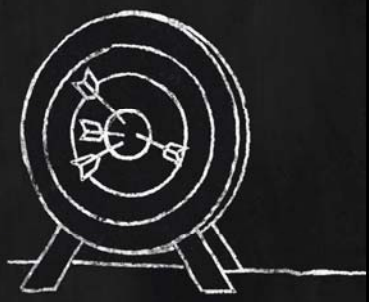
Critical Access Hospital and
Rural Health Clinic Conference

Focusing on the Quadruple Aim

Empowering Patient Care Teams for Excellence

September 13, 2017



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Learning Objectives

- Review the widening circle of team members to ensure a clinical and financial continuum
- Understand the concept of empowerment to drive efficiency, staff cohesiveness, enhanced morale and joy in the workplace
- Discuss opportunities to focus performance improvement efforts to address population health and Pay-for-Performance

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Build an Action Plan . . .

List the steps necessary to advance your work as TEAMS	Person responsible (Who)	When	Where
1.			
2.			
3.			
4.			
5.			

 3

Agenda – 1:00 to 2:30 pm, 2:45 to 4:30 pm

- Introductions
- Overview of the Workshop
- The Evolution to Team-Based Care
- The Roles of the Multidisciplinary Patient Care Team
- The Key Concepts for Leaders
- Linking the Care Team to QI
- The Wrap

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The Evolution of Care Teams

Reinventing the US Health Care Delivery System

SAFE	Avoiding injury to patients from care
EFFECTIVE	Providing evidence-based services and avoiding under/overuse when it is not likely to benefit
PATIENT-CENTERED	Providing care that is respectful of and responsive to individuals' preferences, needs and values, and ensuring patient values guide all clinical decisions
TIMELY	Reducing waits and harmful delays for both those who give and receive care
EFFICIENT	Avoiding waste of equipment, supplies, ideas, energy and staff
EQUITABLE	No variance in quality because of a patient's personal characteristics such as gender, ethnicity, geographic location, or socioeconomic status

Source: Crossing the Quality Chasm, Institute of Medicine, 2001

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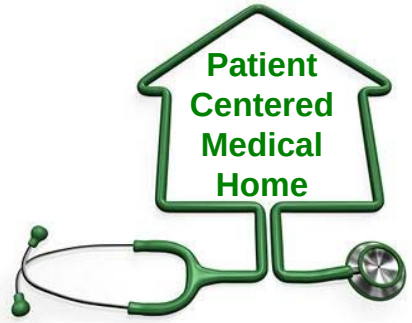
Joint Principles of the PCMH Model

- Personal physician
- Physician-directed medical practice
- Whole person orientation
- Care is coordinated and/or integrat
- Quality and safety are hallmarks
- Enhanced access
- Payment reform



Endorsed February 2007 by AAFP, AAP, ACP, AOA

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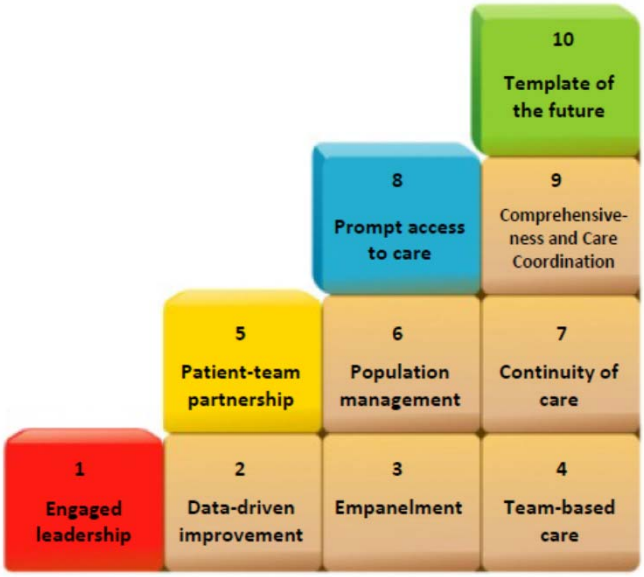
High Performing Primary Care



Source: Tom Bodenheimer, et al; UCSF Center for Excellence in Primary Care, 2011

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Principles of Team-Based Health Care

- **Shared goals:** The team works to establish shared goals that reflect patient and family priorities, and can be clearly articulated, understood, and supported by all team members.
- **Clear roles:** There are clear expectations for each team member's functions, responsibilities, and accountabilities, which optimize the team's efficiency and often make it possible for the team to take advantage of division of labor, thereby accomplishing more than the sum of its parts.
- **Mutual trust:** Team members earn each others' trust, creating strong norms of reciprocity and greater opportunities for shared achievement.

Source: Core Principles and Values of Effective Team-Based Health Care, Institute of Medicine, October 2012

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Principles of Team-Based Health Care

- **Effective communication:** The team prioritizes and continuously refines its communication skills. It has consistent channels for candid and complete communication, which are accessed and used by all team members across all settings.
- **Measurable processes and outcomes:** The team agrees on and implements reliable and timely feedback on successes and failures in both the functioning of the team and achievement of the team's goals. These are used to track and improve performance immediately and over time.

Source: Core Principles and Values of Effective Team-Based Health Care, Institute of Medicine, October 2012

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The Quadruple Aim

Improved Patient Experience of Care

Improved Clinical Outcomes

Improved Provider/Staff Experience in Providing Care

Reduced Cost of Care Overall

Source: T Bodenheimer, C Sinsky. From Triple to Quadruple Aim. Annals of Family Medicine, Nov 2014

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The World according to AHRQ

Well implemented team-based care
has the potential to improve the
comprehensiveness, coordination, efficiency,
effectiveness, and value of care,
as well as the
satisfaction of patients and providers.

- Agency for Healthcare Research and Quality

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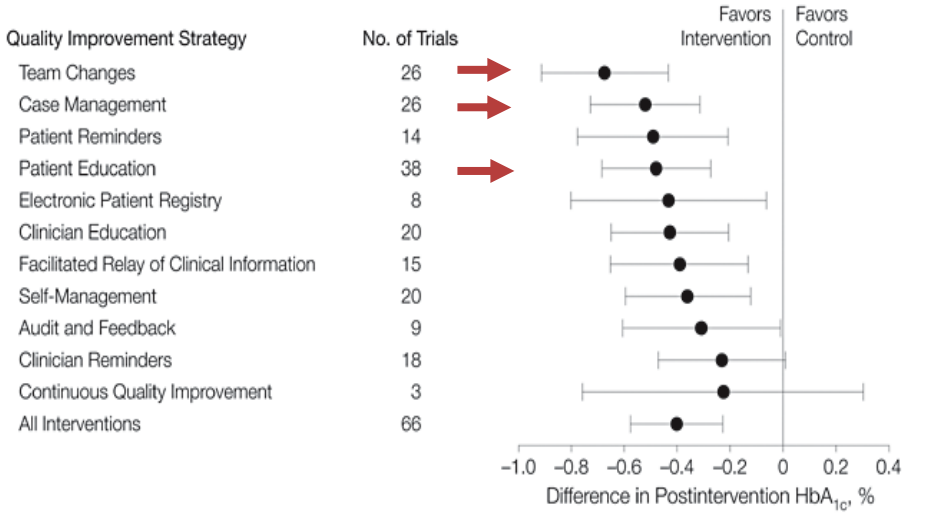
Team Involvement in the Care of the Chronically Ill is the Single Most Powerful Intervention

Effects of QI Strategies for Type 2 Diabetes on Glycemic Control



Source: JAMA. 2006;296:427-440.

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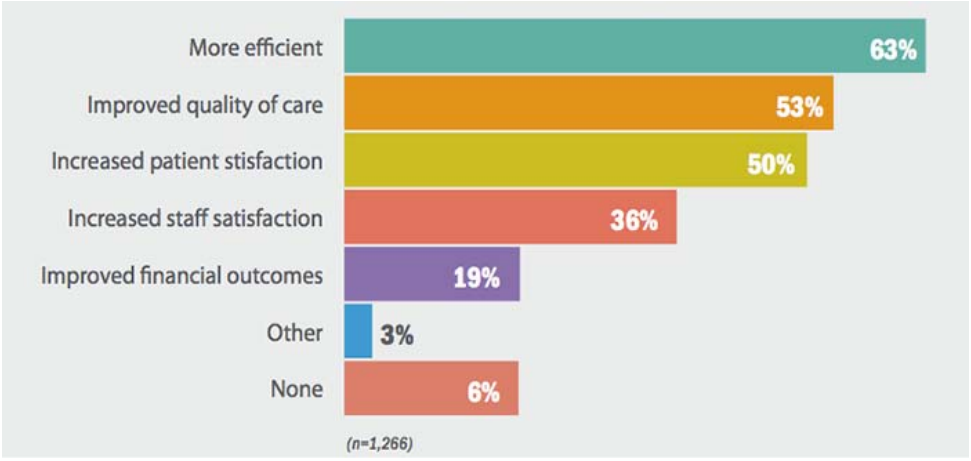
Recent Survey of Cardiology Practices

Benefits of Team-Based Care



Source: The Many Faces of Team Based Care, American College of Cardiology, 2017

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Re-engineering our system of care

Leadership is challenged to engineer a care delivery environment that is efficient, effective and focused on CQI to enhance its revenue stream and mitigate non-payment.

Primary care practices are beginning to implement and/or expand team-based care, the emphasis on providing patient-centered care is a variable.

