


# Effective Strategies for Team-Based Care

The Cambridge Health Alliance  
August, 2018



## 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

Welcome to a vibrant, caring community.

WELCOME TO  
**CHA**




## What is an IPU and why does it matter?

An Integrated Practice Unit is a multidisciplinary team designed to take care of a full cycle of care for a patient

This concept has been used with great success to analyze specialty care interactions since their cycles of care can be circumscribed

Using this methodology in Primary Care provides the opportunity to highlight why primary care teams differ from specialty care teams

What are the essential elements of high quality team care in Primary Care?

### Goals

Define the Primary Care IPU

Outline essential elements in the care redesign from “one doc, one patient” to team care

Discuss the implications of how team care allows care to extend beyond the walls of the institution

# Team

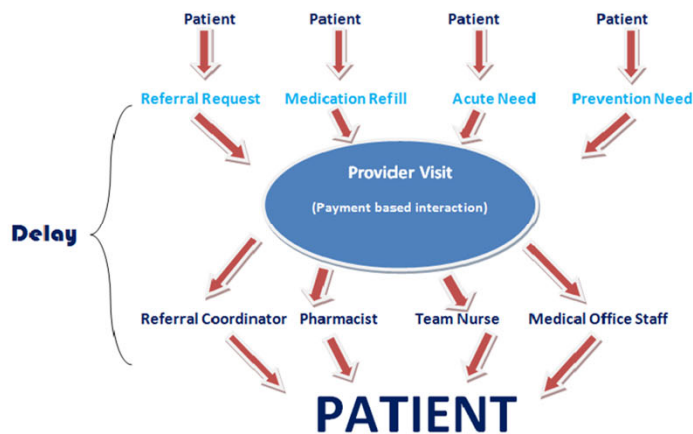
In a team care environment, the focus is on the **patient**—and all the people a patient needs to support their care.

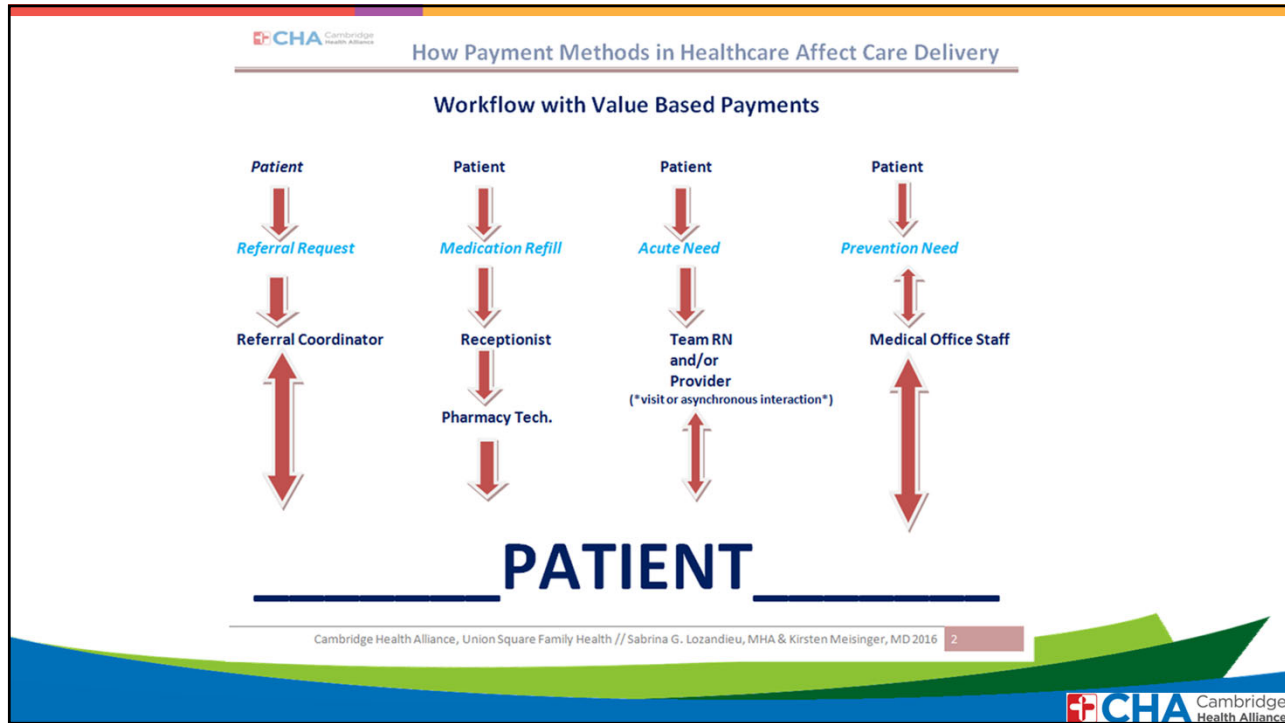
Visits become more about meeting goals of care for patients than getting patients in front of the provider as quickly and as often as possible.

