CHCANYS DEFINING NEW DIRECTIONS
COMMUNITY HEALTH CARE ASSOCIATION OF NEW YORK STATE

PRIMARY CARE DEVELOPMENT CORPORATION

It's the Team That Makes the Difference And The Differences That Make the Team

Care Teams for Executive Management

October 20, 2014
10:45am – 12:15pm

William Rollow M.D. Consulting Medical Director
Peter Cucchiara Managing Director Performance Imporvement

Agenda

I. Describing Team Care
   - What is team-based care?
   - Why do team-based care?
   - What are attributes of high-performing team-based care?
   - Issues and Barriers

II. Care Team Redesign

III. Care Team Models

IV. Care Team Roles

V. Implementing Care Team Redesign

VI. Putting it All together

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I
Team Care:
Why, What, Why Not, and How

William Rollow, MD MPH
Consulting Medical Director
Primary Care Development Corporation

Overview

- What is team-based care?
- Why do team-based care?
- What are attributes of high-performing team-based care?
- Issues and Barriers - What stands in the way of high-performing team-based care and what are some solutions?

What is team-based care?

A Definition

Team-based health care *is the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient—to accomplish shared goals within and across settings to achieve coordinated, high-quality care.*

Institute of Medicine, Core Principles & Values of Effective Team-Based Health Care, 2012

Another Definition

Team-based health care *is the provision of health services by a team of providers that*

- *Optimizes production efficiency*
- *Optimizes patient experience, clinical outcomes, health care resources and cost, staff experience, and organizational vitality*

Why do team-based care?

Environmental Context – Growing Interest In Team-Based Care

- American Medical Association (2014):
  - "As millions obtain health insurance and can access ongoing health care, the American Medical Association supports physician-led health care teams that ensure health care professionals work together to meet the surge in demand. The AMA is working to ensure sustainable physician practices that result in better health outcomes for patients, and having more physician-led health care teams will help us achieve these goals."

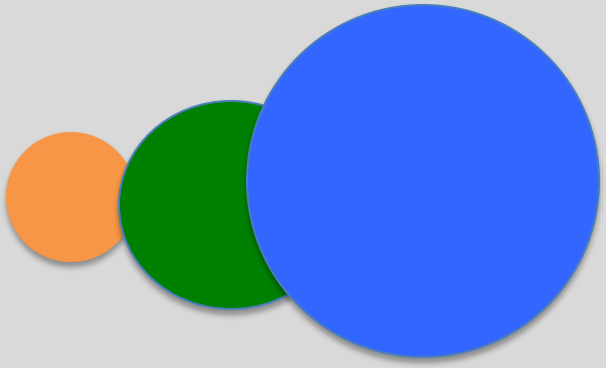
- Institute of Medicine (NIH - 2011) Patients Charting the Course—Citizen Engagement and the Learning Healthcare System:
  - "Team-based care is one of the guiding principles of a learning health system. It stresses interdependence, efficient care coordination, and a culture that encourages parity among all team members. Teamwork should be reinforced at all levels, from leadership to the unit level, and individual patients should understand that they are working with a team. Team-based care has yet to proliferate widely, yet numerous excellent team-based programs around the United States demonstrate their added value in generating superb patient-centered health outcomes and science-driven care."

Forces Driving Team-Based Care

- Shortage of primary care providers, expected to be exacerbated by the Affordable Care Act, which will increase availability of insurance coverage for many people without a current source of primary care
  - Need for greater primary care productivity
- Increasingly powerful yet specialized technologies, coupled with continued fragmentation among care providers
  - The typical Medicare beneficiary visits two primary care clinicians and five specialists per year, as well as providers of diagnostic, pharmacy, and other services.
- New models of primary care, such as the PCMH, and more value-driven payment models
  - Increased importance of care management and care coordination

Care Team Domains

- Office Visit Team – aka Microsystem, Pod, or Teamlet
  - Practitioner(s), medical assistant, receptionist with lab, pharmacy, financial, etc
- Care Management Team
  - Teamlet plus patient, care manager, coach, dietitian, behavioral health, social services
- Care Coordination Team
  - Teamlet plus care manager, external (specialty or other) providers



What Are Your Issues and How Can High-Performing Team Care Help?

1. Access to medical specialty providers (either onsite or offsite)
2. Helping patients make changes to diet and other health factors
3. Access to mental health providers (either onsite or offsite)
4. Helping patients avoid use of the Emergency Department
5. Ability to recruit and retain good clinical practitioners
6. Getting help for patients with housing, employment, and other social service needs, and coordinating with social service programs
7. Achieving good clinical outcomes for patients with chronic illnesses
8. Helping patients stay out of the hospital
9. Ability of clinicians to focus on patients, rather than documentation and information-gathering, during encounters
10. Effectiveness of clinical support staff
11. Providing an experience that satisfies patients
12. Effectiveness of administrative support staff
13. Ability to recruit and retain good support staff
14. Access to primary care providers as a result of too much demand for services
15. Productivity of clinicians (throughput)

Evidence for Team-Based Care

- IOM, 2012
  - "Analyses of the quality and cost of team-based care do not yet provide a comprehensive, incontrovertible picture of success. "
- Boult C, et al. Successful models of comprehensive care for older adults with chronic conditions. JAGS 2009;57(12):
  - Literature search for studies providing evidence of impact of comprehensive care on outcomes for adults with chronic illness
  - Identified 15 successful models, one of which is interdisciplinary primary care, in which a physician teams with a nurse, NP, or social worker
  - Positive impact on quality of care (11/11 studies), quality of life (9/9 studies) and use of services (9/12 studies)
- Sinsky CA et al. In search of joy in practice: a report of 23 high-functioning primary care practices. Ann Fam Med 2013;11:272-278.
  - Identified 6 elements of practices believed to have impacted quality of care and practitioner satisfaction, one of which is use of primary care teams
- Diabetes Prevention Program Research Group. Reduction in type 2 diabetes with intensive lifestyle intervention or metformin. NEJM 2002;346(6):393-403.
  - Intensive lifestyle intervention provided to prediabetics by a case manager resulted in reduced progression to diabetes mellitus, better than through use of metformin in usual care

What are attributes of high-performing team-based care?

Best Practices in Team-Based Care

- Institute of Medicine. Core Principles & Values of Effective Team-Based Health Care, 2012
- Interprofessional Education Collaborative. Team-Based Competencies: Building a Shared Foundation For Education and Clinical Practice, 2011
- NCQA PCMH Standards, 2014

Foundation for Best Practices

- Values
- Principles
- Requirements

Values

Institute of Medicine, Core Principles & Values of Effective Team-Based Health Care, 2012

Case Study

- JR is a 59 y o female who had recently completed treatment for stage 3 breast cancer. At the end of her initial visit, the physician ordered a test that from a specialty lab. The physician put a note in the EHR, which had been implemented on two weeks previously, with the information about the test, so that the medical assistant (MA) could order the testing kit. At the end of the visit, the physician talked briefly with MA about it.
- A week later the physician received an email from the patient, irate that the test had not yet been done, saying that she was not coming back to the practice.
- Was there an error here?
- Whose fault is it?
- What should the physician do?

Honesty

- Team members communicate honestly with each other, with transparency about uncertainty and mistakes
  - When is it difficult to be honest?
    - Admitting you don’t know something
    - Acknowledging a mistake
    - Talking to someone with higher authority

Discipline

- Team members are disciplined in carrying out their responsibilities and avoiding communications that undermine the team
  - When is it difficult to be disciplined?
    - Hand offs – let someone else do it
    - Gossiping – talking about another person

Creativity

- Team members are given the opportunity to solve problems
  - With individual patients
  - In process redesign

  - Why is there often little creativity in a practice?
    - Need for consistency
    - Time pressure

Humility

- Team members recognize that no one person on the team can meet the goals of the team or the needs of the patient
  - Who is this most difficult for?
    - Practitioners

Curiosity

- Team members reflect on what has worked and what has not, using those insights for *continuous improvement* of their own work and the functioning of the team
  - Why is this hard?
    - Time pressure
    - Lack of training

Principles of Team-Based Care

1) Shared goals
2) Clear roles
3) Mutual trust
4) Effective communication
5) Measurable processes and outcomes

Shared Goals

- The team must agree about what it is trying to accomplish, and work through conflicting priorities
  - Example: prescription refills
- Patient goals for health must be articulated and drive the provision of care
  - Example: the spouse

- Enablers
  - Values development
  - Process redesign
  - Care plans

Clear Roles

- There are clear expectations for each team member's functions, responsibilities, and accountabilities
- These expectations should result in work that is both meaningful within the capabilities of each team member – often referred to as "at the top of that person's license or training"

- Enablers
  - Process redesign
  - Training
  - Team meetings
  - Care plans
  - Agreements with other providers

Mutual Trust

- Team members must trust that they will be supported by others on the team
- Patients must trust that the practice places priority on their interests and operates effectively

- Enablers:
  - Training
  - Team meetings
  - Care plans

Effective Communication

- Team member communications are honest and timely
- The team communicates constructively about issues
- Patients communicate with the team about questions and needs and receive timely response

- Enablers
  - Values development
  - Team meetings
  - Asynchronous communication channels: email and via patient portal

Measurable Processes and Outcomes

- Team performance is assessed in relation to measurable processes and outcomes

- Enablers
  - Organizational performance parameters
  - Team meetings

Requirements

March 24, 2014 NCQA announcement:

- "Changes affecting the advantages and requirements of NCQA PCMH Recognition include:
  - **Enhanced emphasis on team-based care** – Revised standards emphasize collaboration with patients as part of the care team and establish team-based care as a "must-pass" criterion for NCQA Recognition."

Element D: The Practice Team (MUST-PASS) — 4.00 points

The practice uses a team to provide a range of patient care services by:	Yes	No
1. Defining roles for clinical and nonclinical team members.	☐	☐
2. Identifying the team structure and the staff who lead and sustain team based care.	☐	☐
3. Holding scheduled patient care team meetings or a structured communication process focused on individual patient care. (CRITICAL FACTOR)	☐	☐
4. Using standing orders for services.	☐	☐
5. Training and assigning members of the care team to coordinate care for individual patients.	☐	☐
6. Training and assigning members of the care team to support patients/families/caregivers in self-management, self-efficacy and behavior change.	☐	☐
7. Training and assigning members of the care team to manage the patient population.	☐	☐
8. Holding scheduled team meetings to address practice functioning.	☐	☐
9. Involving care team staff in the practice's performance evaluation and quality improvement activities.	☐	☐
10. Involving patients/families/caregivers in quality improvement activities or on the practice's advisory council.	☐	☐

Scoring

100%	75%	50%	25%	0%
The practice meets all 10 factors (including factor 3)	The practice meets 8-9 factors (including factor 3)	The practice meets 5-7 factors (including factor 3)	The practice meets 2-4 factors (or does not meet factor 3)	The practice meets 0-1 factors (or does not meet factor 3)

What stands in the way of high-performing team-based care and what are some solutions?

Barriers to Team-Based Care

1. **We lack sufficient staff to support practitioners and patients through care management – care planning, health behavior change (education/coaching), coordinating with other providers**
2. **We don't have effective systems/technology for care planning, supporting health behavior change, or coordinating with other practitioners**
3. **Clinical practitioners don't feel that support staff are reliable or effective**
4. Medical assistants lack skills or training to effectively support clinical practitioners
5. We lack sufficient medical assistants to effectively support clinical practitioners
6. Clinical practitioners and medical assistants don't effectively coordinate with each other during clinic sessions, eg through huddles at the beginning of and during the session
7. Staff don't work to their fullest extent of their training
8. We don't have effective processes for care planning, supporting health behavior change, or coordinating with other practitioners
9. Staff don't communicate well with each other
10. Staff don't understand each other's roles
11. We have care management staff but the lack the necessary skills or training
12. We've tried building effective care teams but didn't succeed
13. Staff don't trust each other

Barriers to Team-Based Care

- Relationships
- Competency
- Processes/Systems
- Resources

Relationships

- Presentation
  - Staff don’t trust each other
  - Staff don’t like each other
  - Staff don’t communicate with each other
  - Staff don’t hand off to each other

- Solutions
  - Values development process
    - Define organizational values
    - Provide organizational supports for these values
      - Leadership modeling and reinforcement
      - Incentives/performance review
      - Training
      - Team meetings

Competency

- Presentation
  - Staff don’t trust each other
  - Staff don’t hand off to each other
  - Errors occur in patient care
- Solutions
  - Define organizational roles
  - Set performance expectations based on these roles
  - Provide training to enable staff to fulfill roles
  - Undertake process redesign/improvement to provide environment in which individuals can succeed

Processes/Systems

- Presentation
  - Staff don't trust each other
  - Staff don't hand off to each other
  - Errors occur in patient care
  - Staff burnout
  - Organization fails to meet performance expectations: quality, financial, patient satisfaction
- Solutions
  - Define organizational goals
  - Support process improvement at organizational level and within care teams
    - Process redesign
    - Team meetings

Resources

- Presentation
  - Staff burnout
  - Staff do not trust management
  - Organization fails to meet performance expectations: quality, financial, patient satisfaction
- Solutions
  - Define and prioritize organizational goals within the context of resources
  - Support process improvement at organizational level and within care teams
    - Process redesign
    - Team meetings

“Never doubt that a small group of thoughtful committed people can change the world. Indeed, it is the only thing that ever has.”

- Margaret Meade

II
Care Team Redesign

You've got Questions

How big is the team? What are its boundaries? Internal? Extended? Team or Teamlet?

What is the right financial model to support care teams?

What do we do if we lack effective systems/technology for care planning & coordination?

How can the Care Team Model Help me with staffing shortages?

What kind of infrastructure and staffing model will I need?

Where Do I Start?