This calls for system redesign, but . . .

- How do we break this down?
- Where will we get the greatest return on investment?

Through a focus on Team-Based Care.

Why ??

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TBC – The Clinical Perspective

- Safety net clinics such as rural health clinics are necessary to provide access to provide care for vulnerable populations
- Health care costs are increasing
- Population Health Management is a conundrum – why?
- Facilities are partnering with community-based organizations to focus on social determinants of health and ensure that they are not barriers to health – this is challenging
- Quality reporting is required for accessing dollars – for both facility and primary care providers
- Provider burnout occurs when the providers carry the burden without a cohesive team

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TBC – The Financial Perspective

- Labor budgets are key – the right resource for the right outcome; train, expand team capabilities and increase encounter volumes
- Must increase revenues to survive as a provider in the health care system
- Efficiencies will allow for increased volume
- Expanding the team to include registration personnel and billers will ensure continual feedback to the clinical staff to improve processes when denials occur

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TBC – The Quality Perspective

- Role clarification is inherently important – it drives operational efficiency
- Proper use of the right resource will decrease waste, time, energy and the patient's time
- Increase satisfaction of all, employees and providers
- Increasing the number of staff who know and respond to patients will increase patient satisfaction because patients are not waiting for only the provider to respond to their needs
- A larger provider team can support quality improvement – with effective intra-team communication and problem-solving, practices can engage in data-driven continuous quality improvement
- In an accountable organization, all staff share the quality improvement effort and contribute to outcomes

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TBC – The Patient's Perspective

- The patient will deal with the same team of people at every visit - CONTINUITY OF CARE !
- The patient knows exactly who will call them regarding their appointment, test results, or other communication
- The patient knows exactly who to contact for clinical advice
- Continuity of Care means:
  - The provider and care team know each patient's health needs and social circumstances
  - Better access to care
  - No fragmentation of services
  - No falling through the cracks
  - No duplicate tests
  - Better medication management

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Change is Necessary – The Evidence is Clear

- Delivering all evidence-based guidelines for preventive and chronic disease care has been estimated to take 18 hours a day for an average sized patient panel.

  (Yarnall et al 2009; Alexander et al 2005)

- Most physicians only deliver 55% of recommended care, 42% report not having enough time with their patients.

  (Center for Studying Health System Change 2008; Bodenheimer and Laing 2007)

- Providers are spending 13% of their day in care coordination and only using their medical knowledge 50% of the time.

  (Gottschalk 2005; Margolis and Bodenheimer 2010)

- Patient care is fragmented and patients are dissatisfied with the level of attention they receive in primary care.

  (Tom Bodenheimer 2008)

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Major Physician Dissatisfiers

- Schedule is too busy to allow for adequate patient care
- Inadequate or inefficient staff and technology support
- Administrative "paperwork" and other non-patient care activities interfere with physician-patient contact
- Lack of input into key decisions involving the practice

Solution: Team-Based Care

Source: Crosson FJ, Casalino L Physician Practice Satisfaction: Why We Should Care. Health Affairs May 9, 2013

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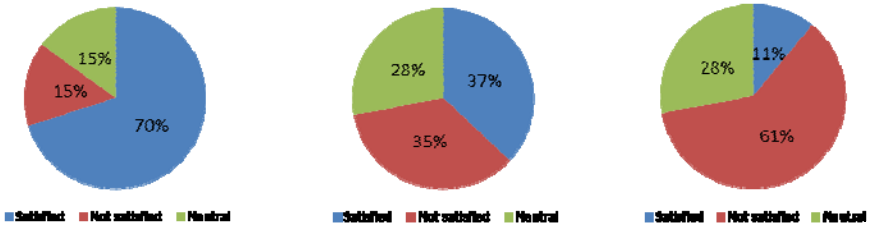
Clinician Satisfaction With Teams

N=135



TEAMLET
(work with same MA)
N = 27

TEAM
(work with group of MAs)
N = 90

NO TEAMS
(work with different MAs)
N = 18

Source: Tom Bodenheimer MD, UCSF 2012

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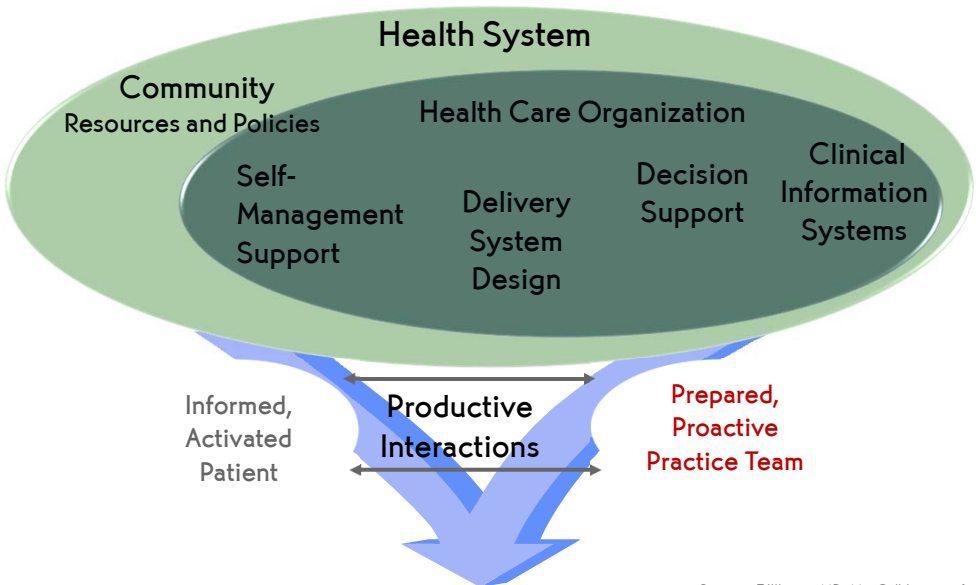
The Roles of the Multi-Disciplinary Care Team

The Care Model



Source: E,Wagner MD, MacColl Institute for Healthcare Innovation, 1998

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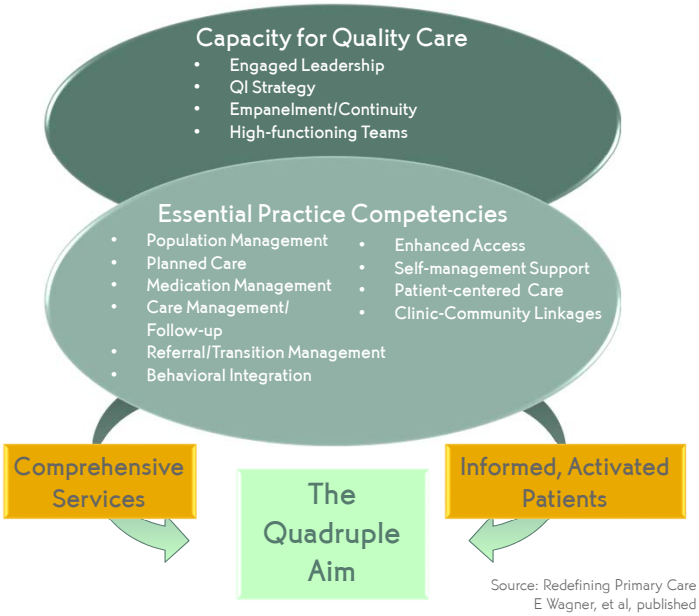
Creating High Quality, Comprehensive Primary Care



Source: Redefining Primary Care for the 21st Century. E Wagner, et al, published by AHRQ, Oct 2016

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What is Team-Based Care?

A model of health care delivery that utilizes individual staff members in various roles, each **functioning at their highest level according to credentials and competencies.**

Shared accountability for overall patient health outcomes within a framework of clearly defined roles and responsibilities under the leadership of the primary care provider.

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What does team-based care mean to a health center?

- Expanded access to care (more hours of coverage, shorter wait times, more staff who know the patients)
- Effective and efficient delivery of additional services that are essential to providing high quality care, such as patient education, behavioral health, self-management support, and care coordination
- Formal roles on a continuum: expanded team to include access and biller
- Increased job satisfaction for staff and providers; impact on staff turnover
- Environment in which all medical and nonmedical professionals are encouraged to perform work that is matched to their abilities.

