Sort Paper Work from Box
- Prepare prescriptions
- Process Radiology Request
- Ask Provider/RN for help
- Rosa Duties
- Clinic/provider Stamp
- Registry Management
- Call Pts with Lab Results
- ? Med reconciliation
- ? Scheduling.com

MD/PA
- T.V.
- Delegate
- Complete Forms

RN
- Support the team
- Panel Management
- Research complicated requests
- Prior Authorizations
- Care Management

"TEAM TIME"

- Care Team meets 2 – 3 times per week for about 10 minutes to identify and sort patient needs and desktop management tasks to appropriate team member
- In-Boxes for each team member allow the distribution of information and tasks. The In-Boxes are checked throughout the day allowing prompt attention to patient needs
- Telephone Visits – Alternative way to meet patient access

What are the results?

- Providers feel better supported to take care of patient needs
- Clerical staff more engaged with patient care issues with better knowledge of the patient
- MA's are very busy – often feeling overwhelmed with additional tasks. Mainly telephone work
- Patients have improved access to the provider through the care team (redesigned the telephone menu; pts now capable of leaving voice mails)
- Decreased inappropriate phone calls to the RN (and decreased duplicate calls) allowing the RN to focus on nursing tasks and demands

Future plans?

- Role of RN within the care team is still being developed
- Panel management from Registries – how to best utilize (RIE March 2010) registries to improve quality measures
- Plan to spread Care Teams and other lessons from Medical home throughout our Community Health Centers at Denver Health

Continuously Improving Patient Care: a Team Model

The experience of two sites at the Cambridge Health Alliance

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Cambridge Health Alliance

- An academic public health safety net system outside of Boston
- 12 medium-sized community health centers, 3 school-based clinics, 3 hospitals, specialty clinics
- Largely public payer mix – 82%,almost all Medicaid
- >50% patients speak language other than English
- 600,000 outpatient visits/year
- 92,000 patients
- Academic and public health mission

Union Square Family Health

- Full spectrum Family Medicine Care
- 9 providers
- Founded 1998
- 21,000 patient visits/yr
- Onsite Services also include Nutrition, Counseling, Psychiatry, Social Work, Family Planning, Lab

Revere Family Health

- Founded in 2004 to provide primary care in an underserved community
- Grew from 1 primary care provider to 9 in 5 years
- Visits 1,800 → 25,000
- Integrated nutrition, diabetes care, women's health/OB-GYN, mental health services, health education, family planning

The CHA Story of Primary CareTeam Development

- How it all started – the need for better diabetes and asthma outcomes
- RWJ Pursuing Perfection grant – Planned Care Team Model for panel management of patients with diabetes and asthma
- Development of IT infrastructure to support team care – registries, EMR

Why teams?

- Places ***patient*** at the center – MD not center of staff attention
- Entire staff know and own the care of the patient
- Work is distributed according to level of staff training (e.g. RNs more free to do RN level tasks)
- Improves quality and efficiency of care
- Makes providing good primary care more possible

There are many roads

- Teams start with a concerted effort but should grow organically
- Functions and roles of teams members change over time based on team member input and clinic experience
  - From the meta level of the community a clinic serves to
  - Who is present to do the work and in what numbers?

How Team Care Developed at USFH

- Initial teams of MA, MD, RN
  - Adequate staffing at every level to use this model
- Front Desk Staff added soon after
  - The complex social relationships between our patients are key to both successful outreach and engaging a population

How can we all be Useful Engines?