Leadership as the Compass and The Beacon

Orient practice leadership to:

- the challenges
- ✓ principles of care teams
- ✓ implementation strategies and tactics

Assist leadership in

- ✓ Developing plans
- ✓ Techniques & Tactics
- Tools
- Advancing their Care Team Agendas

I

Organizational Attributes of the High Performing Care Team

Core Competencies of Team-Based Care

Competency 1: Values/Ethics for Inter-professional Practice

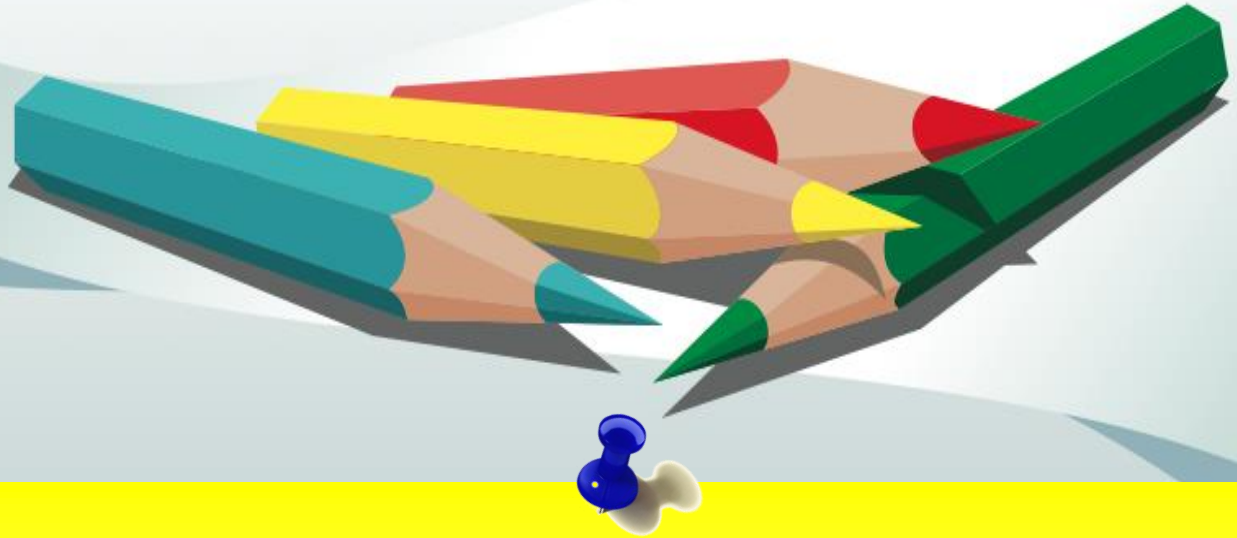
Competency 2: Roles/Responsibilities for Collaborative Practice

Competency 3: Inter-professional Communication

Competency 4: Interprofessional Teamwork and Team-Based Care

Team-Based Competencies: Building a Shared Foundation For Education and Clinical Practice *Interprofessional Education Collaborative (IPEC)*

Organizational Attributes of High Performing Teams



- ✓ **Clear Division of Labor**
- ✓ **Training of Team Members in their roles and team functions including significant and on-going investment**
- Team Supporting **Policies** of the Practice
- Creation of **protocols that define tasks and who will perform them**
- Adoption of **team rules**, including decision making and communication
- **Protected** (non-patient-care) **time** for team meetings
- **Clear expectations** of each person at work and they're **supplied** with the materials and equipment needed to accomplish the role
- **Information availability** about the patient's health and wellness

Attributes of High Performing Teams

- ✓ **High Performing team attributes are measurable and <u>all</u> team members have KPIs**
- ✓ **Feedback on performance is routine**
- Everyone on the staff is **<u>valued</u>**
- Care team members have **<u>positive attitudes</u>**.
- Good Leadership = Organizational leadership must view the **<u>care team model as "the way we do business."</u>**

Want to talk about it

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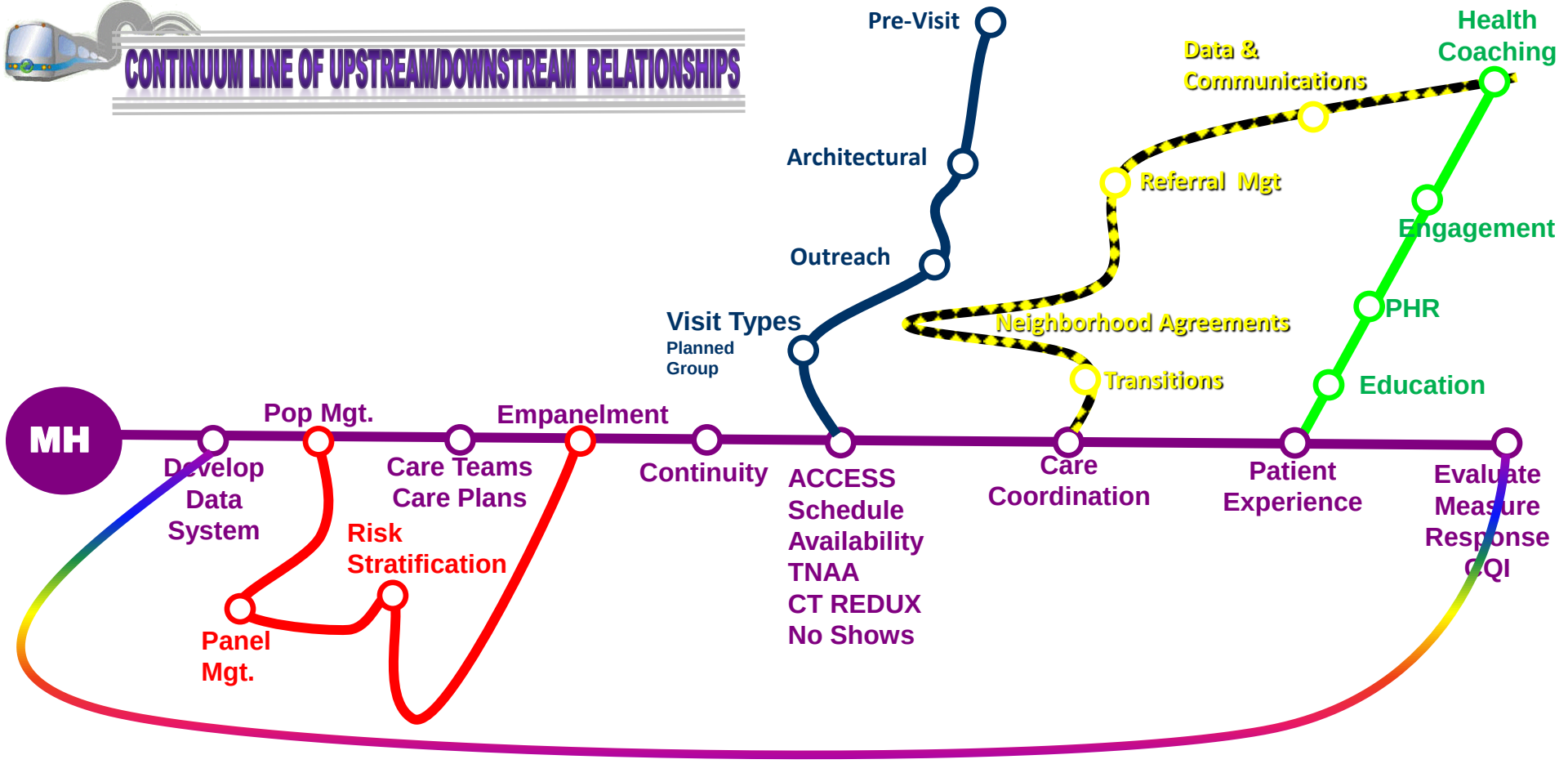
II

Foundations and First Principles

CONTINUUM LINE OF UPSTREAM/DOWNSTREAM RELATIONSHIPS



CHANGE MGT.
Redesign
Process
Workflow
P&P

CAPABILITY
Training
Know-How

ORG

ENDURANCE
Capacity
Task Distribution
Mgt Multiple Priorities
Adaptive Reserve
Morale

COMMUNICATIONS

BUY-IN
OWNERSHIP
Staff
Physicians
Leadership
Patients
Community

LEADERSHIP

INFRASTRUCTURE
Tech
Facility
Budget
Rpt/Analysis
Staff Model
Capacity

Some Qualitative Overlaps

Langley's Change Concepts Categories 1996

- Eliminate Waste
- Improve Work Flow
- Optimize Inventory
- Change the Work Environment
- Enhance the Producer/Customer Relas.
- Manage Time
- Manage Variation
- Design Systems to Avoid Mistakes
- Focus on the Product or Service

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Where the Work Lives

Population Needs
Demand/Supply
Panels
Registries
Workload
Scheduling/Access

Work Inventory
Current Tasks
Match with Population
Task Distribution

Human Resources
(what is your most $$$ resource doing?)
Preferences
Personal Characteristics
Job Descriptions

Skills
Current Inventory
Skills Needed
Systems Needed
Credentials
Education

Optimize
Build Care Teams
Extended Teams
Workflows
Redesign
Evidenced Based GL

Responding to Barriers

Solutions
Strategies
Tactics & Techniques

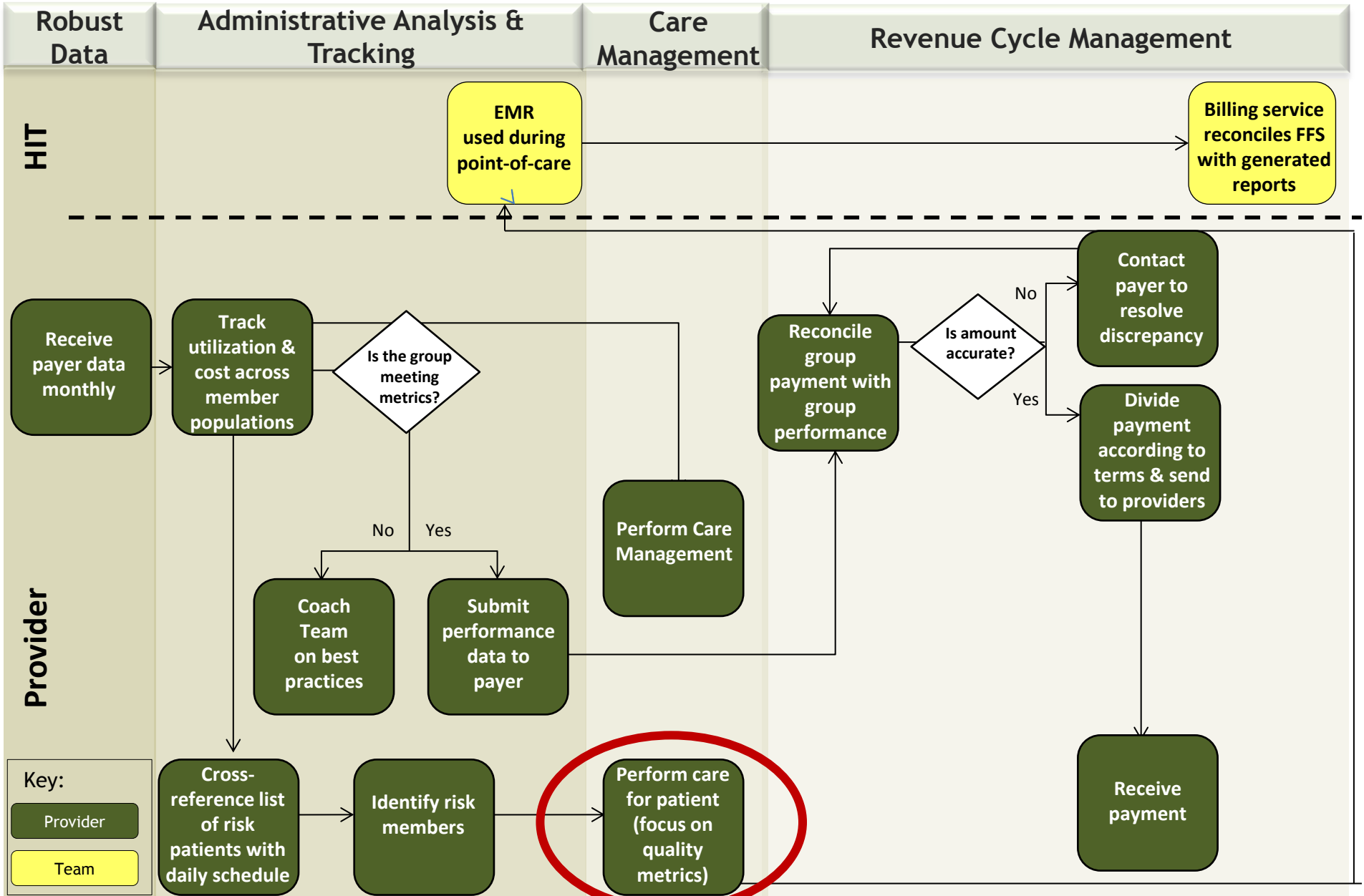
Org. Development
Communications
Leadership Support
HR P&P
Financial Model

Redesign Method

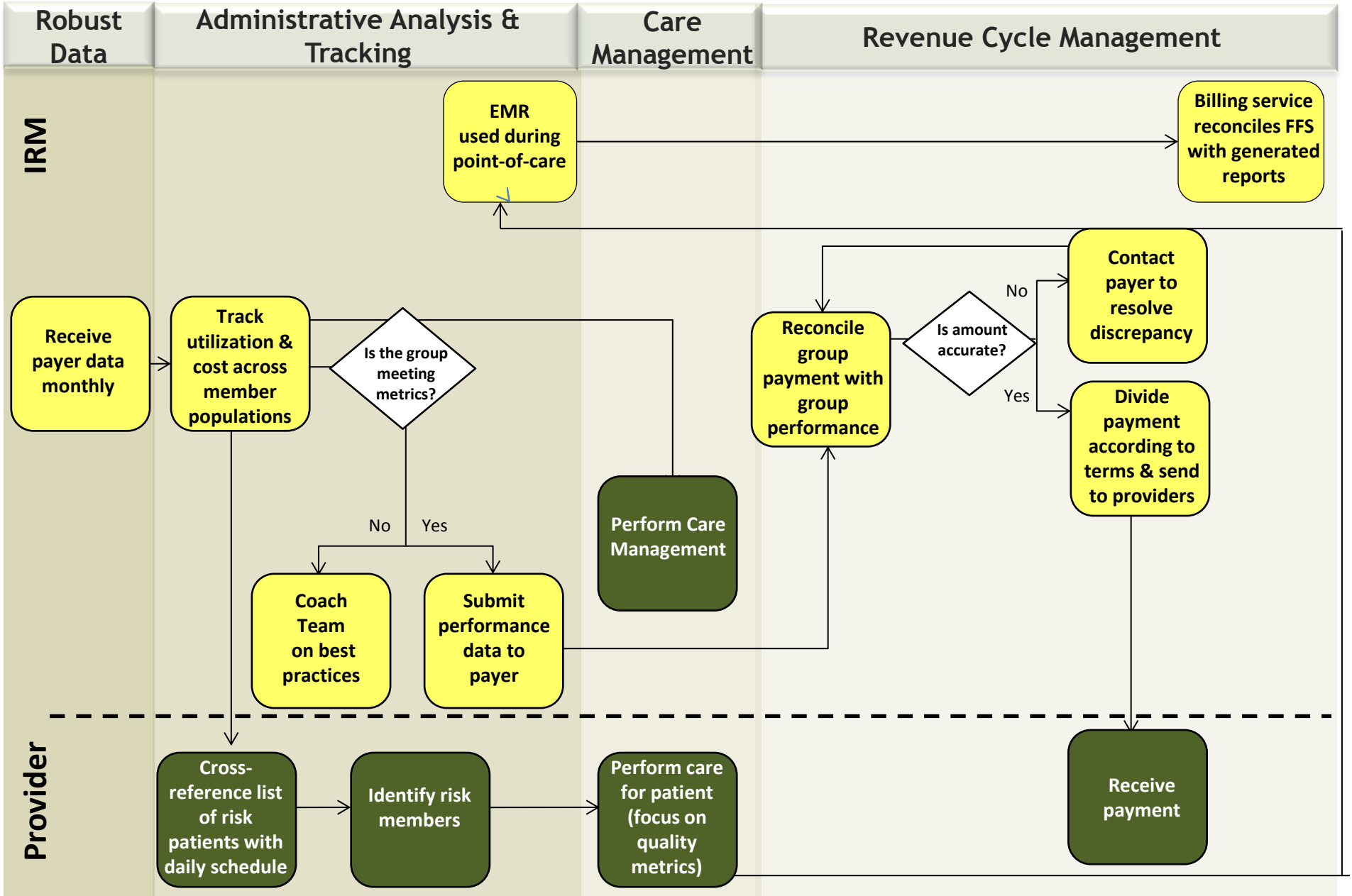
- Create a Change Team
- Define the opportunity for improvement.
- Define the aim(s) for an Intervention.
- Design the Intervention.
- Plan to test the effectiveness of your Intervention.
- Develop an implementation plan - for medical team training and for the Intervention.
- Develop a plan for Continuous Improvement.
- Develop a Communication Plan
- Putting it all together - Write the Action Plan.
- Review your Action Plan with key personnel, and modify according to input

- EXECUTE

The current workflow places almost the unbalanced burden on health care providers



