Idaho Patient Centered Medical Home (PCMH)
Webinar – (March 2, 2016)
Transcription

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Notes

Welcome to the Idaho Patient Centered Medical Home Learning Collaborative Series. Today's talk will be on team-based care.

Today we will be talking about team-based care and getting to the next level in PCMH, particularly about what works and what does not work.

When you think about team-based care the most consistent response that I get when I talk specifically across the country, is that; we are a team, we already work as a team, we get along great as a team. And we talk about team-based care in the concept of patient centered medical homes, team means something a little bit different than that, it goes beyond getting along and really comes around particular coordination of activities and distribution of those tasks and responsibilities among all the team members. And this distribution is consistent with their licensure and skill sets and done to meet the patient's needs.

Every team member is expected to work at the top of his or her license and expand their skill set on their part of the patient centered medical team. Having people work to the highest level of skills and licensure creates some challenges.

One of the most consistent challenges I have seen as teams struggle to develop these delegation of tasks, letting go, creating new ways of managing care, not just in front of the provider during a face-to-face, but at every level, maybe even through outreach or through non-traditional visits is that there has to insist on trust that the standard of care that is performed on any of any of these other levels will equal the standard of care that would be given at that face-to-face provider meeting.

I am going to say this again because it is a critical piece. Unless the providers believe that the standard of care that is provided outside of the face-to-face meeting is equal to the standard of care that they would provide themselves, you are not going to get the team-based technique needed in order to function as a PCMH. In order for this trust to occur, there has to be training for each member of the team as well as very clear delineation and definition of the new roles for people that are licensed and unlicensed that work within the practice. Some of the role is going to be defined by your state and what a licensed person can do as opposed to an unlicensed person. The parameters may be defined by skillsets of people within your clinic.

There also has to be an opportunity for accurate evaluation and assessment of competency. This is best done on a system level if possible rather than as an expectation of the individual provider to do that. And it is very dependent on local leadership that they take very seriously this need for the training. If there is not trust, there is no team. There will not be a delegation of those meetings outside of the

provider, face-to-face. And I would also like to say, too, that this is not a reflection in a negative way it is actually a positive reflection. I like to call this, as the providers say; healthy skepticism.

There is an inherent, for your providers that are very engaged and care about their patients, they want to make sure that the care that they receive, and any of these protocols or other processes is that they will be made aware if there is a need for them to become engaged as well in a consistent way. So that they can trust that the standard of care across the practice is equivalent to what they would provide.

During PCMH transformation some the areas that are, really impact the need, for this team because there is the pride in the amount of services that are provided and the way they are the provided are that there will be more point of care services for your clinic and also more access to different services at different times within your clinic.

Patient's visits might not look the same as they traditionally always looked. There will be different coordination that is required with other parts of the healthcare system and other healthcare providers. And team-based care is a critical component in making sure that your staff demand can handle all these new avenues of communication. There may be changes in the way the practice is managed so, empanelment, in particular, is an area that is being devised. A clinic that is function on a broader point into smaller pods or team of patients and typically there are changes in roles for all members of the team as you get to transfer with your patient into medical homes.

They are also new strategies for patient engagement and patient engagement should begin even from the first call, the first outreach to a patient as they come in. So how that is scripted, how each team member talks about that is a critical piece.
Also:

- How to use new information systems and technology to make sure that you are capturing the data that you need to really inform this visit and future visits for your patient and other patients that are similar to this patient
- How to respond to events that happen outside the clinical setting
- How to contact and call someone who is in the emergency room
- How to talk to someone who just set up hospice or home-based services

You may become so efficient in the timing of your population and what their needs are that you can begin to do additional staffing that is outcomes-based. So in a practice where you know there is a large number of diabetics, perhaps additional staffing with a diabetic educator or areas where the need would exist for someone on coagulation R&D staffing. Now once you begin to collect your data and understand, really understand your population and what their needs are staffing can become outcomes-based as well as based on the volume of patients you see. And there also needs to be quality improvement at every point of care and to look at those process and outcomes for your clinic.

Additional challenges for the team are a need for increased access. There are different scheduling mechanisms that have opened up in different places. One example would be open scheduling where it is completely unscheduled; and that providers have a specific number of openings at each session and people can access them from the panels. It can be designed in a lot of different ways, but full open scheduling has received mixed

reviews, let us say, from both patients and providers on both sides. But there certainly are populations where this may make sense. If you work with a transient population moving toward a migrant population, people that consistently only engage for episodic care. Having open schedules for those patients might make more sense.

But a big critical piece for scheduling as far as access which you need to create some type of scheduling so that the same provider or provider team member can see that patient both for their chronic or scheduled appointments *and* their acute visits; so if they become sick or have worsening symptoms that they get back in front of that same provider or team member. And those visits may or may not be face-to-face and they may or may not be with the provider. They may be with another team member that has developed competencies around certain types of visits.