- Who does what work?
- We are up to 14 different areas of team care (populations requiring outreach to achieve specific care goals e.g. screening mammograms, follow up on abnormal mammograms, patients due for well child visits/vaccines etc.)
- Different care team members run different areas

Paradigm Shifts in Care

- The Prodigal Diabetic
  - An “aha” moment for our clinic
- A mammogram for a URI
  - A celebration of our work

- Nitzali Rivera

A Medical Assistant perspective

On life at Union Square both before and after teams

How Teams Began at RFH

- Dissemination of Planned Care Model to our site created the concept of teams for achieving diabetes and asthma goals.
  - However, panel sizes were small, and it didn't really take hold because the only time the team shared this panel of patients was once a month when they were thinking about diabetes and asthma.
- "Aha" moment: all of our primary care work—not just our quality goal work—could be conceptualized as work done by teams

Development of MD-MA Dyads

- Initially started as MA/MD dyad, who shared the work of seeing patients together
- Defined role of MA and MD during patient care sessions, including expectations for pre-visit, during the visit and the post visit follow-up
- Scheduled to make sure these teams were always working together during patient care sessions

Development of MD-MA Dyads

- Led to the development of a sense of shared panel – these dyads belonged to a certain group of patients and got to know these patients very well for ALL their health and social needs
- Patients came to know both their doctor and their MA by name…and to begin to ask for both.
- MAs began to see themselves as givers of care, not as staff—and began innovating themselves.

Lessons Learned

- Value of defining roles and responsibilities clearly for the clinic as a whole (allows interchangeability when needed)
- Shared understanding of each other's strengths/weaknesses
- New insights: It made more sense for MAs to be the leaders of flow for patient care sessions

Team Expansion

- Expanded teams to include Front Desk and Nursing Staff
- Ongoing work in integrating diabetes educator, nutritionist, mental health team, social work more actively in the work of our teams
  - Depression workflow
- Expanded scope of work – all quality goals, complex case management, etc

How Teams Structure The Work- A learning process

- The work of the team is organized around four processes: pre-visit, visit, post-visit and between visits
- All MA-MD pairs are strongly encouraged to “huddle” prior to and after each patient care session.
  - Expectations of what each person will do during the huddle.
  - Significantly improved the flow and productivity of each session (#s of pts seen, what was done for each patient)
  - Meet regularly as a whole team to manage “between visit” work
  - Celebrate successes , discuss patients who are struggling, review quality goals, plan outreach, assign tasks

Frequency of Team Meetings- A learning process

- Early in our development this was left up to each team to self schedule-not very effective
- We then decided to set time aside once monthly at one of our bimonthly all-staff meetings- improved
- Increased to meet bimonthly at the staff meetings. “A-ha” moment when we realized that patient care team work was more effective during those weeks when we met
- Now have a set schedule for each team to meet each week. This required arranging coverage for front desk staff and nursing but has improved our overall work

How Teams Find Time for This Work

- Ongoing- during down time in sessions or at front desk
- Medical assistants have administrative time built into their schedules
- Front end staff have some preserved time to work on outreach
- We needed to restructure provider and staff time to make this model effective
- The significant improvement in flow and quality have made this feel like productive time for providers.

Engaging and Empowering Team Members

- Orientation
- Education and training
- Empowerment in decisionmaking about the workflow itself
- Envisioning leadership as teamwork

Team Orientation and Training

- Clear hiring strategy to identify candidates who will succeed in this model
- Every new staff member spends time shadowing different team meetings
- Concept of patient care teams and their expected role is a focal point of new staff orientation
- Ongoing training occurs at the bimonthly staff meetings, individual team meetings, and during our all-clinic retreats
- Still an area we would like to improve

Using Workflow Approach to Defining Team Roles

- EMR implementation required us to conceptualize our work in caring for patients as workflows
- At the same time, we were doing a team development series of retreats to strengthen the functioning of our teams
- Most effective workflows were created when we included the perspective of all team members and utilized a shared-decision making approach in their design.

