Health Management Associates

Care Team Optimization

Effective Workforce Strategies supporting the use and importance of all care team members for chronic care management.

Million Hearts Learning Collaborative

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- Identify drivers to care team optimization resulting in better patient care and provider satisfaction
- Describe key principles for highly effective teams
- Learn strategies and tools to build both technical and adaptive culture

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Chronic diseases are defined broadly as conditions that last 1 year or more and require ongoing medical attention or limit activities of daily living or both.

- Hypertension
- Diabetes
- Cardiovascular Disease

We know that 6 of every 10 adults in this country have a chronic disease and 4 of every 10 have two or more.

The only way to successfully help people manage this is through a team-based care approach. It takes a team…….

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“ A collection of individuals who are interdependent in their tasks, who share responsibility for outcomes, who see themselves and who are seen by others as an intact social entity embedded in one or more larger social system (business unit or organization) and who manage their relationships across organizational boundaries. ”

Cohen, S.G. & Bailey, D.E. (1997). What makes teams work: group effectiveness research from the shop floor to the executive suite. Journal of Management, 23(3), 239-290, p., 241

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Teams are used to create more efficient, effective, and patient-centered care in:

- Population health management
- Complex care management
- Patient-centered medical home
- Complex care mgmt. – pop health

Why Use Teams?

- Complexity and morbidity of patients
- Collaborative work means working smarter and together
- One individual working alone is futile and results in poor care and burnout!
- The sum-total of medicine and patient care is vast and requires many disciplines

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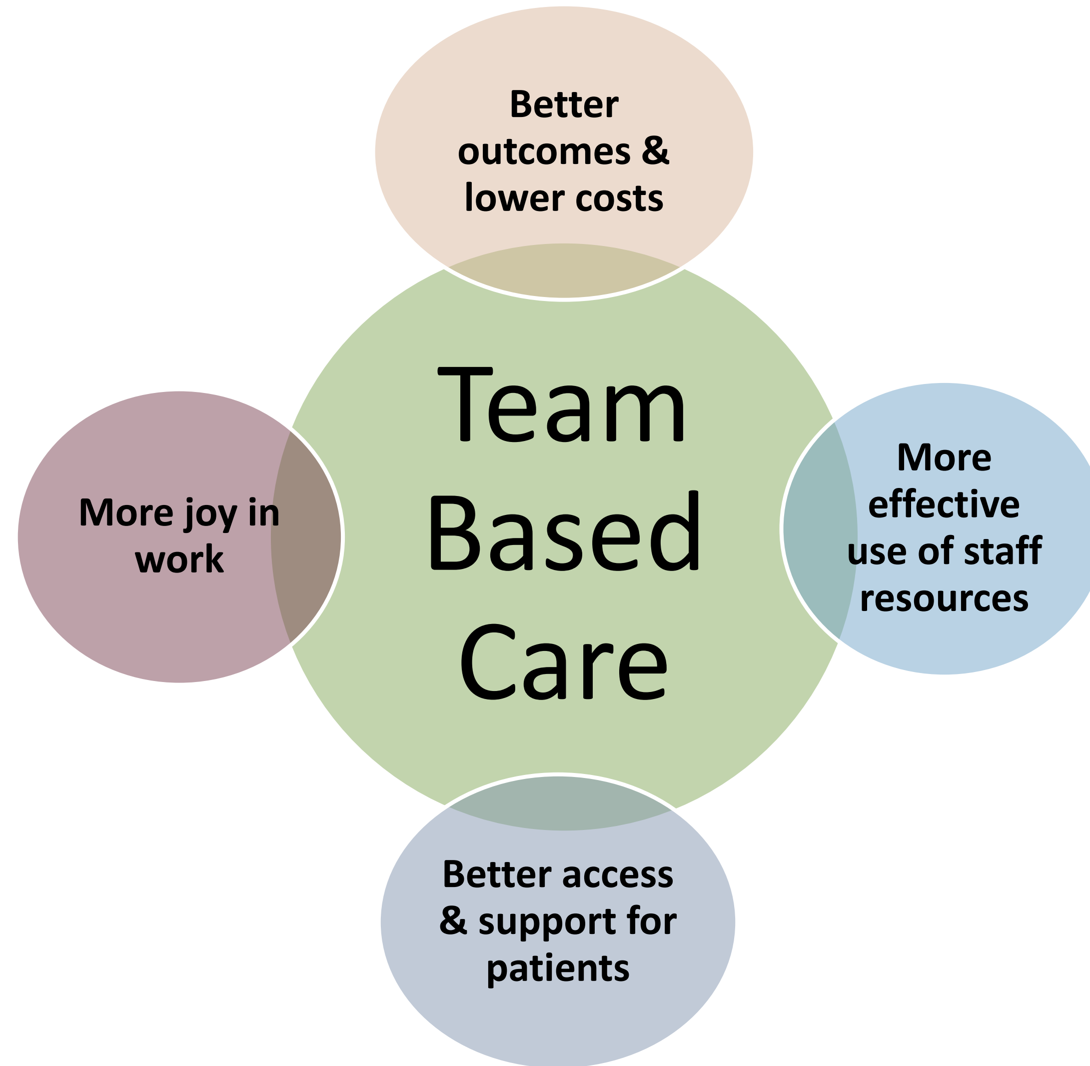

