TEAM-BASED CARE
Go Team!

Discussion of team-based care. Getting to the next level.

- What works?
- What doesn’t work?

Linda Follenweider  
and  
Pat Dennehy
Who Is The Team?

Team-based care is the coordination of activities and the distribution of tasks/responsibilities among clinical team members, consistent with their license and skills, to meet the patient's needs.

Each team member is expected to work at the top of his or her license and/or skill set.
Define PCMH Team

- Highest level of skills and licensure
- New roles for licensed and unlicensed
- Accurate evaluation and assessment of competency
- Local leadership
- No Trust = No Team
Tools for Team Building

• Expand your view of team – include the client
• Eliminate obstacles
• Align:
  – Functional job descriptions
  – Expectations
  – Competencies
  – Reviews
• Do not delay training and standardize it
• Define leadership and oversight
Why Huddles?

- Promotes team work through communication
- Avoids duplicated work
- Uses team members expertise and licensure – right person in the right role
- Frequent communication with team members facilitates the daily plan for care - who is doing what and when and allows the staff to be more efficient
The Ideal Huddle

- Hold twice a day – morning and afternoon
- Need a leader for each huddle – can rotate this job
- Everyone participates
- Keep to 10 minutes
- Becomes established routine
- Stay focused on patients and the day
- Allow no interruptions

Pop management registries are a great tool to use to see more information on each client.
Huddle Speak

• What information is important to plan and give care?
• If you had to make the decision what would you want to know?
• What additional clinical information will help in the decision making?
• Do you have all the information you need to make an informed decision?
• Don’t just report the facts, inform the decision and suggest a plan.
Using Our Team Skills

Welcome to morning clinic exercise
CARE MANAGEMENT AND COORDINATION
Clinic workflows for Care Coordinators and Care Managers using a clinical example.

- What’s working?
- What’s not working?

Linda Follenweider and Pat Dennehy
# Medicaid Accountable Care Enterprises

## Evolution of Models of Care

<table>
<thead>
<tr>
<th>Disease Management</th>
<th>1990’s</th>
<th>Focus on specific disease/disease state</th>
</tr>
</thead>
<tbody>
<tr>
<td>Case Management</td>
<td>About a decade later</td>
<td>Focus on specific patients who often have multiple diseases</td>
</tr>
<tr>
<td>Population Management</td>
<td>Started in the 1990’s with some predictive modeling</td>
<td>Focus on a specific population of patients. Risk stratifying the population to determining the best approach to each risk subgroup</td>
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</table>
| ACO, PCMH, Health Homes    | Present day                 | - Focus on a panel of patients that range from lowest risk to most complex  
                              |                                           | - Use IT to inform and direct management and identify events that may change risk stratification and intervention includes medical neighborhood  
                              |                                           | - Address behavioral health and social determinants of health |

Wallace, P. *Care Whether It Is Called Population or Disease Management, Sidney Garfield MD Would Like the Idea*  
Bodenheimer, T. *Research Synthesis Report No 19 Care Management of Patients with Complex Care Needs*  
December 2009.
Primary Drivers of Avoidable Hospital/ED Admissions and 30-day Readmission
Transition of Care: Definition

The movement of a client from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility) to another.

http://www.cms.gov/EHRIncentivePrograms/Downloads/8TransitionofCareSummary.pdf
What Precipitates Transition?

• **Places**
  – Hospital to home, community, and medical home
  – Jail to community—with a medical home?
  – Nursing home to acute care hospital or to home and community?

• **Events**
  – Trauma
  – Major illness with need for intense specialty care
  – Loss of caretaker

• **Life trajectory**
  – Dependence to independence to dependence
  – End of life
  – Pediatric to Adult Care
Remember What’s Important

• It’s about the CLIENT
  – How/When/Where does the client want/need care?

• It’s about the FAMILY
  – How is the family ready/able/willing to support care?

• It’s about CULTURE
  – Does “the plan” respect the diversity of those we serve?

• It’s about the COMMUNITY
  – What resources support care of the client?
Goals for Supporting Transitions of Care

• Improve client safety
• Improve quality of care
• Improve client experience
• Reduce morbidity and mortality
• Prevent readmission
• Prevent inappropriate or avoidable emergency room visits
• Decrease provider and team stress and burnout
• Avoid poor outcomes and litigations risks
Discharge

• Hospital to home discharges are the most commonly discussed and studied.

• Discharging patients from the hospital is a complex process that is fraught with challenges.

• Preventing avoidable re-hospitalizations has the potential to profoundly improve both the quality-of-life for patients and the financial well-being of healthcare systems.
A heartwarming story about a recent hospital discharge

81 year old U S Army veteran calls 911 asking operator for food
Readmissions

- There were more than 35 million hospital discharges in the United States in 2013.
- Among Medicare patients, almost 19 percent who are discharged from a hospital are readmitted within 30 days.
- We saw the first dip in this number in 2012 as it decreased to 18 percent.
Avoidable Readmissions

- Between 9 and 50 percent of readmissions were judged to be preventable in studies involving retrospective chart review.

- Decreasing the rate of hospital readmissions has been targeted as a high priority for US health care reform.

Modifiable Risk Factors for Readmission

- Premature discharge or inadequate post-discharge support
- Insufficient follow-up
- Therapeutic errors
- Adverse drug events and other medication-related issues
- Failed handoffs
- Complications following procedures
- Nosocomial infections, pressure ulcers, and client falls
Focus on Three Major Drivers

• **Medications**
  – Reconciliation
  – Adherence and access

• **Patient Engagement**
  – Recognized worsening symptoms
  – Client information (written)

• **Warm handoffs**
Primary Factors for Poor Care Transitions

• Absence of single entity (role) responsible for coordination (regardless of setting)

• Lack of communication

• Poorly prepared patients (and/or caregivers) for discharge or lack of understanding

• Genovese syndrome
Genovese Syndrome
March 13, 1964

Catherine “Kitty” Genovese, 28, was stabbed to death within sight and sound of 38 neighbors in Queens, NY.

- Neighbors ignored her cries for help during three separate attacks lasting 35 minutes.
- Police were called only after the third attack had killed her.
- Bystander effect: The human tendency to be less likely to offer help in emergency situations when other people are present.
Discussion

Strategies for follow up with client after a low acuity ED visit.
16 Ambulatory Sensitive Conditions

1. Bacterial pneumonia
2. Hypertension
3. Dehydration
4. Adult asthma
5. Pediatric gastroenteritis
6. Pediatric asthma
7. Urinary tract infection
8. Chronic obstructive pulmonary disease (COPD)
9. Perforated appendix
10. Diabetes short-term complication
11. Low birth weight
12. Diabetes long-term complication
13. Angina without procedure
14. Uncontrolled diabetes
15. Congestive heart failure (CHF)
16. Lower-extremity amputation among patients with diabetes
Preventing Ambulatory Sensitive Conditions Admissions

• **Access**

• **Knowledge**
  - How to access
  - Actionable knowledge about disease state
  - Recognizing control
  - Signs of worsening symptoms
  - Who to call for real time answers
Tell Us What You Are Working On

Work