ENHANCED TEAM BASED CARE

STFM Conference on
Practice Improvement 2013

MAYO CLINIC

LEARNING OBJECTIVES

Apply the concepts of design thinking to outpatient care delivery transformation

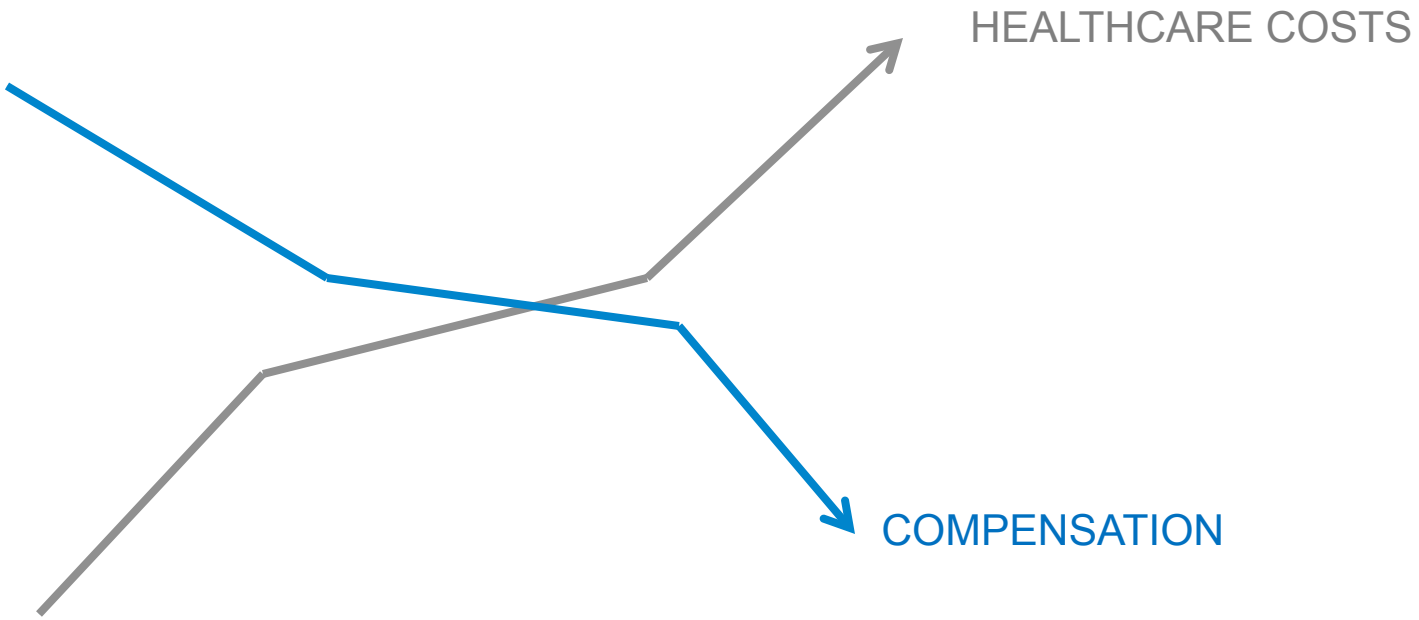
Become familiar with a model for flexible primary care teams that can respond to patient's needs in ways that meet the IHI Triple Aim goals

SPECIFIC TAKE AWAY

The optimized care team is a new model for primary care that shifts away from provider visit driven care and towards collaborative team-based care where each role on the team provides meaningful touch points to enhance the patient care experience

DISCLOSURES

None



1

Beginning NOW, health care organizations will be responsible for **keeping a population healthy** instead of being rewarded for caring for individuals only when they get sick

2

We need to transform our delivery model to one that eliminates waste and **rewards value**

An enhanced team model is the framework through which we can build out this new model of care.

3

New models of primary care must be practical and transformative and enable the shift from fee for service to fee for value to create a customer/patient service driven culture that **consistently improves outcomes and experience at decreased cost**

4

To remain relevant, primary care will require health systems to move beyond the inpatient core business model to invest in the **complete arc of care**

The most successful future requires **shifting investments** away from acute care assets and towards primary and community-based care

5

At the heart of a successful primary care model is a **comprehensive care management** infrastructure that delivers coordinated, integrated care

Effective care management will require significant investment in **non-physician** clinical workforce and workflow

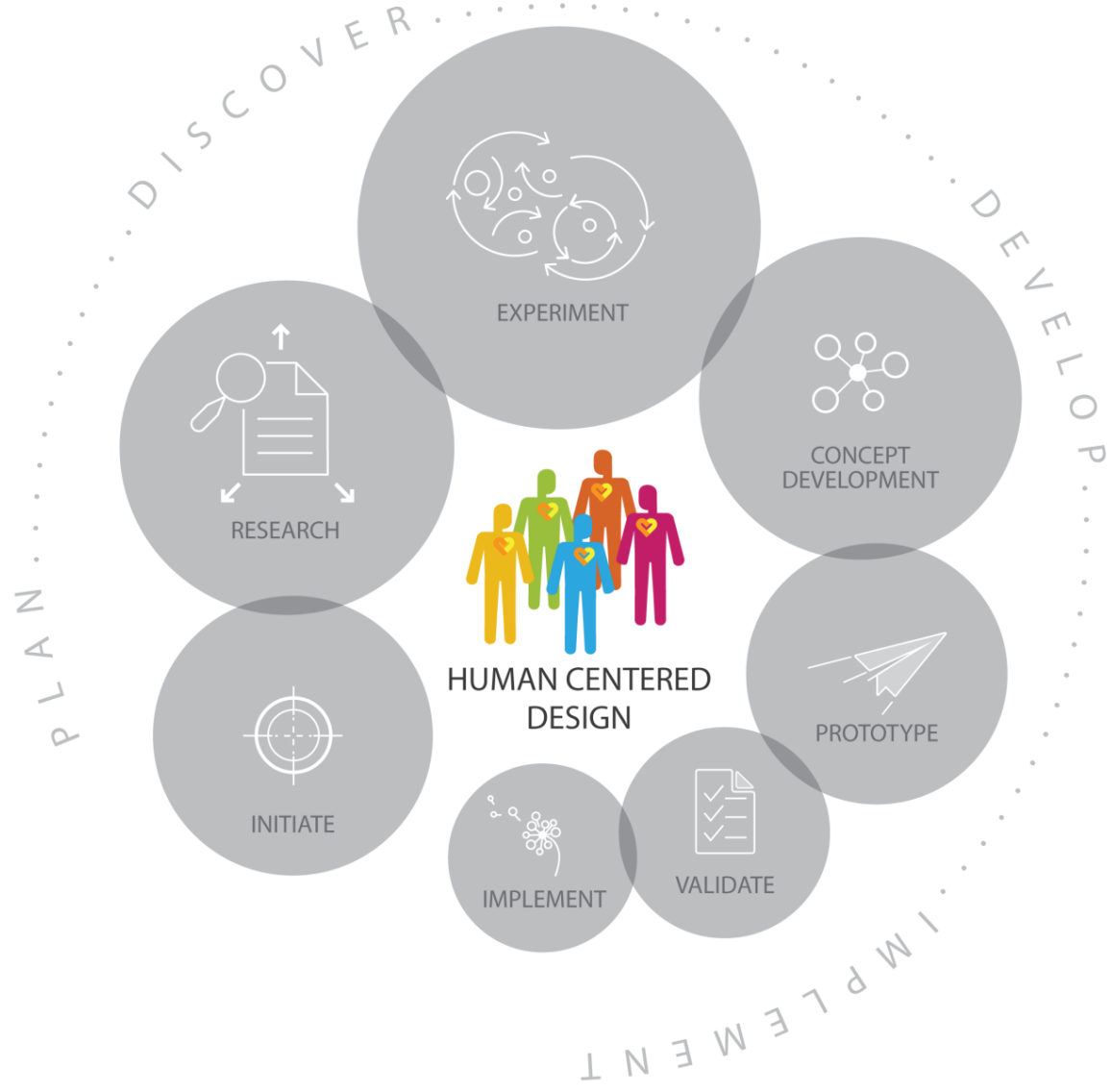
6

Success will require robust and **real time data** on patient needs and clinical performance

The most successful future will require **significant IT investment** to create the tools to analyze and act upon this data

7

The challenge for Primary Care is to **attract and retain new patients** through compelling service offerings and meaningful access to trusted relationships


PLAN
DISCOVER
DEVELOP
IMPLEMENT
EXPERIMENT
RESEARCH
CONCEPT DEVELOPMENT
HUMAN CENTERED DESIGN
INITIATE
PROTOTYPE
IMPLEMENT
VALIDATE

Every system is perfectly designed to achieve exactly the results it gets.

- Donald Berwick, MD

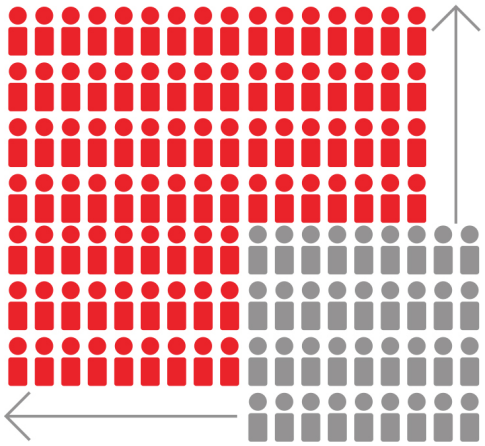
BACKGROUND

In June of 2012, the Center for Innovation (CFI) partnered with Mayo Clinic's Employee Community Health (ECH) Family Medicine practice to explore new models of care delivery that meet the IHI's Triple Aim goals of improving patient experience and outcomes at a reduced cost.

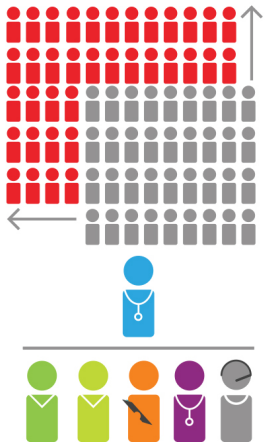
Caveats:

+ This was developed in the ECH practice (salaried physicians).
+ Developed at Mayo Clinic (integrated practice).
+ MN nursing licensure has been interpreted limitedly by Mayo Clinic Primary Care.

