KANSAS PRACTICE TRANSFORMATION NETWORK

Creating a Culture of Engagement & Transformation

A COMPASS PTN LEARNING EVENT
SEPT 12, 2018
SALINA, KANSAS

Today's feature presentations will be available online, as received, at
www.KHConline.org/PTN2018

Kansas Healthcare Collaborative

Transforming health care through patient-centered initiatives that improve quality, safety, and value

- *Provider-led 501(c)3 organization.*
- *Founded in 2008 by the Kansas Hospital Association and the Kansas Medical Society.*
- *Resource for continually improving care delivery.*
- *Trusted source for relevant and meaningful QI education, evaluation, and measurement.*

Kansas Healthcare Collaborative

Transforming health care through patient-centered initiatives that improve quality, safety, and value

Vision

KHC will be THE trusted source for relevant and meaningful health care quality improvement education, evaluation and measurement.

KHC Mission

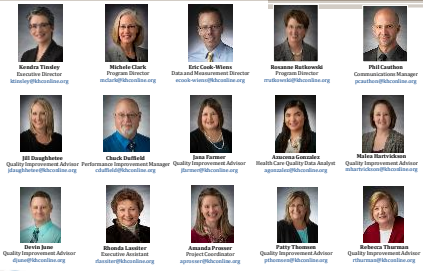
Engaging and aligning providers and stakeholders to establish Kansas as a role model for health care quality and a top-performer in health care outcomes.

Kansas Healthcare Collaborative

Transforming health care through patient-centered initiatives that improve quality, safety, and value

Values

- *We believe those who deliver health care are responsible for leading quality improvement.*
- *We believe collaboration leads to developing, sharing, teaching and learning effective approaches proven to deliver the best possible health care.*
- *We believe effective utilization of meaningful, patient-oriented analytics and objective reporting promotes excellence in health care.*



UP NEXT

Effective Strategies for Team-Based Care

- Kirsten Meisinger, MD, TCPI National Faculty

Effective Strategies for Team-Based Care

The Cambridge Health Alliance
September, 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

Goals for the Session

Discuss effective strategies for creating a strong team culture with well defined roles for each team member

Evolving the template to match the work: one foot in each canoe

Developing Your own Structures: In-reach vs. Outreach

Team

In a patient-centered medical home, it is about the **patient**—and all the people a patient needs to support their care.

Team-based care means that everyone - from folks who register a patient to nurses - focus on the patient, not the doctor visit.

*The patient-centered medical home is about the **entire team** contributing to the care of a patient by developing independent relationships with patients.*

Common Elements exhibited by 29 High-Performing Primary Care Practices

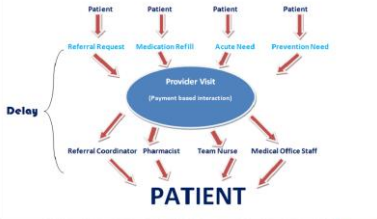
Table 1
The Elements of High-Performing Team-Based Care

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

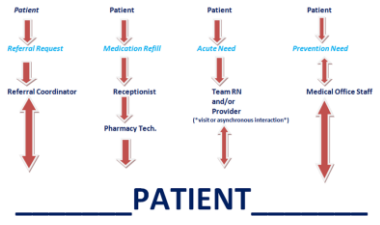
How Payment Methods in Healthcare Affect Care Delivery

Workflows in Fee for Service



How Payment Methods in Healthcare Affect Care Delivery

Workflow with Value Based Payments



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

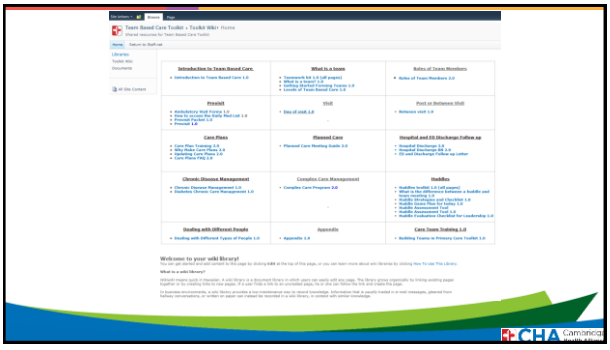
© The Center for Excellence in Primary Care

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.