Workflow Team

- Members include front end staff member, medical assistant, nurse, office manager, nurse manager and a physician
- Work of the workflow team – examples
  - Ongoing practice flow improvement
  - Ongoing quality improvement
  - How to implement new initiatives
    - Colorectal cancer, mammograms
    - H1N1 influx
    - Referral management
- Meets every other week and has executive ability to change workflow of the clinic

Strengths of Workflow Team

- Better workflows
- Gives every team member a voice in decision making and dramatically improves buy-in into workflows (no union grievances!)
- Creates a built-in structure for continuous quality improvement
- Rapid dissemination of best practices across care teams
- Allows for experiment- Pilots and evaluation

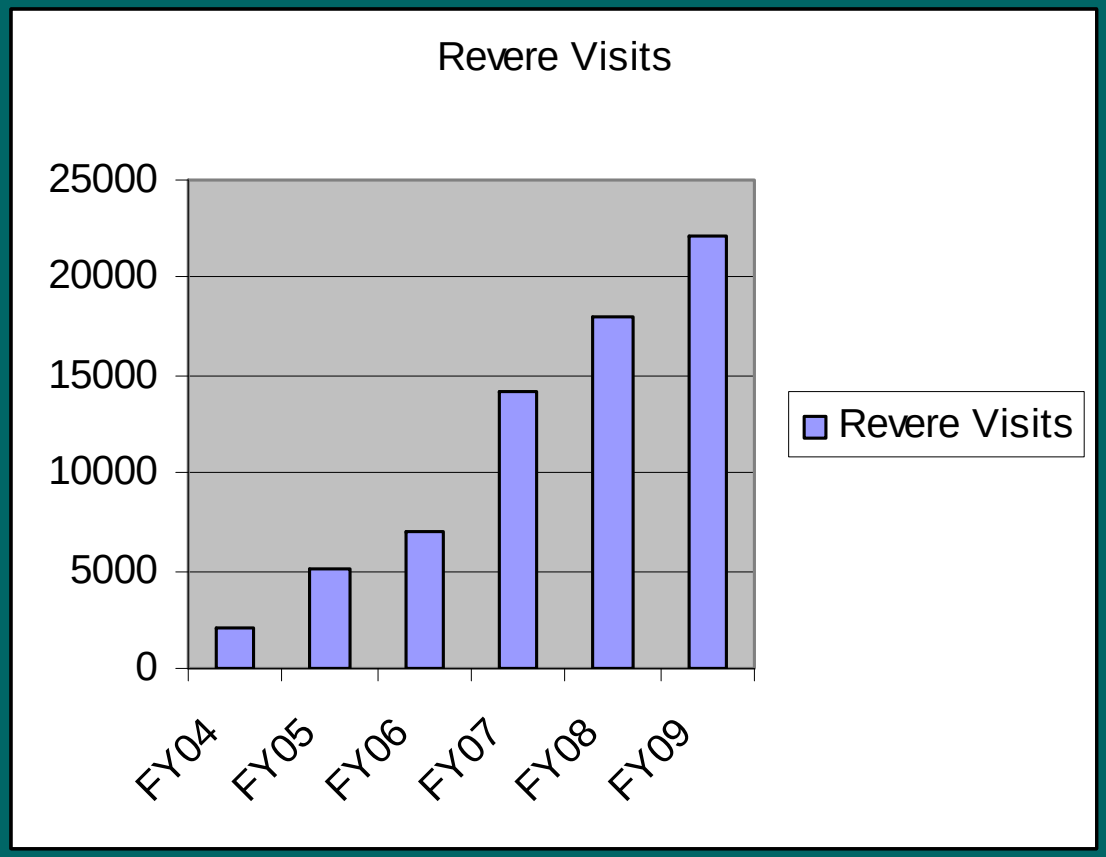
Lessons Learned

- Reward for the work is shared (money, celebration, job satisfaction)
- Using staff in new ways
- Team engagement in defining roles
- Time to meet
- Time to do the work

