Improving Quality: Enhancing Team-based Care

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What do Patients Need to Optimize Outcomes?

- Drug or other treatment that gets them safely to their therapeutic goals
- Effective self-management support
- Preventive interventions at recommended time (planned interactions)
- Evidence-based monitoring and self-monitoring
- Follow-up tailored to severity (proactive follow-up and care management)
- Effective care coordination and shared care

What does the nation need to reduce health care costs?

A More Robust Primary Care Sector that can:

- Reduce avoidable hospital admissions and readmissions.
- Reduce avoidable emergency room visits.
- Take better care of the chronically ill including mental illness.
- Reduce the rampant fragmentation of care.

Primary Care on the ropes?

- 2006 -Primary Care: Will It Survive

What to do?

The future of primary care (and our healthcare system) depends upon

- its ability to improve quality (first aim) and reduce costs (second aim), especially for the chronically ill and “complex” patients.
- it’s recommitment to meet the needs of patients for timely, patient-centered, continuous and coordinated care (third aim--improve patient experience).
- making primary care a more attractive career path (fourth aim).
- **major transformation or redesign of practice**, not just an EMR and better reimbursement.

A New Model to Save Primary Care?

The Patient-centered Medical Home -- 2007

Building a PCMH

Safety Net Medical Home Initiative – www.safetynetmedicalhome.org

+NCQA Patient-Centered Medical Home 2014 Standards

**The 10 Building Blocks of High -Performing Primary Care*. Tom Bodenheimer, et al. Annals of Family Medicine. March/April 2014.

PCT-LEAP Project goals:

1. **Select 31 innovative primary care practices that can serve as models for improving primary care teams.**
2. **Visit and study each practice for 3 1/2 days**
3. **Summarize what we learn in a web-based Guide.**
4. **Disseminate the Guide to practices involved in practice transformation, and evaluate.**

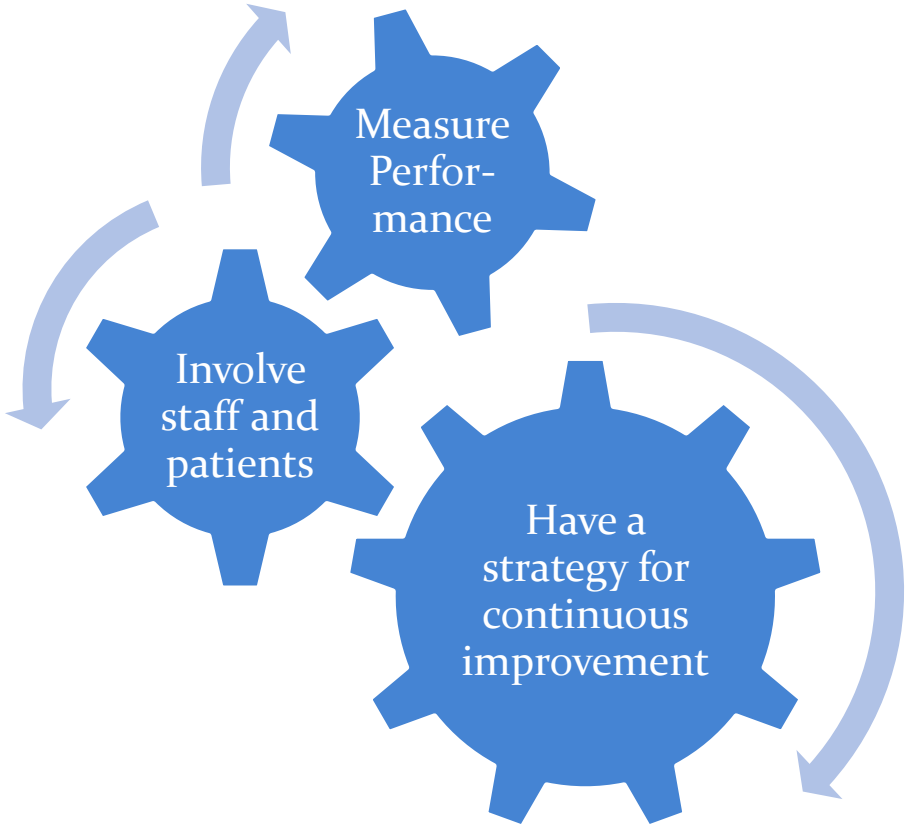
What are we learning from high-performing practices?