Need to move toward models where others can hand their work domain



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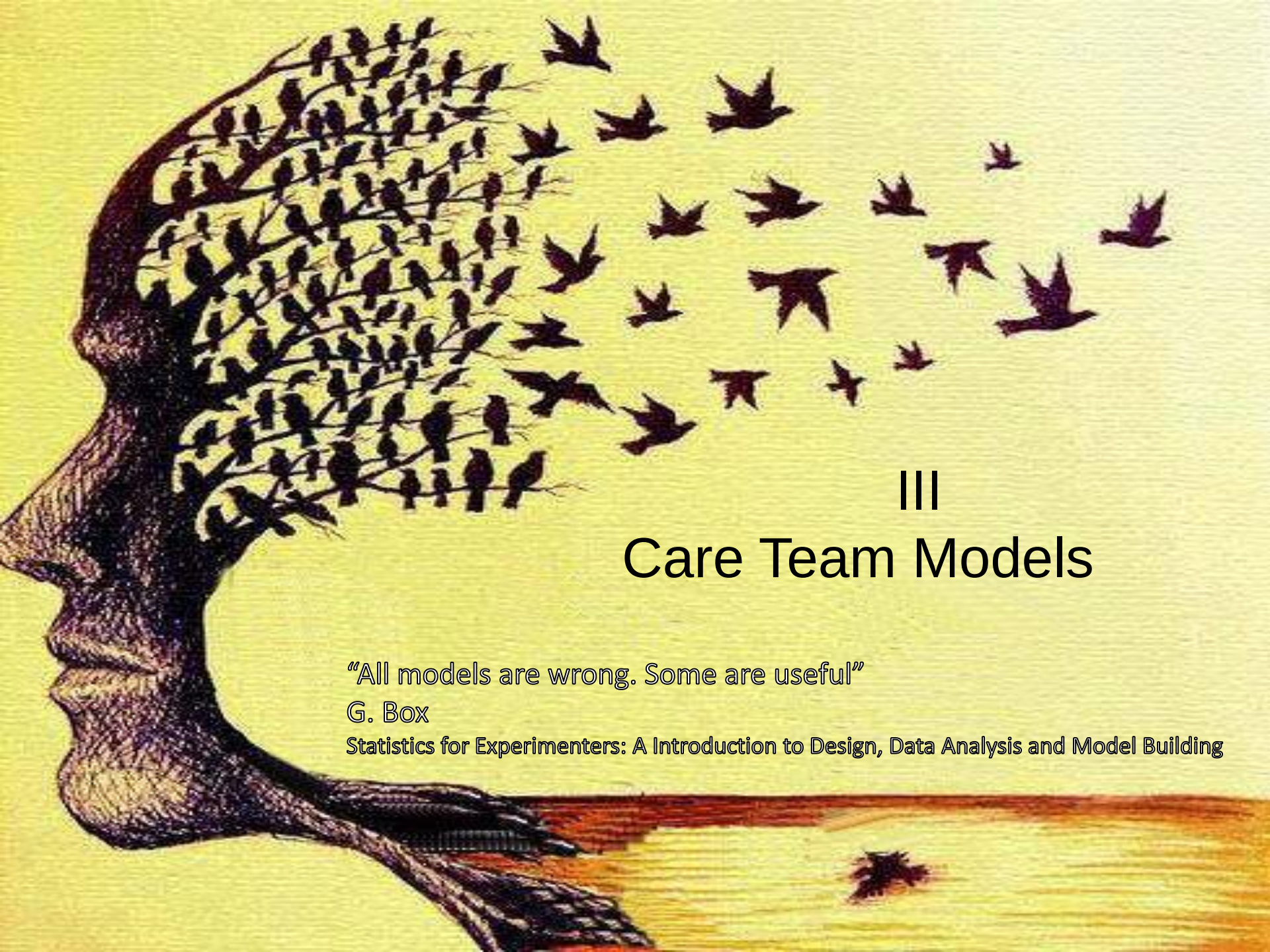
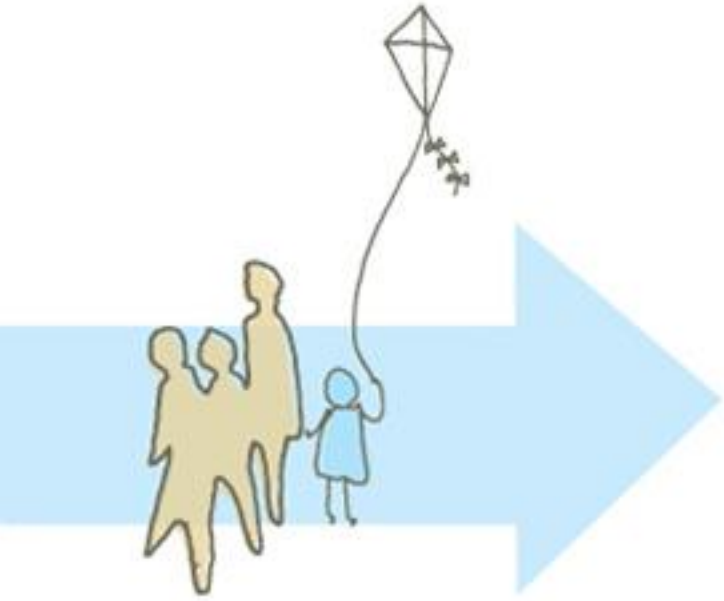


III
Care Team Models

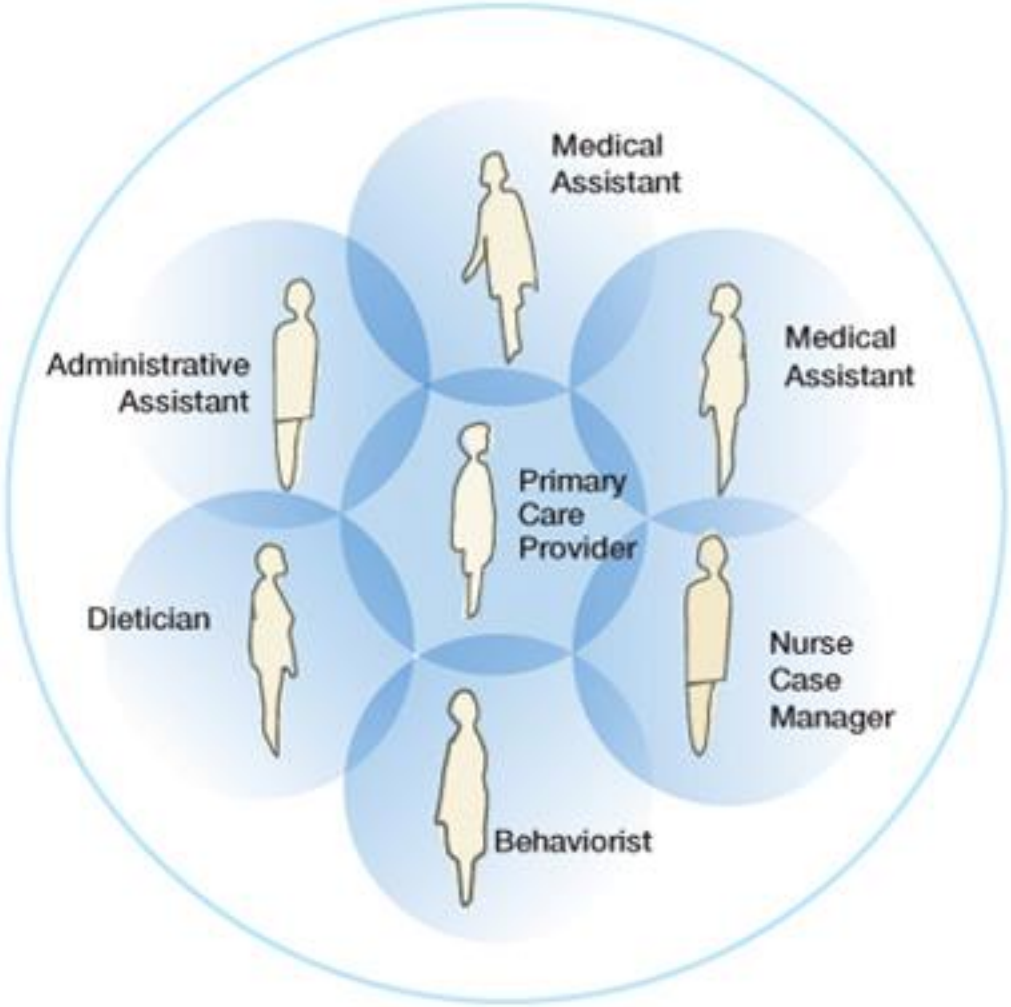
"All models are wrong. Some are useful"

G. Box

Statistics for Experimenters: A Introduction to Design, Data Analysis and Model Building



patient and family



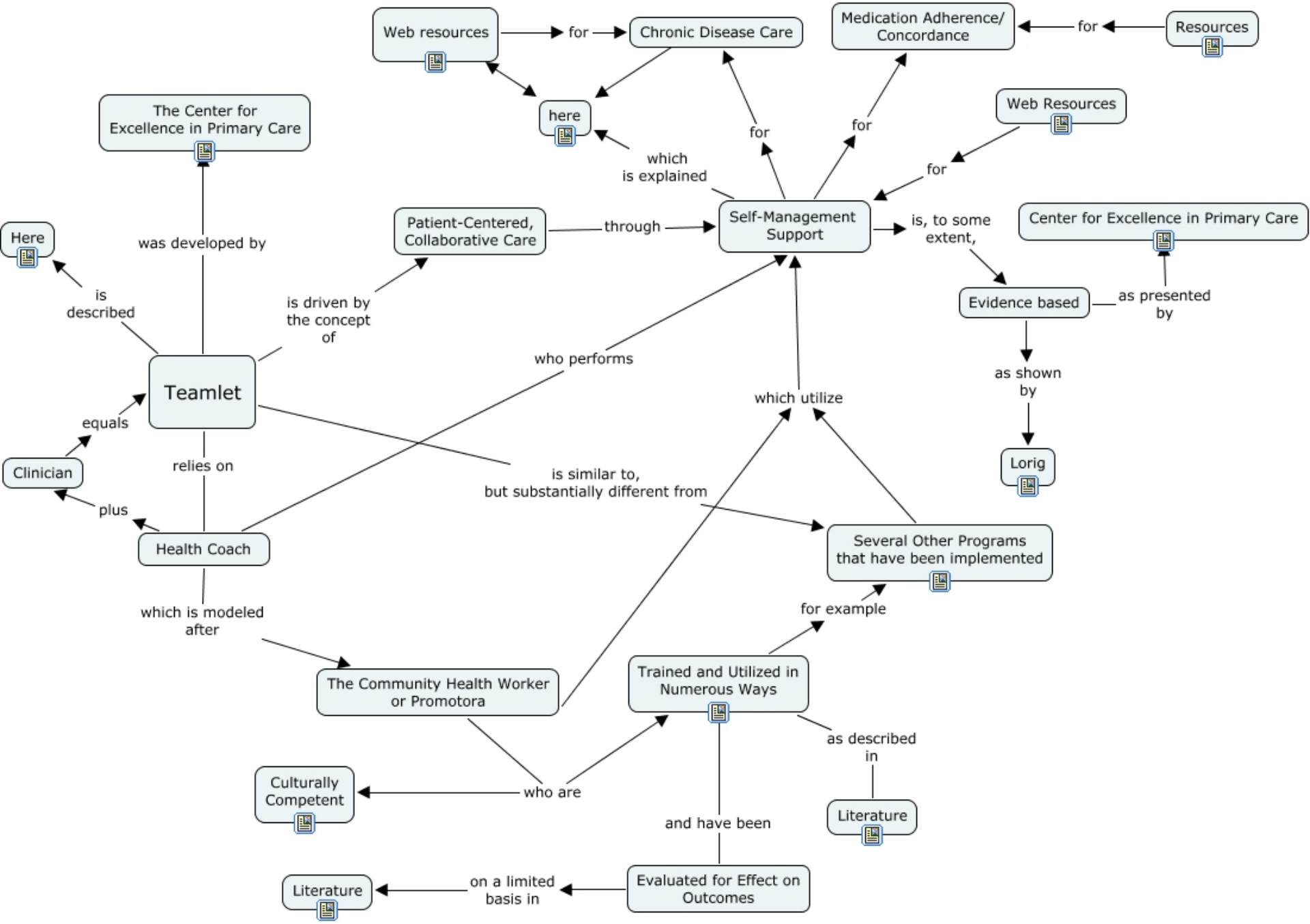

Primary Care Nurse
Physicians / Clinicians
Primary Care Team
Psychologists
Case Manager / Social Worker
Case Finders
Peer Buddies

Health Care Home Team


Speech therapy
Genetic counseling
Respiratory therapy
Occupational therapy
Nutritional & dietary therapy
Psychosocial therapy
Physical therapy
Care Coordinator


Pharmacy
Multidisciplinary Review Team
Nursing
Patient and Referring Physician
Case Management
Reimbursement
Intake Coordination


Who Would You Add?
MD
Oriental Medicine
Physical Therapy
Your Provider
YOU!
Nutritionist
Aesthetics & Skin Care
Psychologist
Naturopath
Health Coach
Massage
Acupuncture


Web resources
for
Chronic Disease Care
Medication Adherence/ Concordance
for
Resources
The Center for Excellence in Primary Care
here
which is explained
for
for
Web Resources
for
Here
was developed by
Patient-Centered, Collaborative Care
through
Self-Management Support
is, to some extent,
Center for Excellence in Primary Care
is described
is driven by the concept of
Evidence based
as presented by
who performs
as shown by
Teamlet
which utilize
equals
Lorig
relies on
is similar to, but substantially different from
Clinician
plus
Several Other Programs that have been implemented
Health Coach
which is modeled after
for example
The Community Health Worker or Promotora
Trained and Utilized in Numerous Ways
as described in
Culturally Competent
who are
Literature
and have been
Literature
on a limited basis in
Evaluated for Effect on Outcomes

Care Team Collaborative

The Care Team System of Care

Tier Three: Intensive Services
- Weekly Care Team meetings
- Individualized plan for each child
- plan is youth and family driven
- Wrap around services
- Progress monitoring, data collection

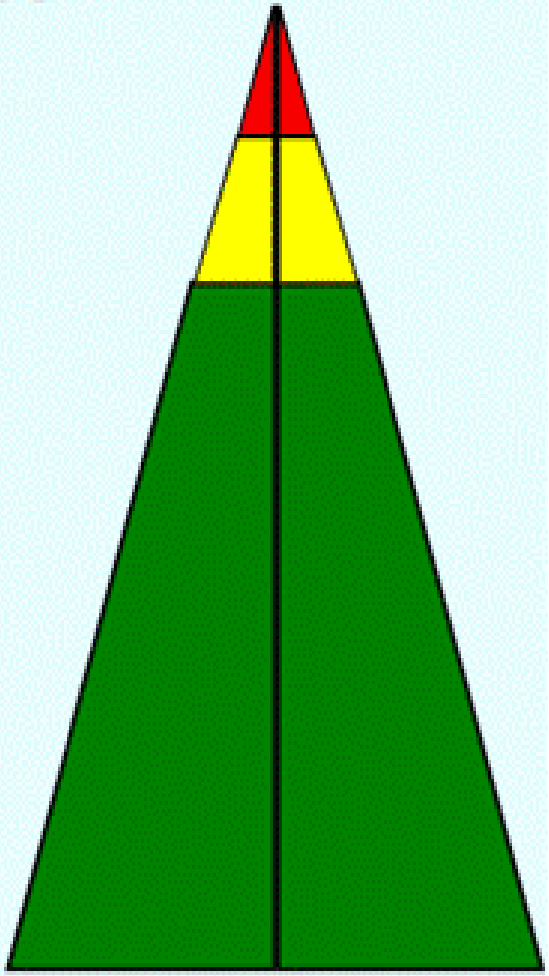
1-5%

5-10%

Tier Two: Early Intervention
- Target youth with some needs
- Community and school based
- Extended day programs
- Small group counseling, bullying prevention
- Student leadership training
- Classroom presentations on youth issues