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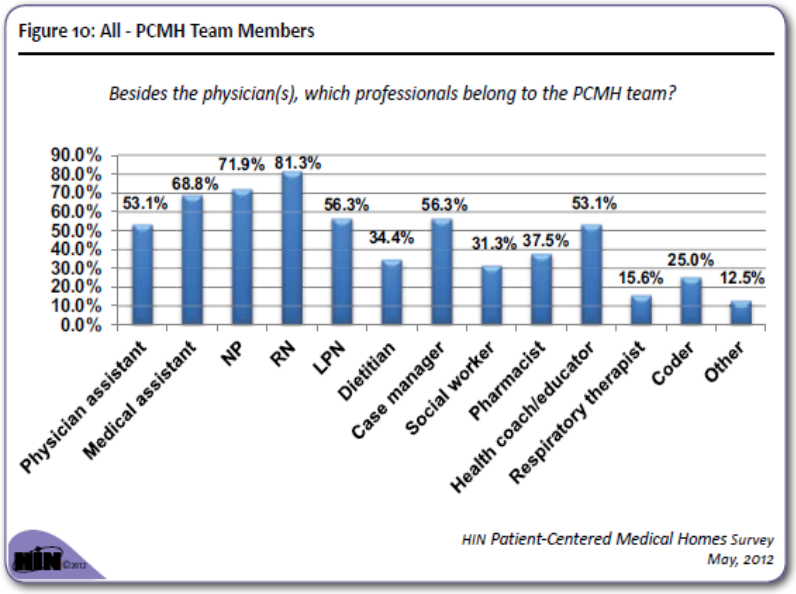
PCMH Team Members



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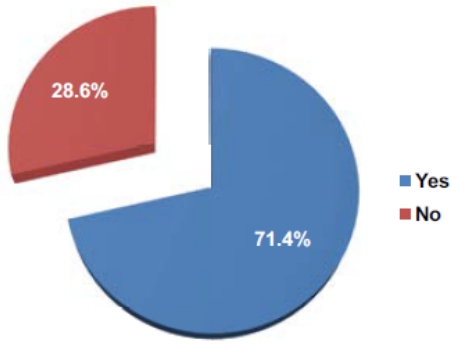
Clinic-Based Care Managers

Figure 11: All - Case Manager Embedded in PCMH

If you have a case manager on the PCMH team, is the case manager embedded in the physician practice?



HIN Patient-Centered Medical Homes Survey May, 2012

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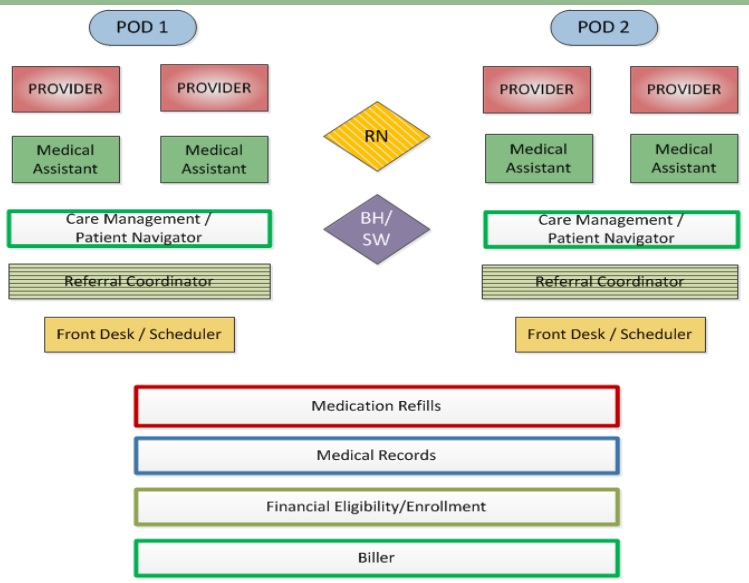
How are Care Teams organized?



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Team Visualization Exercise

- If you are here with an organizational team, sit together and perform this exercise as a group.
- Read the labels on the plastic cups
- Read the 10 tasks on the page
- Apportion 10 jelly beans per task
- As you read each task, place 10 jelly beans in the plastic cup bearing the label of the staff member that you think performs the task
  - If you are 100% sure that the task is completed by one person, place 10 jelly beans in the cup.
  - If you think that more than one person performs this task, place a proportional number of jelly beans in each labeled cup

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The Paradigm Shift

FROM	TO
Acute reactive care	Proactive planned care
Solo provider mindset	Team-based care
Volume-driven	Value-based
Chaos	Control
Fragmented services	Full service integration

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The Paradigm Shift

Solo Mindset

What can I do to care for the 30 patients on my schedule today?

Team-Based Care

What can we do to maximize the care of the 1500 patients on our panel?

PCMH Model

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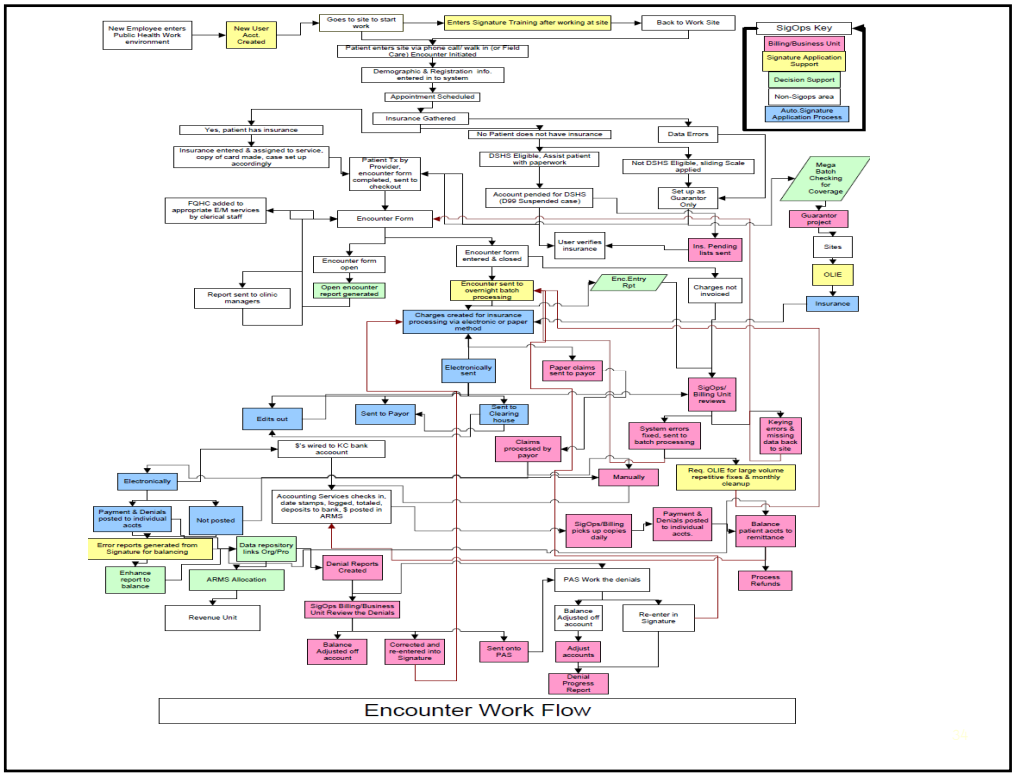
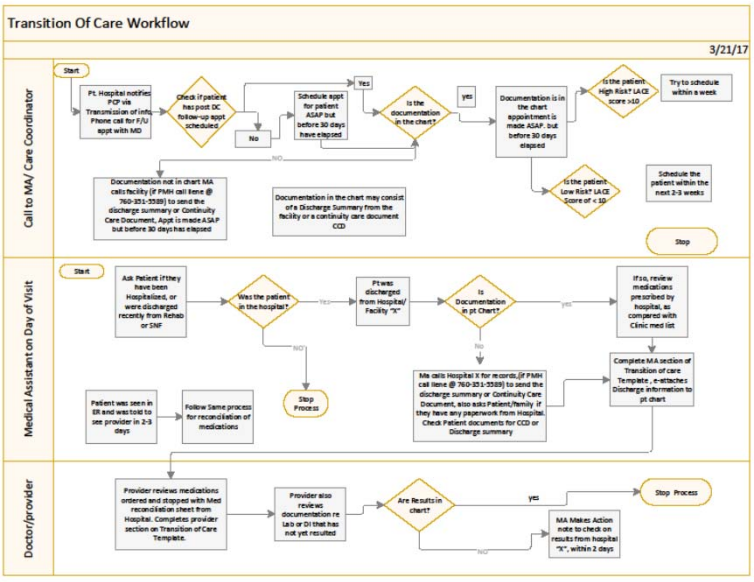


Workflow: CT in the outpatient clinic



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How do teams help improve care?

- The ***patient*** becomes the center of staff attention, rather than the provider
- Entire staff knows and owns the care of the patient
- Work is distributed according to level of staff training (e.g. RNs free to do RN level tasks)
- Engaged teams are problem-solvers, working to improve quality and efficiency of care
- Care delivery becomes organized, possible and ENJOYABLE!

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Traditional Roles are Changing

PROVIDER	RN	MED ASST	ADMIN
Clinical care	Clinical Care/Triage	Team support	Team support
Standards of care	Chronic Care Mgmt/ Standing Orders/ Patient Educator	Rooming/Vital Signs/ Clinical Documentation	Referral Management
Evaluates staff for Core Competencies; Delegates tasks	Staff Training Core Competencies Supervision	Care Coordination/ Standing Orders	No-Show Follow-up/ Patient outreach
Authorizes Standing Orders	Liaison to Hospitals and Emergency Departments	Health Coach/ Patient Self Management Support	Data entry and retrieval
Quality Improvement	Workflow Analysis and Improvement	Population Health Management	

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Provider Role – beyond clinical care

- Will understand and work to standards of evidence-based care, review data, and receive feedback.
- Will understand the training protocols for support staff, will participate in evaluation of core competencies, and will become comfortable delegating tasks.
- Will be involved in development of workflows, offering ideas, opinions, and concerns; will have "ownership".
- Will be accountable for implementation and sustainability of processes and workflows for the care team.