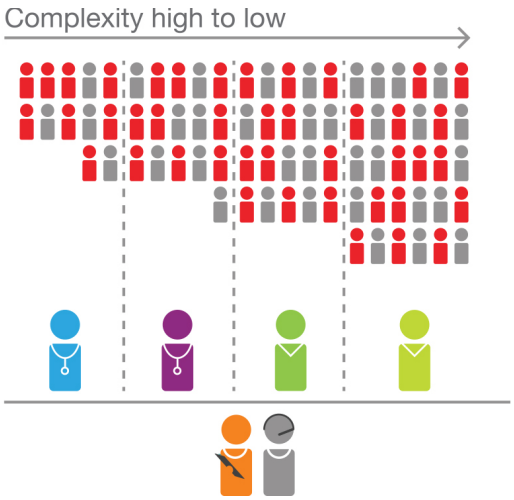
WHY DOES OPTIMIZING THE TEAM MATTER?



INCREASED DEMAND FOR PRIMARY CARE ACCESS



CURRENT PRACTICE



LEVERAGING THE TEAM INCREASES CAPACITY FOR PATIENT CARE

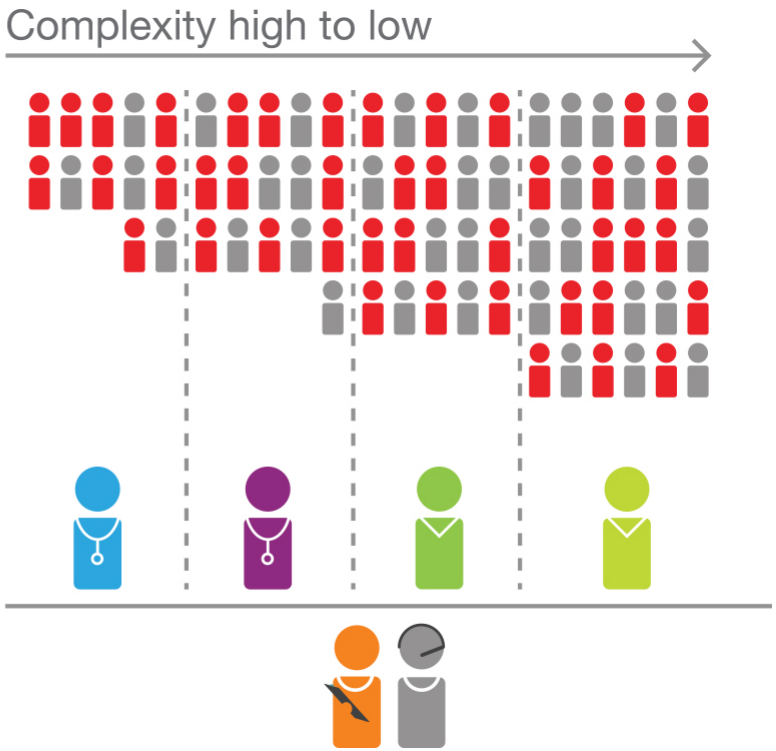
*Estimates that increased demand will double panel sizes and influx of patients from specialty will weight panels towards the higher tier end.

WHY DOES OPTIMIZING THE TEAM MATTER?

We're leveraging previously under-utilized roles to deliver the right care, to the right patients, at the right time.

Sharing care responsibilities across the team means:

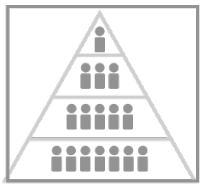
+ Increasing nurse-only visits
+ Improving the integration of allied staff members providing specialized services.
+ Daily communication and coordination of patient care across the team.
+ Increasing non-visit care options.



WORKING WITH THE PHYSICIAN,
NOT FOR THE PHYSICIAN

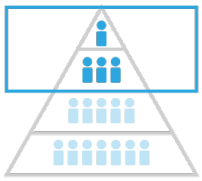
WHAT DOES THE TEAM LOOK LIKE?

Collaborative teamwork delegates care to the most appropriate team member.



Scheduler

+ Elicit Patient Needs
+ Match those Needs to the Right Provider



MD/NP/PA

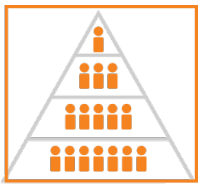
+ Diagnosis and Treatment Plans for Complex Patients
+ Team Leadership
+ Reviewing Team Panels
+ Acute Diagnostic Needs

RN

+ Ongoing Management
+ Patient Education
+ Non-Visit Care
+ Triage Support

LPN/MA/CA

+ Patient Needs Assessment
+ Preventive Service Oversight
+ Triage Support
+ Panel Management Support



WN

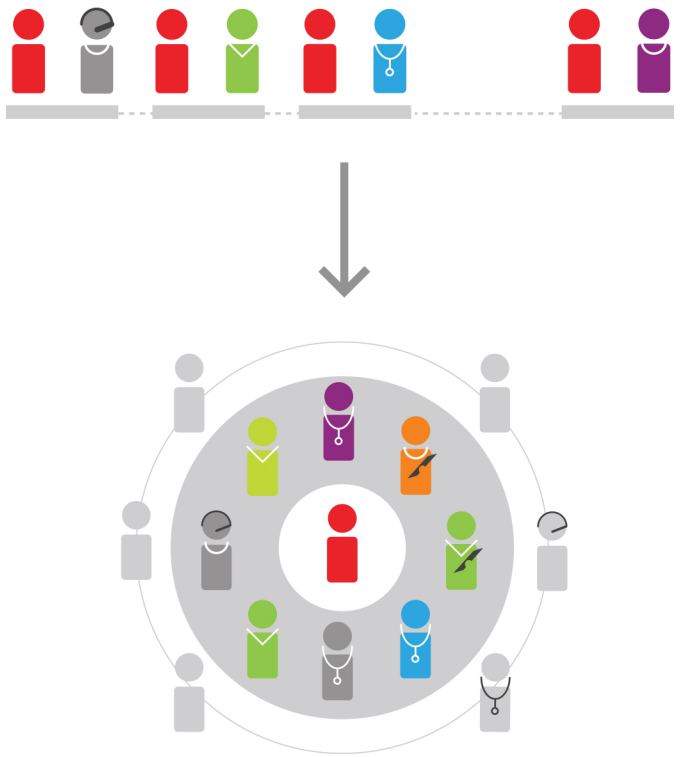
+ Social Needs Assessment
+ Connection to Community Resources
+ Health and Lifestyle Coaching

WHAT IS THE OPTIMIZED CARE TEAM?

A collocated, multi-disciplinary group that works together to meet the needs of a shared team patient panel.

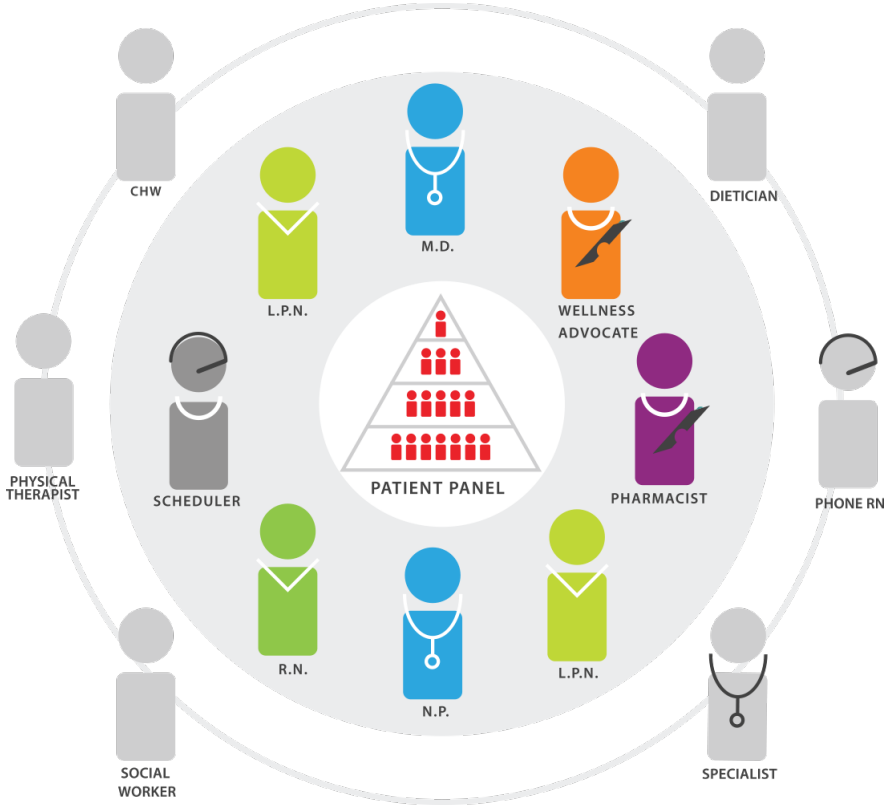
+ Conveyor Belt = disconnected, overly structured, single purpose visits.

+ Wrap-Around Care = flexible, timely, collaborative, shared.



FROM CONVEYOR BELT CARE TO WRAP-AROUND CARE

HOW IS THIS DIFFERENT FROM OTHER CARE TEAM MODELS?



We are not simply emphasizing physician efficiency and maximizing individual physician productivity.

The Optimized Care Team:

+ Establishes how each member of the team can add the most value to direct patient care.
+ Emphasizes the delegation of care across disciplines.
+ Diversifies the relationships patient's have with their clinic.
+ Diversifies the access touch points patients have with their clinic.

WHAT DOES DELEGATING CARE LOOK LIKE?

Working to the Top of Licensure:
A documented, mutually agreed on scope of practice for each member of the team that accounts for national and state specific limitations.

Team-Huddles:
Discus patient case-loads as a team in order to identify anticipated patient needs and the plan for their care.

Warm Hand-offs:
Introduce patients to team members they haven't met, who will be providing care for them.

Engage Patients:
Treat patients as a member of the team. Invite them to actively participate in the management of their health needs.

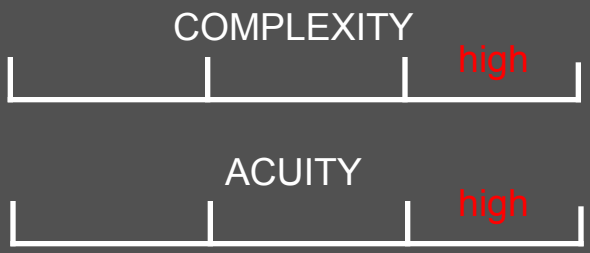
Patient Centered Care Planning:
Identify a single plan of care for each patient that encompasses all actions required for all active: conditions, medications, treatment plans, etc. Include anticipatory guidance. Leverage these plans to delegate care.