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CHATTER FALL

WHAT DO YOU THINK ARE THE BARRIERS TO HAVING SUCCESSFUL TEAM BASED CARE?

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Why is it so hard to build an effective team?

The Five Dysfunctions of a Team: A Leadership Fable, Patrick Lencione, Jossey Bass, 2002

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Team Based Care – takes both technical and adaptive work

- Technical Components - concrete systems, tools and/or knowledge to support an approach of Team-based care
- Adaptive Components – freely changing or adjusting to another type of behavior or situation

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TEAM BASED CARE – TECHNICAL

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- Clear roles and workflows
- Use of evidence-based protocols, standing orders, guides
- Hand-offs and communication processes
- Supportive IT tools
- Care plans
- Huddles/pre-visit/tracking and follow-up
- Training
- Measures/feedback

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TEAM BASED CARE – ADAPTIVE

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- Role Clarity and agreement
- Shared goals
- Trust
- Honesty
- Effective Communication skills
- Patient-centered
- Measures/Feedback

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Principles of Effective Team-Based Heath Care

Principles

- Shared goals
- Clear roles
- Mutual trust
- Effective communication
- Measurable processes and outcomes

Person Values

- Honesty
- Discipline
- Creativity
- Humility
- Curiosity

Mitchell, et al 2012, Institute of Medicine, Washington, DC. www.iom.edu/tbc

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Shared Goals -

The team, including patient and family, works to establish shared goals that reflect patient priorities and can be clearly articulated, understood and supported by all team members.

Mutual Trust -

Team members earn each other’s trust, creating strong norms of reciprocity and greater opportunities for shared achievement.

- Trust is earned through good and reliable communication, follow-up and open dialogue about problems as well as successes.
- Psychological safety…..

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Effective Communication -

The team prioritizes and continually refines its communication skills.

It has consistent channels for candid and complete communication, which are accessed and used by all team members across 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.

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TEAM BASED CARE - TECHNICAL TOOLS