Tier One: Whole School Prevention
- Every Setting, Every Student
- Asset Training (adults, youth)
- Preventive, proactive
- School climate initiatives
- 3+ positive adult relationships
- Integrate Asset building into classroom instruction

80-90%



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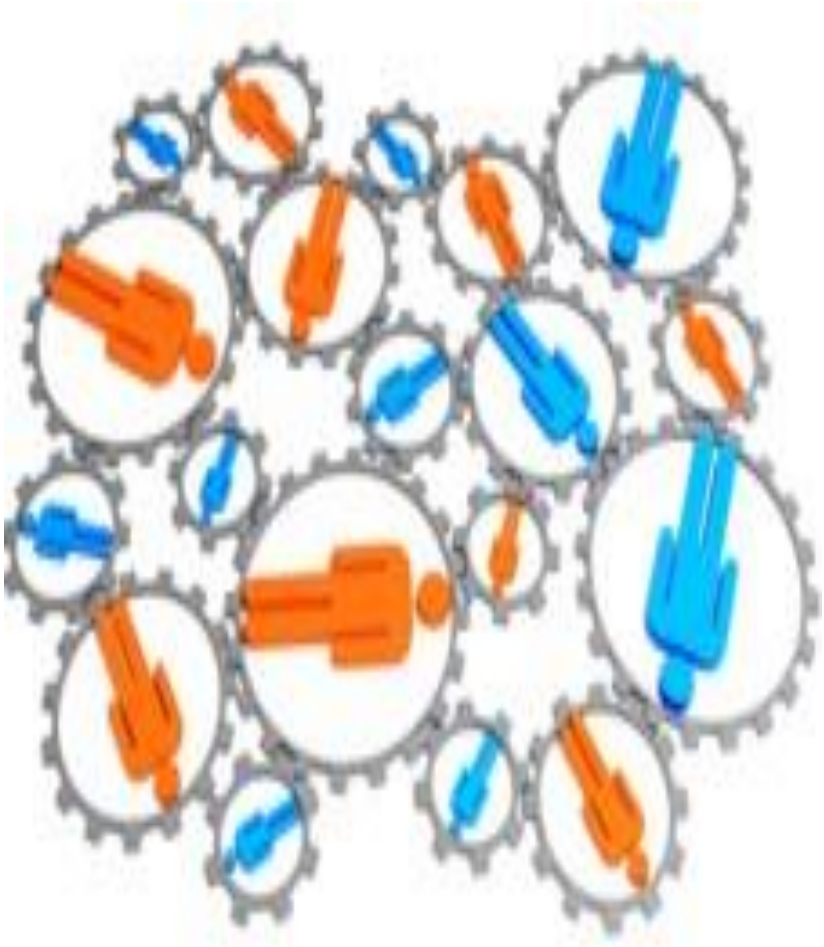


IV

Care Team Roles

Skill and Task Alignment

The Unnecessaries:

Processes

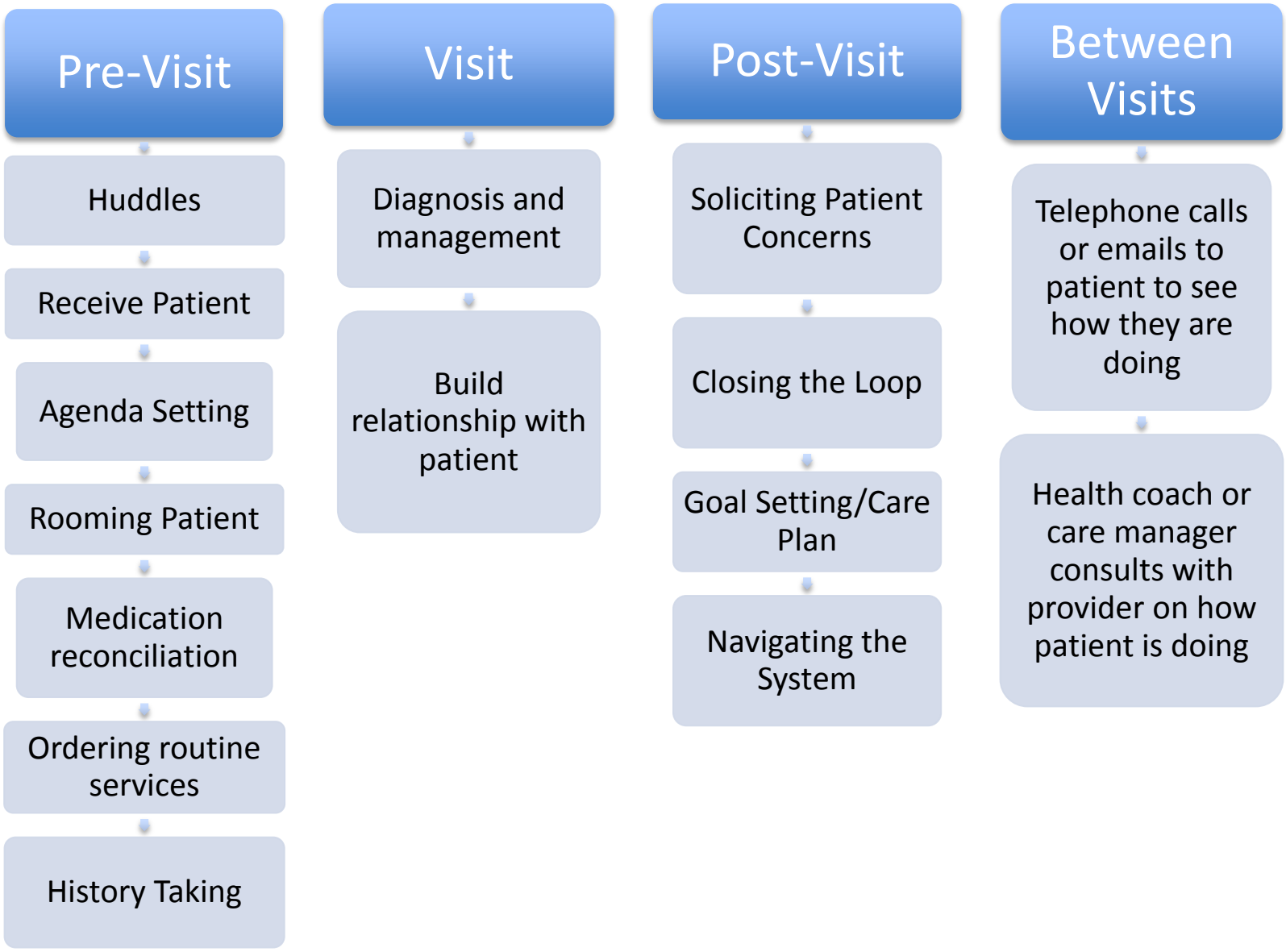
Services

Role Placements

MD | PA | NP | RN | LPN | MA | Patient Navigator Advocate | Care Mgr. | BH Partners

Providers | Nurses | Clinical Support Staff

Using the care team to expand the 15 minute visit



Care Manager Role

- Registry work/Panel management
- Pre-Visit Planning
- Planned visits
- Provide educational materials
- Care Manager
- Health Coaching/Care Plans
- Coordinating transitions of care
- Linking patients to community resources

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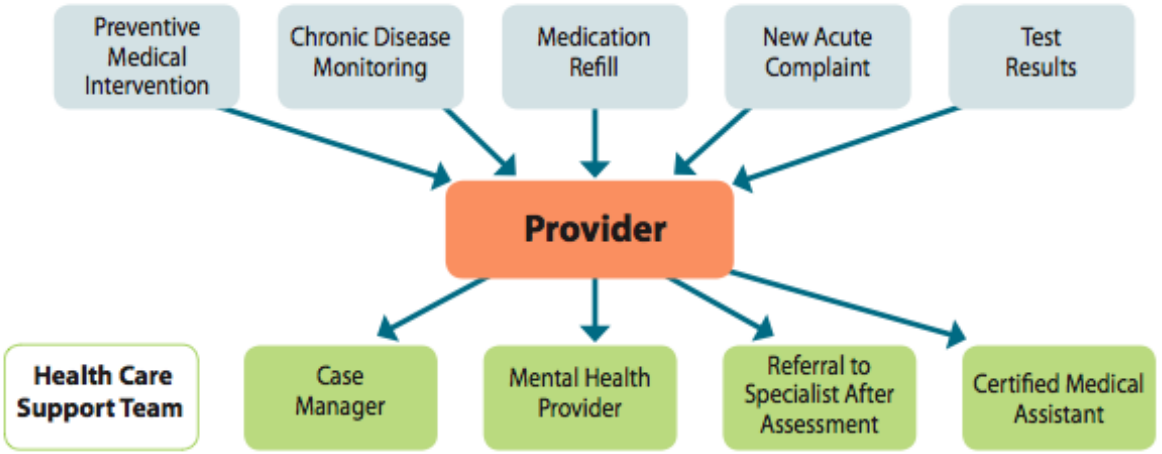
Providers	Registered Nurses	Clinical Support Staff
– Assess, diagnose and treat patients – Prescribe, manage and reconcile medications – Perform procedures – Consult with specialists and facilities – Lead the team(s) – Lead the practice's strategic QI plan – Choose evidence based guidelines and establish standing orders – Mentor, leader, role model	– Clinical advice expert – Triage – Interpret reports and plan for population management – Planned care and group visit organizer and participant – Care management, patient education and self management support for high risk and complex patients – Train and supervise team – Assist with policies, guidelines, standing order development – Mentor, leader, role model	– Patient flow – Collect information and populate records – Cue up orders, referrals – Clinical list changes, RX refill requests – Populate registry – Planned care and group visit participant – Care coordination – Patient education and self-management support for less complex patients – Use guidelines and standing orders to support evidence based care

Workflow Redesign

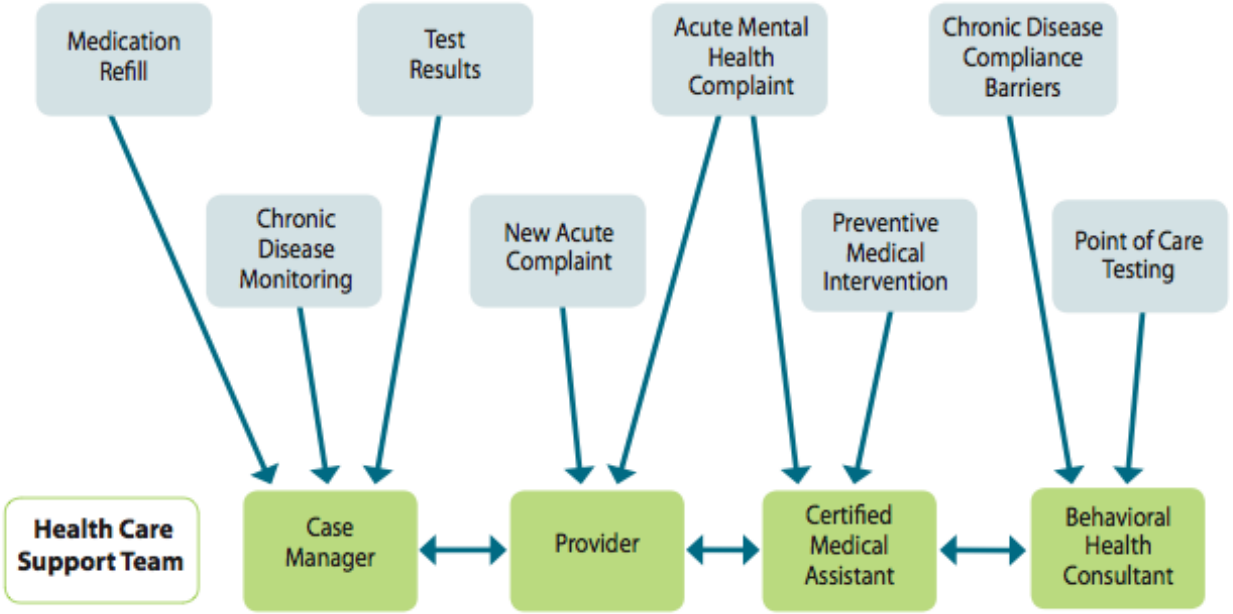
The Old Way...

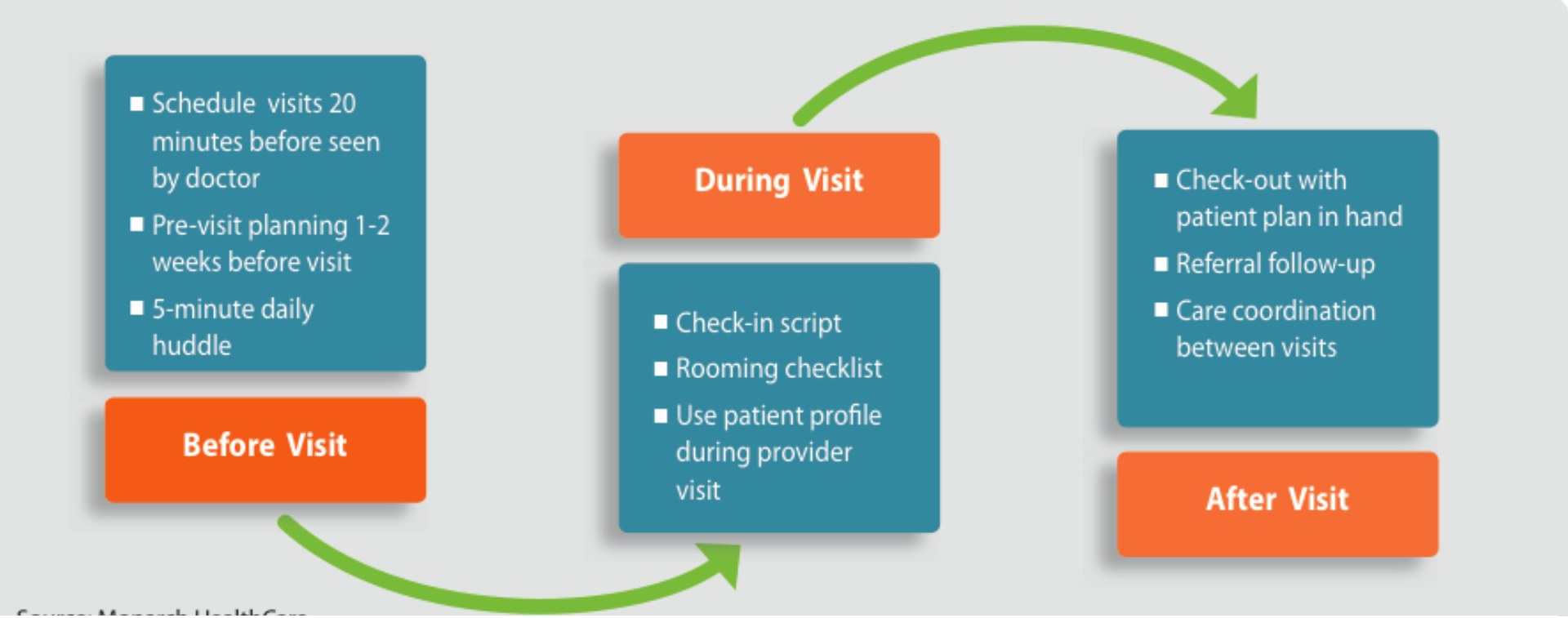
Traditional Method



A Better Way...

Parallel Structure





Changing Staff Perceptions about Roles

RNs

Nurses do not like other staff taking roles traditionally assumed by nurses.