Collaborative Practice Agreements:
Create agreements with specialized service providers such as pharmacy, so that patient care can happen more seamlessly in real time.

Shared Patient Panels:
Encourage interaction and trusting relationships between patients and the broader team so that continuity becomes redefined with the care team and not with a single individual.

CHARLOTTE

Charlotte is a female in her late-thirties who struggles to manage her obesity, COPD, and anxiety.



Charlotte receives a weekly call from her RN Coordinator. She has run out of rescue inhalers.

The latest developments in Charlotte's case are discussed with the team. An appointment is scheduled.

The MD is able to proactively reach out for specialty advice on Charlotte's medication plan.

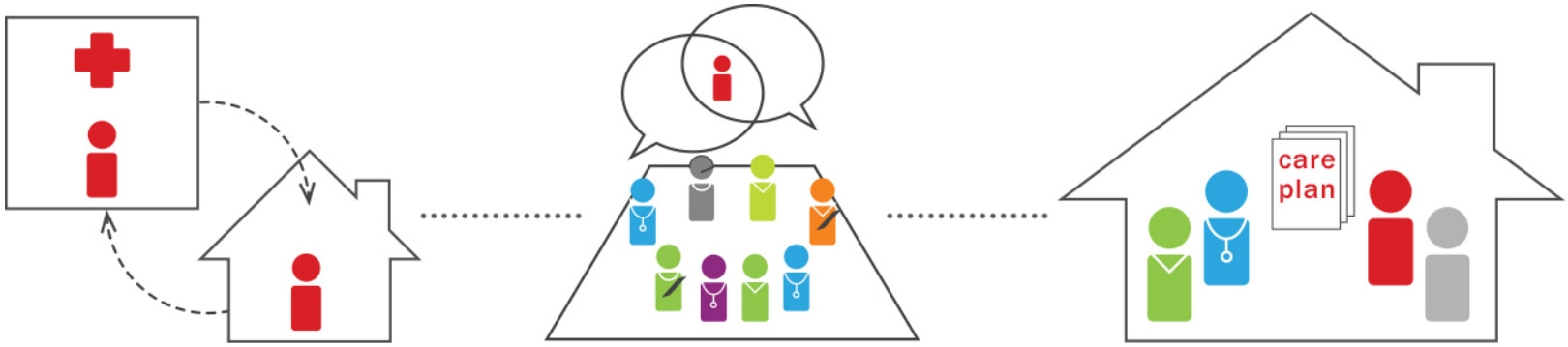
The MD and RN coordinator tag team the visit to ensure new self-management plans are discussed in detail.

FRANK

Frank is an elderly gentleman who suffers from multiple chronic conditions due to age and lifestyle choices. He currently lives at home and is motivated to stay independent.

COMPLEXITY
high

ACUITY
medium



Frank is frequently in and out of the ED and ICU.

The team recognizes Frank's high utilization. They carve out time for a special intervention.

A home visit by a team MD and RN enables a specialized care plan to be established.

BETSY & BABY

Betsy's infant has been struggling with breastfeeding and she turns to her care team for advice on how to handle the current situation.

COMPLEXITY
medium

ACUITY
high

Betsy calls into the clinic and is triaged by the team to the MD.

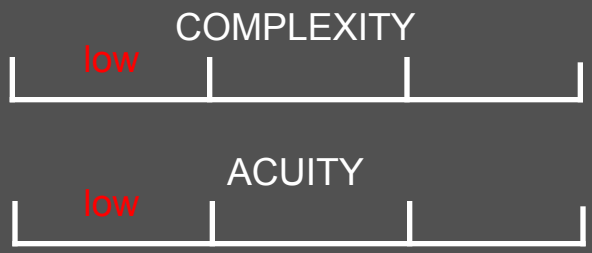
RN and MD work together reviewing the infant's history and symptoms.

RN follows the plan for the visit with Betsy- delivering relevant education.

MD checks in at the end of the visit.

JOHN

John is a young healthy individual who is interested in ways to optimize his current health.

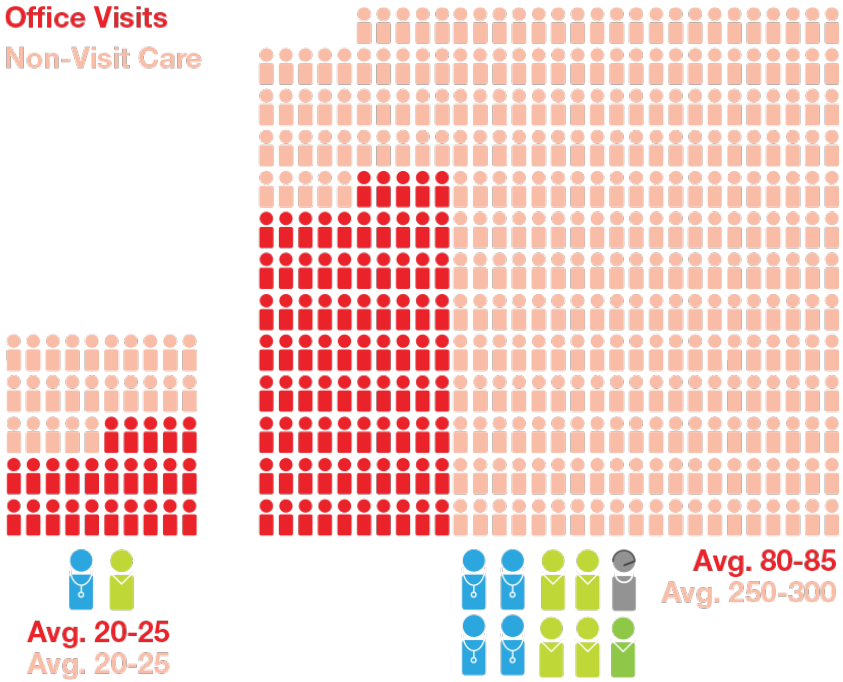


John asks questions via portal, phone, shared care plan and email.

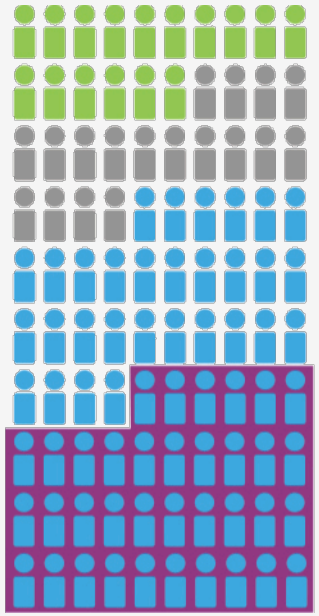
His care team acts as his “health expert,” engaging and answering his questions.

John sets up time with the dietician to discuss nutrition and diet. He does not need to see the care team MD.

HOW MUCH CAPACITY WAS GAINED?



WHO SAW THE PATIENT?



16%
with an RN visit

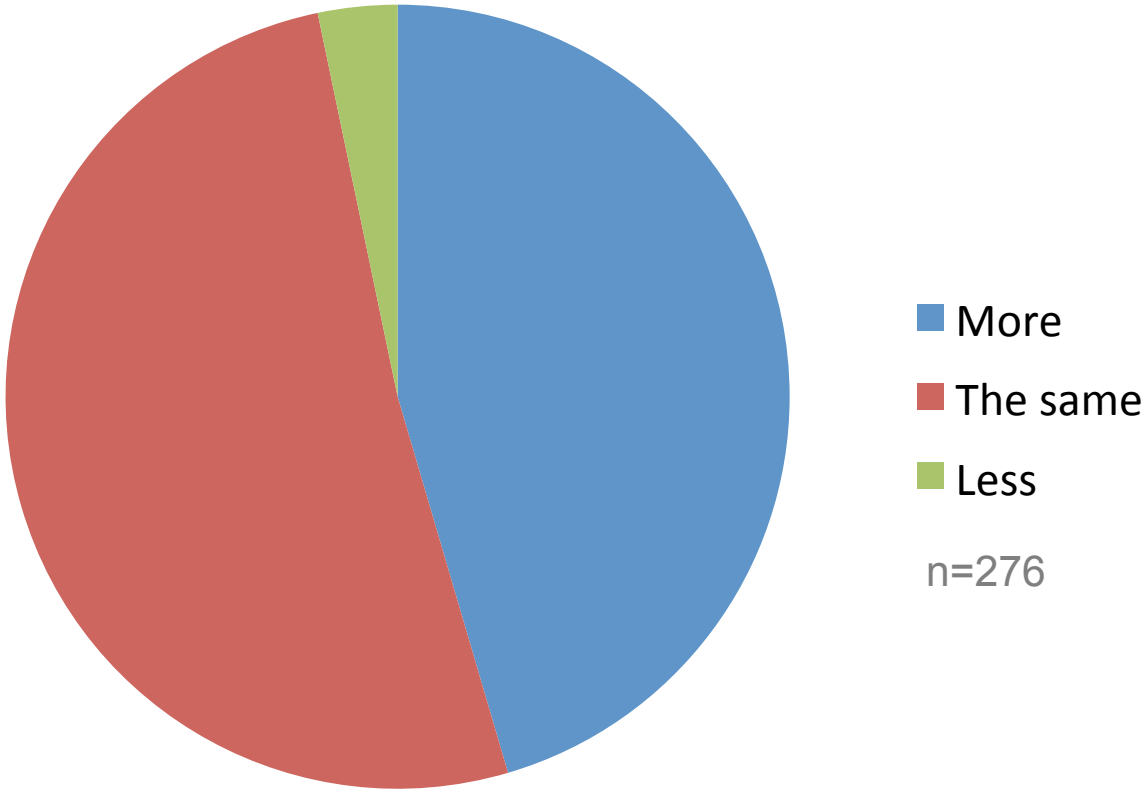
18%
through non visit care

66%
with an NP / PA / MD visit

36%
with integrated team care as part of the visit (e.g. pharmacist)