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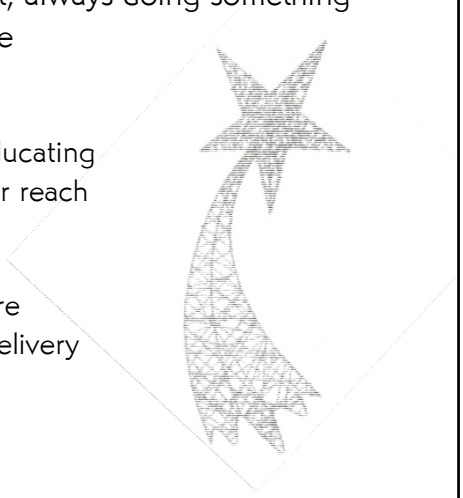
Imagine a High Functioning Care Team

- Providers assess, diagnose, and treat, always doing something that requires their clinical knowledge
- Nursing role is re-established
  - Clinical expertise, leadership and educating becomes their focus, extending their reach
- The MA/LVN role is enhanced
  - With training, MAs can function more independently and enhance team delivery
- Upward mobility strategy



Opportunities for stars to shine!

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System Level Changes for Team-Based Care

- Reorganize staff roles and responsibilities
- Redesign patient flow
- Performance measurement and feedback
- Recognition/reward
- Registries and reports
- Patient-specific reminders and outreach

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Teams in an EHR World

- Two major unintended negative consequences of the EMR:
  - Physicians are awash in unorganized data
  - Physicians are doing a tremendous amount of data gathering and data entry
- The enhanced MA role:
  - Moves data entry to the MA
  - Now a full partner in data gathering
  - Allows development of clinical skills through close communication with the provider

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Successful Care Team . . .

- Organize care delivery through daily huddles
- Recognize the care team is responsible for data entry
- Communicate regularly with each other
- Use technology tools:
  - EHR organized for documentation
  - Health Maintenance Prompts – for preventive care
  - Registries – for condition-specific population management
- Review data to understand gaps in care
  - Hold brief, frequent meetings to review and plan PDSA cycles
  - Continuous attention to improvement eventually becomes part of the Care Team's thought process, culture and daily work
- Communicate with leadership to discuss successes and barriers

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Use Stages of the Care Cycle to Define Team Member Roles and Responsibilities

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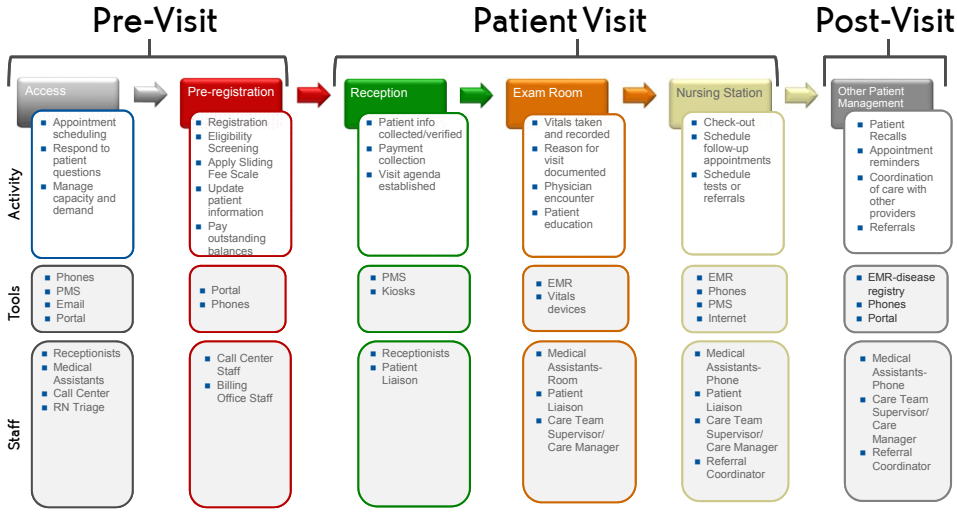
Workflows in the Patient Visit Cycle



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Who's on the core Care Team?

The UCSF Advanced Practice Model

For optimum supply and optimum efficiency

- 12 exam rooms
- 4 FTE providers
- 2 FTE RN
- 10 FTE MA

Efficiency Formula for Team-Based Care:
1 MD : 2 MA : 0.5 RN : 3 exam rooms

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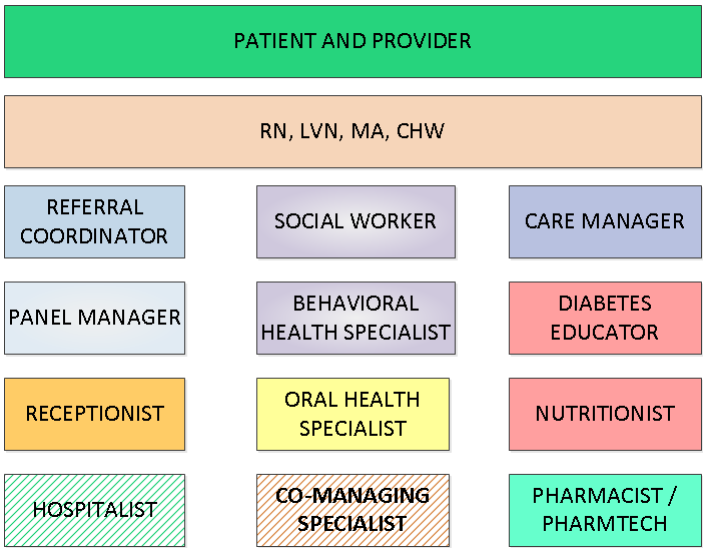
Who is on the expanded Care Team ?



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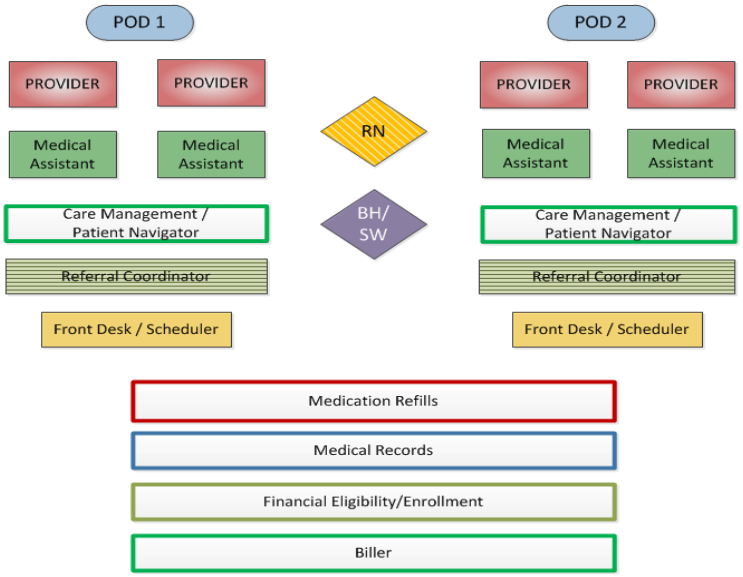
Example: Care Team Organization



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Draw the Patient Care Team

THE PATIENT CARE TEAM TODAY

THE PATIENT CARE TEAM TOMORROW

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The Enhanced Medical Assistant Role

Team Partner, Care Coordinator, Health Coach

- Allows team members to function at their highest level
- Provides job satisfaction, potential for upward mobility, and retention of excellent staff
- Provides enhanced, trusting relationships with patients, practical advice on self-management when cultural background is shared

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MA Scope of Practice – California

MAY PERFORM	MAY NOT PERFORM
• Injections • Skin tests • Bandaging • Suture removal • Ear lavage • Exam preparation • Shaving and disinfection of treatment sites • Phlebotomy	• Start IV or administer meds through IV line • Chart pupillary responses • Interpret skin tests • Independently conduct telephone triage • Inject collagen • Perform laser hair removal • Administer chemotherapy

http://www.aama-ntl.org/employers/state-scope-of-practice-laws

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Standard Work = "Gold Standard" Work

- Allows work to be done the best way every time
- Assures the highest quality of work
- Allows identification of waste
- It is the foundation from which improvements may be made
- Ensures that improvements are sustained
- Assists with training
- Specifies responsible person and the expected time for completion of every task

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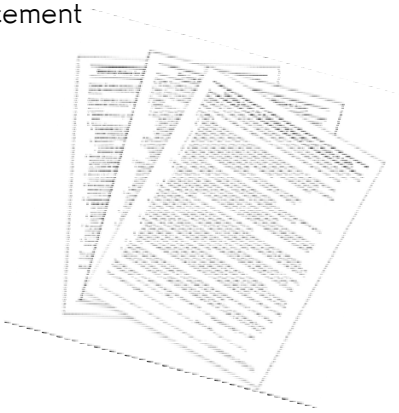
Examples of Standing Orders

- **Lab testing**
  - Pregnancy test, Rapid Strep, PPD placement
  - Random glucose (finger stick)
  - In-house HbA1C
- **Well Child Check procedures**
  - Hearing and vision screenings
  - Lead tests
  - Fluoride varnish
- **Immunizations**
  - Childhood
  - Flu, Pneumovax
- **Preventive Health screenings, including depression and risk assessments**



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More Standing Orders

Condition Specific:

- Prenatal Care, Postpartum Care
- Well woman exams, mammogram referrals
- Diabetes Management: Labs, referrals, supplies, monofilament foot exam, glucometer review and teaching
- Hypertension management
- Hyperlipidemia management
- Other ??

Team Huddles

Huddles enhance communication

Why?

- Sets the tone for the day
- Establishes competence
- Disavows perfection
- Predicts what will happen later

When?