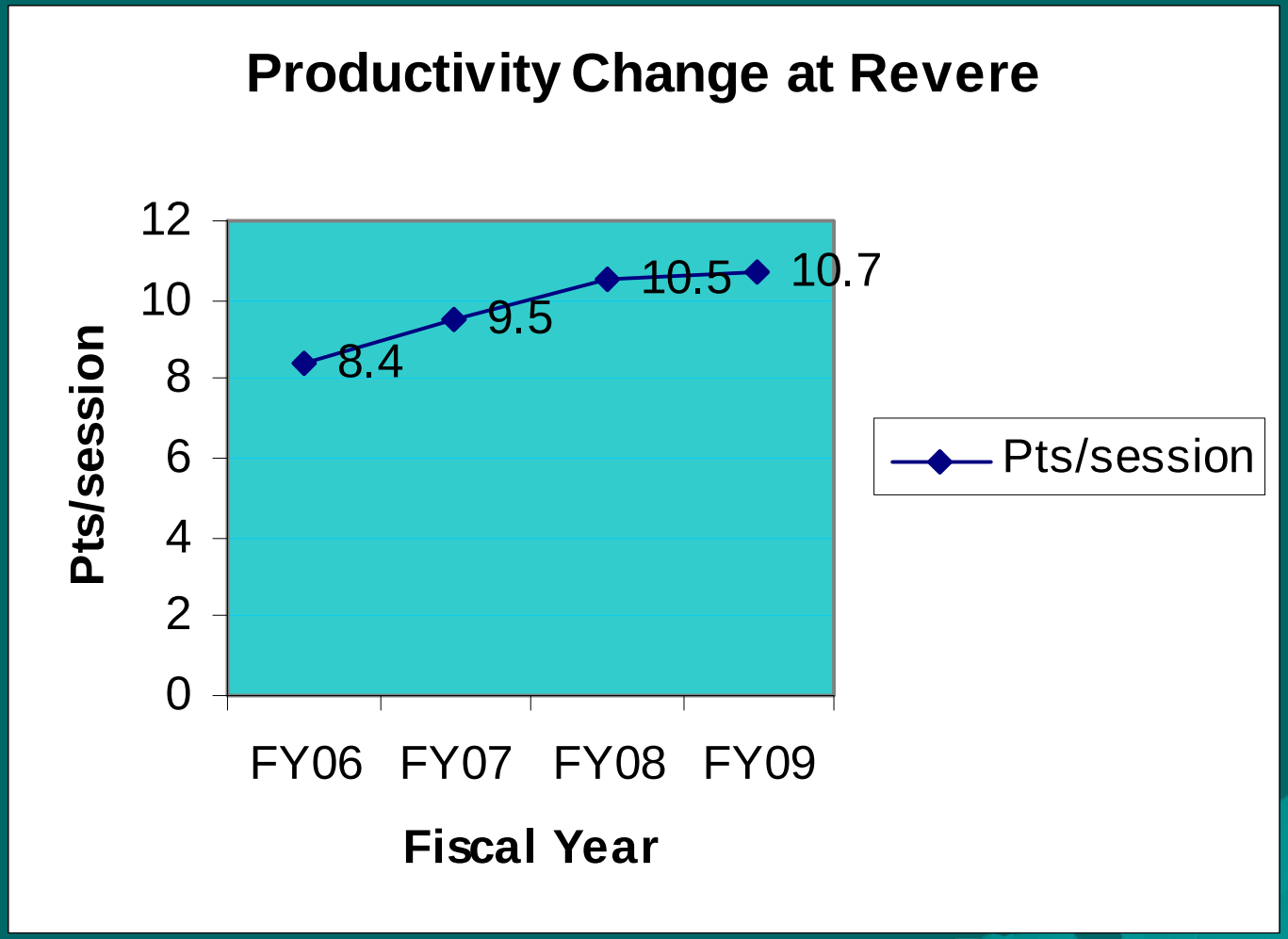
Measures of Success

- Patient satisfaction
  - 86% of patients feel they wait less than 15 minutes past their appointment time in order to be seen (Wait cycle time 9-21min, depending on provider)
  - 98% of them felt connected to and treated courteously by the receptionist
  - 96% felt they would recommend clinic to family friends