- Successful practices view performance as a system property, not a function of how smart everyone is.
- Successful practices carefully measure performance and regularly review it.
- Successful practices are constantly trying to improve their metrics.
- Successful practices have the will, the ideas, and the execution to change.

Transforming practices involve staff (and even patients) in QI strategies

Practices that have improved:

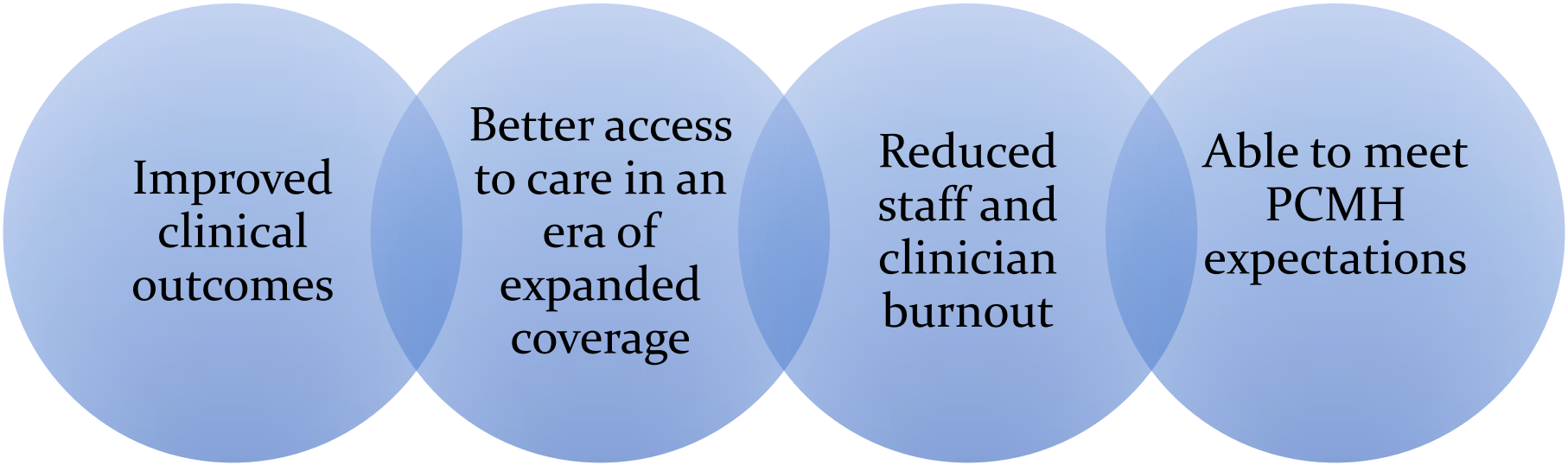
- Routinely measure performance
- Broadly engage staff and patients in the improvement process—both design and execution.
- Have a strategy for continuous improvement and a culture that supports it.