*Thus, the **entire team** contributes 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





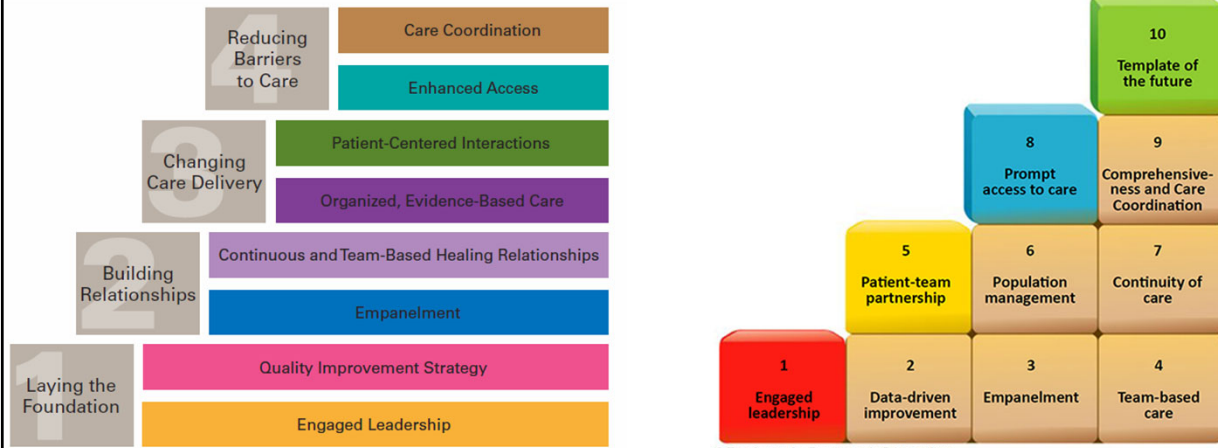
## Common Elements exhibited by 29 High-Performing Primary Care Practices

**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

# Change Concepts for Practice Transformation 10 Building Blocks of High-Performing Primary Care



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.

© The Center for Excellence in 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.



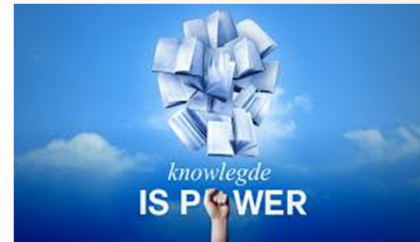
## Redesigning Care Delivery:

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



## Dual Strategy: In-reach and Outreach

- Integration of **Population Health** into the work adds incredible power
- This strategy is what we use across all of Primary Care now at Cambridge Health Alliance
- **Huddles** help organize the work of the day when the team sees patients
- **Team Meetings** happen weekly to think about and organize the work around patients who are NOT coming in and make sure they are also getting the care they need
- This is a **paradigm shift**
- This new work needs to be funded and new team roles need to be created



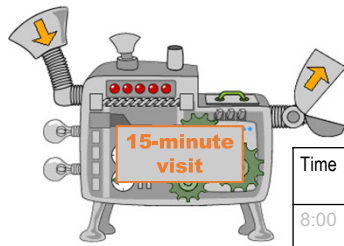
## This is what a day looks like without team support:

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?