→

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

Providers

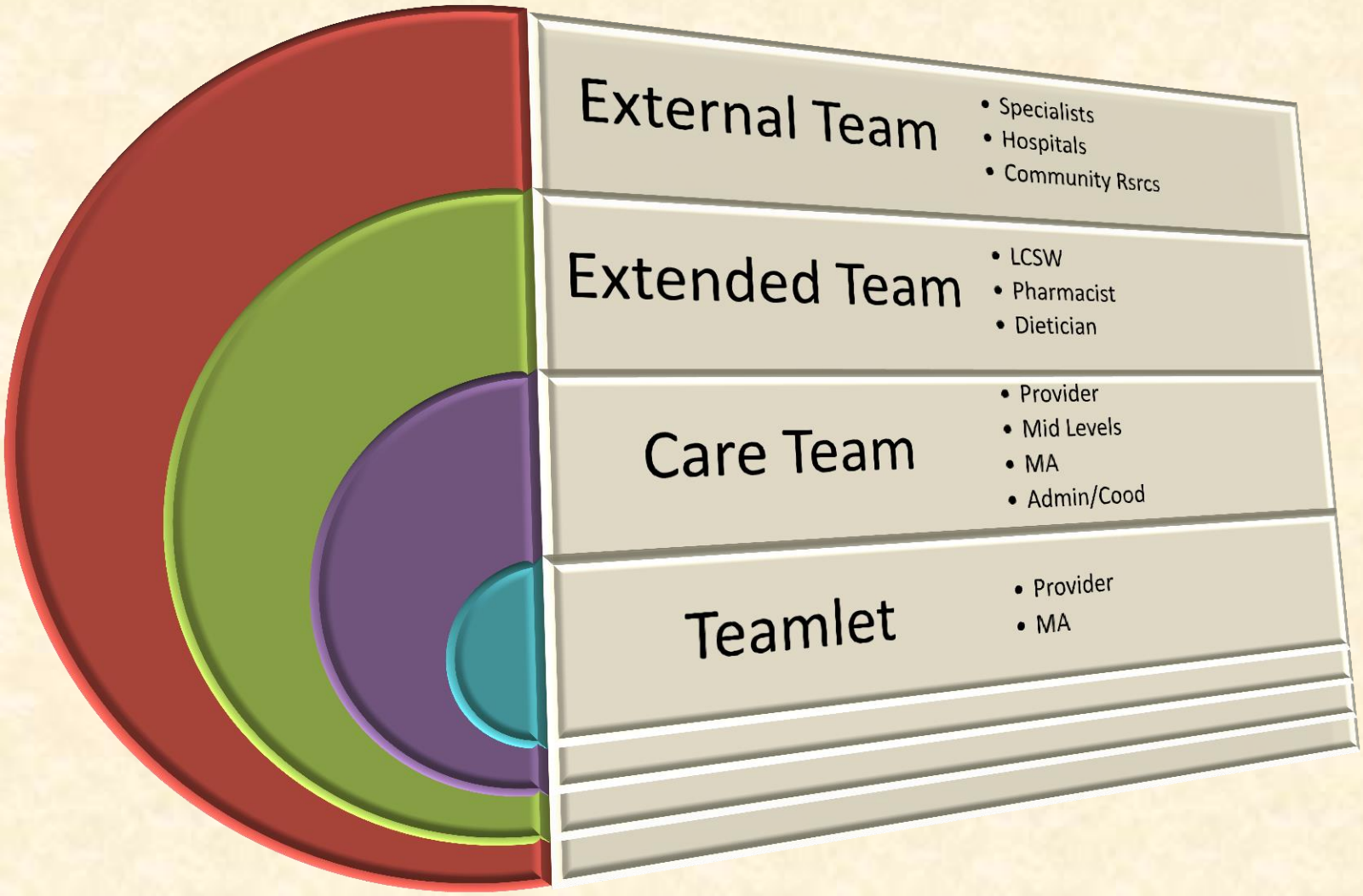
I felt like I was on a treadmill going as fast as I could without producing many results.

→

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.

Source: Center for the Health Professions

Boundary Categories



Want to talk about it

PRIMARY CARE
DEVELOPMENT
CORPORATION

CHCANYS DEFINING NEW DIRECTIONS
COMMUNITY HEALTH CARE ASSOCIATION OF NEW YORK STATE

PRIMARY CARE DEVELOPMENT CORPORATION

V
Implementing the Care Team Redesign

Redesign Strategies and Tactics

Applying Models and Approaches

" The first step in the redesign was to define what our business was really about. It is about **trusting relationships between human beings**. Prior to our redesign, the medical system misunderstood the core product as being tests, diagnoses, pills and procedures. "

Dr. Douglas Eby
Vice President of Medical Services
Southcentral Foundation
Primary Care Center II & III
Anchorage, AK, USA

Treatment $\neq$ Care

Rule #1

Prepare
for the
Predictable

Redesign Method

- Create a Change Team
- Define the opportunity for improvement.
- Define the aim(s) for an Intervention.
- Design the Intervention.
- Plan to test the effectiveness of your Intervention.
- Develop an implementation plan - for medical team training and for the Intervention.
- Develop a plan for Continuous Improvement.
- Develop a Communication Plan
- Putting it all together - Write the Action Plan.
- Review your Action Plan with key personnel, and modify according to input

- EXECUTE

Where the Work Lives

Population Needs
Demand
Panels
Registries
Workload
Scheduling/Access

Work Inventory
Current Tasks
Match with Population
Task Distribution

Human Resources
(what is your most $$$ resource doing?)
Preferences
Personal Characteristics
Job Descriptions

Skills
Current Inventory
Skills Needed
Systems Needed
Credentials
Education

Optimize
Build Care Teams
Extended Teams
Workflows
Redesign
Evidenced Based GL

Responding to Barriers
Solutions
Strategies
Tactics & Techniques

Org. Development
Communications
Leadership Support
HR P&P
Financial Model

Techniques and Tactics Inventory

Panels
Registries
Essential Workflow Redesign
Cycle Time, Lead Time and Task Timing
Waste Identification
Load Balancing
Task Redistribution and Workflow Mapping
Reduce Rework
Handoffs and waits
Idle time
Team Hazards

Workplan

- ☐ Define the Problem
- ☐ Build Change Team
- ☐ Intervention Design
- ☐ Master Implementation Plan
- ☐ Training Plan
- ☐ Communications
- ☐ Measure & Sustain

PATIENT PANEL SIZE WORKSHEET

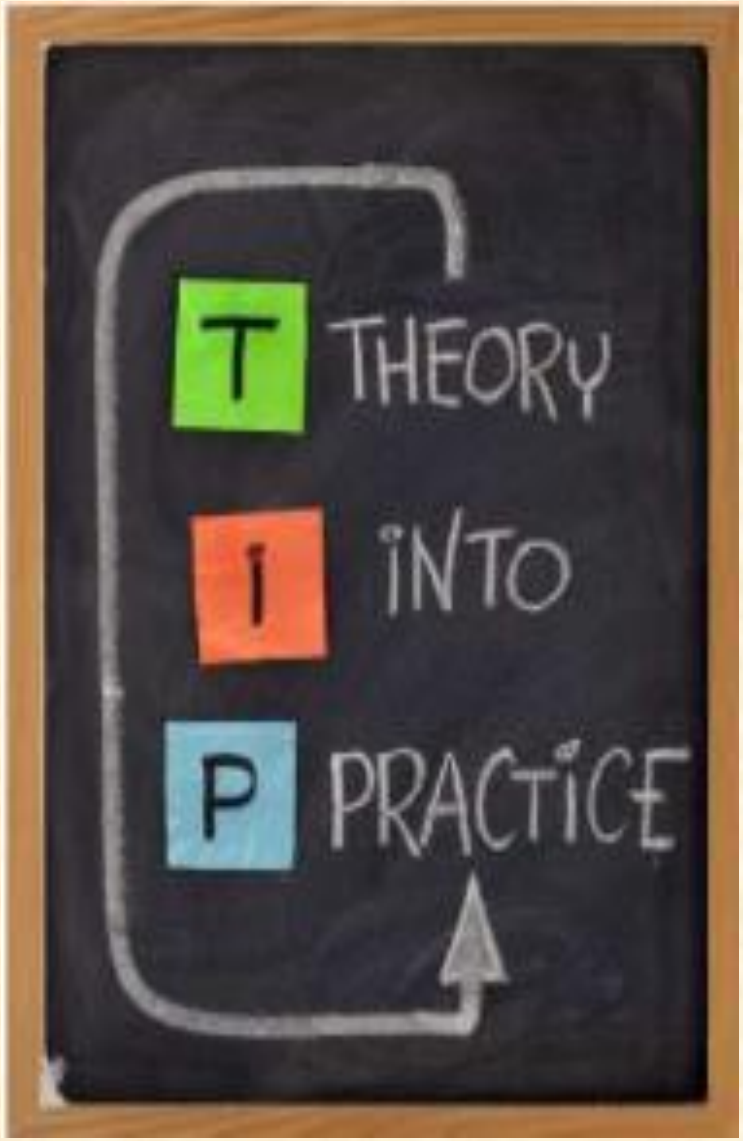
The following worksheet can help you capture the data you need to calculate your current and ideal panel size. You can download an Excel version of this spreadsheet, which performs many of the calculations for you, at http://www.aafp.org/fpm/20070400/44pane.html.

	CURRENT PANEL	Example	Your practice
A	The practice panel: The number of unique patients who have seen any provider (physician, NP or PA) in the practice in the last 12 or 18 months	6,000	
B	Full-time-equivalent (FTE) providers	4.0	
C	FTE providers devoted to nonvisit work	1.0	
D	FTE clinical providers (B - C)	3.0	
E	The "target" panel for each FTE clinical provider (A ÷ D)	2,000	
	For an individual provider		
F	Clinical FTE of the individual provider being analyzed	0.80	
G	Actual panel for the individual provider (This can be determined using the "four-cut" method described in the article.)	2,000	
H	Difference between actual and target panel for the individual provider (G - (E x F))	400	

	IDEAL PANEL	Example	Your practice
I	Visits per patient per year (The average is 3.19, but your number may vary and can be adjusted based on patient acuity, as described in the article.)	3.19	
J	Provider visits per day	24.0	
K	Provider days per year	240.0	
L	Ideal panel size ((J x K) ÷ I)	1,806	
M	Difference between actual and ideal panel for the individual provider (G - L)	194	

Note: Strategies for reconciling the actual and ideal panels are provided in the article.

Panels



The “four-cut” method :

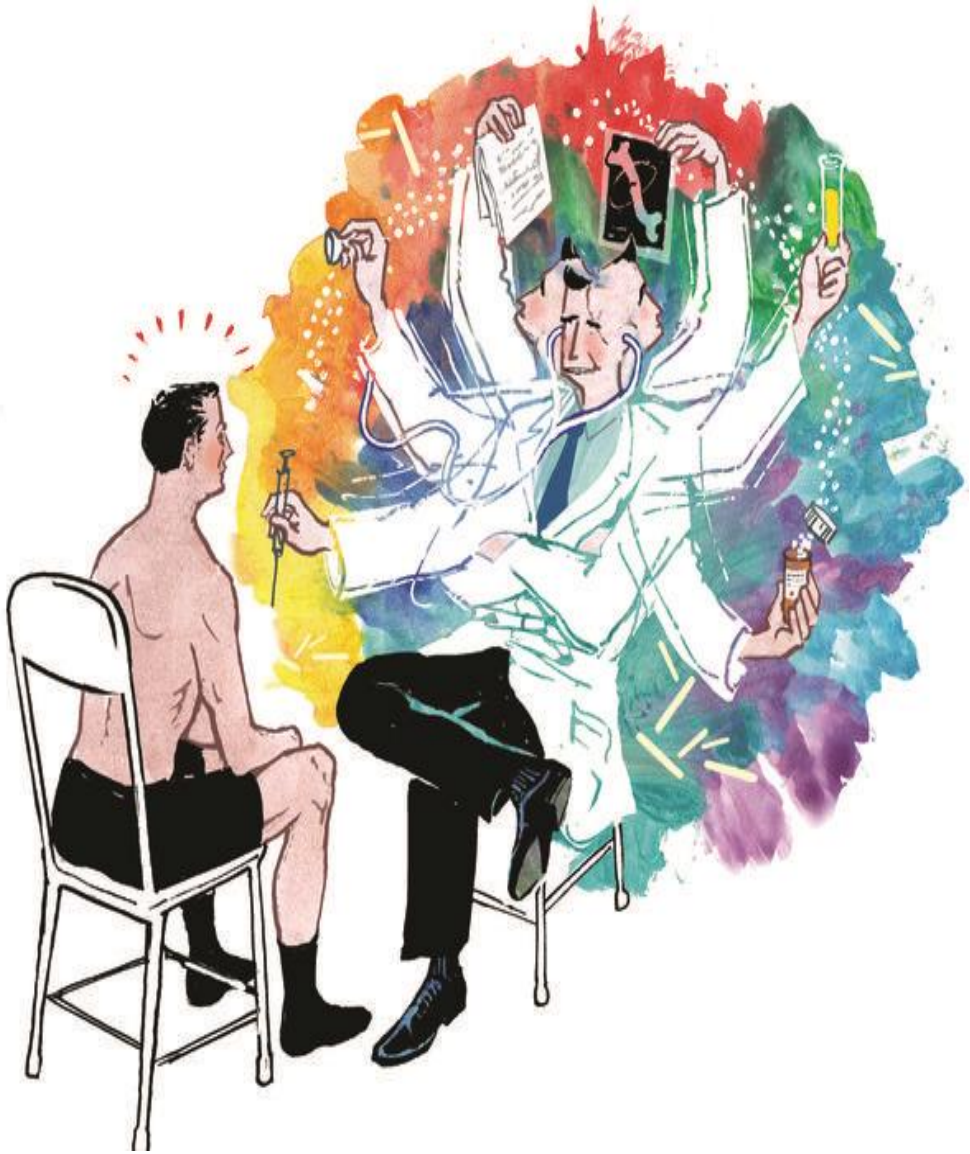
1. Patients who have seen only one provider for all visits are assigned to that provider.

2. Patients who have seen more than one provider are assigned to the provider they have seen most often.

3. The remaining patients who have seen multiple providers the same number of times are assigned to the provider who performed their most recent physical or health check.