- Start of the day
- Prior to a procedure
- On the spot – as the situation changes
- When joined by a new team member

Huddles vs. Team Meetings

	HUDDLES	TEAM MEETINGS
FREQUENCY	Daily	Weekly, biweekly
TIME	10 minutes or less	30-60 minutes
ATTENDEES	Clinical care team	Expanded care team
FOCUS	Planning for care of individual patients on today's schedule	Planning for care of a population of patients

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Planned Care Visits

Use planned visits and telephone follow-up for proactive care.

A typical planned visit includes:

- Patient self-assessment
- Medication reconciliation: Make sure medications are appropriate
- Have patient bring equipment, i.e. peak flow meters/ inhalers/ spacers/Accucheck
- Labs/tests/results/orders
- Update/initiate/review self-management goal(s), barriers and confidence levels

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Examples of Planned Care Visits

Well Child Check

- Developmental milestones
- Immunization status
- Lead testing
- Asthma Action Plan

Diabetes Follow-up

- Medication Review
- Goals, barriers, confidence
- Labs review
- Monofilament foot exam
- Retinal exam
- Behavioral health support
- Nutrition education

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Medicare Wellness Visits are planned care, too

Establish . . .	Detect . . .	Provide . . .
Medical History	Cognitive Impairment	Preventive Screening Schedule
Personal History	Hearing Deficits	Education
Family History	Signs of or Risk for Depression	Counseling
Social History	Functional Ability	Referrals
Baseline Vitals	Fall Risk	Brief written plan
BMI	History of fall with injury	Advance Care Planning
Visual Acuity	Home Safety	Personalized Health/Wellness Advice
Medication List		
Regular providers		

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Other Essential Team Functions

Care Coordination

- Test Tracking – orders, resulting, notifying patients
- Referral Tracking – orders, communication with specialists, communication with patients

Care Management

- Population Management – evidence-based guidelines, continuous improvement, data review, outreach
- Self Management Support – education, goal setting, follow-up, health coaching

Care Transitions

- Post hospitalization follow-up
- Post ED visit follow-up

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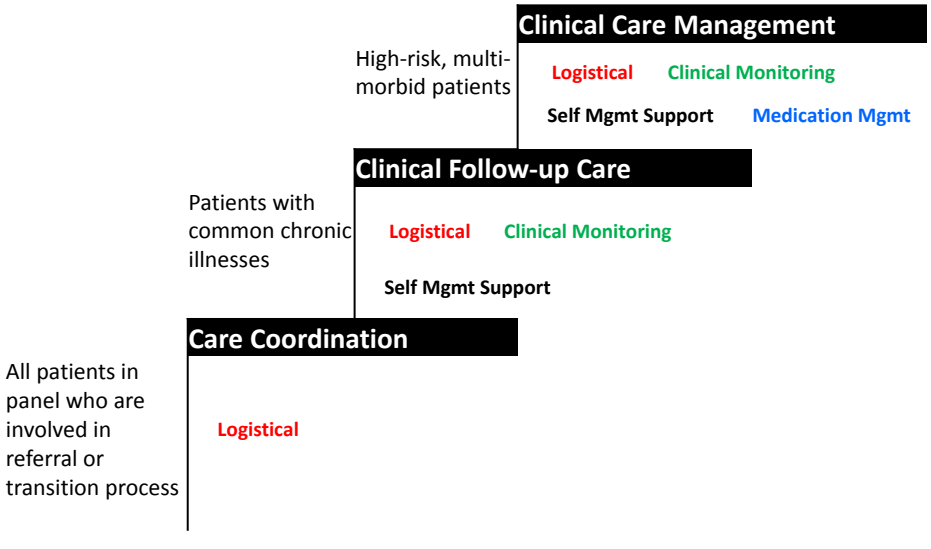
Levels of Clinic-Based Care Management Support



Source: MacColl Institute for Healthcare Innovation 2011

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Care Coordination – the Evidence

Care coordination leads to better medical care through:

- Decreased medical errors.[1]
- Decreased medication errors.[1]
- Increased accuracy of post-discharge plans.[2]
- Decreased probability of adverse medication interaction.[1]
- Lower rates of hospital readmission.[2]
- Shorter future hospital stays.[2]
- Decreased duplication of procedures.[2]

Sources:
1. Moore et al., Medical errors related to discontinuity of care from an inpatient to an outpatient setting. J Gen Intern Med. 2003
2. Misky et al., Post-hospitalization transitions: examining the effects of timing of primary care provider followup. J Hosp Med 2010

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Care Management Benefits

- Improves quality and reduce cost
- Reduces acute inpatient admissions and LOS
- Reduces 15- and 31-day readmission rates
- Reduces Emergency Department utilization

and PCPs report:

- Time savings -- 30 minutes or more daily
- Improved patient engagement
- Improved staff engagement and satisfaction
- "I can do a much better job as a physician with this level of support for myself and my patients."

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Team-Based Care Influence on Panel Size

If portions of care delivery are delegated to nonphysician team members, larger practice panels are possible.

	Level of Delegation of Preventive/Chronic Care Management Responsibilities			
	NONE	LOW	MED	HIGH
Panel Size	983	1,387	1,523	1,947
% Increase from Base	0%	41%	55%	98%

Source: Altschuler, et.al., Estimating a Reasonable Panel Size for Primary Care Physicians with Team-based Task Delegation. Annals of Family Medicine, Vol 10, No. 5; September/October 2012

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Elements of a Successful Care Team

- Culture shift to "Share the Care"
- Stable teamlets
- Team members sit in close proximity
- Standing orders / protocols / standard work
- Defined workflows
- Clear roles and responsibilities
- Training, skills checks, cross-training
- Ground rules
- Communication - huddles, team meetings, constant interaction

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Measures of Team Effectiveness

- Employee satisfaction surveys
- Employee turnover rates
- Tools to measure "team cohesiveness"
- Continuity and empanelment reports
- Operational reports such as office wait time, visit cycle times, no-show rates, call abandonment
- Clinical process reports, especially as related to a standing order service
- Direct audit of items in standardized workflows
- Patient experience and satisfaction surveys

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Key Concepts For Leaders

Redesigning a System of Care

Many health care organizations have made important advancements in the design and performance of their current systems of care. Despite these improvements:

- Many improvements remain unused, partially implemented, fragmented, and isolated.
- Clinicians often feel overworked and unable to take on new work.
- Patient satisfaction levels are not optimal.
- Wait time for patients continues to increase.

It is a leadership imperative to assess your delivery system—people, processes, and quality outcomes—against your peers and benchmarks.

- Determine your strengths and opportunities for improvement.
- Use the "Primary Care Team Guide Assessment" tool to assess your current state and develop an action plan.

 67

Primary Care Team Guide Assessment

Empanelment

	Components	Level D	Level C	Level B	Level A
1	Patients…	are not assigned to specific practice panels.	are assigned to specific practice panels but panel assignments are not routinely used by the practice for administrative or other purposes.	are assigned to specific practice panels and panel assignments are routinely used by the practice mainly for scheduling purposes.	are assigned to specific practice panels and panel assignments are routinely used for scheduling purposes and are continuously monitored to balance supply and demand.

The Practice Team

	Components	Level D	Level C	Level B	Level A
2	Clinical leaders…	intermittently focus on improving quality.	have developed a vision for quality improvement, but no consistent process for getting there.	are committed to a quality improvement process, and sometimes engage teams in implementation and problem solving.	consistently champion and engage clinical teams in improving patient experience of care and clinical outcomes, and provide time, training, and resources to accomplish the

Enhancing Access

	Components	Level D	Level C	Level B	Level A
13	Patients are encouraged to see their paneled provider and practice team …	only at the patient's request. 1☐ 2☐ 3☐	by the practice team, but is not a priority in appointment scheduling.. 4☐ 5☐ 6☐	by the practice team and is a priority in appointment scheduling, but patients commonly see other providers because of limited availability or other issues. 7☐ 8☐ 9☐	by the practice team, is a priority in appointment scheduling, and patients usually see their own provider or practice team. 10☐ 11☐ 12☐

Source: The MacColl Center for Healthcare Innovation, Group Health Research Institute, 2015

 68

Leaders must . . .

- Provide teams with the decision support and resources necessary to deliver high quality care.
- Ensure the practice has the resources to make optimal care routine . . . it becomes the default. It is the standard of care for the practice.
- Make it easiest to do what is best. Eliminate the need for "work-arounds."

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Mitigate resistance to new roles

- Communicate the intent and how it relates to the clinic's mission
- Include appropriate staff in planning and piloting
- Train and mentor in an organized fashion
- Provide incentives to recognize and reward the courage and hard work
- Use data as proof that the changes have helped patients and are related back to mission

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Develop a standardized infrastructure

Develop documentation to support team-based care:

- Job descriptions
- Performance evaluation tools
- Competency checklists
- Training program descriptions
- Clinical practice guidelines
- Standing orders
- Standards for medical record/EMR documentation
- Simple, easy to follow workflows
- Scripting/patient education protocols
- Patient communication guidelines

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Include "teamness" expectations in job descriptions

Core Competencies:

- Recognizes intra- and interdepartmental coworkers as customers by working together as part of the multidisciplinary team
- Indicates awareness of staffing, scheduling process, scopes of practice, policies and procedures , and is focused on patient-centered care and team cohesiveness.
- Proper use of PTO
- Sick call process
- Understands Scope of Practice
- Knows how to find or inquire about Heartbeat Health Center policies and procedures

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Team members have rights . . .