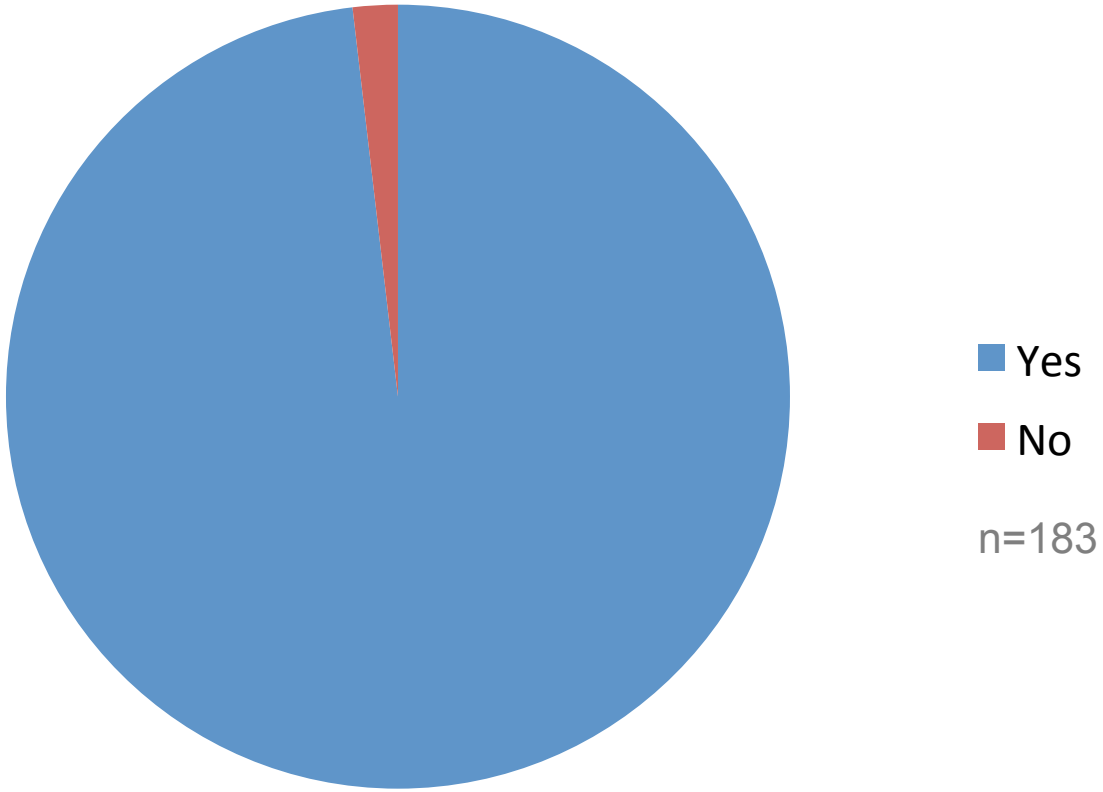
THE PATIENT EXPERIENCE

Were you more or less satisfied with a team based visit as compared to previous visits?



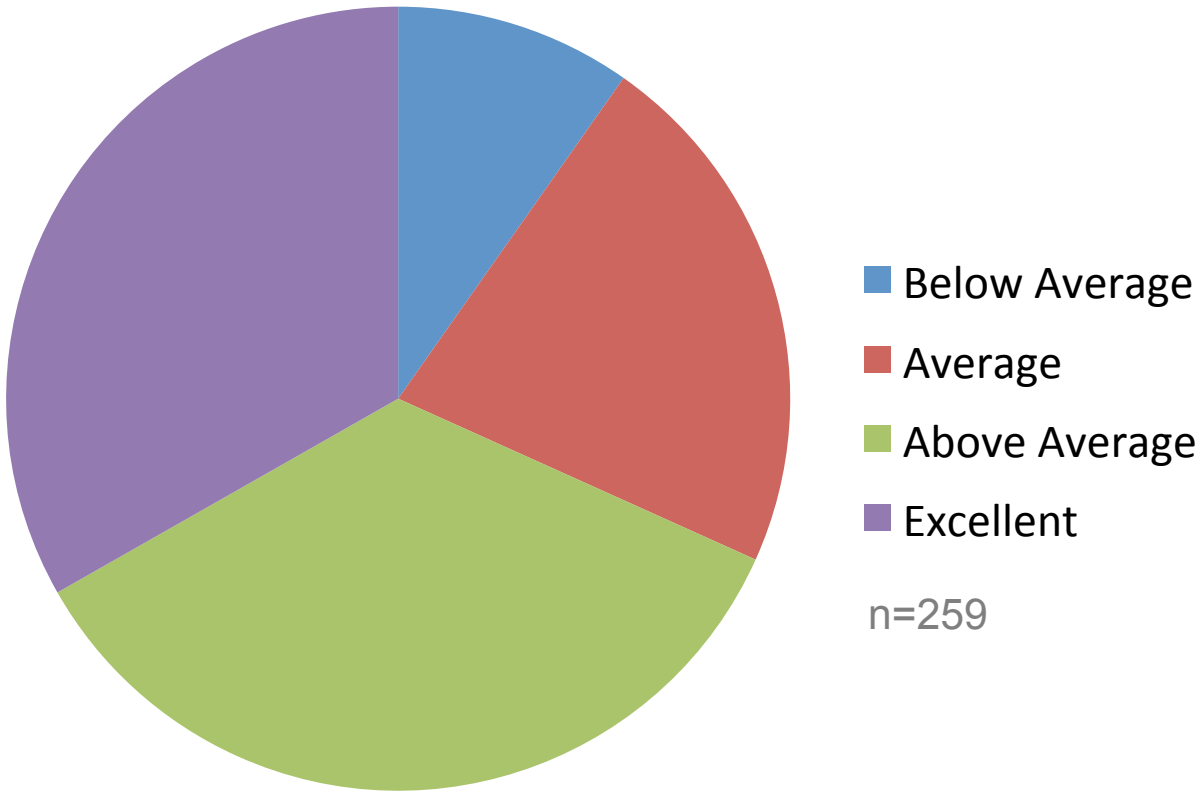
THE PATIENT EXPERIENCE

Was the quality of care you received in a team based visit comparable or better than previous visits?



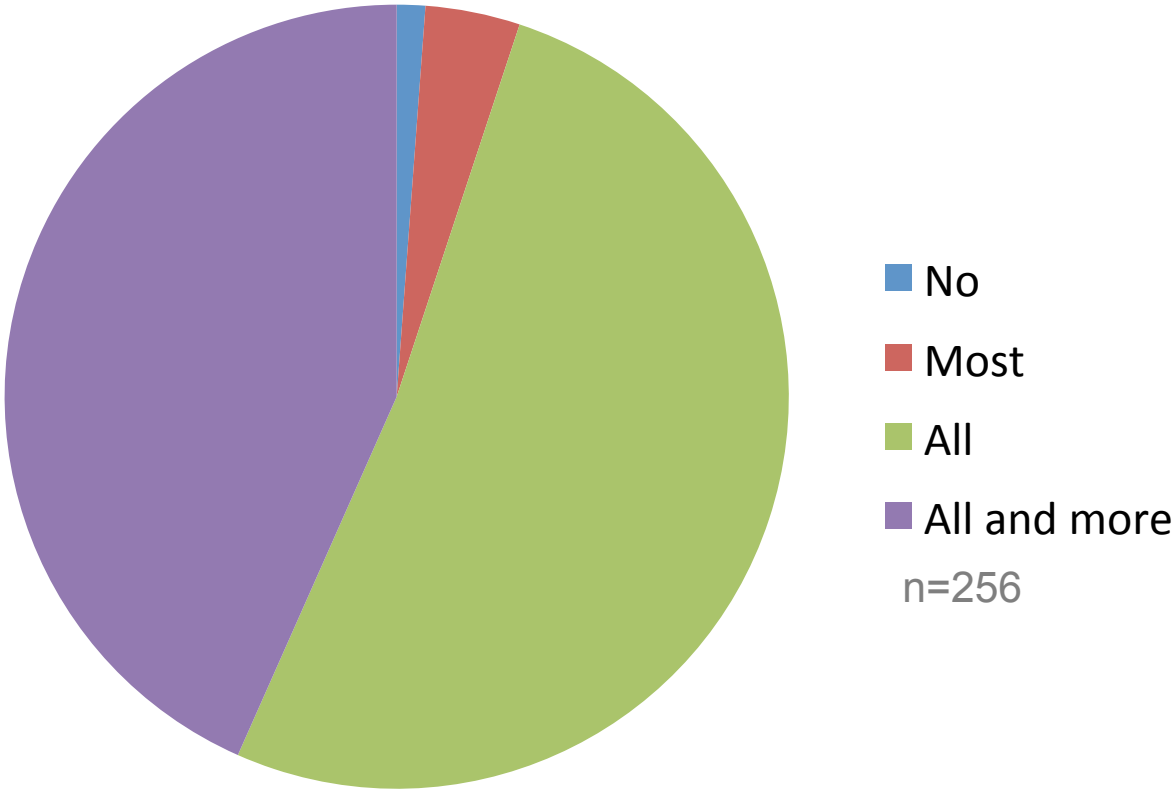
THE PATIENT EXPERIENCE

How would you rate the timeliness and efficiency of team based visits as compared to previous visits?