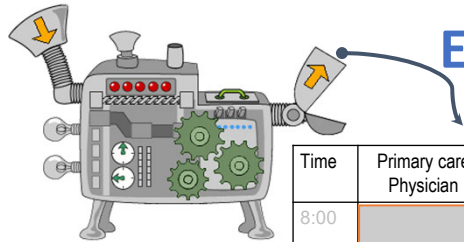
N Engl J Med 2003; 348:2635-45



## 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

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## Evolving Template

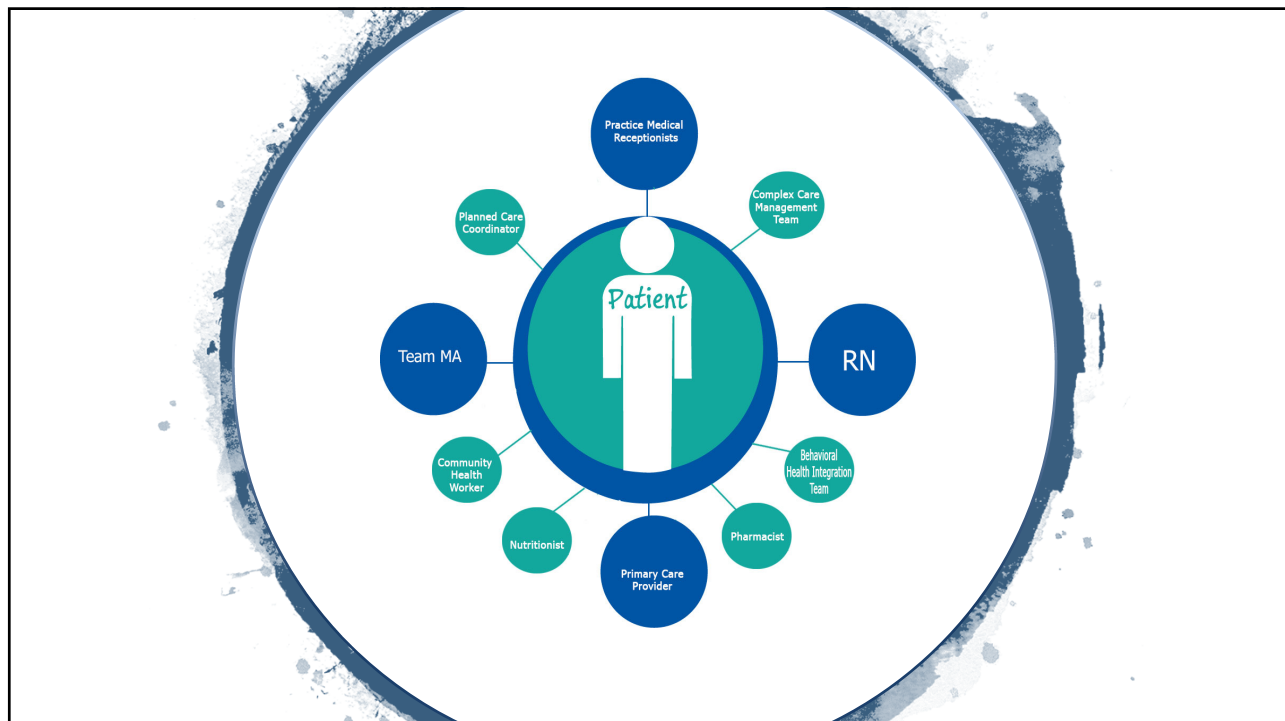
Time	Primary care Physician	Medical assistant 1	Team RN	Physician Assistant	Medical Assistant 2
8:00	Huddle				
8:10	E-visits and phone visits	Panel management	RN Care management	Acute Patients	
8:30					
9:00	Complex patient				
9:30	Complex patient			E-visits and phone visits	Panel management
10:00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

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30 patients are seen or contacted in the first 3 hours of the day

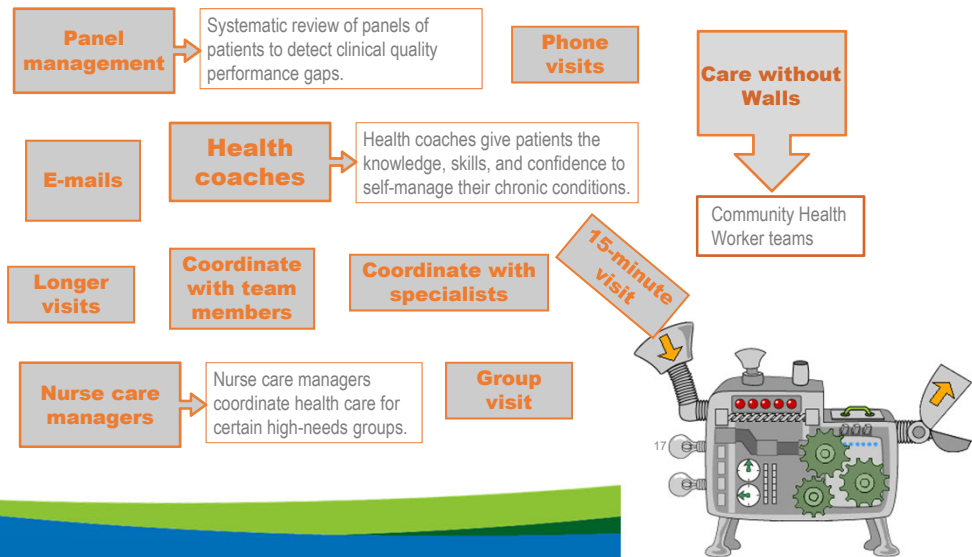
- “...(An) Integrated practice unit (IPU), which includes a team of clinical and nonclinical personnel trained to provide both outpatient and inpatient care for a particular medical condition or set of related conditions. The multidisciplinary team is ideally co-located and works closely together to deliver coordinated, integrated, and high-quality care.”
- “Accordingly, Porter’s primary care IPU might manifest as a multidisciplinary team dedicated to a defined set of patients, with a complex care management team available as needed. This was Union Square’s approach. By using pods, multidisciplinary teams, patient registries to track clinical outcomes, and a team for patients needing more intense services, the clinic provides efficient, patient-centered, value-based care.”

