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

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.*

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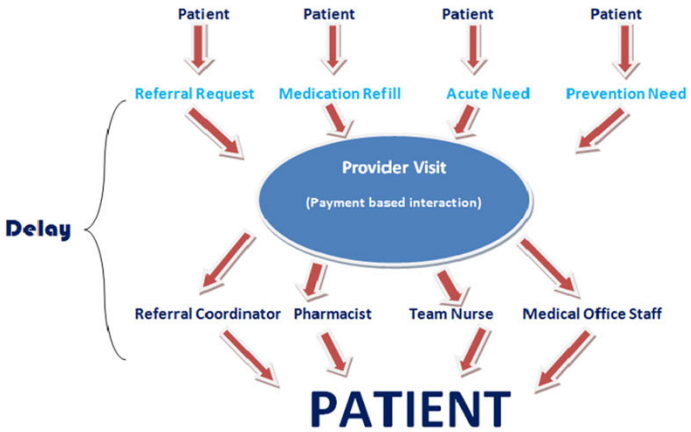
How Payment Methods in Healthcare Affect Care Delivery

Workflows in Fee for Service



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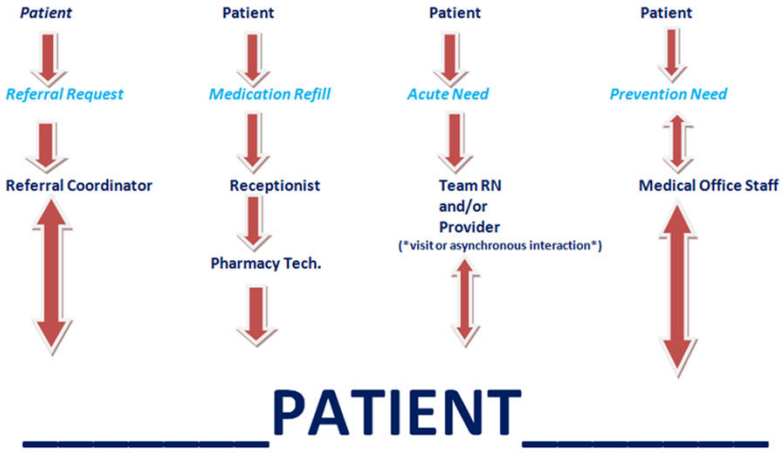
How Payment Methods in Healthcare Affect Care Delivery

Workflow with Value Based Payments



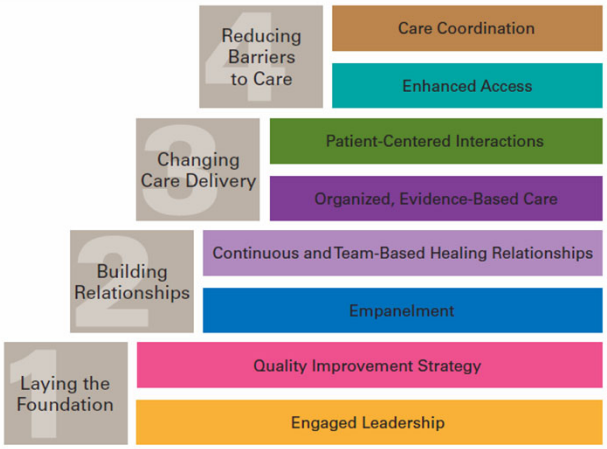
Common Elements exhibited by 29 High-Performing Primary Care Practices

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



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, MDîî, 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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Redesigning Care Delivery:

Previsit	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	Completion of visit plans/actions to previsit Care management

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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:

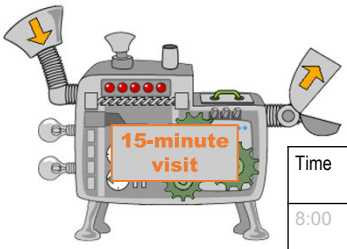
Acute Care	4.6 hours/day
Preventive Care	7.4 hours/day
Chronic Care	10.6 hours/day

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?