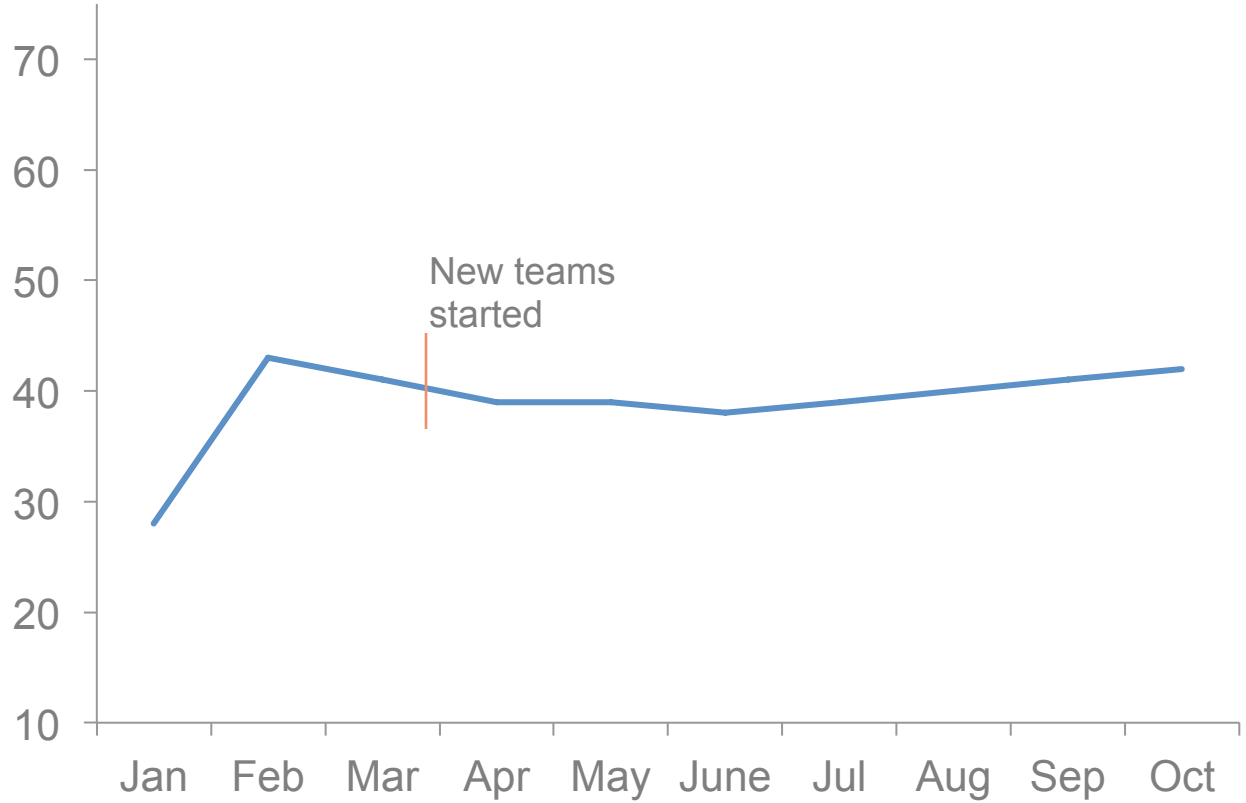
THE PATIENT EXPERIENCE

Was the team able to address all of your needs today?



PATIENT OUTCOMES

Percentage of Diabetic Patients at goal for A1c, LDL and BP



PATIENT OUTCOMES

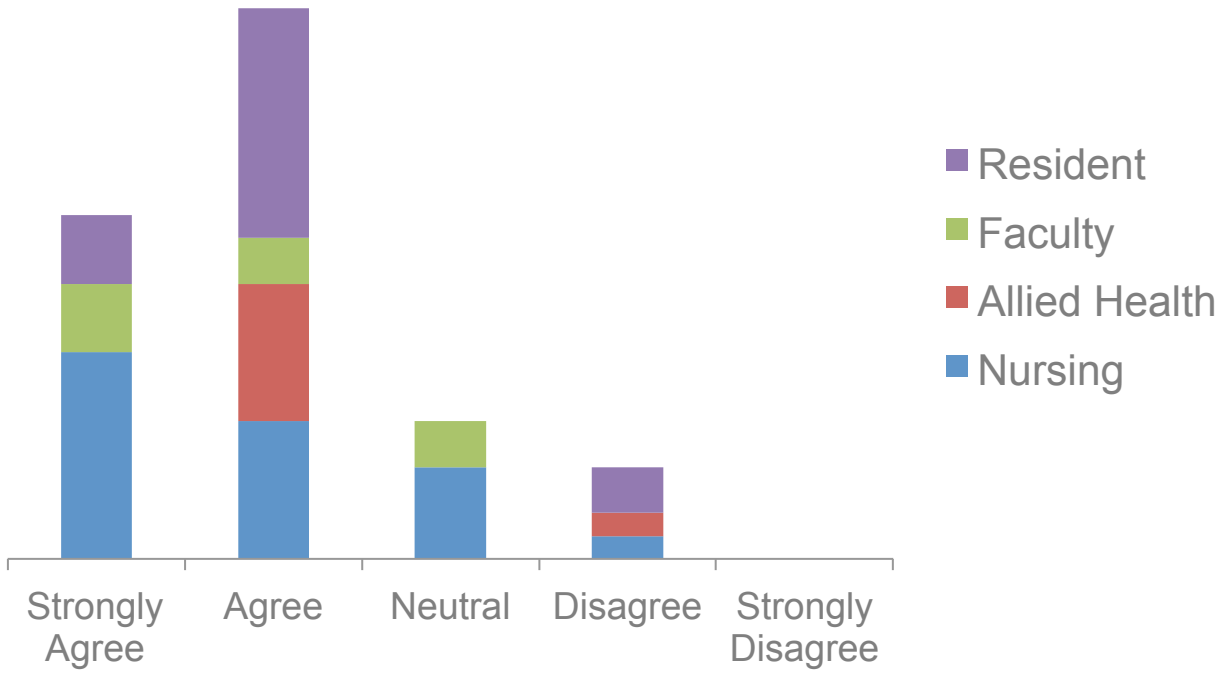
Percentage of pediatric patients receiving recommended vaccinations

STAFF EXPERIENCE

Change in volume of electronic messaging

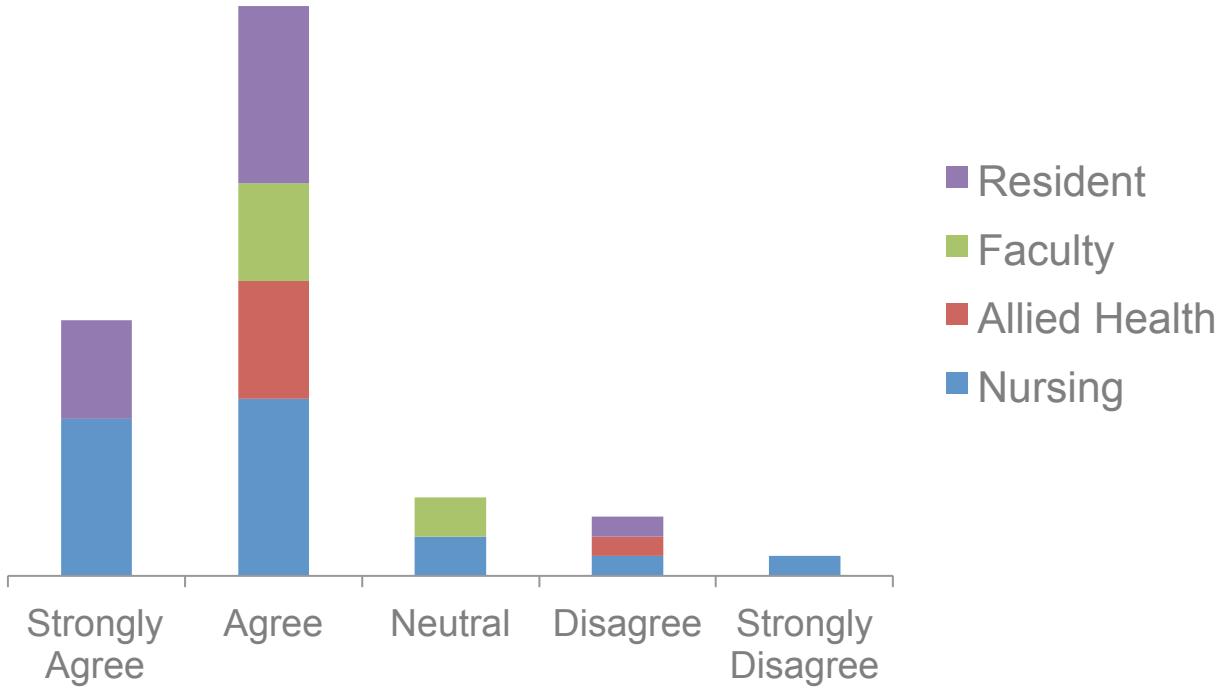
STAFF EXPERIENCE

My input is well received in the team setting



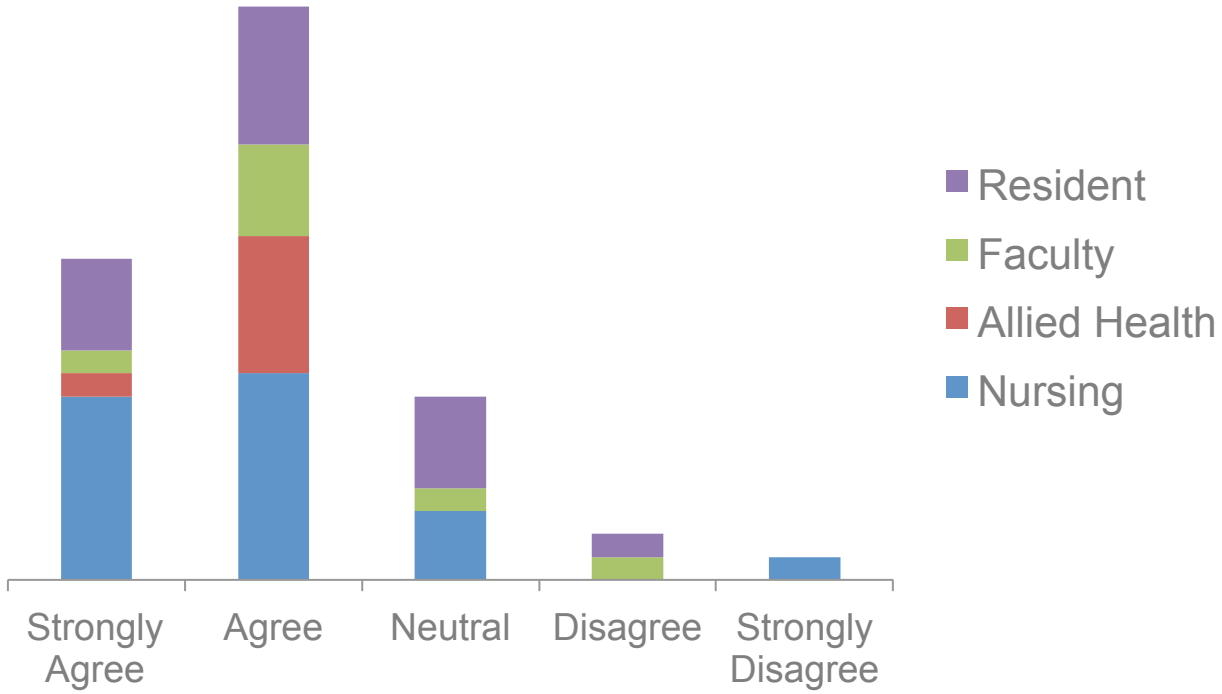
STAFF EXPERIENCE

In the team setting, I have the support I need to take care of patients



STAFF EXPERIENCE

I am optimistic about the future of my job



HOW DID IT FEEL FROM A PRACTICE PERSPECTIVE?