There also may be differences of types. So group visits are an example. You may bring in people with certain – diabetic group visits are an example of visits that have been used in the past that are effective. Centering pregnancy as a cohorted, prenatal visit; where those studies have good outcomes for women. And they also – depending on your practice and the type of patients that you have, you may determine another type of group that is also valuable for you.

When I worked as the Director for Asthma for Cook County Health System, I created a Thursday morning group visit that was for any new patient that had been seen in the emergency room for asthma. And the emergency rooms through the Cook County system were allowed to schedule those patients into my group visits. Patients would show up on Thursday. It did not show you how many patients there would be, but every Thursday we would get a group of patients that would come in and we would start their visit with some basic teaching around the county health system, how to access medication in the pharmacy, how to schedule an appointment as well as information on basics around asthma. And then after the group visits they would often have some discussion about their worsening symptoms, what they felt prior to the asthma, but providers would take different people for their individual visits from that group.

It was a very effective way for us to engage a – group of patients who were really vulnerable. And that we wanted to make sure that we set up the right way to be a part of the system. It was well received by the providers because a lot of that information is stuff that they did not want to have to explain over and over again and were well explained by the nurse and medical assistants who attended the groups. You could also suggest a nurse or phone visit or a multi-disciplinary visit. But other types of visits that you set up, you want to make sure that the patient gets everything that they need in that visit.

You do not want to set up a visit just for a visit or it actually becomes a delay in care for that patient. So if you set up a nurse visit let us say around hypertension management, the nurse should be able to, within in a protocol, increase the blood pressure medication for that patient if it falls within the protocol or give them the prescription that they need for three months if they – if it does not work.

One of the clinics that I worked with in Baton Rouge the nurses had a high transient population that would come in for blood pressure treatment but they would only come in after they had run out of medication. So they never knew if the dose that they had been on was appropriate.

So the nurses were for that specific group, people who came in and had been seen at some point, now had not had medicine for a week were allowed to give the patient a certain number of days of that last blood pressure medicine be it three or seven days based on how long the onset of action would be expected for the meds. And then schedule a visit to come back and see the nurse at that time and make an adjustment in the blood pressure meds. It became a very effective way to getting people to go on blood pressure medicine. And again it was very well received, eventually, by the providers as well because there is a frustration to those types of visits when people come in and you cannot really move them where you want to move them in the visit.

Also we need to think how do we determine who we see and how frequently we see them? Does it need to be based on how frequently they need a prescription for their mail order medication company or is it how frequently they truly to be seen? And if they focused on their health outcomes would we keep the interval between visits the same?

What our current problem is that we have a payer system that does not match our current practice situation. In other words, you paid for face-to-face provider visits but as we look at PCMH care management and care transitions, what we are really looking at is a lot of value of visits which are not reimbursable to current plans. So as we are thinking of moving towards PCMH with your team, eventually there is an expectation that these care management visits will be covered, but until that time how do you bridge the time until the payers actually catch up to the philosophy of care that comes with PCMH?

One good way to look at your current team and help them see what the expectation is for them from the patient is to look at the Consumer Assessment of Healthcare Providers and Systems (CAHPS) PCMH question survey. And this is not a satisfaction survey but what it does is ask really specific patient's questions to help them, help identify how close you are to PCMH. So this says does the provider office give you information about what to do if you need care evenings, weekends and holidays is one example of multiple questions that would help your staff understand the type of expectations that are needed for PCMH. And this questionnaire, this patient survey, also is a great opportunity for you to get some feedback from patients as well if you do implement that in your practice.

A critical part to think about as far as when you engage the team is to look at areas where there are specific values. And one of those is outreach. There is an expectation for significant outreach with PCMH. It has been shown to improve the benefits of having care measures. And it does not need to be done by the provider. Here is a list of two different studies that have shown improvement based on outreach. But in addition to that, there is an outreach post-hospitalization expectation and that being done in 48 to 72 hours as well as the outreach to proactively help people schedule for appointments that are needed. And as you begin to think of team a member; who does it make sense to align to do those types of services?

Just to give you some examples of some innovative things addressing those areas is - Thinking Outside the Doc is the Children's Welfare Society in Chicago, actually the Chief Financial Officer (CFO) worked with the response from the state around their certain measures with Medicaid populations where they were paid if they hit certain metrics. And one of them they were consistently found very short on, less than 20 percent was the health assessments, complete exams, for a child at two, the age of two. Children did not come back for that exam very frequently, and it was an area that he really – it was also aligned with the financials of the state if he did it. So what he determined to do was

to actually look up who, of their patient population, who would have been turning two, three months before their second birthday and start to set up calls to schedule them in and bring them in for that two-year exam. And they moved from less than 20 percent to greater than 90 percent and they also received their money from the state for that success which they used to hire another person to come in during the evening who spoke Spanish to even increase outreach that they were doing around this and other areas as well.

If you begin to think of your team, your team is bigger even than those that touch the patient themselves, those considered billing and finance people as allies in health. They can help you a great deal in setting up your registry, looking at old claims, finding out prior diagnoses, identifying your shadow panel to people that you have spoken, great and unseen but that do not come into the office, and how to reach them.