Team members have the right to:

- Be treated with respect
- Be successful
- Be informed that you are doing a good job
- Be informed about problem performance
- Have a voice in what happens to your work

 73

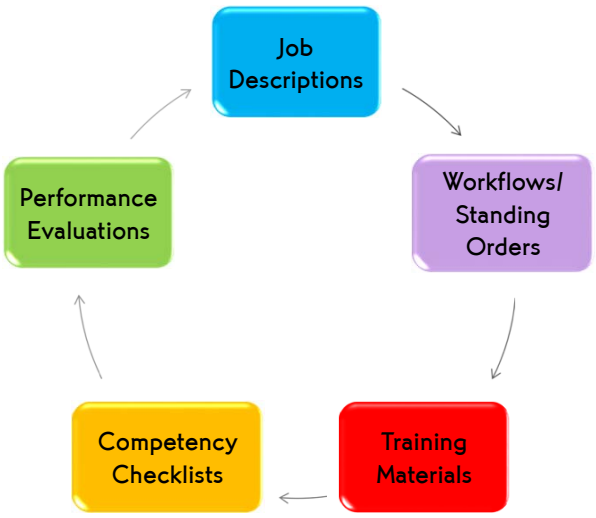
. . . and responsibilities

As a team member, I will:

- Actively engage in the care of our patients
- Support my team members in their work
- Provide information to the team to enable quality patient care
- Ask questions and verify provider's orders
- Contribute to the success or failure of my team
- Behave professionally and keep the environment safe for proper team interactions

 74

Cycle for Sustaining Standard Work



Creating the Team Identity

- Co-location
- Color coding
- Uniforms
- Celebrations/rewards
- Team photographs in exam rooms
- Compliments/praise – be specific

- Posting examples of team member success
- Posting quality improvement trends
- Other examples?

Invest in Technology

- EHR with customization as needed
- Interfaces to lab, imaging, immunization registry
- Patient registry
- Report writing application
- Patient portals or interactive website
- Lab and imaging interfaces
- Telehealth
- Automated phone systems
- Walkie-talkies
- Headsets

Always involve the team in
planning for technology design and use!

 77

Invest in Training

Ensure training to use systems effectively and efficiently

- Written policies and standards
- Written training materials

Create multiple training opportunities

- New employee orientation
- All staff training
- Team-based training

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Ensure protected time

- Allow time for planning and implementation of the Team-Based model
  - Define roles
  - Establish guidelines/protocols
  - Revise policies and job descriptions
  - Develop training programs
  - Deliver initial training

- Allow time for sustaining the model
  - Huddles, team meetings, staff meetings, pre-visit planning
  - Measurement and improvement initiatives
  - Continuing education

 79

Strengthening internal capacity for quality

- The PATIENT becomes the center of our work.
- QUALITY becomes our common language.
- CURIOSITY is a valued (and desired) characteristic of our Board, employees and patients.
- Staff are EMPOWERED to drive improvements.
- TECHNOLOGY enables reporting.
- TRANSPARENCY in reporting accelerates improvement.
- RECOGNITION encourages future efforts.

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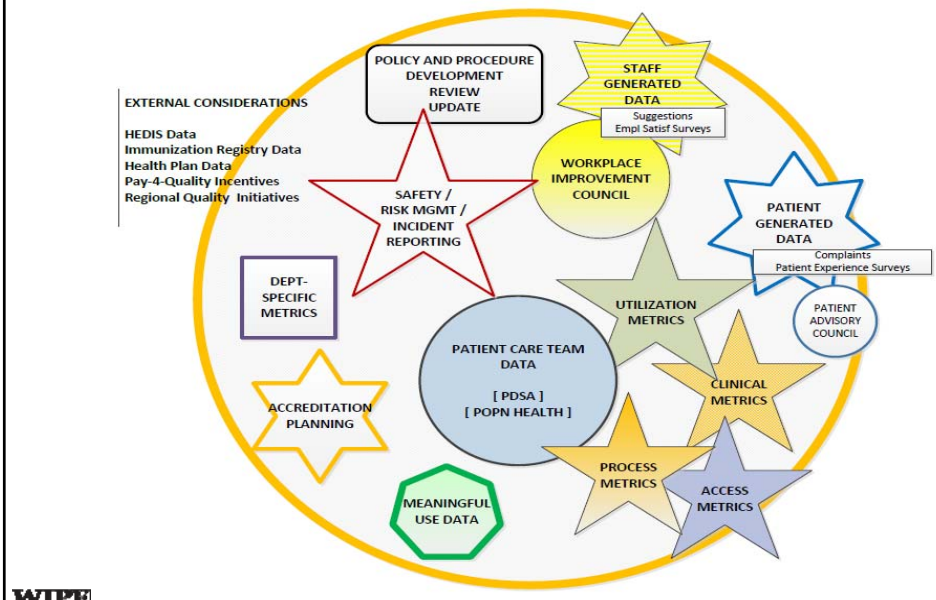
Linking the Care Team to Quality Improvement

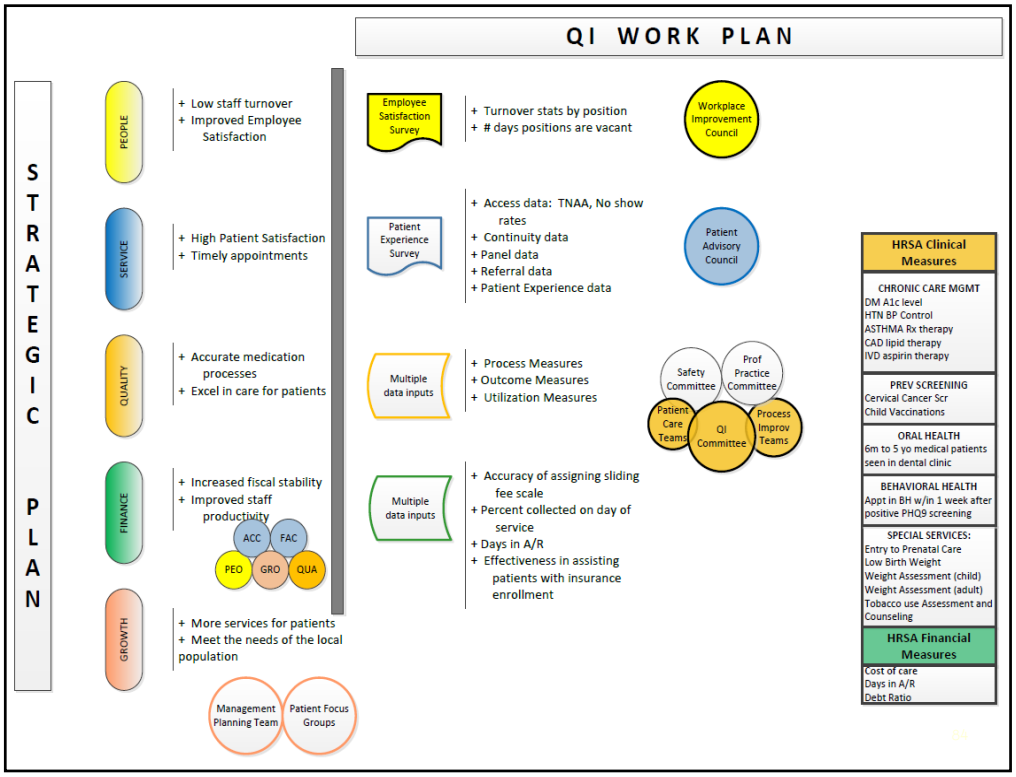
Start with the Strategic Plan

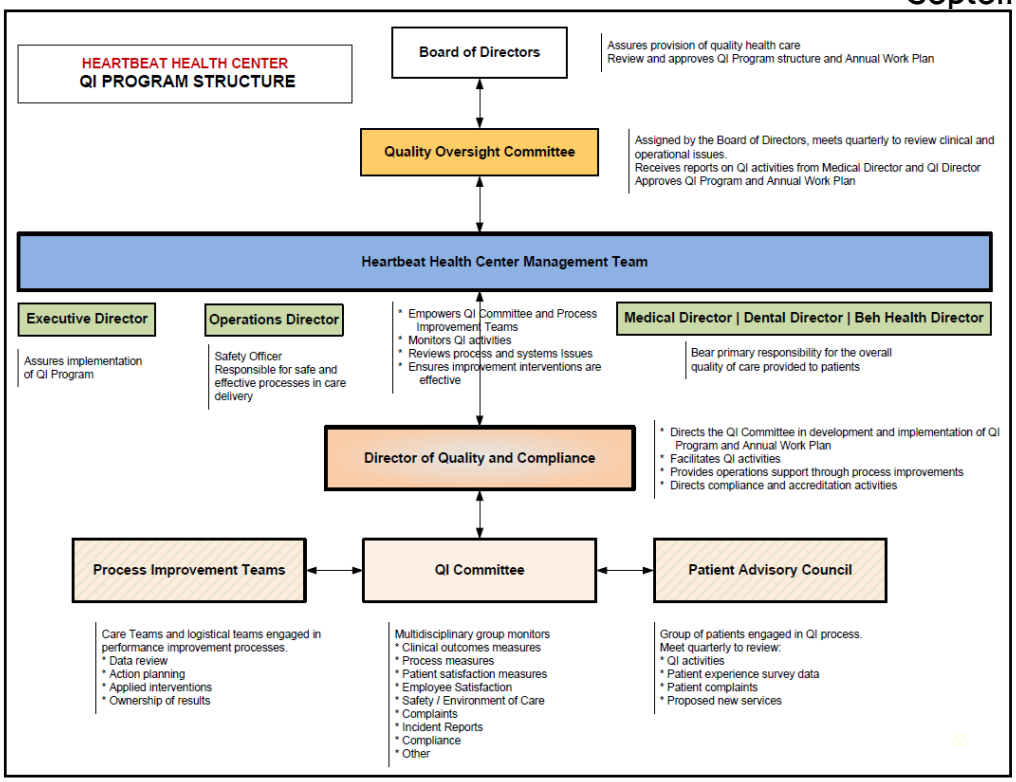
Heartbeat Health Center – Strategic Vision – 5 Pillars