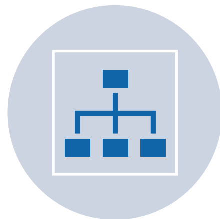
CLEAR ROLES AND WORKFLOWS

USE OF EVIDENCE-BASED PROTOCOLS, STANDING ORDERS, GUIDES

HAND-OFFS AND COMMUNICATION PROCESSES

SUPPORTIVE IT TOOLS

CARE PLANS



HUDDLES/PRE-VISIT/TRACKING AND FOLLOW-UP

TRAINING

MEASURES/FEEDBACK

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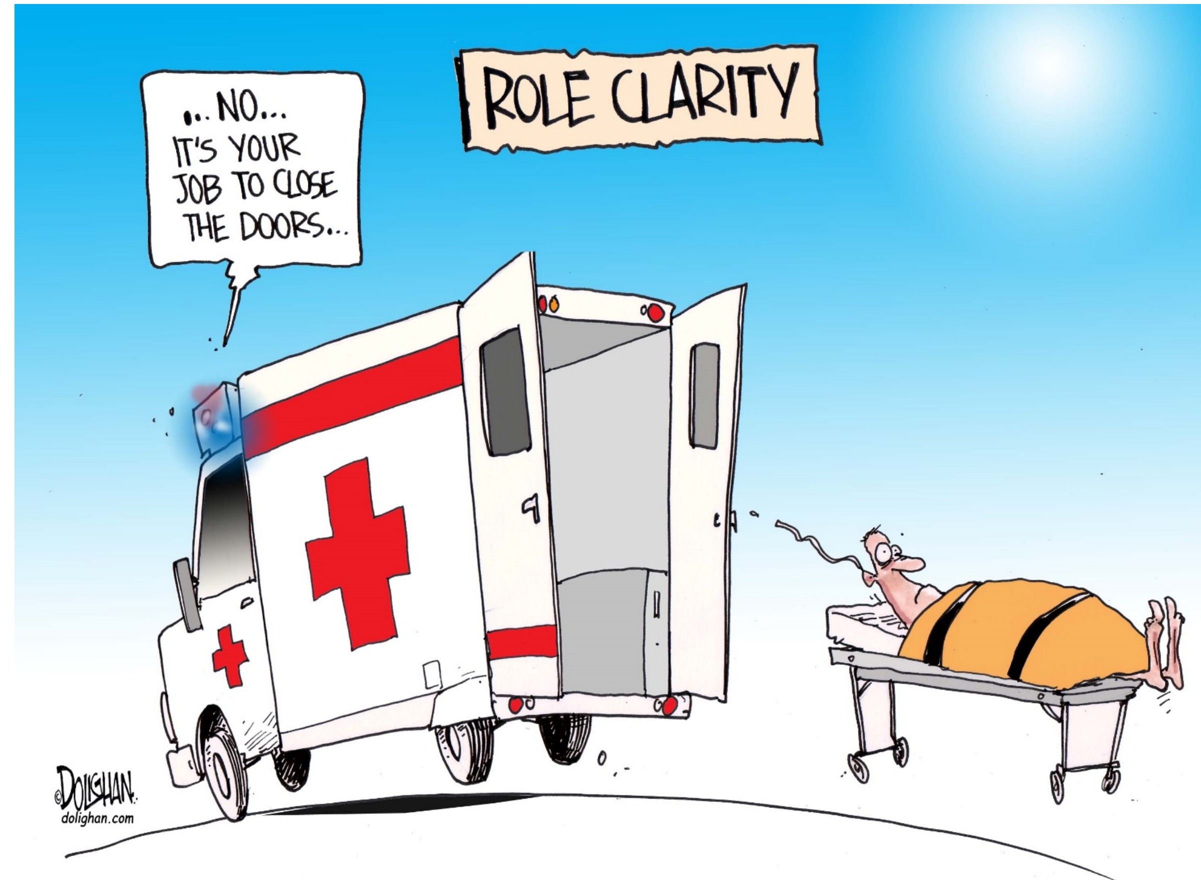
Clear Roles are Essential

Title Versus Function



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Leveraging everyone on the team to Identify and improve Cholesterol, Blood Pressure and Diabetes control through:

- Right person/right role – top of skills/training/licensure
- Education/consistency- speaking the same language
- No wrong door/relationship with patient as a team
- Check in/huddle
- Change/process improvement
- Motivational interviewing
- Medication adherence strategies
- Follow up and follow through
- Communication and feedback