Jain et al “Leveraging IPU Principles in Primary Care”, NEJM Catalyst, June 27, 2018

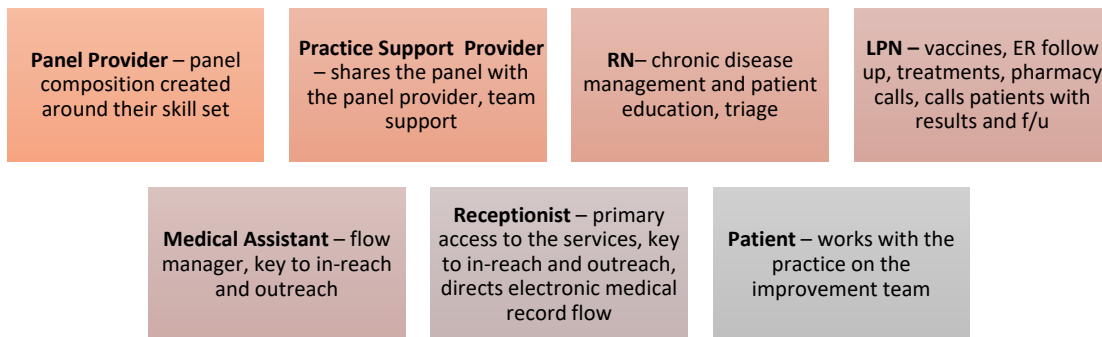




## How we take care of our panel NOW



## The Cambridge Health Alliance Team Model of Care: Role Definition



## Extended Care Team

### Shared team members at the practice level

#### Referral Coordinator

**Integrated Behavioral Health** (Care Partner/CHW, Therapist and Psychiatry MD)

### Regional

#### Family Planning

**Complex Care** (Nurse and Social Worker)

#### Pharmacist

#### Nutrition

### Other Resources:

Central refill process through the OP pharmacy

Home care programs (SCO, Hospital to Home/CHW)

### System wide team members

**Central Complex Care Team** (Social Worker and CHW)

**Hospice/Palliative Care Team**

**Visiting Nurse/SNF/Aging agencies**

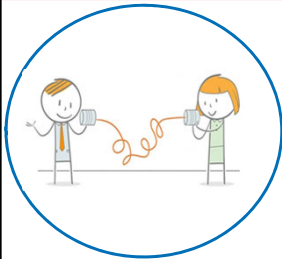
**Community Mental Health (CHW)**

**Specialty Partners** (econsults, chart reviews, televisits)

### Patient Team Members

**Patient Partners** - two per practice

**Patient Family Advisory Councils** – two at CHA as a whole



## Team 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

## Designing the Core Team: Roles Clearly Defined



## Planning the dance



### Huddle/Pre-visit work

- Define the roles but let teams figure out the specifics that work for them
- Checklist
- Document and Communicate!
- Anticipate and plan for the unexpected
- Rooms, special procedures ahead of time

**Late/walk-ins:**  
**MA:**  
**LPN:**  
**RN:**  
**Provider:**  
**[Timestamp]**

# Checklist: Health Maintenance

Due Date	Topic	Date (Reason)
6/5/1984	TETANUS (16 AND OVER)	
6/5/1986	LIPID SCREENING	
6/5/1986	HEP B HIGH RISK VACCINE EVAL (ONCE)	
6/5/1986	PHQ-9	
6/5/1986	AWQ Questionnaire	
6/5/1989	PAP SMEAR	
6/5/1998	HPV SCREENING	
6/5/2008	PHYSICAL EXAM (AGE 40-49)	
3/8/2015	MAMMOGRAPHY	9/8/2014 (DISCU...)
1/29/2016	CARE PLAN	7/29/2015 (APPT... 7/24/2015 (APPT... 12/19/2014 (APP... 12/17/2014
4/1/2016	ABNORMAL RAD RESULT 1 YR F/U	4/1/2015 (APPT... 4/1/2015 (APPT...
6/9/2020	HEALTH CARE PROXY	6/9/2015 7/31/2014 (APPT...
Addressed	HIV SCREENING	7/31/2014 (NOT I...