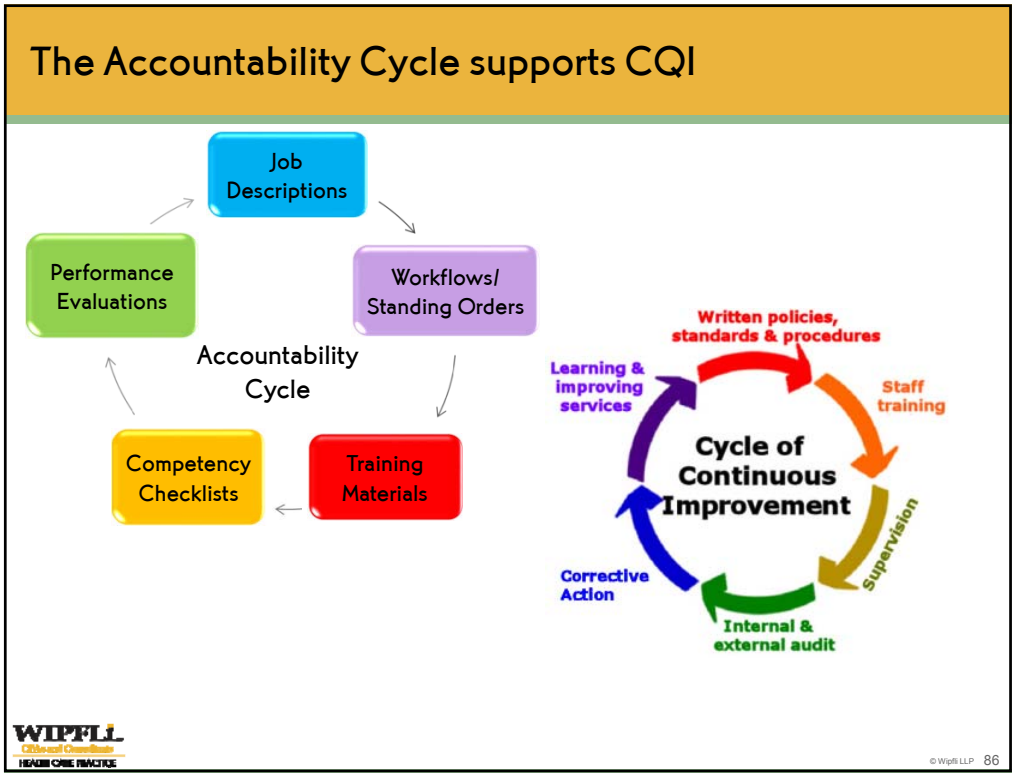
PEOPLE	SERVICE	QUALITY	FINANCE	GROWTH
LOW STAFF TURNOVER	HIGH PATIENT SATISFACTION	ACCURATE MEDICATION PROCESSES	INCREASED FISCAL STABILITY	MORE SERVICES FOR PATIENTS
IMPROVED EMPLOYEE SATISFACTION	TIMELY APPOINTMENTS	EXCEL IN CARE FOR PATIENTS	IMPROVED STAFF PRODUCTIVITY	MEET THE NEEDS OF THE LOCAL POPULATION

Patient Care Teams Advance the QI Agenda






HEARTBEAT HEALTH CENTER
QI PROGRAM STRUCTURE
Board of Directors
Assures provision of quality health care
Review and approves QI Program structure and Annual Work Plan
Quality Oversight Committee
Assigned by the Board of Directors, meets quarterly to review clinical and operational issues.
Receives reports on QI activities from Medical Director and QI Director
Approves QI Program and Annual Work Plan
Heartbeat Health Center Management Team
Executive Director
Assures implementation of QI Program
Operations Director
Safety Officer
Responsible for safe and effective processes in care delivery
* Empowers QI Committee and Process Improvement Teams
* Monitors QI activities
* Reviews process and systems Issues
* Ensures improvement interventions are effective
Medical Director | Dental Director | Beh Health Director
Bear primary responsibility for the overall quality of care provided to patients
Director of Quality and Compliance
* Directs the QI Committee in development and implementation of QI Program and Annual Work Plan
* Facilitates QI activities
* Provides operations support through process improvements
* Directs compliance and accreditation activities
Process Improvement Teams
QI Committee
Patient Advisory Council
Care Teams and logistical teams engaged in performance improvement processes.
* Data review
* Action planning
* Applied interventions
* Ownership of results
Multidisciplinary group monitors
* Clinical outcomes measures
* Process measures
* Patient satisfaction measures
* Employee Satisfaction
* Safety / Environment of Care
* Complaints
* Incident Reports
* Compliance
* Other
Group of patients engaged in QI process.
Meet quarterly to review:
* QI activities
* Patient experience survey data
* Patient complaints
* Proposed new services


The Accountability Cycle supports CQI
Job Descriptions
Performance Evaluations
Workflows/ Standing Orders
Accountability Cycle
Competency Checklists
Training Materials
Written policies, standards & procedures
Staff training
Supervision
Internal & external audit
Corrective Action
Learning & improving services
Cycle of Continuous Improvement
WIPFLI
HEALTH CARE PRACTICE
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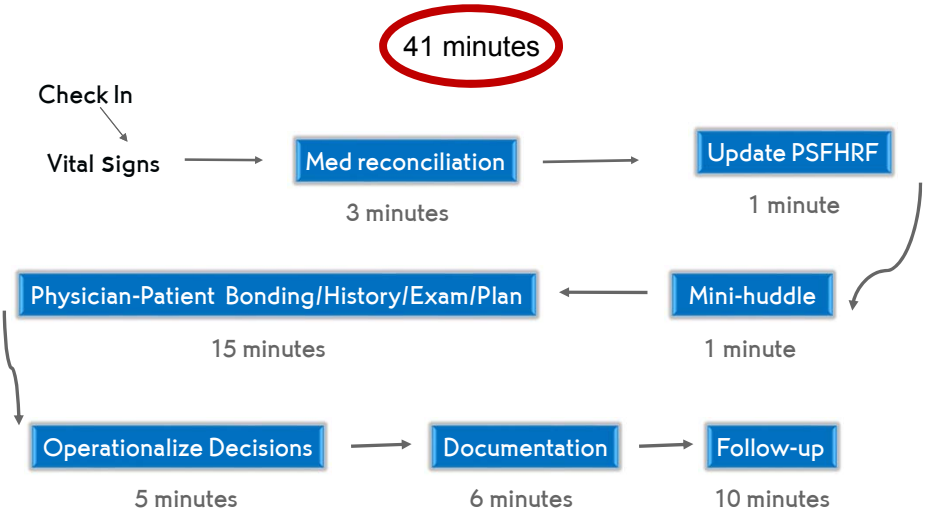
Patient Care Teams and Process Improvement Teams

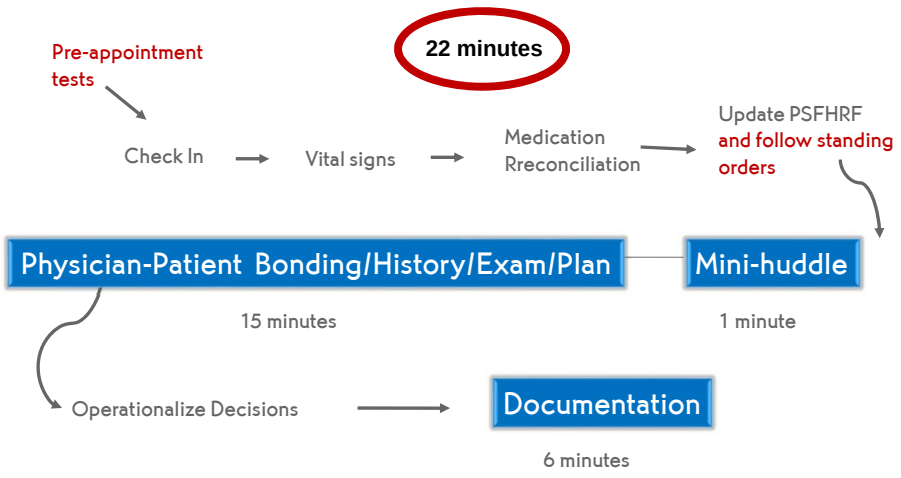
- Align Team Vision to meet health center goals
  - Patient flow processes
  - Clinical outcomes
  - Clinic culture
- Discover the flaws
  - Understand the situation in detail
  - Generate options for action
- Facilitate action
- Monitor results
- Repeat

TRANSFORMERS!!