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- Workflows
- Use of evidence-based protocols, standing orders, guides
- Hand-offs and communication processes
- Supportive IT tools
- Care plans
- Huddles/pre-visit/tracking and follow-up
- Training

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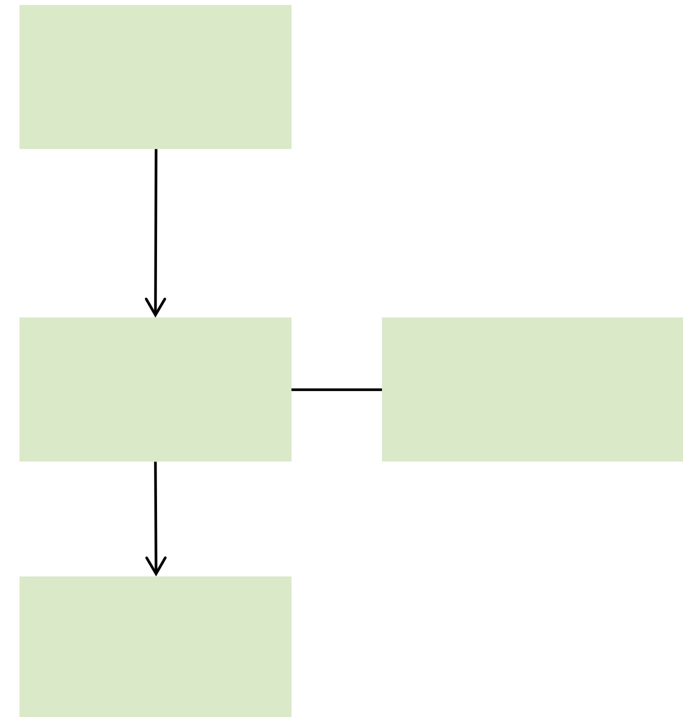
- Communication links between roles
- Hand-offs to team members
- Care transitions



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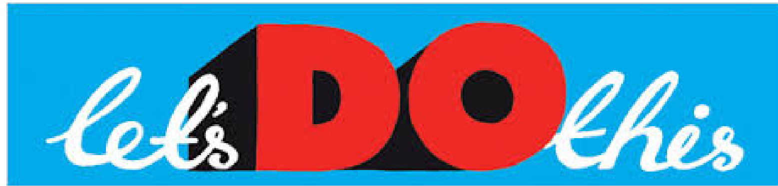

- Huddles
- SBAR
- Call out
- Check Back

- Use Professional Jargon
- Assume understanding
- Communicate once

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IT SUPPORTS & OTHER TOOLS

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- Pre-visit planning – who does it and how, EMR capabilities and tracking/reminders
- Huddles – brief, proactive, routine, team meeting to prep for day
- Care Plans – one common plan used by all on the team (including the patient)
- Treat-to-target protocols – guides for each team member, standing orders for efficiencies,
- Risk assessment and stratification – helps to build the appropriate care and resources
- Registries for tracking and follow-up