4. The remaining patients who have seen multiple providers the same number of times

Panels & Population



Organized Team Models

Panel >= 2000

Large Practice Team

Relationship Centered Models

Panel 600-1200

Small Team

Neighborhood Members

Kaiser

Panel 10,000 -20,000

Greenfield

Panel 1000

EisenhowerPC

Panel 700

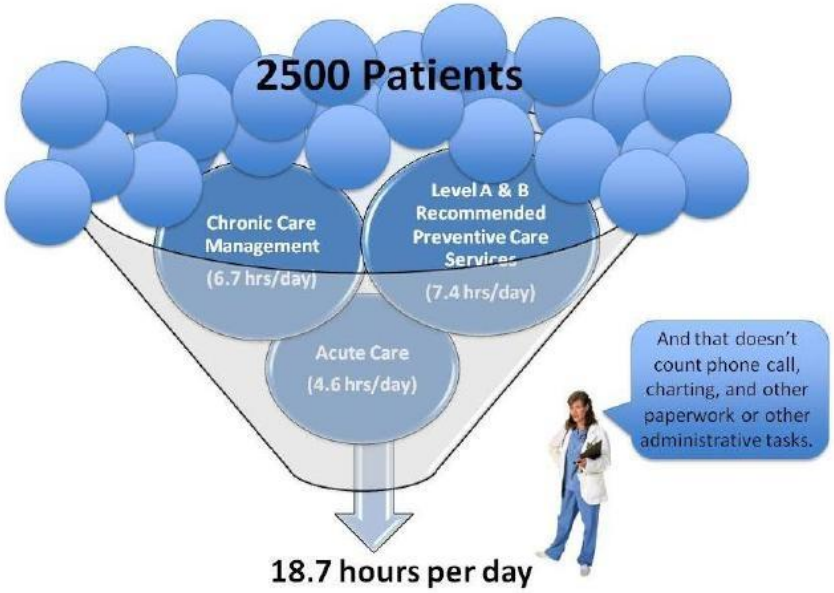
Concierge

Registries

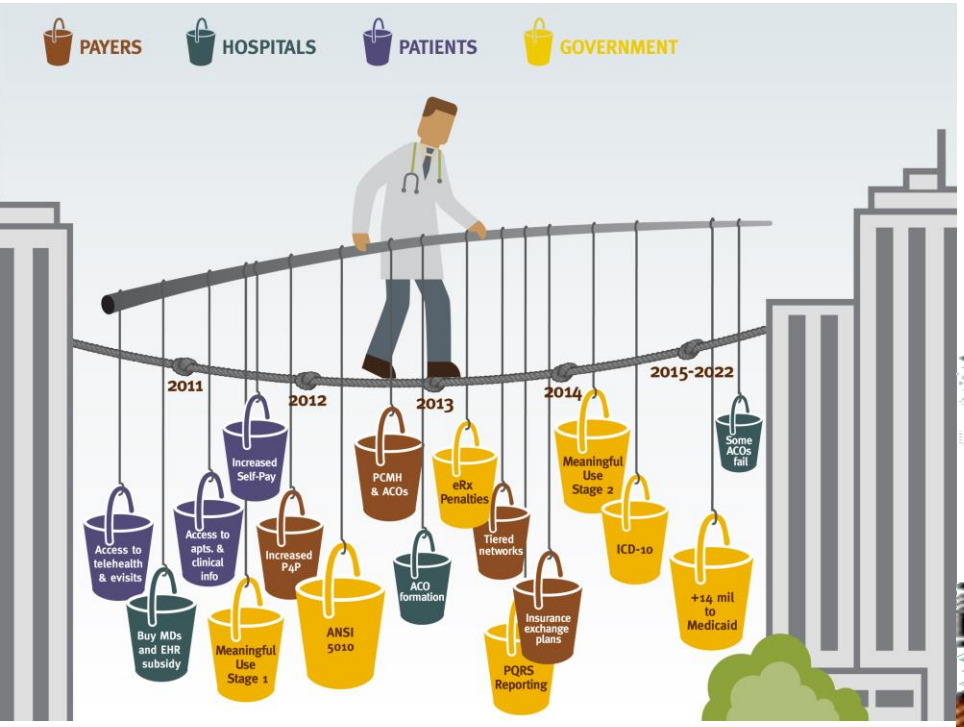
- **Registries: lists of patients your practice is responsible for**
- **Includes clinical information**
- **Example: diabetes:**
  - **Date of last A1c, LDL, blood pressure, eye exam, foot exam, microalbumin,**
  - **Results of A1c, LDL, blood pressure, etc.**
  - **What patient education was done?**
  - **Does patient have a goal and plan to achieve that goal?**
- **Cochrane review of 5 trials: registries that identify diabetic patients at risk and bring those patients into care demonstrate reduced HbA1c levels compared with usual care. [Griffin, Kinmouth. Cochrane Library, Issue 3, 2003]**

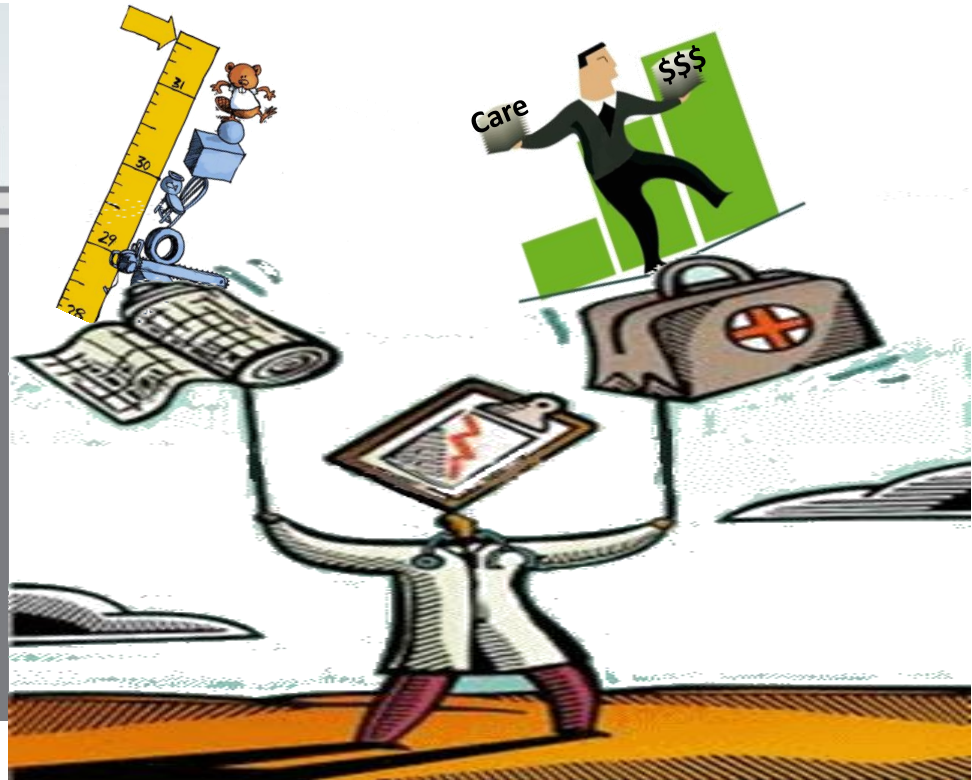
Registries and teams

- A registry is useless unless someone repeatedly and compulsively uses it
  - Searches for care gaps
  - Tries to close the care gaps
- Care gap = deficiencia en atencion medica
  - Process care gap
    - Patient with diabetes: no HbA1c for 1 year
    - 60 year old woman: no mammogram for 5 years
  - Outcome care gap
    - Patient with diabetes: HbA1c > 9
    - Patient with hypertension: Blood pressure 160/95
- Requires a team to do this work