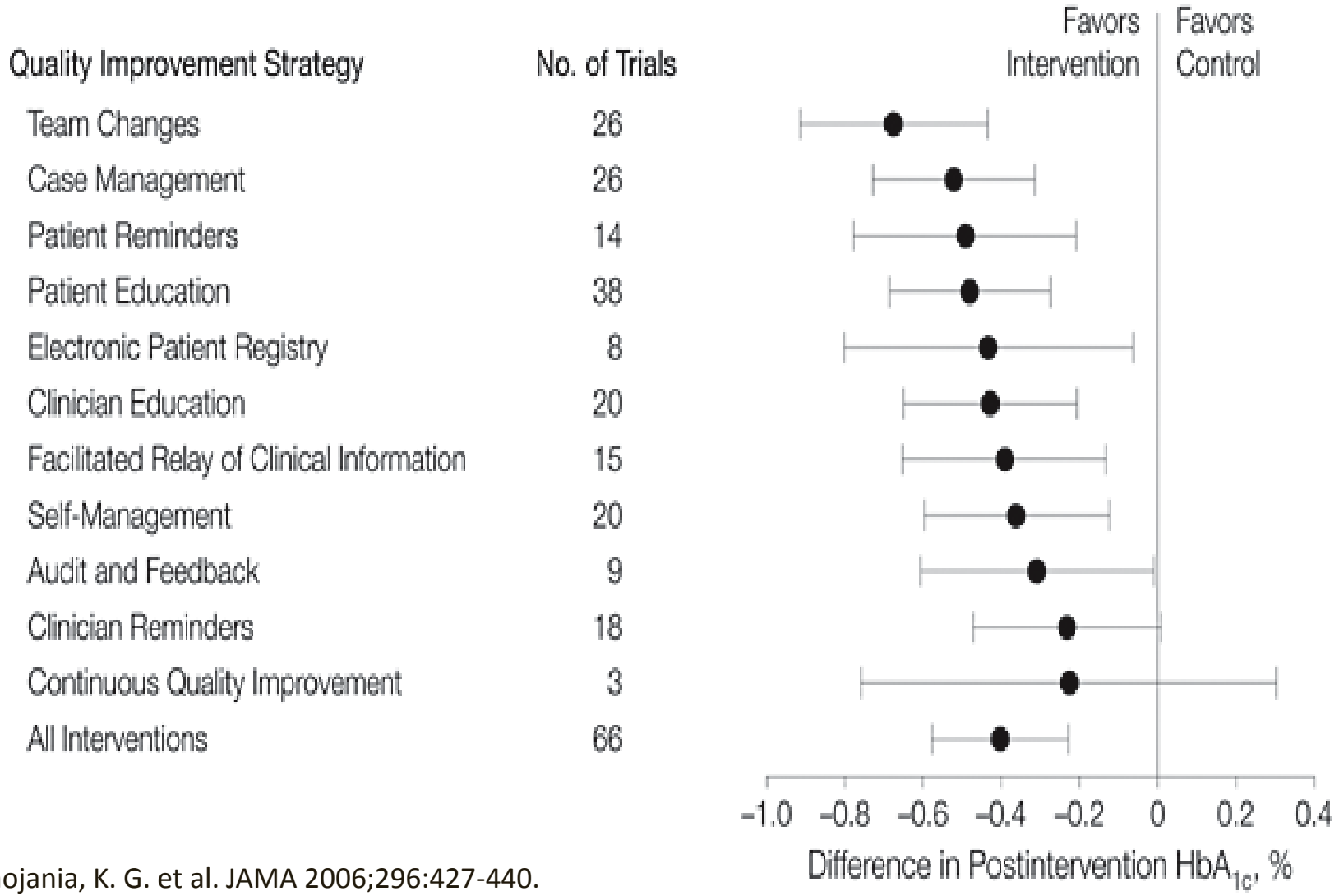
Does measurement work? A testimonial.

- Measurement focus drives board meetings, staff meetings, strategic planning and where we focus management energy
- Staff engagement measurably increased after measurement focus
- Staff turnover decreased from 31.9% (2007) to 15% (2009) to 6% (2010)

Why primary care teams?



Teams improve outcomes



Shojania, K. G. et al. JAMA 2006;296:427-440.