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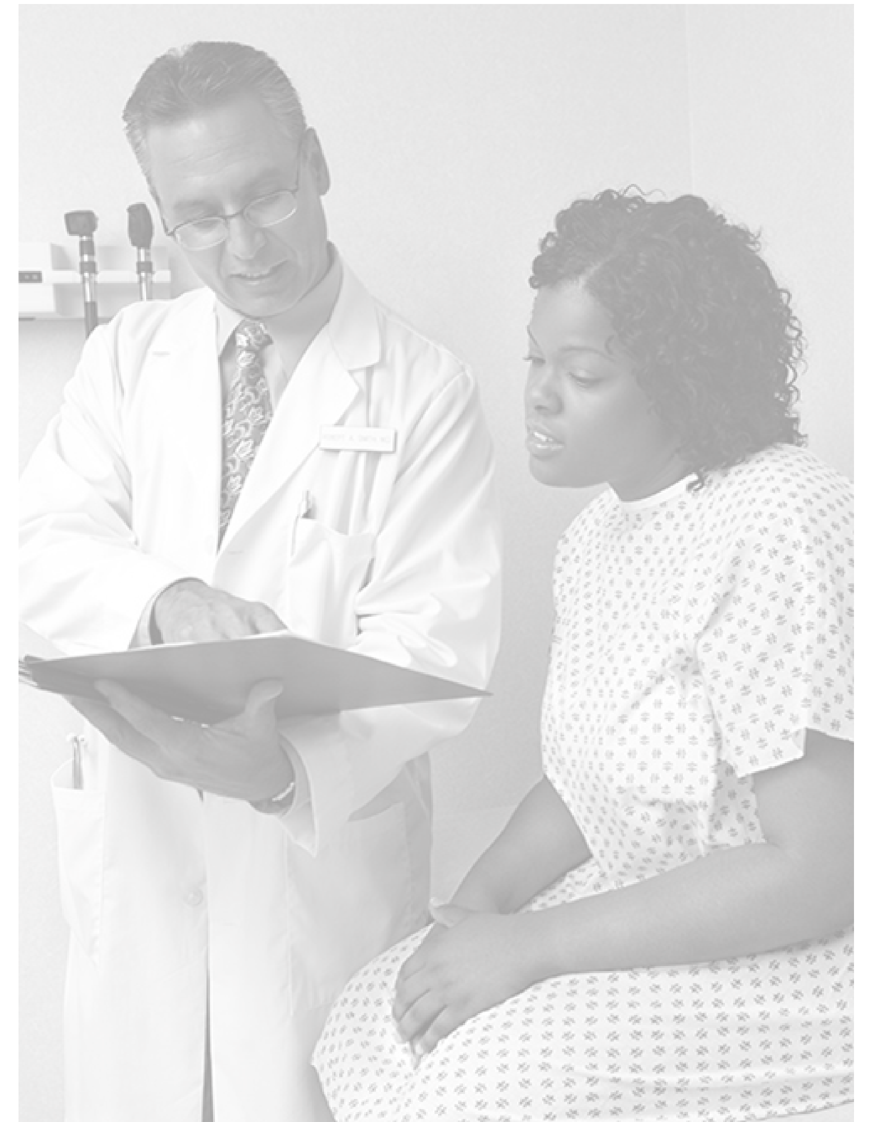
- Care plans
- Readiness for change
- Social determinants
- Literacy
- Identifying barriers
- Resources
- Shared decision making – patients wants and needs



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The Value of Using the Whole Team for Virtual Care of Chronic Diseases

Facilitates Population Health Management for the most common chronic diseases

Removes barriers to guideline-based care

Enables provision of education, severity assessments, and routine monitoring

Where appropriate, some of these telehealth services can be delivered by non-clinician staff