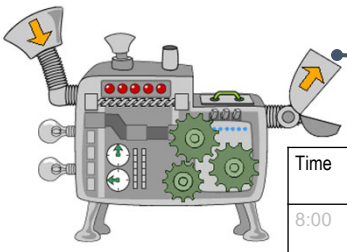
N Engl J Med 2003; 348:2635-45



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

13



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		

14

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

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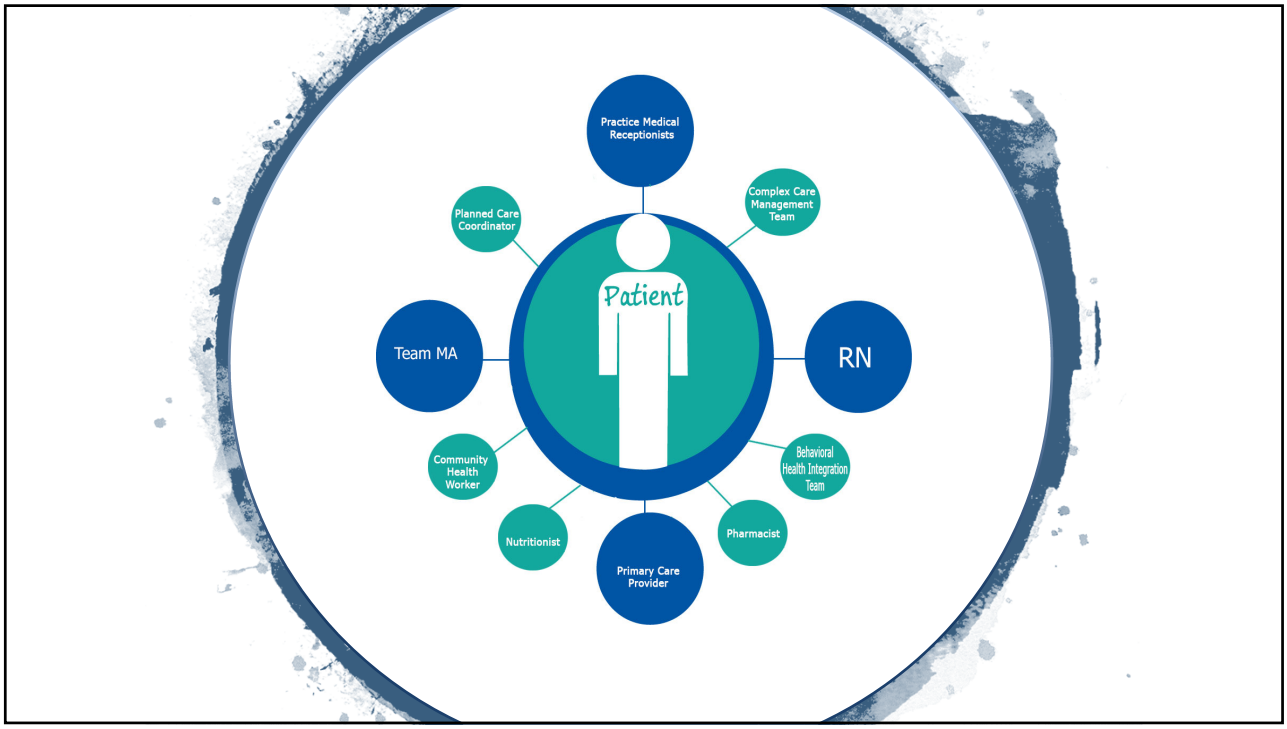
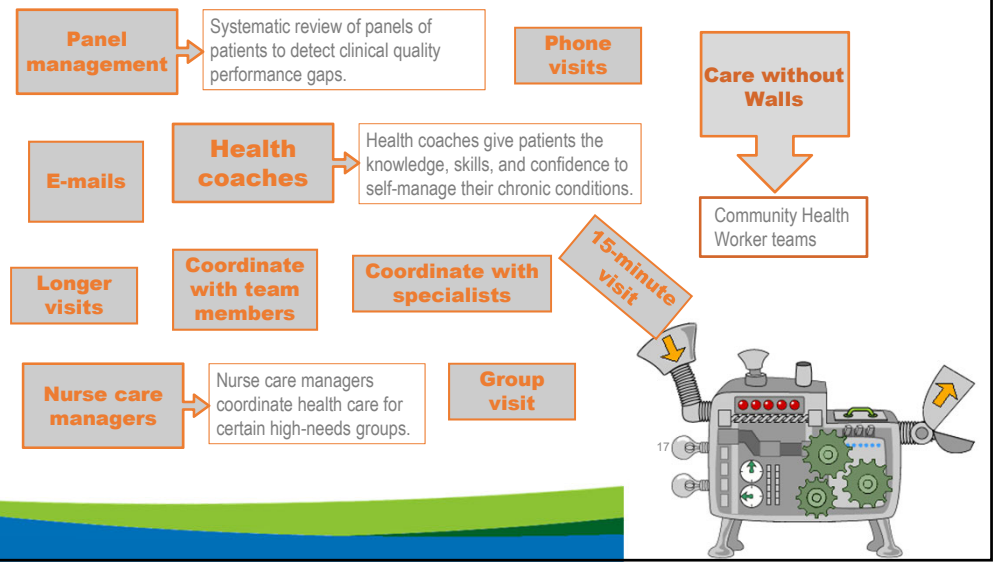


How we take care of our panel NOW



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/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

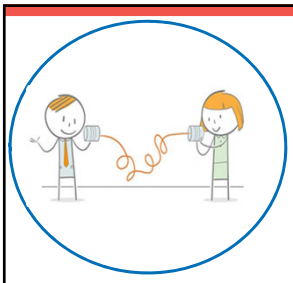
Community Mental Health (CHW)