TO-DO list for the patient's health care

Health Maintenance Modifiers	Status Legend
Abnormal Rad Result 1 Year F/U Care Plan - PHQ9>15 (Automatic: Do Not Remove) CHA TEST PATIENT MAMMO - Birads 3 F/U 6mo PAP HIGH RISK (YEARLY) PHQ-9 MAINTENANCE (YRLY)	Overdue <input checked="" type="checkbox"/> Due On <input type="checkbox"/> Due Soon <input type="checkbox"/> Postponed <input type="checkbox"/>
Health Maintenance Plans	Definitions
ABNORMAL RAD RESULT 1 YR F/U AWQ Questionnaire CARE PLAN HEALTH CARE PROXY HEP B HIGH RISK VACCINE EVAL (ONCE) HIV SCREENING-ONCE HPV SCREEN EVERY 5 YRS LIPID SCREENING (FEMALES 18-75) MAMMO BIRADS 0 F/U 6MO PAP EVERY 5 YEARS (30-65YRS) PAP HIGH RISK (YEARLY) PHQ-9 MAINTENANCE (YRLY) PHYSICAL EXAM (40-49) TETANUS (16 AND OVER)	Completed: Done with the required satisfactions Addressed: Overridden with the intention of not completing the topic
Override Type Abbreviations	Override Type Abbreviations
Declined SEXUALLY INACTIVE INA NOT INDICATE DISCUSSED APPT COMPLET appt out cha LOW RISK OTHER - SEE (N/S) Done (inactive) Postponed (inactive)	Discussed/Declined Sexually Inactive Not Indicated Discussed/Patient Education Completed at CHA Completed outside CHA Low Risk Other - See comments Reason not specified Done Postponed



Introduction to Team Based Care	What is a team	Roles of Team Members
<ul style="list-style-type: none"> <li>Introduction to Team Based Care 1.0</li> </ul>	<ul style="list-style-type: none"> <li>Teamwork kit 1.0 (all pages)</li> <li>What is a team? 1.0</li> <li>Getting Started Forming Teams 1.0</li> <li>Levels of Team Based Care 1.0</li> </ul>	<ul style="list-style-type: none"> <li>Roles of Team Members 2.0</li> </ul>
<p><b>Previsit</b></p> <ul style="list-style-type: none"> <li>Ambulatory Visit Forms 1.0</li> <li>How to access the Daily Med List 1.0</li> <li>Previsit Packet 1.0</li> <li>Previsit 1.0</li> </ul>	<p><b>Visit</b></p> <ul style="list-style-type: none"> <li>Day of visit 1.0</li> </ul>	<p><b>Post or Between Visit</b></p> <ul style="list-style-type: none"> <li>Between visit 1.0</li> </ul>
<p><b>Care Plans</b></p> <ul style="list-style-type: none"> <li>Care Plan Training 2.0</li> <li>Why Make Care Plans 2.0</li> <li>Updating Care Plans 2.0</li> <li>Care Plans FAQ 2.0</li> </ul>	<p><b>Planned Care</b></p> <ul style="list-style-type: none"> <li>Planned Care Meeting Guide 2.0</li> </ul>	<p><b>Hospital and ED Discharge Follow up</b></p> <ul style="list-style-type: none"> <li>Hospital Discharge 2.0</li> <li>Hospital Discharge RN 2.0</li> <li>ED and Discharge Follow up Letter</li> </ul>
<p><b>Chronic Disease Management</b></p> <ul style="list-style-type: none"> <li>Chronic Disease Management 1.0</li> <li>Diabetes Chronic Care Management 1.0</li> </ul>	<p><b>Complex Care Management</b></p> <ul style="list-style-type: none"> <li>Complex Care Program 2.0</li> </ul>	<p><b>Huddles</b></p> <ul style="list-style-type: none"> <li>Huddles toolkit 1.0 (all pages)</li> <li>What is the difference between a huddle and team meeting 1.0</li> <li>Huddle Strategies and Checklist 1.0</li> <li>Huddle Game Plan for today 1.0</li> <li>Huddle Assessment Tool</li> <li>Huddle Assessment Tool 1.0</li> <li>Huddle Evaluation Checklist for Leadership 1.0</li> </ul>
<p><b>Dealing with Different People</b></p> <ul style="list-style-type: none"> <li>Dealing with Different Types of People 1.0</li> </ul>	<p><b>Appendix</b></p> <ul style="list-style-type: none"> <li>Appendix 1.0</li> </ul>	<p><b>Care Team Training 1.0</b></p> <ul style="list-style-type: none"> <li>Building Teams in Primary Care Toolkit 1.0</li> </ul>

Welcome to your wiki library!  
 You can get started and add content to this page by clicking **Edit** at the top of this page, or you can learn more about wiki libraries by clicking **How To Use This Library**.