Teams expand access

Type of care	Percent of physician's time in traditional practice	Estimated percent of physician's work that can be reallocated to non clinicians	Estimated percent of physician's time saved
Preventive	**17**	**60**	**10**
Chronic	**37**	**25**	**9**
Acute	**46**	**10**	**5**
Total	**100**	**—**	**24**

Thomas S. Bodenheimer and Mark D. Smith: Primary Care: Proposed Solutions To The Physician Shortage Without Training More Physicians, *Health Affairs*, 32, no.11 (2013):1881-1886

Teams improve patient AND provider experience

"Multiple elements related to team function were positively correlated [with clinical] quality, patient satisfaction, and clinician satisfaction."

Day et al. Ann Fam Med 2013; 11,Supp1: 550-9.

Teams enable practices to perform the functions/activities expected of a PCMH

- Engaged Leadership
- QI Strategy
- Empanelment
- **High-performing teams**
- Supportive IT

- Planned Care
- Self-management Support
- Medication Management
- Population Management
- Care Management/ Follow-up
- Referrals & Transition Mgt.
- Behavioral Integration
- Community Linkages

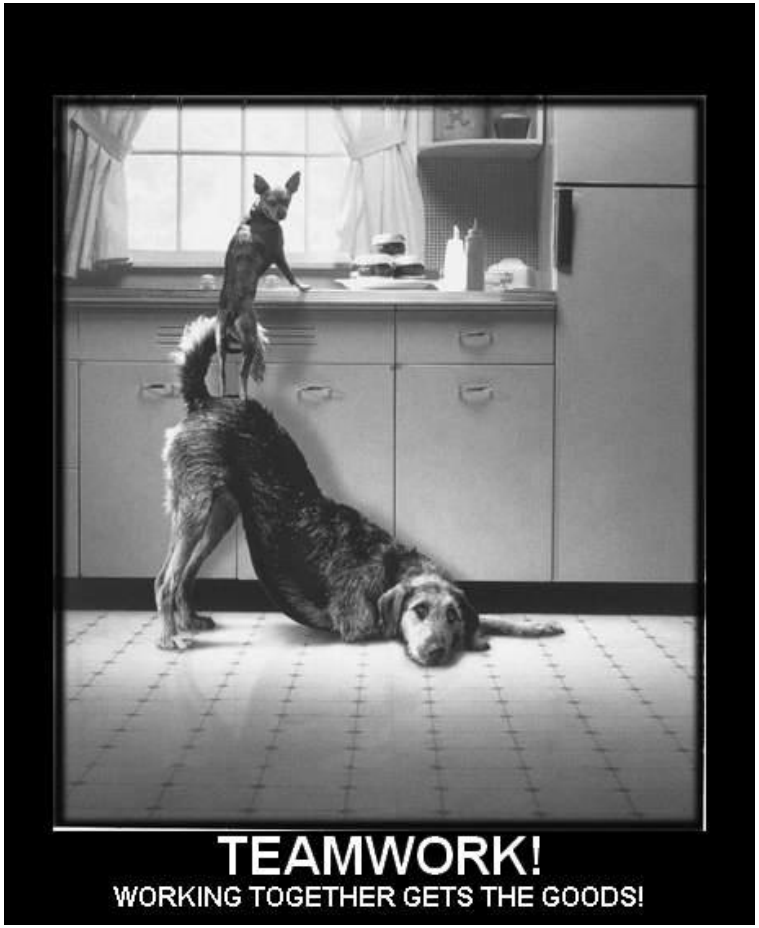
- Improved Health
- Improved Patient Experience
- Reduced Total Costs
- Improved Staff Experience

Major Findings from Site Visits:

- Sites have well-developed core teams surrounded by An extended team with care mgrs., pharmacists, behavioral health, etc.
- Traditonal roles are extended so everyone is working at the "top of their license"
- Staff play major patient care roles and are encouraged to develop personal relationships with patients..

What have successful practices done to create effective teams?

- Hire bright, energetic folks with good interpersonal skills.
- Define roles and tasks and distribute them among the team members.
- Give teams time to meet.
- Train staff to perform tasks and monitored performance.
- “Hire for attitude, train for skills”.