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

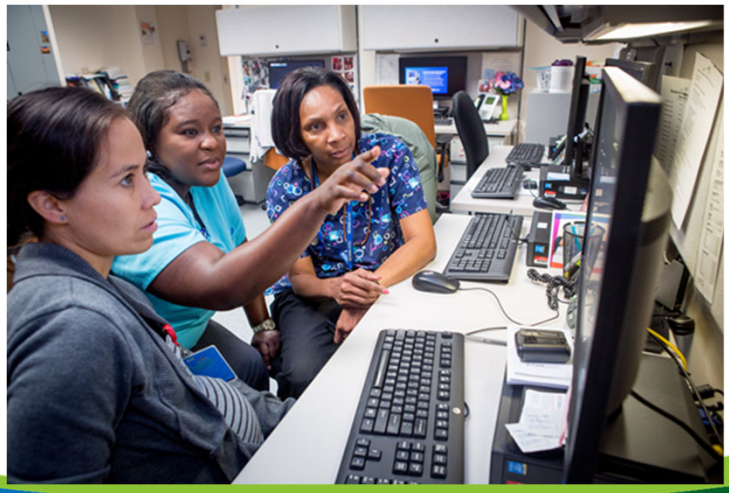
Don't criticize

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



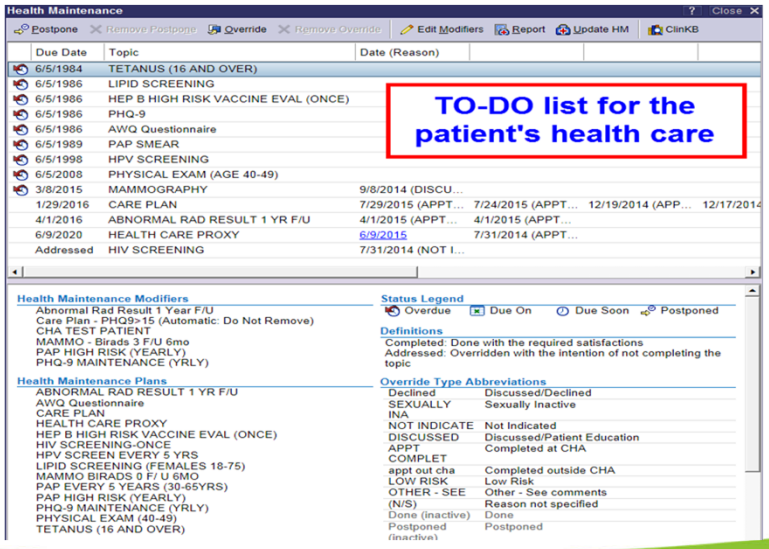
Planning the dance

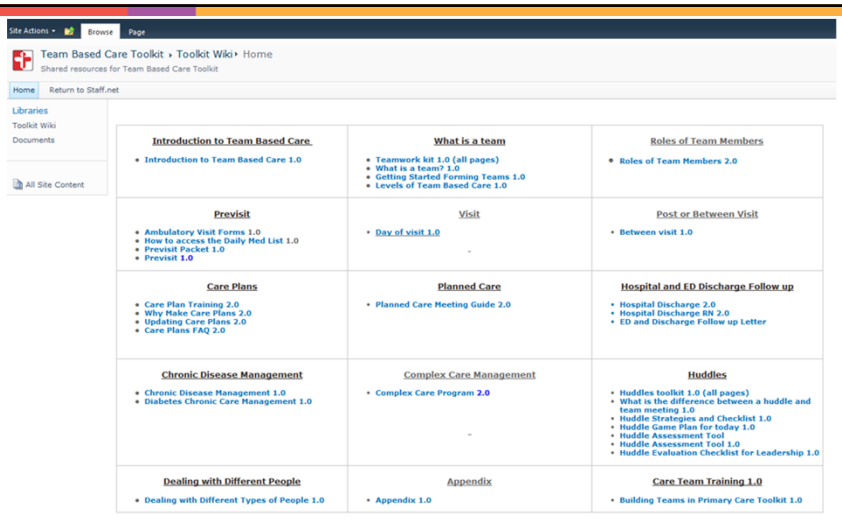
Huddle/Pre-visit work

- 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]

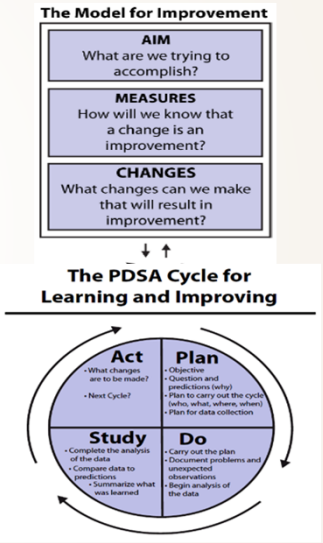
Checklist: Health Maintenance





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



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Daily Leadership Huddle & Staff Meetings