**What is a wiki library?**  
 Wikilink means quick in Hawaiian. A wiki library is a document library in which users can easily edit any page. The library grows organically by linking existing pages together or by creating links to new pages. If a user finds a link to an uncreated page, he or she can follow the link and create the page.

In business environments, a wiki library provides a low-maintenance way to record knowledge. Information that is usually traded in e-mail messages, gleaned from hallway conversations, or written on paper can instead be recorded in a wiki library, in context with similar knowledge.



## Practice Improvement Teams (PITs): Put it together

Clinic based, multidisciplinary performance improvement teams

Each PIT is partnered with two patients

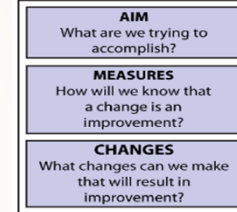
Mandate to pursue improvement initiatives at a site level

Led by staff, one site leader and a coach

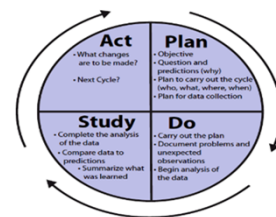
PITs trained in IHI's model of improvement

Bi-weekly meetings attended by all members

### The Model for Improvement



### The PDSA Cycle for Learning and Improving



## Daily Leadership 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 eliminated once a leadership team is "in the swim"

### Staff Meetings

- Review site overall AQC performance via Primary Care Dashboard
- 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

## Integrating Population Health Management into Primary Care



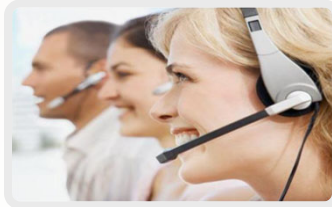
### Planned Care Infrastructure

#### *In-Reach*



- In-Reach Workflow (i.e. planned care activities that occur the day of the visit)
  - Daily Huddles
  - Patient check in
  - Encounter visit

#### *Outreach*



- Outreach Workflow (i.e. planned care activities that occur in between visits)
  - Phone calls to patients
  - Letters to patients
  - Secure emails
  - Text messages

#### *Planned Care Meeting (PCM)*



- Weekly gathering of a primary care team to review population health registries and assign planned care interventions among the care team members

## In Between Visits

Team meetings

Outreach

Follow up and care coordination in teams

Discuss team dynamics

Tracking registries eg. mammo, colon screenings, HTN

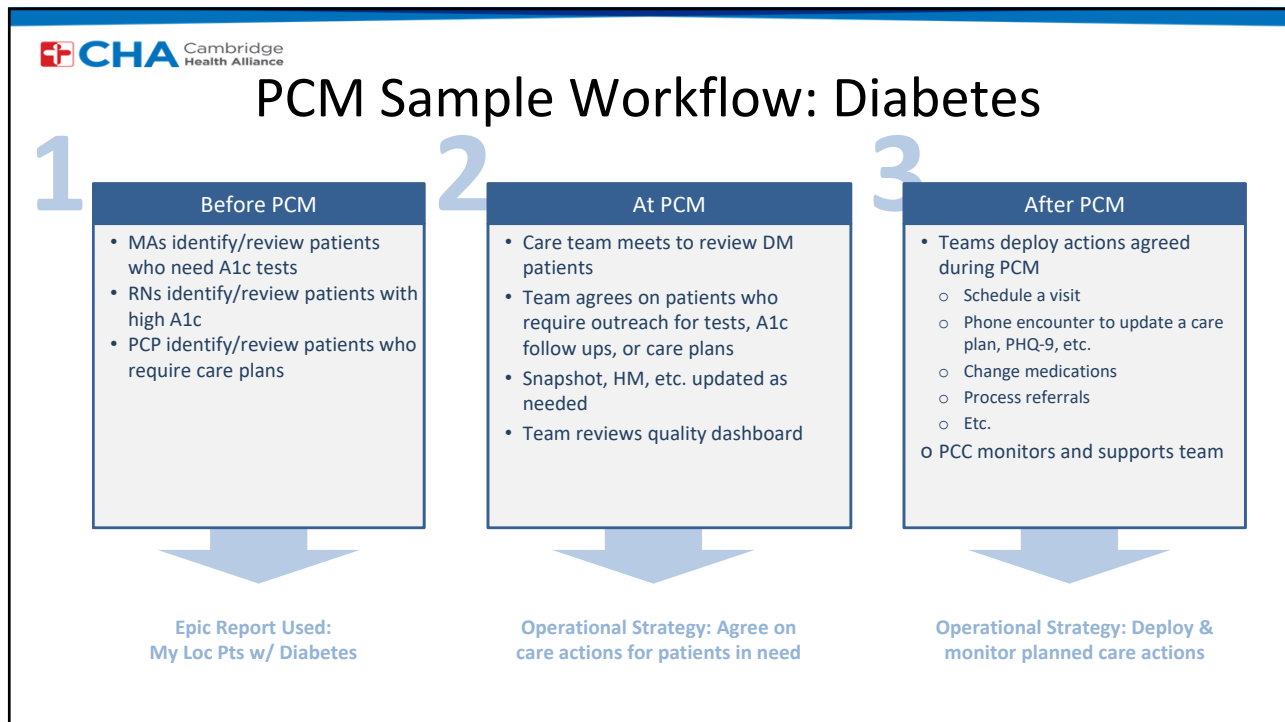
Every team member has a "panel"