Rebuilds practice visit flow with needed and often neglected care

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EXAMPLES OF VIRTUAL CARE WORKFLOWS FOR HYPERTENSION

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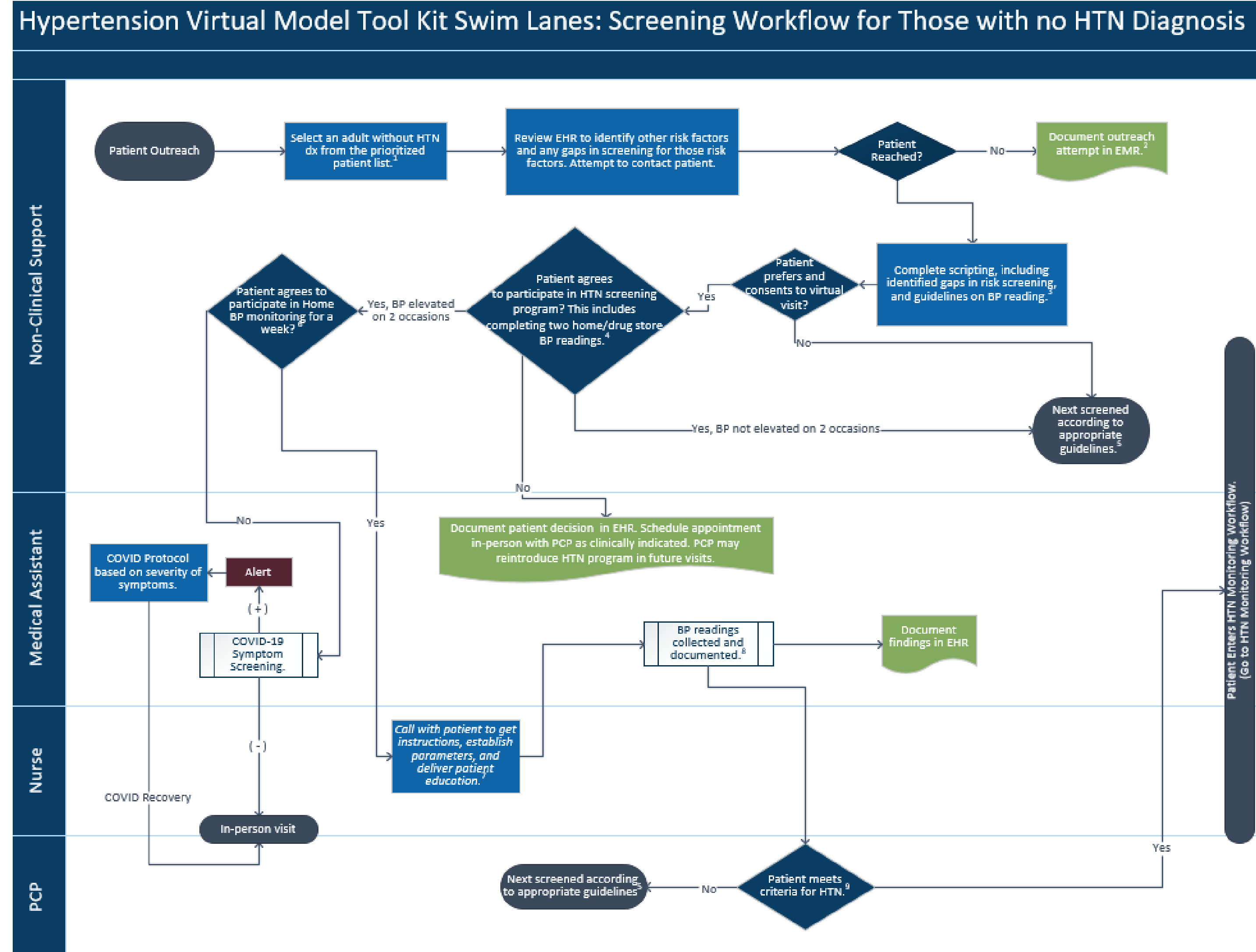
- Prioritizing patients based on risk stratification
- Enrollment of newly diagnosed patients into ongoing self-management
- Patient outreach and engagement
- Coordination for remote patient monitoring device needs – patient self monitoring
- Patient check in visits for BP updates, labs, etc.
- Ensuring appropriate PCP and specialist visits
- Addressing SDOH in helping to manage HTN
- Patient education



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Don Berwick, MD **“Joy in work is not flaky...Joy in work is an essential resource for the enterprise of healing.”**

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We are here to help you !

- ✓ one to one coaching on developing your team
- ✓ assessing how your existing team is functioning and how it can improve
- ✓ participating in internal team meetings
- ✓ reviewing policies/procedures, job descriptions
- ✓ other ideas? Give us a call

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1. To what extent did the session meet the stated objectives? (1 not a all to 5 met all objectives)
   - Identify drivers to care team optimization resulting in better patient care and provider satisfaction
   - Describe key principles for highly effective teams
   - Learn strategies and tools to build both technical and adaptive culture

2. How would you rate the session overall? (from 1-5, where 1 is poor and 5 is excellent)

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