Building Effective Teams

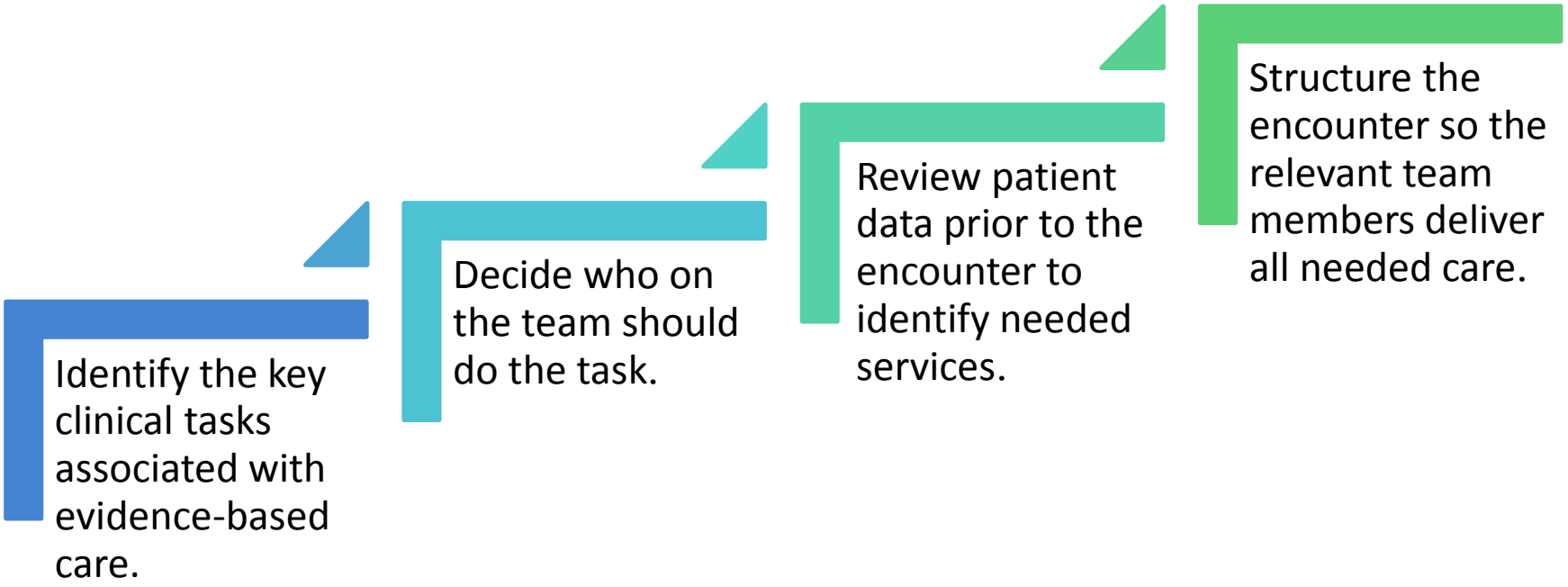
- Co-locate
- Meet regularly: daily huddles to plan the day's care, and scheduled full team meetings to discuss issues and new developments, review metrics, and celebrate successes.
- If the provider is doing all the talking, consider structured team building activities.

A day in the life of a high-performing PCMH

Population Management

- Staff are continuously identifying and trying to close care gaps
- Panels have been defined and staff use IT tools to identify care gaps.
- Done by MAs pre-visit, and by a variety of staff for reviews of various populations.
- Staff reach out to patients with care gaps. (Has major impact on performance metrics).