Tools are disease based, but teams prefer holistic care!

## Planned Care Meetings

- PCM Objective: provide care at a panel level
- Meetings are meant to review a panel of patients, not 1-2 patients
- Coordinated development of action plans by care teams for targeted patient cohorts; some actions include:
  - Send a staff message to remind a team member to schedule a visit with PCP, PA, RN, BH, Pharmacy, LPN, etc.
  - Phone call to update PHQ-9, care plan, ADHD check-in
  - Perform a change in medications
  - Update HM, problem list, etc.
  - Perform a referral to CCM, Specialty, community resources, etc.
  - patient attribution and panel management
- Recommended PCMs typically occur weekly and last 30 mins.

Week 1	Week 2	Week 3	Week 4
Cancer Screening & Follow Up	Diabetes & Hypertension	Depression	Complex Care



## EPIC Diabetes Registry: Reporting Workbench

**★ REAL TIME!!!**

**★ ONE report with all the information you would need!!!**

**★ Reporting Workbench is in EPIC, you can go directly into the chart by clicking on the patient once and then clicking [Chart]**

Patient	DOB	PCP	A1C	Last A1C Dt	Last PHQ-9	Last Date	ABU/C	ABU/O	LDL	Last LDL Dt	Last BP	Last BP Date	Sys	Dia	Exam Due	ED Count	Last Hb Me	Neut w/ Me	Tobacco Use	MyC	Inst	Care Pt Status	Benefit Plan	Allergy List
Danesh, Marhal R.	6.8	4/8/2015	0	12/4/14	5-ug/mg	5/22/2014	120	12/4/2014	4/23/2015	4/27/15	145	82	11/26/2015	04/27/2015	0	0	04/27/2015	None	✓	HEALTH CARE	PGD BLUE	USUNOPREL		
Danesh, Marhal R.	7.1	4/23/2015	16	4/23/15	6-ug/mg	7/18/2014	80	9/23/2014	4/23/2015	4/23/15	90	57	3/23/2015	3	04/23/2015	0	0	04/23/2015	None	✓	HEALTH CARE	PGD BLUE	USUNOPREL	
Danesh, Marhal R.	7.6	11/25/2014	0	12/4/13	5-ug/mg	1/25/2014	113	11/25/2014	11/25/2014	11/25/14	125	57	1/23/2014	0	11/25/2014	0	0	06/11/2015	Quit	✓	HEALTH CARE	PGD BLUE	USUNOPREL	
Danesh, Marhal R.	7.7	5/16/2014	4	12/4/13	11-ug/mg	7/30/2013	98	1/13/2014	7/2/2014	7/2/14	148	85	11/1/2014	0	07/30/2014	0	0	07/30/2014	Quit	✓	HEALTH CARE	PGD BLUE	USUNOPREL	
Danesh, Marhal R.	5.6	11/28/2014	0	11/28/14	6-ug/mg	4/5/2014	134	1/2/2014	11/28/2014	11/28/14	130	72	12/29/1993	3	11/28/2014	0	0	05/21/2015	Quit	✓	MEDGAD-PCC	SILETA ANTIBIOTICS, PREGABALIN, TRAMADOL		
Danesh, Marhal R.	7.6	2/23/2015	2	11/24/14	24-ug/mg	5/1/2014	90	11/24/2014	2/27/2015	2/27/15	140	82	2/23/2016	1	02/23/2015	0	0	02/23/2015	None	✓	MEDGAD	TRAMADOL		
Danesh, Marhal R.	8.8	4/6/2015	0	4/6/15	10-ug/mg	4/6/2015	42	4/6/2015	4/6/2015	4/6/15	140	60	4/6/2015	1	04/06/2015	0	0	04/06/2015	None	✓	NEIGHBORHOOD PHQ-9			
Danesh, Marhal R.	8.8	4/24/2015	8	12/11/14	9-ug/mg	2/25/2015	71	12/11/2014	4/24/2015	4/24/15	124	80	2/12/2016	1	04/24/2015	0	0	05/28/2015	None	✓	HEALTH CARE	PGD BLUE	USUNOPREL	
Danesh, Marhal R.	6.6	4/17/2015	4	11/4/14	105-ug/mg	7/21/2014	52	4/21/2014	4/17/2015	4/17/15	140	86	11/3/2015	0	11/03/2015	0	0	11/03/2015	None	✓	HEALTH CARE	PGD BLUE	USUNOPREL	
Danesh, Marhal R.	6.9	5/26/2014	1	9/25/14	5-ug/mg	5/26/2014	85	9/26/2014	5/26/2014	5/26/14	117	74	10/12/2013	0	09/26/2014	0	0	09/26/2014	None	✓	HEALTH CARE	PGD BLUE	USUNOPREL	