Sample Provider Time Study



Impact of a Strong Patient Care Team



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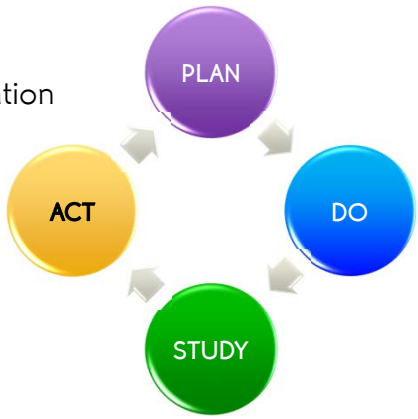
Empower Care Teams/Process Improvement Teams to improve workflow

- Evaluate:
  - Patient wait times
  - Extra walking due to disorganization
  - Lack of coordination between providers and staff
- In order to eliminate waste:
  - Consider all processes
  - Standardize operations
  - Tidiness leads to efficiency
  - Conduct repeated PDSA cycles



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What is Population Health?

Population Health has been defined as "the health outcomes of a group of individuals, including the distribution of such outcomes within the group." This approach to health aims to improve the health of an entire human population.

Population Health Management is the aggregation of patient data across multiple health information technology resources, the analysis of that data into a single, actionable patient record, and the actions through which care providers can improve both clinical and financial outcomes.

 91

Implementing Population Health Management

Population Health Management is the core of payment reform.

Implementation requires the following:

- Empanelment of patients to providers
- Adoption of evidence-based guidelines
- Ability to prepare "exception reports" from the EHR
- Evolution to team-based care
- Intentional care coordination
- Systematic outreach to patients to close gaps in care
- Transparent reporting across the practice and regionally

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Population Health Management Process

Health Assessment	• Collect information on patients
Risk Stratification	• Stratify patients into meaningful categories for targeted interventions
Intervention	• Reach out to patients and provide services and resources
Evaluation	• Assess impact on patient, the clinic, and the community

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Population Management is a part of Quality Improvement

If patients got the service in the first place, there would be fewer names on those lists!!!

- The idea is to get the patient to complete the service before it becomes overdue.
- Addressing care gaps is everybody's job!

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Care Team accountability supports the QI Agenda

EXAMPLE: TEAM MEETING STRUCTURE

Week 1: Well Child Outreach/Pedi-asthma

Week 2: Diabetes/Depression

Week 3: MA/FD: Normal PAP/Mammo

RN/MD: High-Risk patient case review

Week 4: ED Utilization: Seen for ambulatory-sensitive problem during open clinic hours

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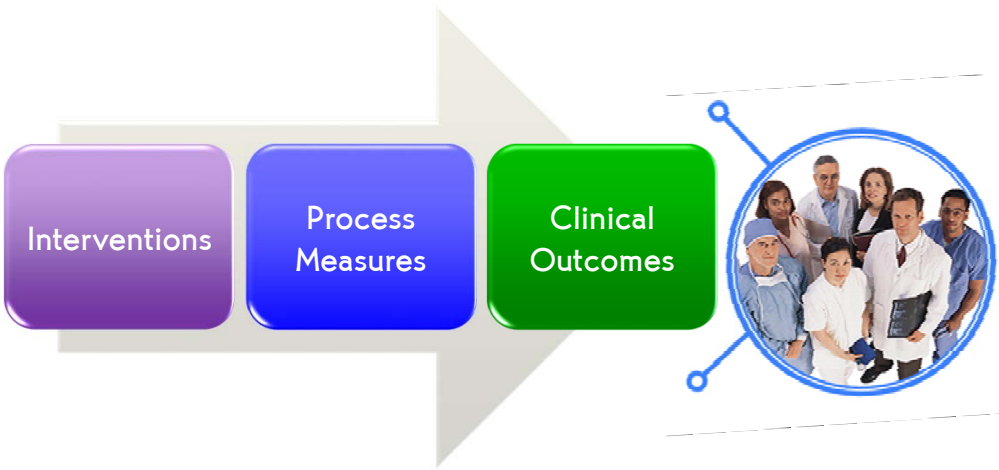
Teams work together to impact quality



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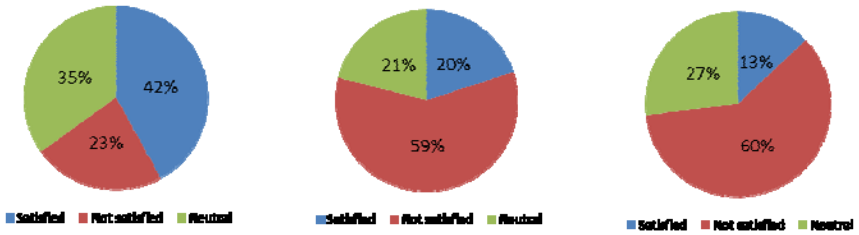
Provider Confidence in Panel Management for Cancer Screenings Using Teams

N=129



TEAMLET
(work with same MA)

N = 26

TEAM
(work with group of MAs)

N = 88

NO TEAMS
(work with different MAs)

N = 15

Source: Tom Bodenheimer MD, UCSF 2012

Other examples of QI engagement

Referral metrics

- Number of days to appointment with specialist
- Number/% of no-shows for specialty appointments
- Number/% of referrals completed
- Internal vs. external referrals

Utilization metrics

- Brand vs. generic prescriptions
- Orders for high-cost imaging procedures
- ED Utilization: Seen for ambulatory-sensitive condition during open clinic hours

Meaningful Use metrics

Measures of Team Effectiveness

- Employee satisfaction surveys
- Employee turnover rates
- Tools to measure "team cohesiveness"
- Continuity and empanelment reports
- Operational reports (i.e., office wait time, visit cycle times, no-show rates, call abandonment rates)
- Population health reports
- Direct audit of items in standardized workflows
- Patient experience/satisfaction surveys

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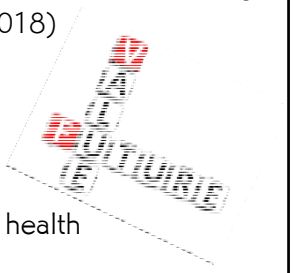
The Wrap

The future

- Trending towards value based payment
  - Medicare goals:
    - ~ 85% of Medicare FFS payments to be tied to quality or value by 2016
    - ~ 30% of Medicare payments should be tied to quality or value through alternative payment models by 2016 (50% by 2018)
- Increased importance on population management
  - Hot spotting / segmentation
  - Better understanding of who we serve
  - IOM recommendations on social determinants of health
- Improvement will become increasingly incentivized
  - Health plan contracts tied to quality performance (P4P/P4Q/P4R) and accreditation



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Five Attributes of Highly Effective Care Teams

1. Shared sense of purpose and responsibility to a defined patient panel
2. Stable team structure that is recognizable to patients
3. Good communication, including daily huddles and ground rules
4. Organization, with defined workflows and standing orders
5. Confidence and trust among team members (a result of role clarity), effective orientation for new staff, and ongoing training and performance management

Source: CHCF, California Improvement Network, August 2016

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Care Teams improve patient satisfaction

- Direct provider engagement is enhanced via reduction in clerical and EHR tasks
- Training and skills in care management increase capacity for support of complicated patients
- Higher level of patient engagement is experienced through trusting relationship with care team members
- Improved patient satisfaction scores result from a better experience of care

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Care Teams improve provider satisfaction

A "share the care" model reduces the provider's burden of care delivery:

- Pre-visit planning and pre-appointment lab tests
- Higher level of support for providers and patients
- Standing orders – non-physician order entry, including streamlined prescription management
- Enhanced team communication through electronic messaging/tasking, meetings and co-location
- Team participation in workflow mapping increases trust and improves team function

Source: In Search of Joy in Practice: A Report of 23 High-Functioning Primary Care Practices." Annals of Family Medicine.

 104

Care Teams improve the health system

- Improved patent experience and satisfaction
- Improved patient loyalty
- Improved staff retention and recruitment
- Improved quality scores
- Improved financial viability through efficiency, increased capacity and patient thru-put

 105

The Synergy . . .

There is a synergistic relationship in these concepts. When focusing on outcomes of care concurrent with redesigning systems, satisfaction is positively impacted.

- Quality is inherent in organizations that redesign systems and processes and effectively train staff to achieve the best outcomes for patients.
- Provider satisfaction is enhanced when systems work for them and the patient. Team-based care, with enhanced oral and electronic communication modalities, care coordination processes, and complex care management, improves provider and staff satisfaction and improves outcomes.
- Patient satisfaction is an indicator of quality care (physical, psychosocial, communication that ensures understanding and a focus on the patient's goals).

 106

Table Talk – What Steps Will You Take?

List the steps necessary to advance your work as TEAMS	Person responsible (Who)	When	Where
1.			
2.			
3.			
4.			
5.			

Questions?

Thank you!

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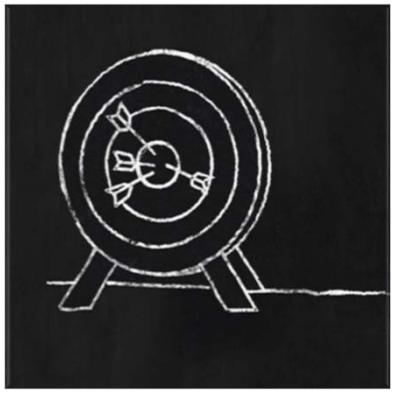

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