Steps for planned care



How do successful teams implement self-management support

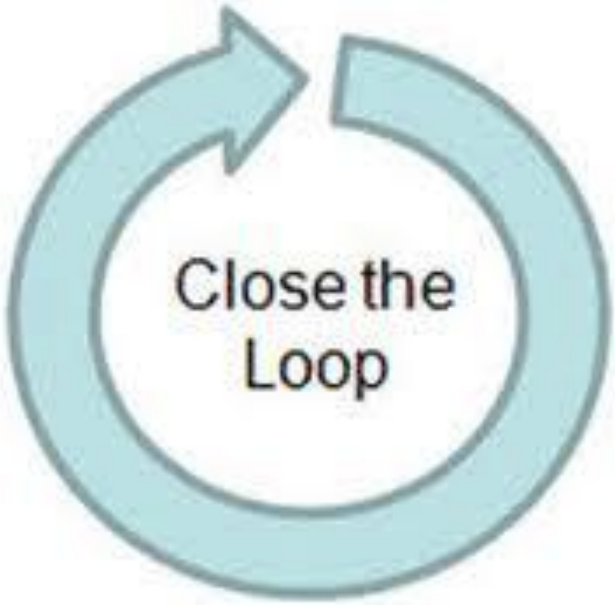
Forge	linkages with self-management programs in the community.
Organize & train	Health coaches (MAs, laypersons, RNs) to provide basic self-management support.
Build	self-management support into every interaction.
Document	self-management goals and their attainment in the patient's record.

Medication Management

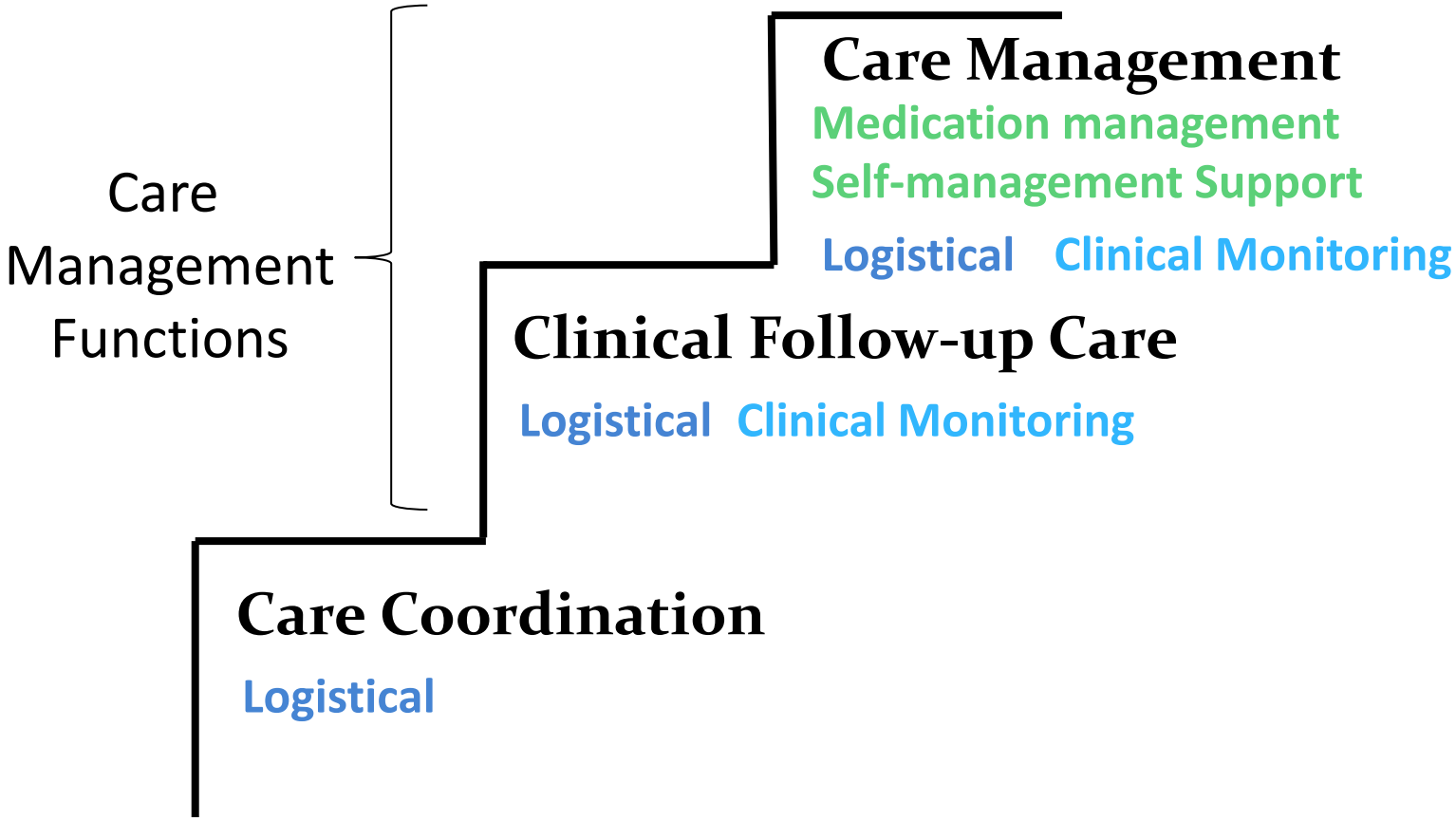
- Protocol-based prescribing and monitoring of adherence and outcomes is associated with better outcomes.
- LEAP sites view medication reconciliation as a critical intervention for both patient and practice.
- Pharmacists and RNs play important roles in complex med. rec., titrating medications, and addressing non-adherence and other drug problems.