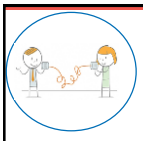
How to strengthen our team

~sharing the care~

Establish and provide **organizational support** for care delivery teams accountable for the patient population/panel
Link patients to a provider and care team so both patients and provider/care team recognize each other as partners in care
Ensure that patients are **able to see** their provider or care team whenever possible
Define roles and distribute tasks among care team members to reflect the skills, abilities and credentials of team members



Team Communication



Every idea matters

Don't criticize

Combine and build on ideas of others

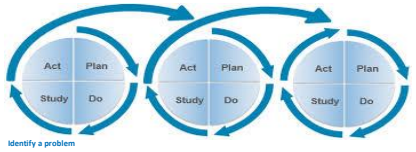
Creating opportunities for team communication throughout the day

- Huddles
- Co-location
- Structured team meetings

Role of Performance Improvement

Choose and use a **formal model** for quality improvement
Establish and monitor metrics to evaluate improvement efforts and outcome; ensure all staff members understand the metrics for success
Ensure that patients, families, providers and care team members are **involved in quality improvement** activities
Optimize use of **health information technology**

Performance Improvement can help drive culture change



Identify a problem

Quantify the problem

Identify stakeholders

Design a workflow

Test the workflow

Analyze the results

Test it again……

What do I Need to do This?

A Real Life Example: Health Care Proxy

New Workflow send to leadership

Leadership shares workflow with whole staff via email

Fully intend to discuss at meeting that week – doesn't happen!

Medical Assistants take workflow and start using it

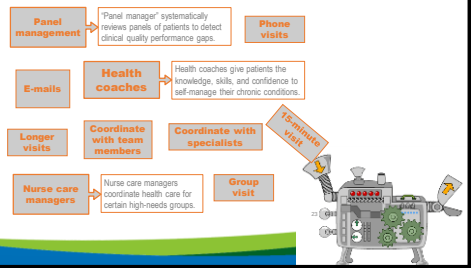
Request feedback over email and in person from providers

Email conversations for 1 day, workflow continuously adjusted

Final workflow presented to leadership (in writing!) 2 days later

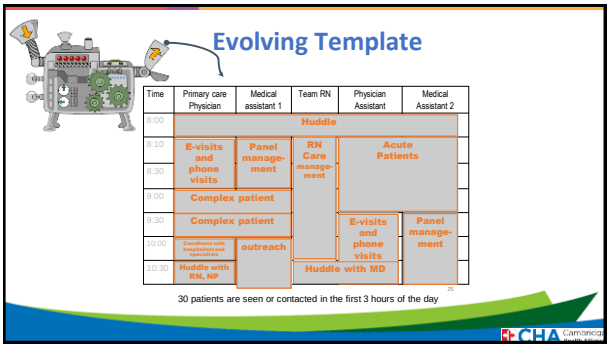
Reaction of the Leadership Team

How we take care of our panel NOW



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



Define and Design the Team

- Provider, MA, RN, PA, Receptionist, LPN
- Non-hierarchical
- Involves everyone as an expert, including the patients!
- Co-Location ideal
- Well defined workflows: Pre-visit, During Visit, Between Visit

Real-world solutions to enhance practice effectiveness - STEPS Forward. (n.d.). https://www.stepsforward.org/

This is what a day looks like without team support:

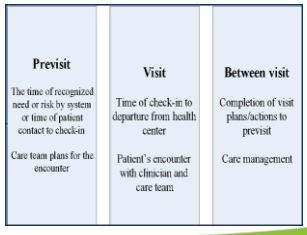
Acute Care	4.6 hours/day
Preventive Care	7.4 hours/day
Chronic Care	10.6 hours/day

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

Redesigning Care Delivery:



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, Therapist and MD)

Regional

Family Planning

Complex Care (Nurse and Social Worker)

Pharmacist

Nutrition

Panel Manager (Planned Care Coordinator)

Other Resources:

Central refill process through the OP pharmacy

System wide team members

Central Complex Care Team (Social Worker and CHW)

Hospice/Palliative Care Team

Visiting Nurse/SNF/Aging agencies

Community Mental Health

Specialty Partners (econsults, chart reviews, televisits)