"We should not live and work in silos and lob inboxes at each other. Seeing patients and interacting with the team is rewarding. I don't want to go back to my silo."
– Care Team M.D.

"When we first started, I hated it. Now, I love it!"
– Resident M.D.

"Keep an open mind, keep trying different things, it will work."
– Care Team R.N.

"Collocation, that has really transformed the relationship between pharmacy and clinic."
– Care Team Pharmacist

"Small efficiencies add up- I'm not always running around trying to find people anymore."
– Care Team L.P.N.

"What's in it for me? 5 years ago our diabetes all or none was 8% , now it's 38%. Our group takes care of about 600 patients with diabetes, our panel has grown 500 in the last 4 months since we've started doing this. That's what we need to do, take better care of patients, take care of more patients, and take care of more complex patients."

– Care Team M.D.

HOW DID IT FEEL FROM A PATIENT PERSPECTIVE?

"I'd rather come in for one very thorough 45min appointment where I see the whole team, than come back 3 times in 3 months."
— Patient interview

"Today we saw [the new provider] instead because she has a background in cardiology. Is that because you guys are back there looking ahead and discussing my husband's visit? I love that!"
— Patient Interview

"I'm sitting here jealous. I wish it had been my visit!"
— Caregiver accompanying patient to appointment

PATIENT QUOTES FROM OPTIMIZED CARE TEAM EXPERIMENTS

"I kind of already knew about healthy habits, but I felt jump started! It was good to talk about it."

"It seemed continuous even though there were three people coming in. They knew what I said to the others."

"It was nice because the nurse could provide more education. It didn't feel rushed."

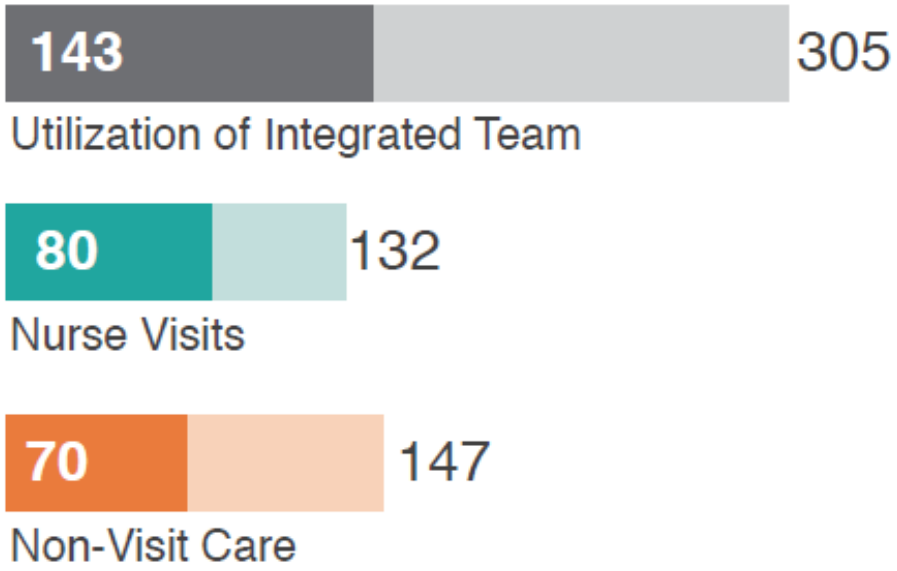
"Seeing the pharmacist was great. I pick up the meds for the family and I got to ask questions I otherwise would have forgotten."

"I liked that everyone seemed to know about me. "

"Before, you had to make an appointment just for one thing, it's nice to have everything taken care of."

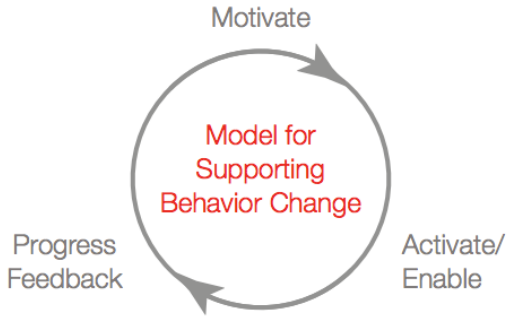
FUTURE POTENTIAL

Capacity Gained
Actual Recorded vs Potential



HOW DO YOU GET STARTED?

This is a behavior change for the practice. It involves and fundamental re-design of the way the practice defines and delivers care.

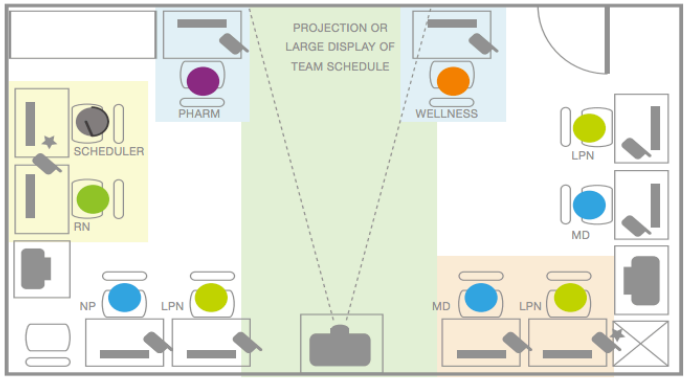


A motivated team is critical for initial testing:

+ agree on goals for shifting to and testing an optimized care team model in your clinic
+ identify clinical champions to support messaging and communication at a peer to peer level.
+ create slack for new workflows and the inefficiencies of learning new workflows.
+ identify teams by complimentary working styles and strengths

HOW DO YOU GET STARTED?

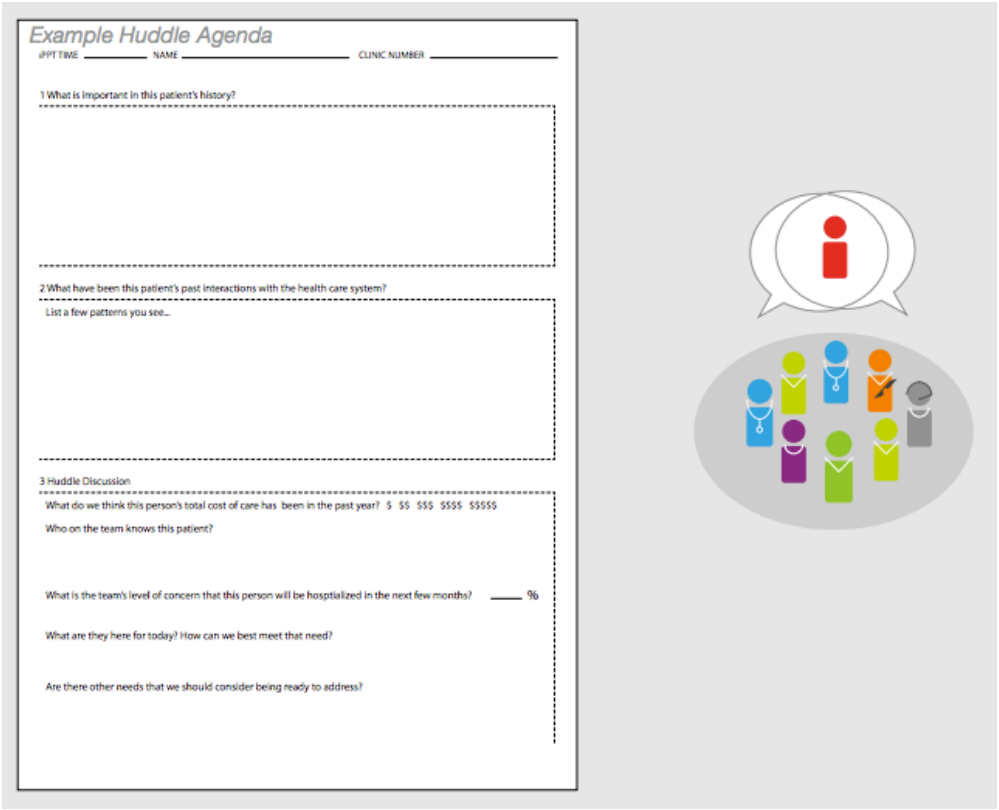
Give up offices and collocate as a team: Whether you can build a new team room or must use existing clinic space, collocation is critical to improving teamwork, communication and team efficiency.



HOW DO YOU GET START?ED?

Huddle as a Team:

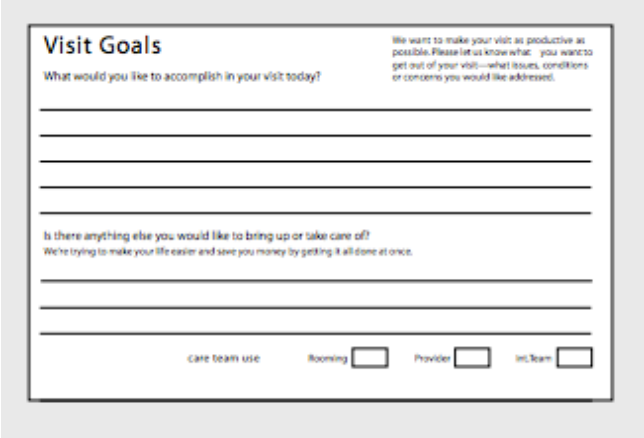
Plan ahead for patient care, incorporate the expertise of each team member into non-traditional appointment types, learn about the expertise of each team member, build a knowledge base about team patients and to reinforce working together as a team.



HOW DO YOU GET STARTED?

Ask Patients What They Hope to Accomplish:

Many times, needs emerge once patient's arrive. Try leveraging the team to react to those needs in real time.


Visit Goals

What would you like to accomplish in your visit today?

We want to make your visit as productive as possible. Please let us know what you want to get out of your visit—what issues, conditions or concerns you would like addressed.

Is there anything else you would like to bring up or take care of?

We're trying to make your life easier and save you money by getting it all done at once.

care team use: Rooming ☐ Provider ☐ Int.Team ☐

Practice Warm Handoffs:

Help patients and teams build trusting relationships by introducing new team members and describing their skill set and abilities.