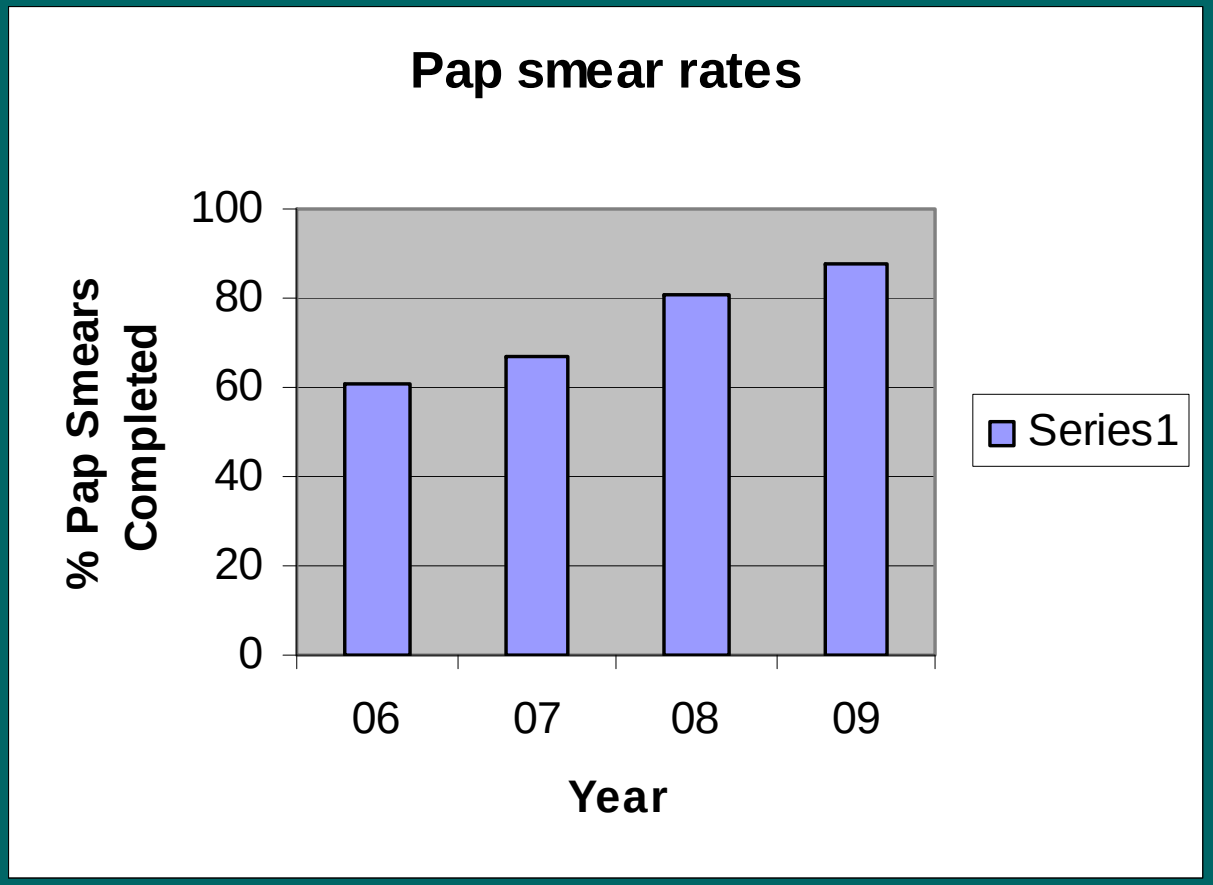
Measures of Success: Growth of the site



Measures of Success: Productivity



Measures of success: Quality



Measures of Success

- Provider and staff satisfaction
  - Extremely low rate of avoidable turnover despite very challenging financial hurdles as an organization
  - Professional development of staff
  - Easy to recruit new staff members to the site
  - Staff-led visioning and initiatives
  - Providers identified this as a best practice site in organization-wide survey

Things to Watch Out For

- 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

Works in Progress

- Continued team education and engagement
- Continued teamwork development
- Accountability
- Dissemination of Best Practices