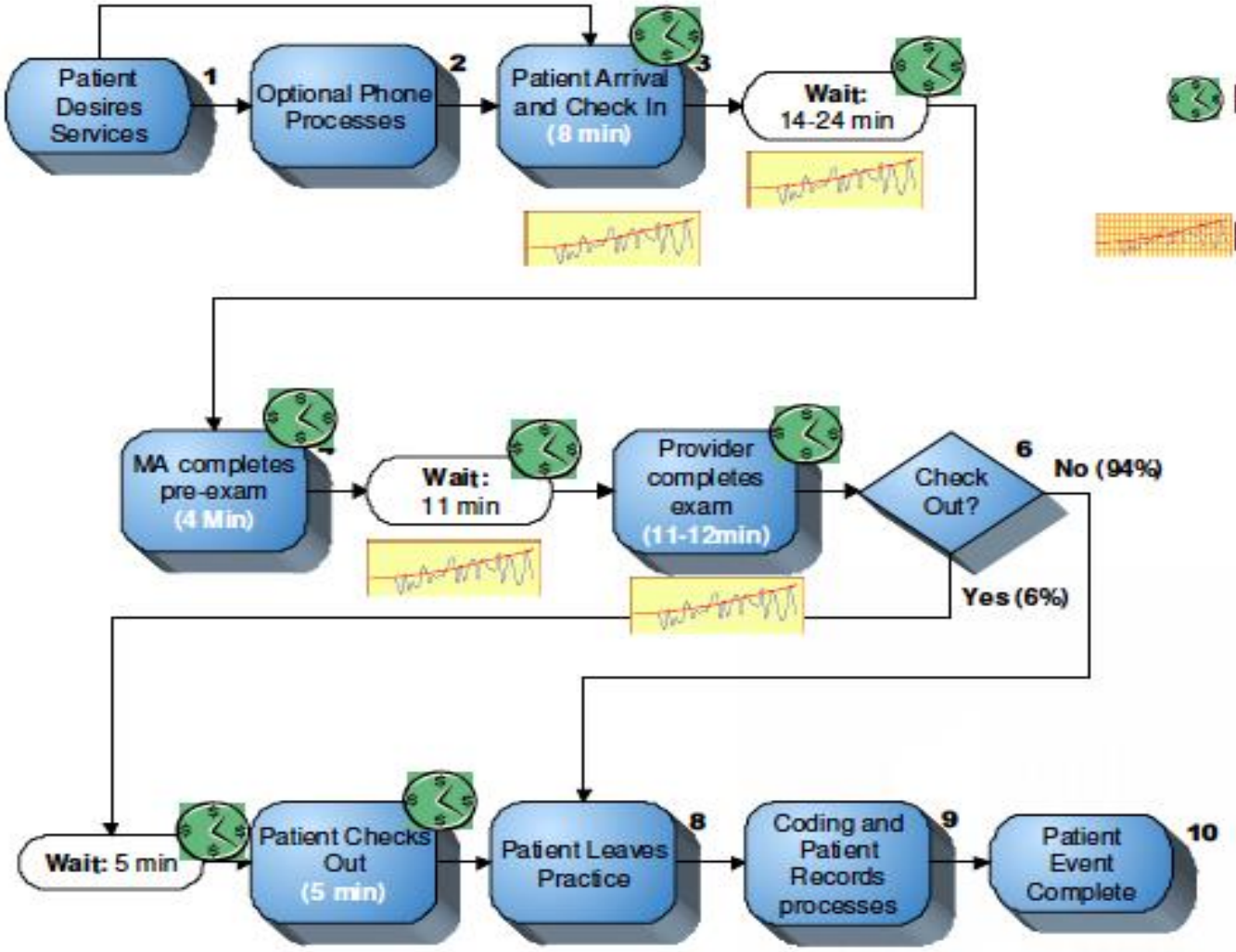


Cutting panel size to 1250 = 9.35 hours per day

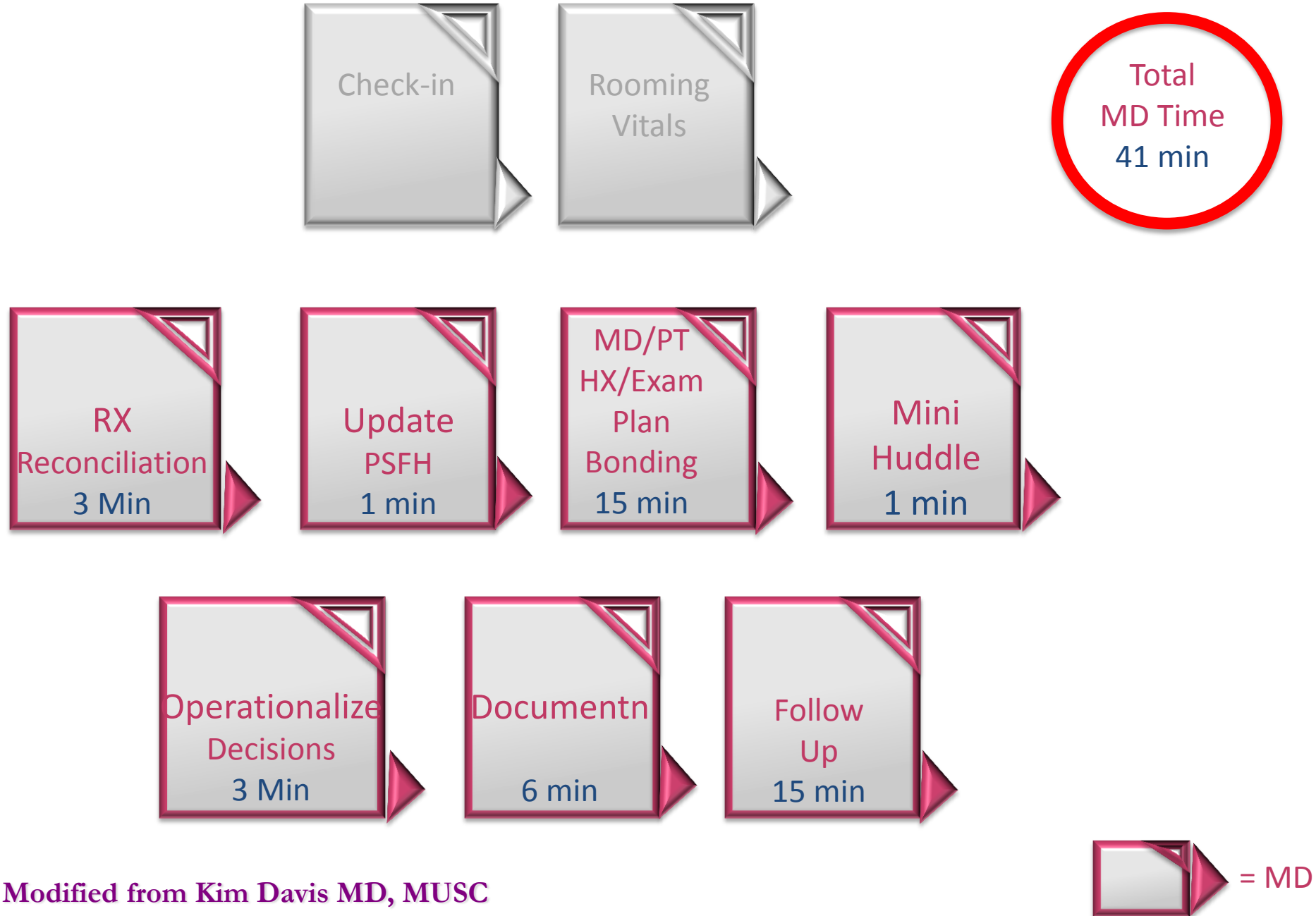




Current High Level Workflow

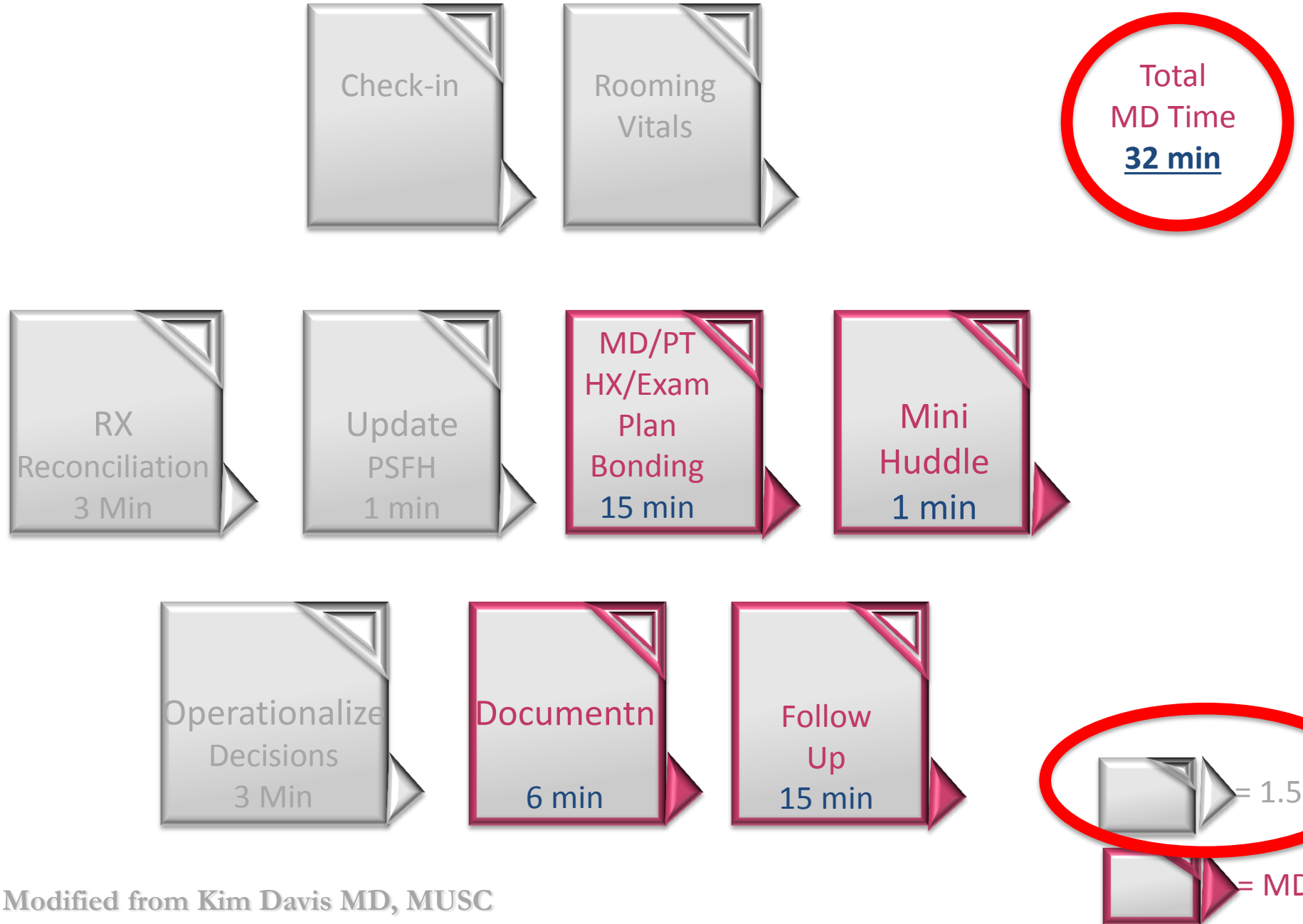


Primary Care Time Task Map



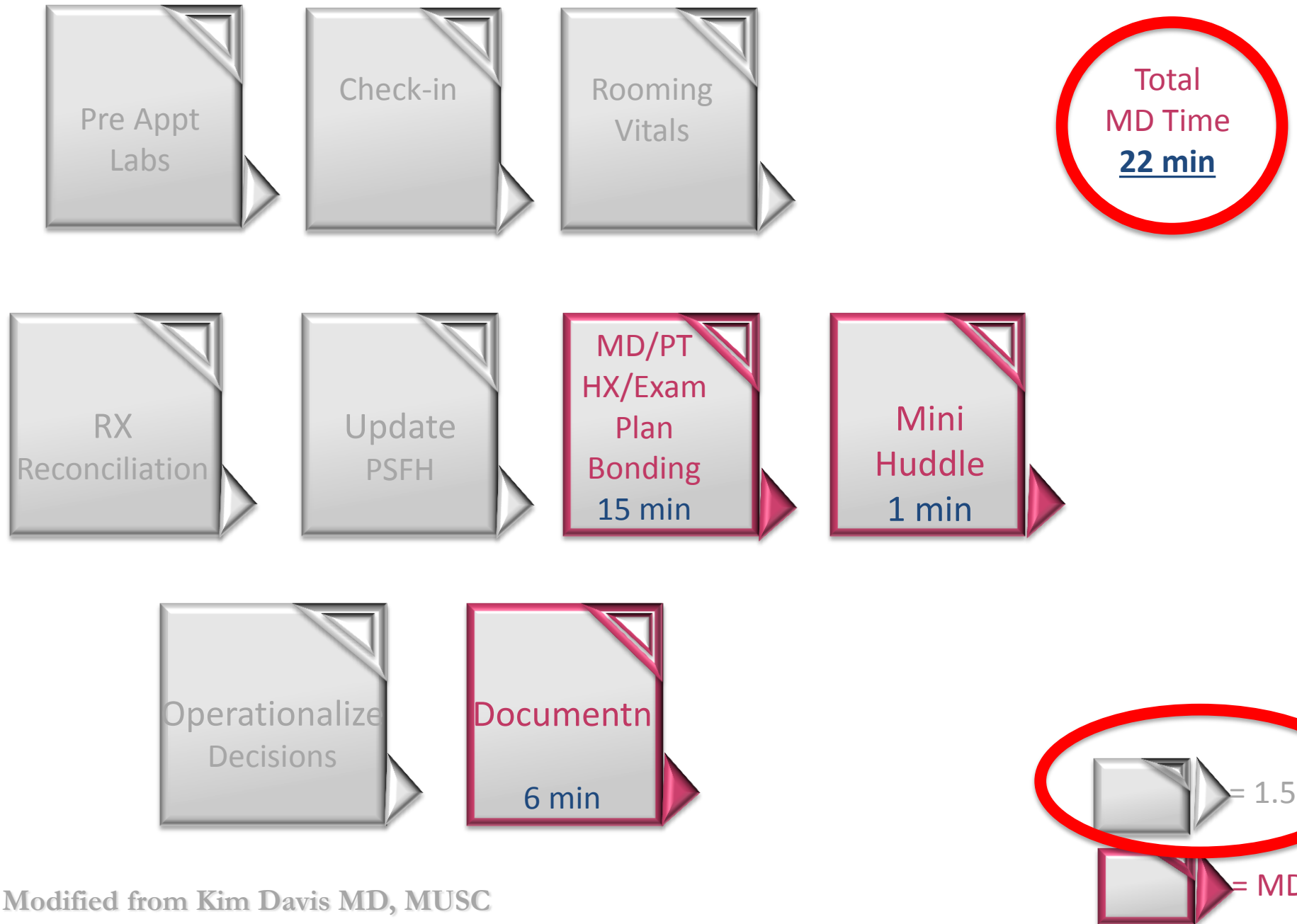
Modified from Kim Davis MD, MUSC

Add 1.5 MA



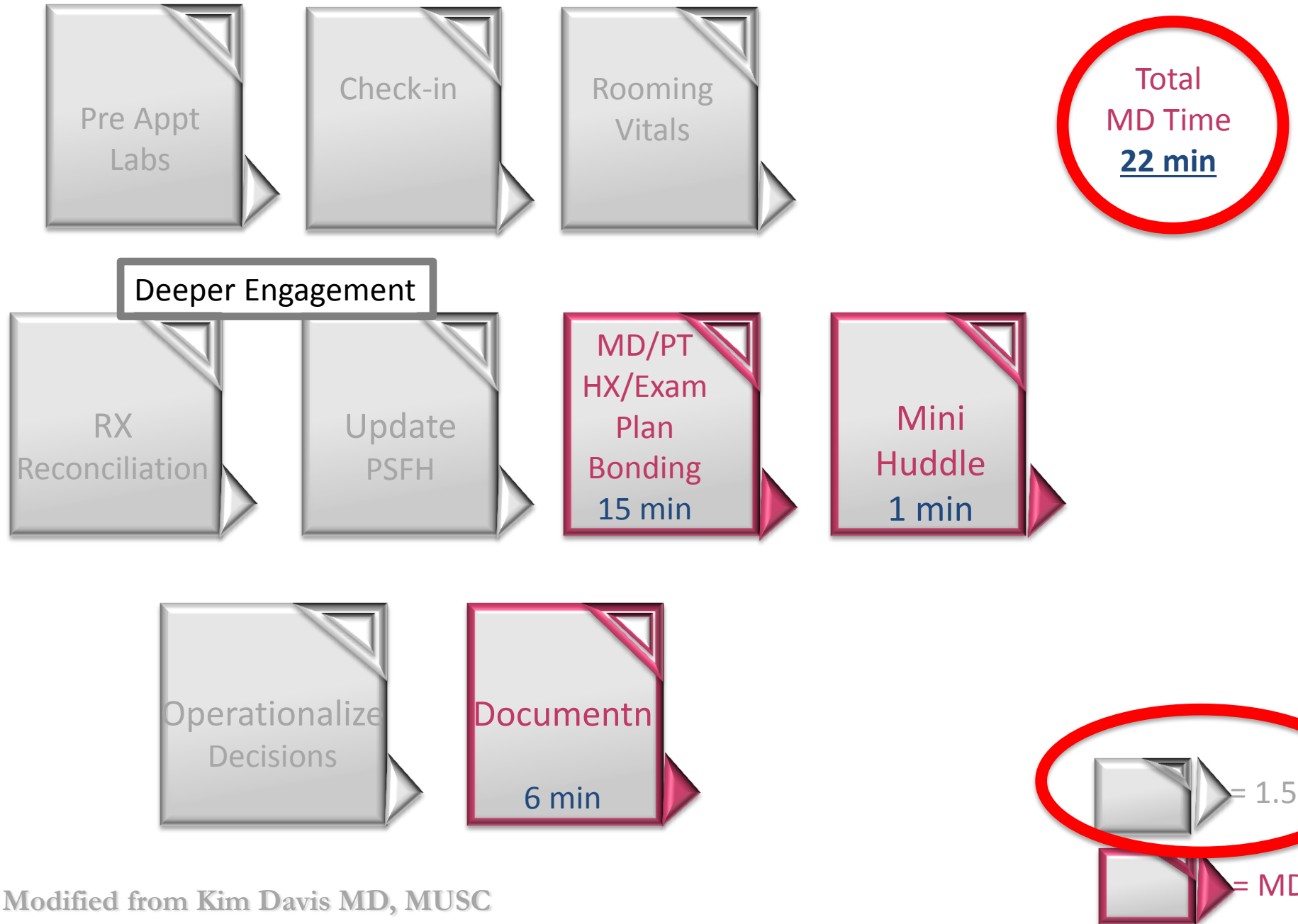
Modified from Kim Davis MD, MUSC

Do Today's Work Today



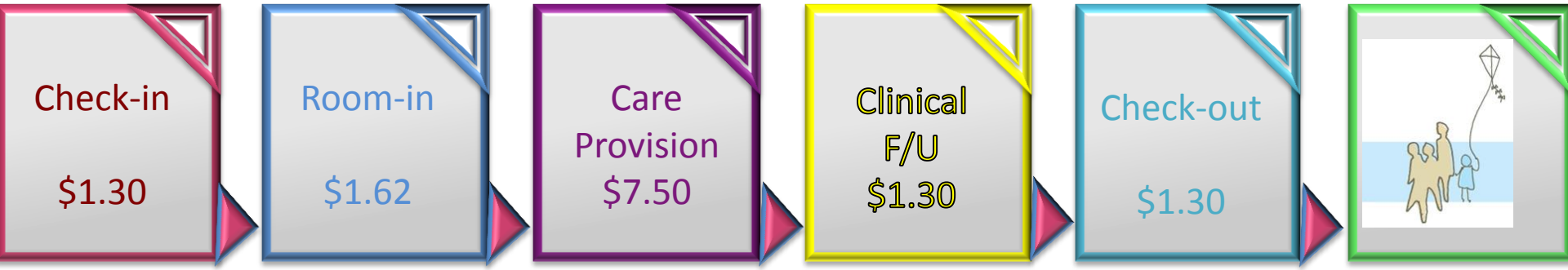
Modified from Kim Davis MD, MUSC

Staff Satisfaction Case



Modified from Kim Davis MD, MUSC

Visit Flow Value Chain: Cost/Minute



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COMMUNITY HEALTH CARE ASSOCIATION OF NEW YORK STATE

PRIMARY CARE DEVELOPMENT CORPORATION

Strategies Catalog

Strategies to create patient-centered, collaborative care teams

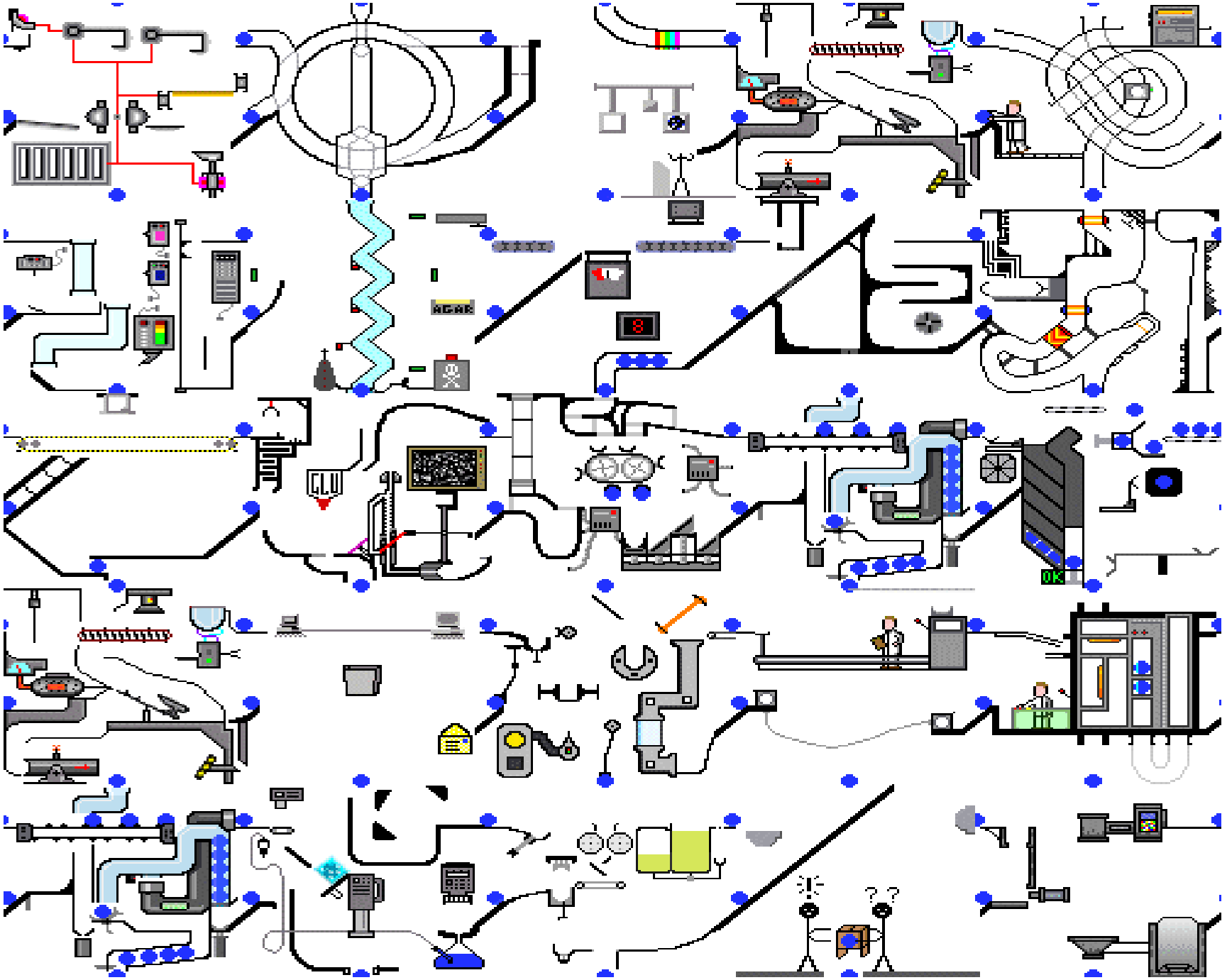
- Invite patient and family representatives to participate in the care team
- Promote excellent team communication daily and ongoing
- Proactively plan care for individuals and for the panel of patients by anticipating fluctuations in demand for care and planning needed care.
- The care team meets weekly to review processes of care and fine-tune roles and functions
- Provide regular feedback on process and outcome measures to the care team.
- Improve minute-to-minute communication by moving care team members into physical proximity.
- Optimize each person's role on the team based on the scope of practice, experience, skills, and abilities.
- Collaborate with community resources to improve the health of people in that com- munity.