Daily Leadership Huddle	Staff Meetings
• 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"	• Review site overall AQG performance via Primary Care Dashboard • Transparency • Workflow development o maintains the culture of performance improvement o Highlight teams that have perform exceptionally well o Discuss ways to leverage tactics across all other care teams

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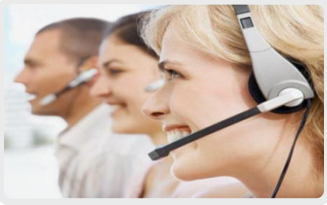
Integrating Population Health Management into Primary Care

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
  - Tracking registries eg. mammo, colon screenings, HTN
  - Every team member has a "panel"
  - Tools are disease based, but teams prefer holistic care!
- Follow up and care coordination in teams
- Discuss team dynamics

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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

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PCM Sample Workflow: Diabetes

1 Before PCM

- MAs identify/review patients who need A1c tests
- RNs identify/review patients with high A1c
- PCP identify/review patients who require care plans

2 At PCM

- Care team meets to review DM patients
- Team agrees on patients who require outreach for tests, A1c follow ups, or care plans
- Snapshot, HM, etc. updated as needed
- Team reviews quality dashboard

3 After PCM

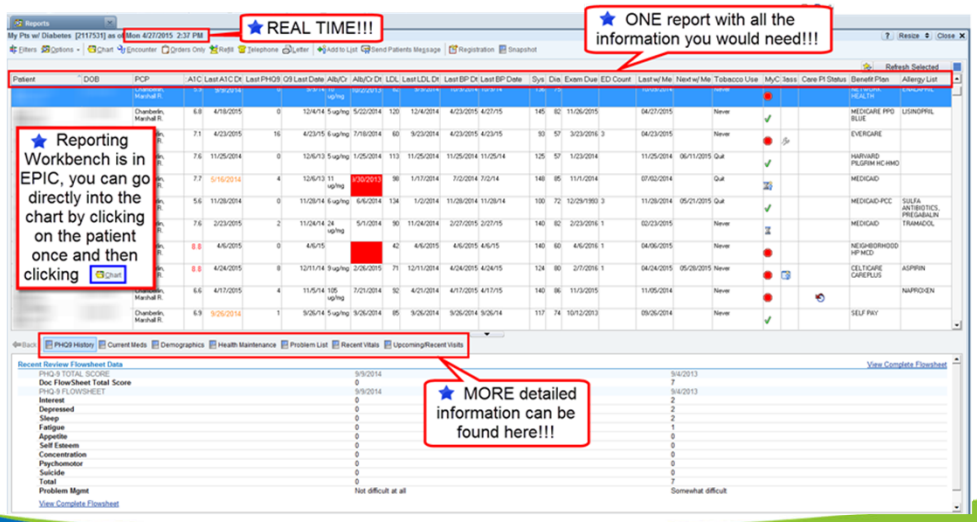
- Teams deploy actions agreed during PCM
  - Schedule a visit
  - Phone encounter to update a care plan, PHQ-9, etc.
  - Change medications
  - Process referrals
  - Etc.
- PCC monitors and supports team

Epic Report Used: My Loc Pts w/ Diabetes

Operational Strategy: Agree on care actions for patients in need

Operational Strategy: Deploy & monitor planned care actions

EPIC Diabetes Registry: Reporting Workbench



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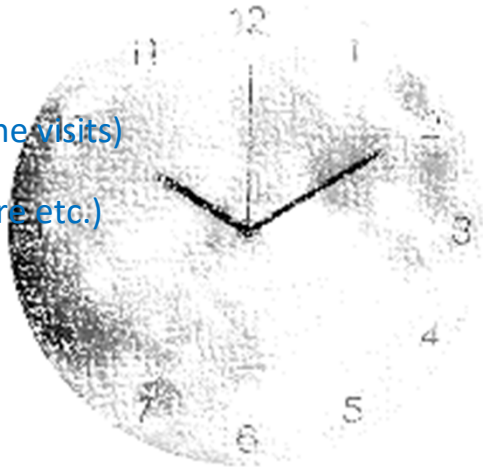
How we care for patients when they don't or can't come in for a visit



- 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 95th percentile (2015) and 98th percentile (2018)
Patient satisfaction at 98% for likelihood to recommend practice
Staff satisfaction at 80th percentile (2015) and 84th 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?

		Union Square		Benchmark		Gap to Benchmark	
	Question	% 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%
	*** 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.*						

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Takeaways

- Primary Care IPUs 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

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¿QUESTIONS?

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