Successful practices monitor and support their patients when they leave the practice.

- Many patients need monitoring beyond what can be done in office visits.
- Many patients need services beyond what can be provided in the clinic.
- A few patients need clinical management beyond what can be done in office visits.



Relationship between care coordination & care management activities in primary care



Care management

Providing follow up, clinical management, and self-management support to patients outside of clinic visits.

Services and intensity of services vary with the severity of the illness.	Provided by a staff person for lower risk patients and by a nurse or other health professional for high-risk patients.	Works best when the care manager: • Is an integral member of the practice team • Can influence drugs • Has clinical support structure.

Behavioral Integration

Primary care team and a behavioral health team form one “integrated care team” and together share accountability for the total health care needs and outcomes of a panel of patients. They work together to provide the majority of mental health care in the primary care setting.

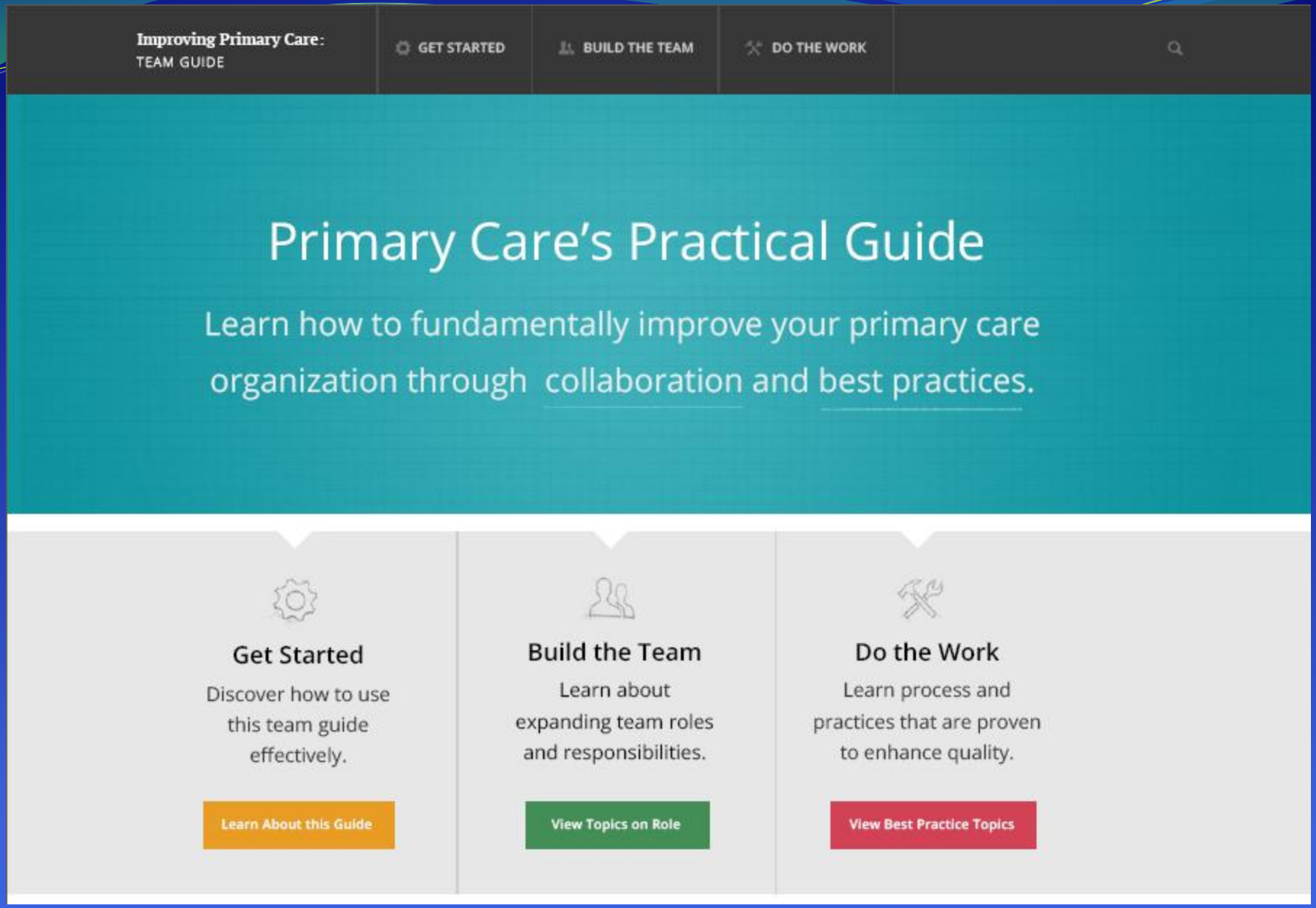
1. Collaborative Care
- Evidence-based management of major depression and other chronic disorders
- Care remains in PC supported by a care manager (RN or MA) in the practice and BH consultant including medication expertise