Patient Team Members

Patient Partners - two per practice

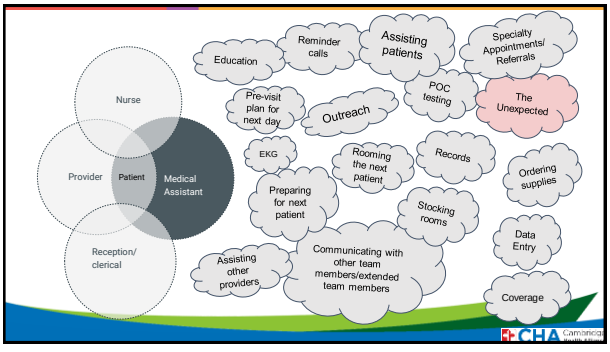
Patient Family Advisory Councils

Designing the Core Team: Roles Clearly Defined

Role of the Receptionist

- First impression of care - sets the tone for the whole visit
- Initiates the care someone receives with contact information, patient portal initiation, screenings for the visit
- Previsit work done ahead of time or at the time of the visit if same day
- Care coordination for the visit and after the visit - person to person and over the phone with calls
- Professionalization of this role is essential to the patient experience!

Designing the Core Team: Medical Assistant



Role of Nursing

Patient and team facing

RNs are chronic disease management leader: panels include everyone not at goal or with abnormal screening test (Pap, PSA etc.)

Triage/Walk-ins

Hospitalization and ER follow ups (48 hr phone call, visit within 7 days)

Team supervision

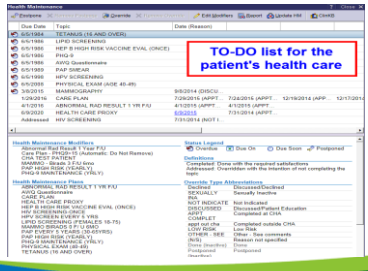
Before the Session

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

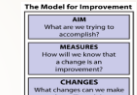
Each PIT is partnered with two patients

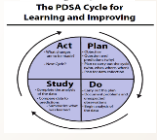
Mandate to pursue improvement initiatives at a site level

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

- 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 AQG 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

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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

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

In Between Visits

Team meetings

Outreach

- Tracking registries eg. mammo, colon screenings, HTN
- Every team member has a "panel"

Follow up and care coordination in teams

Provide appropriate patient education

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

Epic Report Used: My Loc Pts w/ Diabetes

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

Operational Strategy: Agree on care actions for patients in need

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.

o PCC monitors and supports team

Operational Strategy: Deploy & monitor planned care actions

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PCM Sample Workflow: Hypertension

1 Before PCM
- MAs identify/review patients who need a BP test
- RNs identify/review patients with high BP

Epic Report Used: My Loc Pts w/ Hypertension

2 At PCM
- Care team meets to review HTN patients
- Team agrees on patients who require outreach for tests, BP follow ups, or other
- Snapshot, HM, etc. updated as needed
- Team reviews quality dashboard

Operational Strategy: Agree on care actions for patients in need

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.

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Operational Strategy: Deploy & monitor planned care actions

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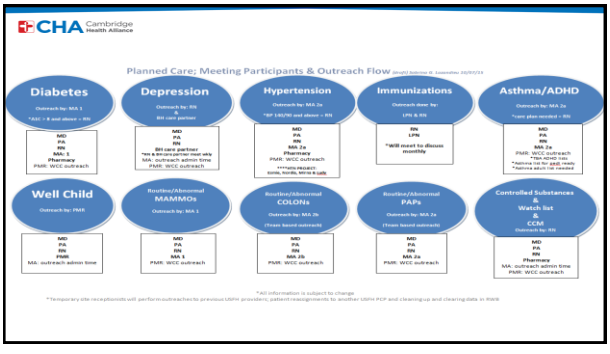
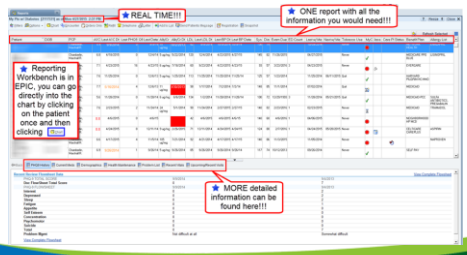


EPIC Diabetes Registry: Reporting Workbench



How do we sustain the team-based model of care?

- Engaged Leadership who provides consistent messaging
- Strong Team relationship
- Consistent team scheduling
- Communication across team members
- Regular meetings
- Well defined roles/expectations
- Celebrations/accomplishments

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 85th percentile (2018)

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

Takeaways

- Implement a Performance Improvement structure so all work ultimately gets done in team
- Clearly define roles so the work becomes joyful and the focus is on our patients
- What to do on Tuesday?
  - Optimize your huddle with pre-visit work done by the team
  - Establish team meetings to drive performance
  - Consider establishing a Practice Improvement team

¿QUESTIONS?