And also, but do not forget the front desk as important people. In California they use the front desk people in Los Angeles (LA) County, they set up and have the front desk people begin to do the Patient Health Questionnaire (PHQ)-2 depression screening when they call for appointments on anyone who identified as positive that saw the nurse for the PHQ-9 prior to seeing the provider.

And initially people were nervous about that, they were like what if people say yes, do you have them schedule for an appointment? It became a great program. Actually, [they were] quite excited even about questions to ask. Typically, they did not ask in the past. And they also then, because they enjoyed it so much, began to ask people if they smoked. If they said “no,” they said, “would you like to quit?” And if they said “yes,” they pulled them to sit with a person who talked to them about smoking cessation. Education right in that moment to help them step up with a quit date and prep them for smoking cessation visits.

And they became very successful in helping people with that and with quitting. And they actually created one of those speedometers at the front desk and everyone that they helped to quit smoking they recorded how many lives they touched with that. But again, when you think of team really broaden it and begin to think of other people, there is opportunity in the script and there is a real need in in-reach and outreach to engage a larger group of the team members to assist.

In addition to the outreach we talked about there is in-reach which means that at the point that a person enters the clinic anything, any other needs should be addressed. The motto is “every patient, every time,” and that there is no wrong way to come into the clinic and receive all the things that you need to have your best health outcomes and be your healthiest. And again, this is a scenario where your front desk and the medical assistant (MA) staff and their abilities to pre-chart and make sure that they are entering data, really discrete fields, that helps to drive your registry in a way so it can inform is critical.

And other – how they intersect with things like lab specialty and diagnosis is critical and that as well. So you think of the functional job description and what people do, make sure you broaden your team-based care to include *all* of these important PCMH measures.
In addition to every one we talk about as you expand your ideas of team, include the client. The client is a critical piece of your team, and very important person to engage

and to contribute to the decision making for their care. Shared decision making is a critical piece so if you are not circling back to include the client you are basically leaving that out.

Try to eliminate any obstacles that you have. And frequently, internally we create our biggest obstacles with policies or procedures that eliminate people from doing a critical function. Align the functional job descriptions with expectations, competencies, and reviews. Again, creating a trust that the standard of care is going to be what is needed to provide the excellent services that you expect at your clinic.

Do not delay your training; do not wait until everything is perfect. Start training right away, start it yesterday if you can do that, and standardize it. And it is best if the training occurs at the highest system level so as people are hired there is training around PCMH and training around what the expectations are. And make sure you define leadership and oversight. Both are at a high level as well as local leadership and oversight.

One of the tools that you can use once you have your team in place is to use a huddle. Huddle helps teams learn how to communicate. Huddles also help all team members feel like they have a voice in the team. It avoids the duplication of work and it makes sure that people are using their expertise and licensure so that you have the right person in the role. It provides for frequent communication with team members that facilitates the plan of care. And it helps staff to be more efficient. And it helps them to learn from each other.

Ideally, you should hold a huddle twice a day, morning and the afternoon. Each huddle should have a leader and this job should be rotated between team members so that everyone gets a turn. Eventually it may make sense to have one person do them consistently and prepare. Everyone should participate in it. Keep it 10 minutes. A lot of places, they do it standing so that people do not get too comfortable. It should become an established routine and you should stay focused on the patients and that day and what is going to happen that day. Do not allow anyone else to interrupt your huddle. It is a critical piece to make sure your day is moving the way you want it to do.

And the types of things you should talk about in the huddle; if you think about each patient and these questions help to set up the how the non-clinician team members to think about what is important to plan and get care for this patient? What do I need? And if you are the leader of this you might want to call out the patients, “What about Mr. Smith do we really need to know to plan his care today?” And if I had to make a decision about Mr. Smith’s care what additional pieces do I need to know to help make that decision or what would I want to know specifically to make that decision.

And do we have all of that information here in the clinic or should someone do some outreach this morning to the emergency room or the lab to make sure we have that information when he gets there. And also stay in the mode of just reporting what the facts are about the individual and stick with the facts inform the decision and set a plan. It is not set up as a time for gossip or for side information.

So you made it to the end of the presentation and we have an exercise for you to try to practice your huddle skills, and also to practice your ability to work together as a team, and assign roles on the team.

You just had a typical day in the office. You just found out the provider is going to be an hour late. You need to look at both today's schedule so the call-ins, requests for services, and try to set up that day and prioritize what is important and to expedite through the patient after you have had some chance to figure it out together as a team. We will have you do it as a practice huddle, stand and the assigning and do it as a practice huddle.

And the second step is information that you would have from a registry or if you had people actually calling you, getting information to help inform around those patients and try the exercise again, now with the new information. And practice the huddle again and see if there are any differences that you notice that are from the assistance of those registry information.

Thank you for your attention today, and if you have any questions please contact your PCMH coordinator or practice team for assistance with any of these skills or ideas. Thank you.