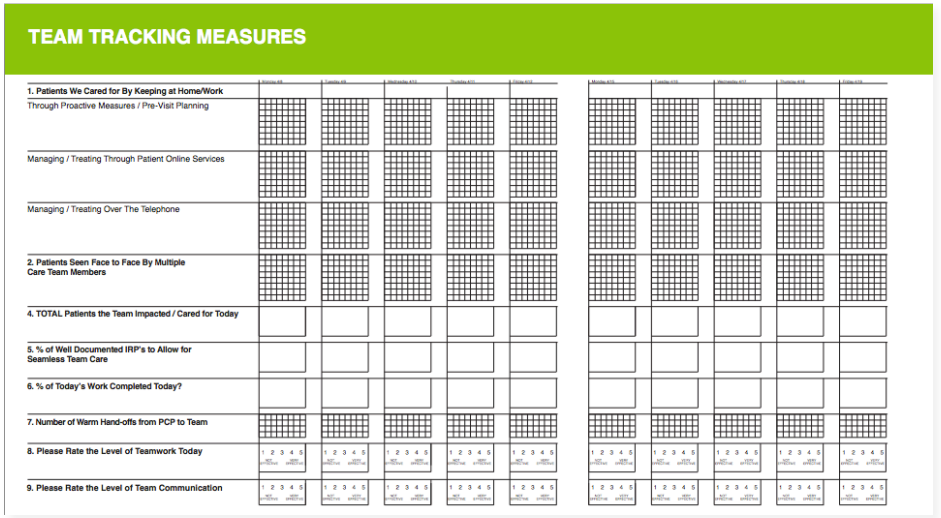
HOW DO YOU GET STARTED?

Measure Your Progress as a Team:

Identify process metrics that are easily identified and captured to provide real-time feedback on progress made as team.

Debrief and Collect Feedback:

Discussing what went well and what could have gone better is crucial for discovering opportunities to improve the model. Do not be afraid to ask patients to contribute their ideas and feedback.

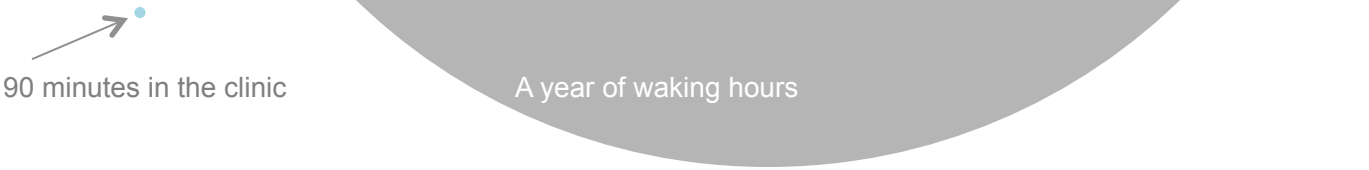


5 KEY TAKEAWAYS

1. Work as a team to increase the capacity and flexibility to always provide care; whether clinical or social.
2. Center the team's interactions around what matters to patients.
3. Find champions in your practice who are motivated to get started.
4. Start will small tests and iterate quickly.
5. Know that it will be challenging during the adjustment period but it will get better and it will work.

Reorient your perspective from clinic to community.

People spend 99% of their lives outside of the clinic.

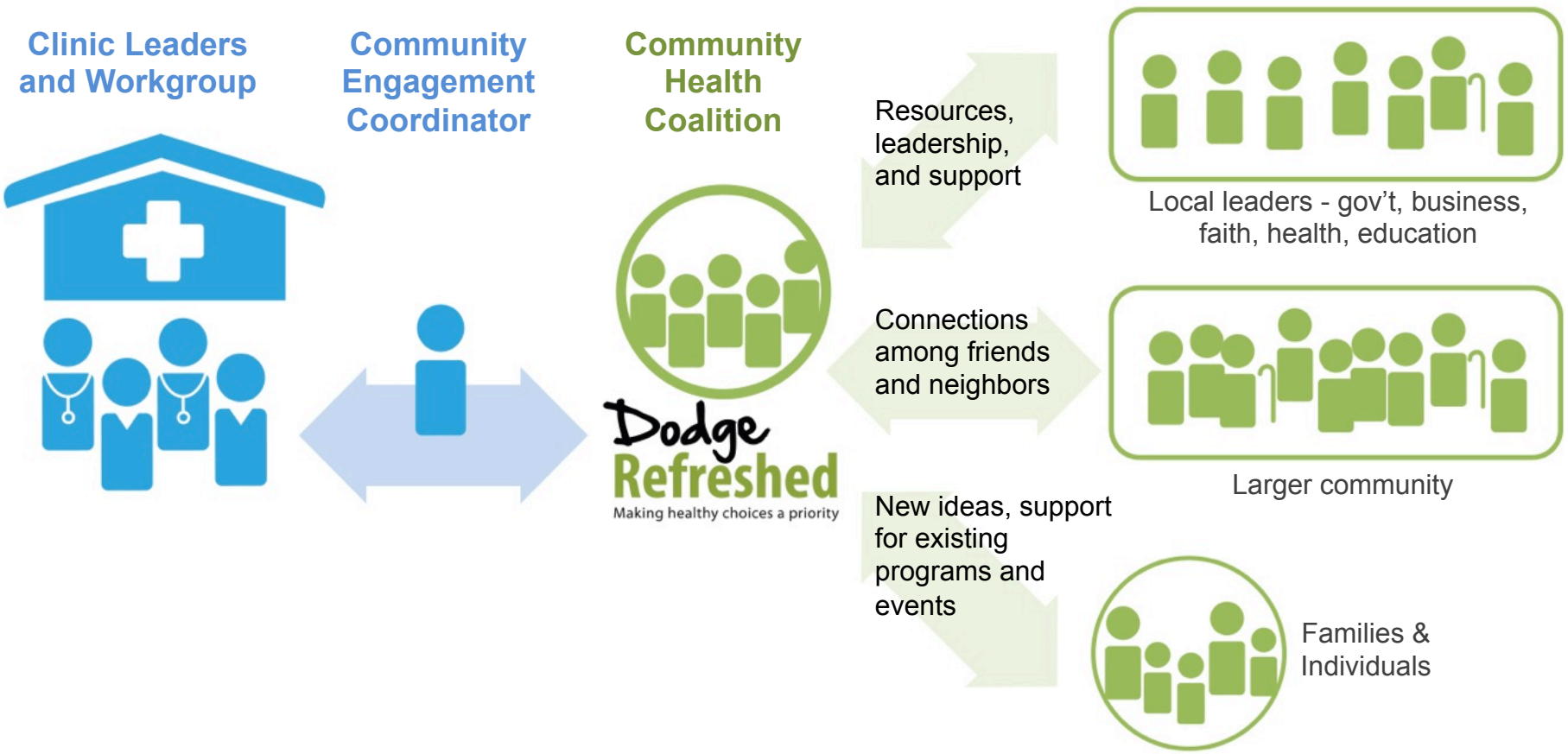


Invite people to talk about their everyday concerns.

Actively help them navigate to resources and lower their own barriers to good health.

Examples of new roles that can address social determinants of health.

The Community Engagement Coordinator is a key connector between the clinic and the community.



Community Engagement Coordinator role bridges the clinic and community

The multidisciplinary Health Leads model – **volunteer students working in partnership with providers** - has been able to connect the medical home with community-based resources.[1]

It works in an urban environment…

Integrated into hospitals such as Massachusetts General, Johns Hopkins, Bellevue, & Children's National Medical Center

Can it work in a rural environment?

1. *Clinical Pediatrics.* 2012;51(12):1191-1193

Wellness Navigators

Research in Austin, MN identified the need for a new service integration model to effectively coordinate existing services, including physical fitness, senior services, mental health, and childcare.[1]

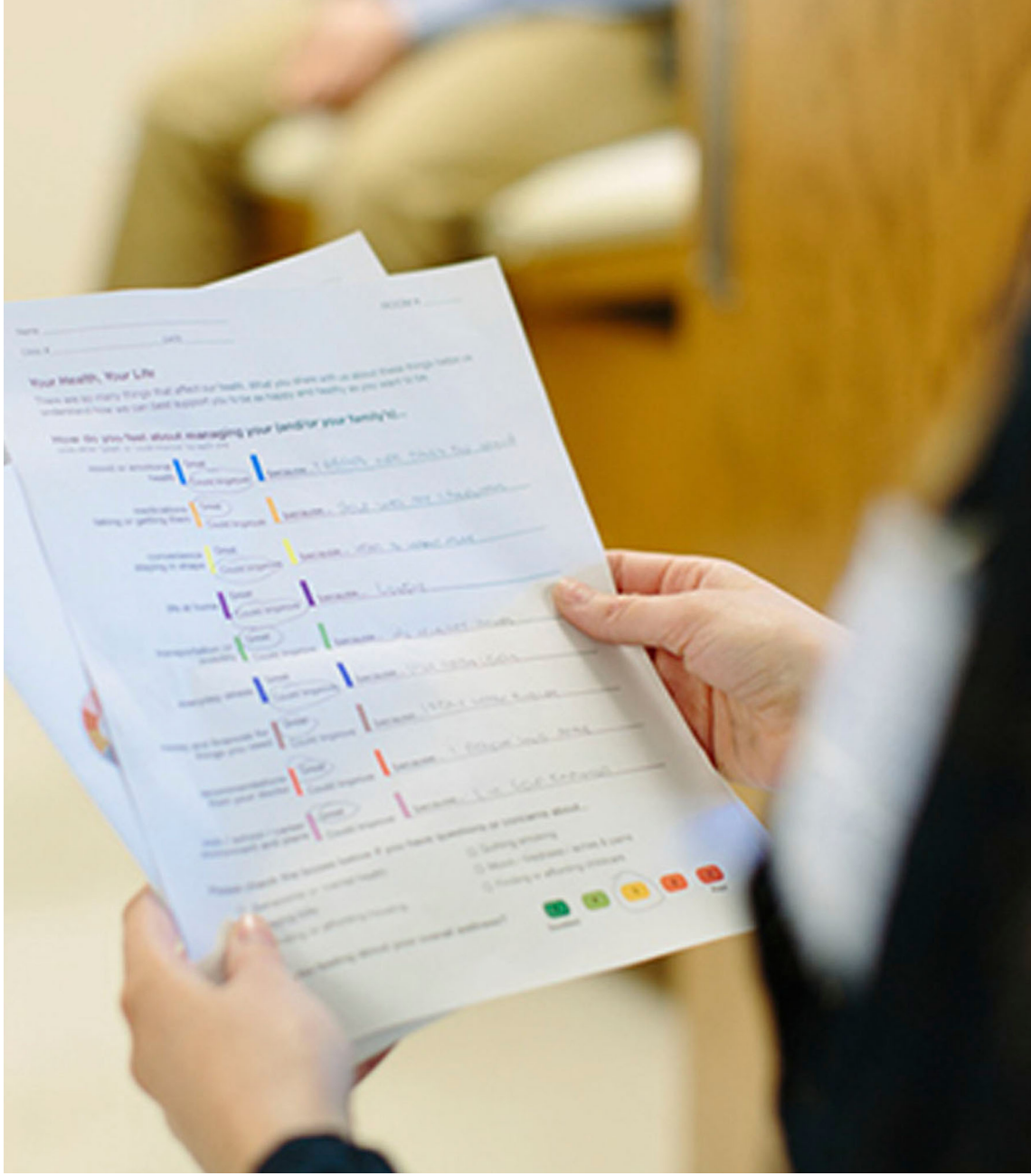
Wellness Navigators are a volunteer-provided, clinic-embedded service that **connects patients with resources to address social determinants of health.**

The program is currently being tested at Mayo Family Clinic Kasson in Dodge, MN.