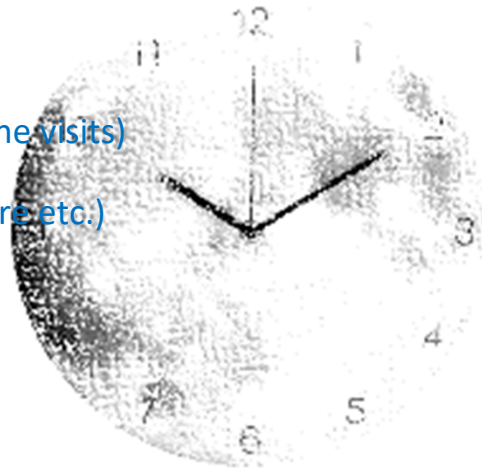
**★ MORE detailed information can be found here!!!**

**CHA Cambridge Health Alliance**



## How we care for patients when they don't or can't come in for a visit

- Virtual visits (mychart, econsults, telephone visits)
- Home visits
- Extended team partners (BH, Palliative Care etc.)
- BEST team
- School based HC
- Churches, mosques, synagogues
- Community Agencies
- Local Government
  
- Eg: Shape Up Somerville



Does it work? And what is our destination, anyway?

## Huddling & Team Satisfaction

Workforce Perception	Total N	% Frequent Huddlers who strongly agree/agree	P-Value
Overall, I am satisfied with my current job	351	62%	0.0087
I would recommend this practice as a great place to work	277	64%	0.0023
People in my care team operate as a real team	354	63%	<0.0001

## Union Square Family Health Center

Provider satisfaction at 95<sup>th</sup> percentile (2015) and 98<sup>th</sup> percentile (2018)

Patient satisfaction at 98% for likelihood to recommend practice

Staff satisfaction at 80<sup>th</sup> percentile (2015) and 84<sup>th</sup> percentile (2018)

- 100% participation in surveys for providers and staff
- Every patient seen gets an invitation to review the practice by email (multi-lingual)



## Burnout?

Question	Union Square		Benchmark		Gap to Benchmark	
	% Positive	% Negative	% Positive	% Negative	% Positive	% Negative
#1 I feel emotionally exhausted by my work.**	54.5%	18.2%	39.3%	19.2%	15.2%	-1.0%
#2 I feel overwhelmed by my workload.**	54.5%	9.1%	43.3%	15.1%	11.2%	-1.9%
#3 I feel detached from my patients.**	45.5%	9.1%	75.3%	3.4%	-29.8%	5.7%
#4 The work I do every day does not have a meaningful impact.**	36.4%	9.1%	76.7%	5.3%	-40.3%	3.8%
#5 I feel burned out.**	45.5%	9.1%	52.1%	13.2%	-6.6%	-4.1%
<p>** Indicates a negatively worded question. With negatively worded questions the % Positive indicates the desired response on the response scale. For negatively worded questions % positive accounts for the Disagree/Strongly Disagree responses.</p>						

## Takeaways

- Primary Care IPU's incorporate the entire lifecycle of patients and families and are increasingly asked to move outside of traditional practice environments
- Care redesign is necessary to accomplish this and team based care with in-reach and outreach infrastructures appears to be one successful approach
- Significant gains in patient, provider and staff engagement in this new model



# ¿QUESTIONS?