2. Crisis Management and Brief Therapy
- Provided by accessible on-site or affiliated BH specialist

3. Substance Abuse Treatment

Primary Care Team Guide
www. Improvingprimarycare.org

- Material presented in modules: the practice team, the people (MA, RN, etc.), the work (the functions like population management)
- Each module includes: a brief assessment, brief text emphasizing actions, a variety of resources and tools (job descriptions, training materials, protocols, videos, case studies).
- Now includes 0ver 200 tools.


Improving Primary Care:
TEAM GUIDE
GET STARTED
BUILD THE TEAM
DO THE WORK
Primary Care's Practical Guide
Learn how to fundamentally improve your primary care organization through collaboration and best practices.
Get Started
Discover how to use this team guide effectively.
Learn About this Guide
Build the Team
Learn about expanding team roles and responsibilities.
View Topics on Role
Do the Work
Learn process and practices that are proven to enhance quality.
View Best Practice Topics

A Guided Tour of the Guide

- https://www.youtube.com/watch?v=hx-2IBBnyfk

Is practice in a LEAP site more satisfying?

	All staff	Physicians
Most people in the practice enjoy their work	79% agree	84% agree
This practice is a place of joy and hope	64% agree	69% agree
People in our practice actively seek new ways to improve	92% agree	94% agree