1. *Mayo Clinic proceedings.* October 2011;86(10):973-980.

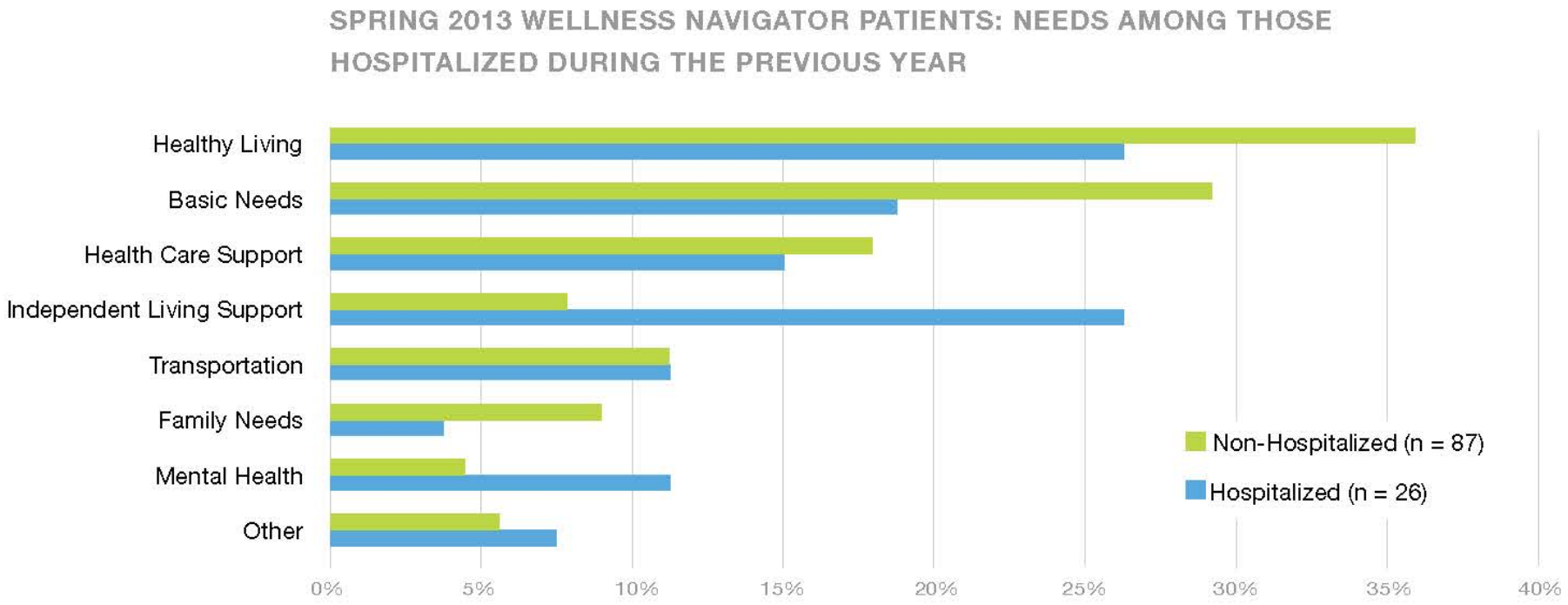
"It seems like when you go to the doctor they care about one aspect of you; they don't care about your personal life. ***It was nice to have someone care for me on an emotional level****."*

- Patient, 56 y/o female



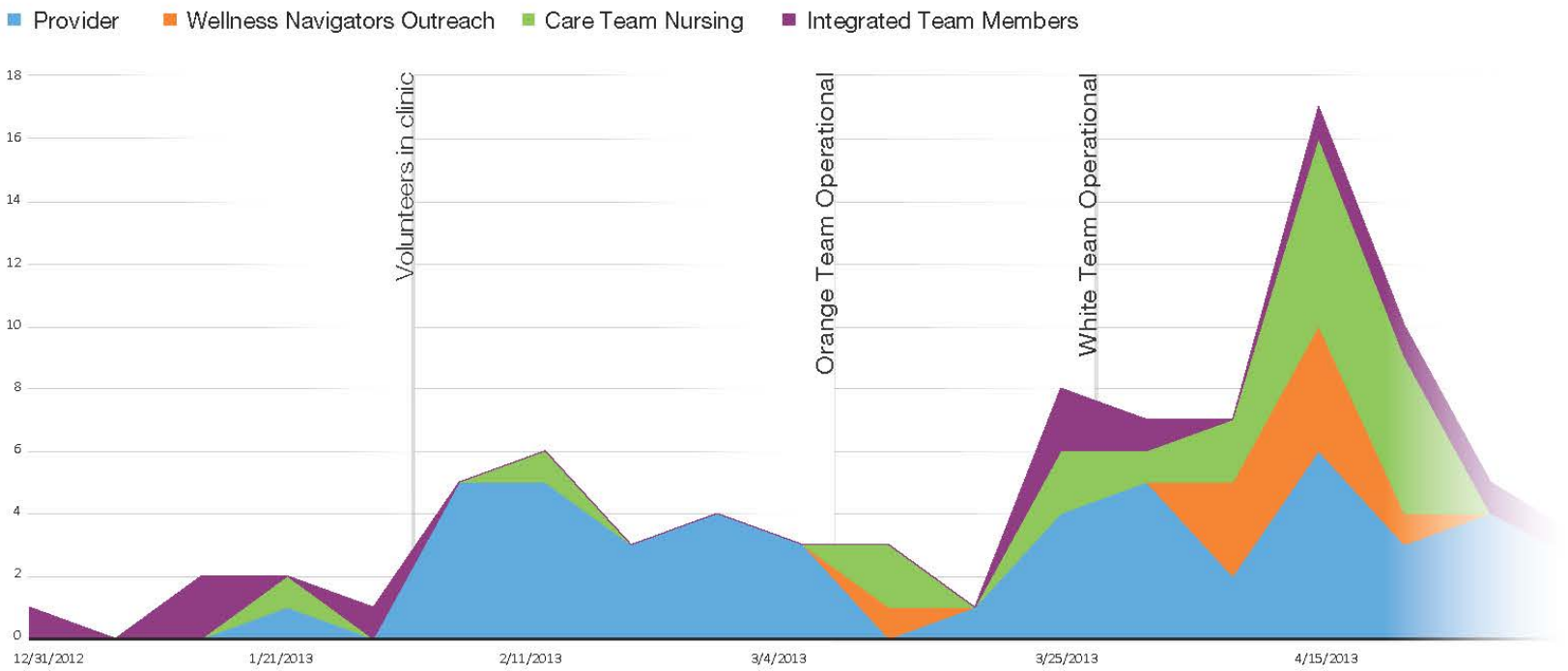
Wellness Navigator role addresses social determinants within clinical workflows.

By asking about people's every day concerns, we gain a better awareness of non-medical barriers to health.



Wellness Navigator role addresses social determinants within clinical workflows.

Including Wellness Navigators in Care Team huddles, increases awareness and discussion of non-medical needs.



Referral rates Spring 2013

Wellness Navigator role addresses social determinants within clinical workflows.

Needs exist

WN Referral Reasons

(spring 2012 and fall 2013, n=221)

28% Healthy Living Smoking cessation, stress, weight loss, healthy activities, exercise programs, social isolation

22% Basic Needs Financial assistance, commodities, employment, housing, food, utilities

14% Healthcare Affording medications, health insurance, appointment no-show, pain relief, advanced directive planning

10% Independent Living Support / Home Modifications

9% Transportation

7% Family Needs

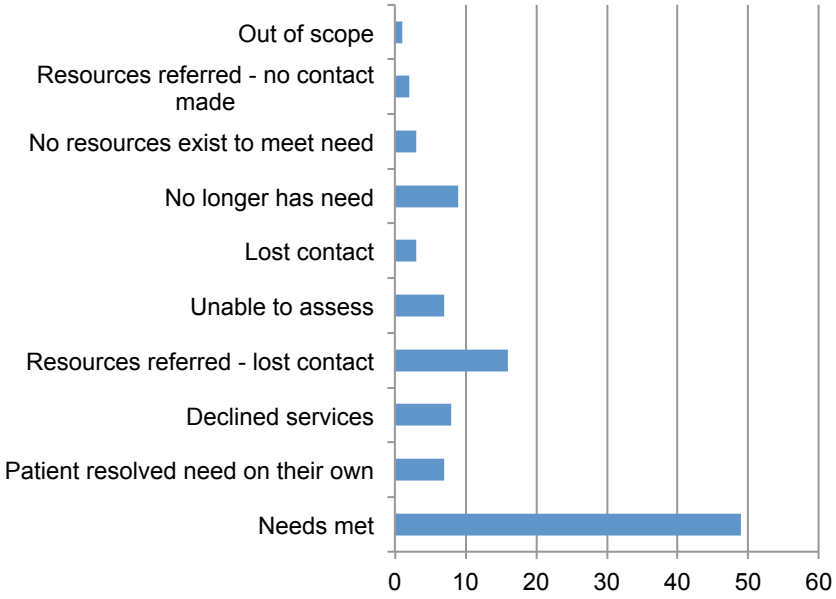
5% Mental Health

5% Other

Needs can be resolved

Case Resolution Reasons

(58% resolved within one month of referral)



But needs can be cyclical.

How have we affected people's capacity?

Wellness Navigator role addresses social determinants within clinical workflows.

A great building must begin with the unmeasurable, must go through measurable means when it is being designed and in the end must be unmeasurable.

Louis Kahn

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