Strategies to create patient-centered, collaborative care teams

Team Characteristics

- Close physical proximity
- The same group of staff working together each day
- Includes all areas needed to advance the visit – either directly or shared
- Everyone works to top of license to advance the care delivery and meet the patients needs
- Direct communication
- Sharing explicit accountability every day for a specific panel of patients

VI
Putting it all Together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Treatment $\neq$ Care

The Case Study

Activity Case Study

Something about our QI efforts is not right.
Our practice has a lot of diabetics. Quite a few are getting worse.
A lot are holding steady. And some are getting better.
We were hoping to get those out of control from HGa1C >=12 lowered without medication by using diet, group visits, etc.
Those at HGa1C =9 we were hoping to lower to 7 without meds as well.
Cannot seem to understand why our patients are not getting better.
How could a care team model possibly help this situation?
How could everyone's role be revised to help us remedy this situation?

Standing orders?
Templates?
Population Management?
Panels?
Registries?
Extended Team?

Note: working harder and faster is not a solution.

Work Plan Step 1 – The Problem

- ❑ Define the problem that will be improved by the care team
- ❑ What is the evidence to support the problem selection:
  - ❑ Adverse event due to breakdown in team skills
  - ❑ Near miss due to breakdown in team skills
  - ❑ Staff is concerned about the two above possibilities
  - ❑ What data do you have?
    - ❑ Outcomes
    - ❑ Anecdotal
    - ❑ Incident Reports
    - ❑ Surveys
    - ❑ Other

Work Plan Step 1 – Problem Location

- Identify in which process (clinical, visit, communication) the target problem occurs
  - For all processes
    - **What** process?
      - Visit – ☐ Pre-visit ☐ Visit ☐ Post-visit ☐ Between visits
      - Clinical
      - Communication
    - **Who** is involved in the "problem" process?
    - **When** does the problem occur?
    - **Where** does the problem occur (setting, site)

Work Plan Step 2 – Intervention Design

- ❑ Process improvement target is specific
- ❑ What do we want to achieve
- ❑ Who is involved
- ❑ Complies with (AHRQ, NCQA, JNC8, PQRS, P4P)
- ❑ Aligns with practice mission and vision
- ❑ Benefits
- ❑ Risks
- ❑ Evidence
- ❑ Measures (Key Performa
- ❑ Feasible (Technically, Ec
- ❑ Patient focused
- ❑ Integrates into current o
- ❑ Sustainable
- ❑ Includes a training plan
- ❑ Addresses human factor

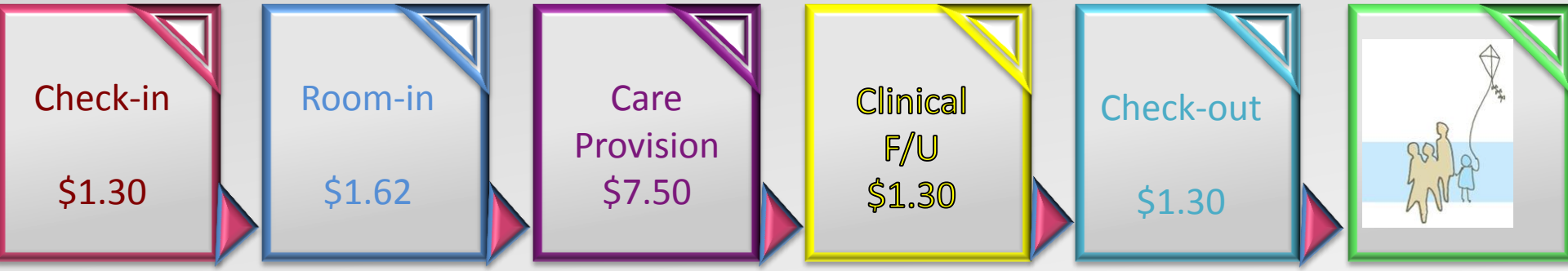
Human Factors Example:

o Simplifies procedures and protocols
o Standardizes equipment, procedures, protocols
o Minimizes reliance on memory
o Clarifies responsibilities and details task descriptions
o Ensures most qualified person performs each task
o Improves communication and information transfer between staff and between patients and staff
o Avoids excessive workloads
o Reduces handoffs

Work Plan Step 3 – Manage the Project

- ❑ Develop Implementation Plan

Visit Flow Value Chain: Cost/Minute



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When ‘I’ is
replaced by ‘We’

Even
‘Illness’
becomes
‘Wellness’

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Peter Cucchiara is the Managing Director of the Performance Improvement Practice for Primary Care Development Corporation (PCDC). He has built a performance improvement consultancy and led the development of a portfolio of assessment, implementation and evaluation life-cycle services around Patient Centered Medical Home, HIT/Meaningful Use and practice operations improvement.

PCDC has delivered these services throughout New York and around the country to hundreds of FQHCs and other primary care organizations. Currently the PCDC Performance Improvement Practice is delivering a unique set of integrated meaningful use and medical home adoption and evaluation services to primary care practices and consortiums nationally. Under Mr. Cucchiara's direction the Performance Improvement Practice has advanced its product and service lines to not only include assessment and implementation tools and methods but also to include the delivery of process and performance improvement evaluation and analysis services.

Peter Cucchiara is a senior HIT Executive with over 30 years of experience in adding value in small to mid-size private and public organizations by leveraging Health Information Technology as a catalyst for business growth. He leads efforts in strategic plan realization, business development, and in product and services development for many types of Healthcare and Healthcare Professional Services organizations. Further areas of experience include organizational embrace of technology, operations, Electronic Medical Records, primary care performance improvement and medical informatics.

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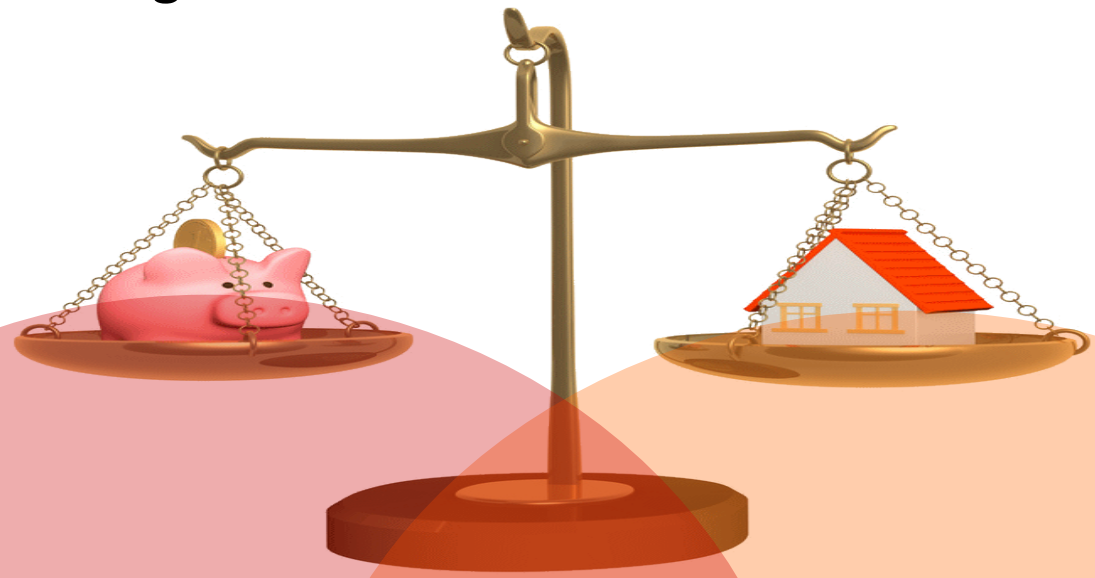
Dr. Rollow is Assistant Professor in Family Medicine and Director of Clinical Services at the Center for Integrative Medicine at the University of Maryland. Board-certified in family medicine, in integrative medicine, and with a master's degree in public health, he has an extensive background in primary care practice transformation, quality improvement, healthcare technology, medical management, managed care, federal government programs, and administration, having developed and led the EmblemHealth Medical Home High Value Network Project, directed the CMS group with responsibility for the Medicare Quality Improvement Organization and End Stage Renal Disease Networks programs, provided technology-based strategic and analytic consulting services at IBM, and held senior medical director positions at BlueCross BlueShield of Illinois and at Anchor HMO. Dr. Rollow seeks to promote transformation: in the lives of individuals through clinical care, in organizations through delivery system redesign resulting in improvements in outcomes and cost, and in communities through policy and practice that support health and wholeness

Appendicies

At Issue : Creating a care team driven visit that is reimbursable



Creating a visit that is **reimbursable** in a FFS world means getting $$$/provider touch

that is an **efficient**

Creating a visit

use of staff resources that through efficiency Manages costs

Is this a matter of apples and oranges?

How does reimbursement influence the structure of care teams and the structure of work?

Are hybrid practices an option?

The New York Times
SundayReview | The Opinion Pages

EDITORIAL

A Formula for Cutting Health Costs

¶**Assigning small teams** — consisting of a doctor, a nurse, and various medical, behavioral and administrative assistants — to be responsible for groups of 1,400 or so patients. The team members sit in the same small work area and communicate easily. When a patient calls, the nurse decides whether a face-to-face visit with a doctor or other health care provider is required or whether counseling by phone is sufficient. The doctors are left free to deal with only the most complicated cases. They have no private offices and the nurses have no nursing stations to which they can retreat.

¶**Integrating a wide range of data to measure medical and financial performance**. Southcentral's "data mall" coughs up easily understood graphics showing how well doctors and the teams they lead are doing to improve health outcomes and cut costs compared with their colleagues, their past performance and national benchmarks, and it provides them with action lists of what they can do to improve and mentors to guide them. That almost always spurs the laggards. One doctor whose team ranked well behind 10 others in scheduling annual eye exams for diabetics jumped to first place within two months once she became aware of how poorly her team was performing.

¶**Focusing on the needs and convenience of the patients** rather than of the institution or the providers. The facilities feature rooms where providers and families can chat as equals on comfortable chairs, in sharp contrast to examination rooms where a doctor looms over a patient. Every patient visit is carefully planned so the patient can get in and out quickly without being delayed because, say, a needed lab test result is not available.

¶**Building trust and long-term relationships** between the patients and providers.

¶**Changing from a reactive system** in which a sick patient seeks medical **care to a proactive system** that reaches out to patients through special events, written and broadcast communications, and telephone calls to keep them healthy or at least out of the hospital and clinics.

What Is an Integrated Practice Unit?

1) An IPU is organized around a medical condition or a set of closely related conditions (or around defined patient segments for primary care).

2) Care is delivered by a dedicated, multidisciplinary team of clinicians who devote a significant portion of their time to the medical condition.

3) Providers see themselves as part of a common organizational unit.

4) The team takes responsibility for the full cycle of care for the condition, encompassing outpatient, inpatient, and rehabilitative care, and supporting services (such as nutrition, social work, and behavioral health).

5) Patient education, engagement, and follow-up are integrated into care.

6) The unit has a single administrative and scheduling structure.

7) To a large extent, care is co-located in dedicated facilities.

8) A physician team captain or a clinical care manager (or both) oversees each patient's care process.

9) The team measures outcomes, costs, and processes for each patient using a common measurement platform.

10) The providers on the team meet formally and informally on a regular basis to discuss patients, processes, and results.

11) Joint accountability is accepted for outcomes and costs.

Defined Goals
Overall organizational mission statement
Specific, measurable operational objectives

Systems
Clinical systems
Administrative systems

Team Characteristics Division of Labor/Roles
Clear definition of tasks
Clear assignment of roles

Training
Training for the functions that each team member regularly performs
Cross-training to substitute for other roles

Communication
Communication structures
Communication processes
Communication Styles

Panels and Visits

What do I Need to Do My Work?

Clinical systems

Examples :

- EMR
- HIE
- Standing Orders
- Registries
- Procedures for providing prescription refills
- Procedures for informing patients of laboratory results
- Clinical Decision Support (Alerts/Reminders)
- Chronic Disease and Preventive Care Templates

Administrative systems

Examples :

- Stratifying Patients By Risk
- Community Resource
- Incentives

What critical CHC processes need systems support to optimize performance?

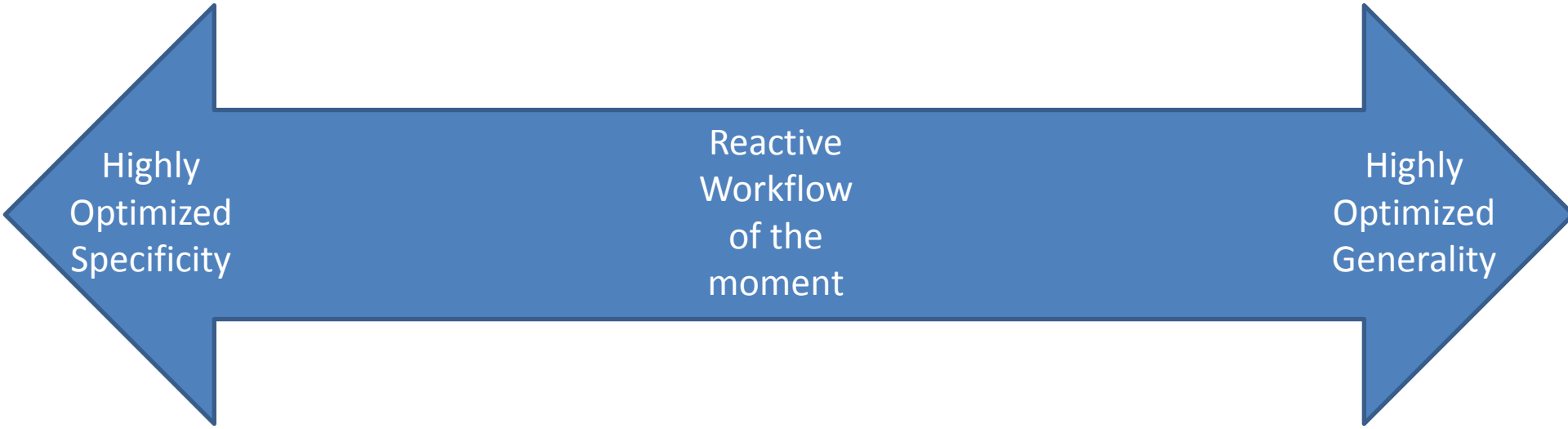
- Front desk activities. - Scheduling must facilitate access and continuity. Collections and billing must optimize finances.
- Clinical encounters. - Information must be readily available to maximize clinician productivity.
- Panel management. Patients needing outreach must be identifiable; outreach must be automated.
- Transitions management. Information from hospitals and EDs must be received and integrated with care coordination workflow.
- Specialty care coordination. Information from specialists, including mental health and social services providers, must be received and integrated with care coordination workflow.
- Care planning. A care planning application must be able to uptake data from other sources, provide condition-specific intervention/self-management recommendations, receive patient input, prompt for subsequent care management, and support care plan revision.

Care Team Hazards to avoid

Team care can also result in **fragmentation** of communication, continuity, and accountability. This fragmentation can result in a **degraded experience** of care and **worse outcomes** for the patients served .

Optimizing roles to such a degree that a team member might impede workflow by saying, "That is not my job." At the other extreme, team members perform work that should optimally be provided by another team member. Both can lead to bottlenecks.

Failure to reorganize the care team's work to better match each individual's licensure and scope of practice.



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In Search of Joy in Practice
A Site-visit Analysis of Twenty-three Highly Functional Primary Care Practices

Christine A. Sinsky MD, Rachel Willard MPH, Andrew M. Schutzbank MD, Thomas A. Sinsky MD, David Margolius MD, Thomas Bodenheimer, MD

"Working at Starbucks would be better" Primary Care Physician, 2008

"I look forward to going to work each day. I'm loving it!" Same primary care physician, 2011

Demand

Scope of Access

- Schedule Availability
- Same Day Appointments
- TNAA
- Cycle Time Reduction
- No Shows
- Pt. Satisfaction

- Information
- MD messaging
- Telemedicine
- Specialty Medicine