ADOPTING A TEAM CARE APPROACH

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How do we get to the primary care of the future?
“Why we need team-based care”

- Primary care pillars and principles
- The practice of the future (PCMH)
- Moving toward team care models
Pillars of primary care

- Barbara Starfield’s 4 pillars of primary care
  - Continuity of care
  - First contact care [requires Access]
  - Comprehensive care
  - Coordination of care
Modern additions

- **Additional principles**
  - Concern for entire population of patients
  - Measurement to drive quality improvement
  - Patient-centered care
    - Patient self-management support

- **Model components**
  - Team-based care
  - Meaningful use of EHR, linked to rest of medical neighborhood
  - Payment incentivizes the above attributes
Equity

- How do we build this model for the entire US population, despite a growing demand and lessening supply of providers?
Adult primary care crisis

- Plummeting numbers of new practitioners entering primary care
- Declining access to primary care
- Practitioner burn-out
- Unsatisfactory quality
- The primary care medical home is falling off the cliff
Residency Match, 2010

% of graduating US medical students

- GIM: 3.0%
- FamMed: 6.0%
- AnesRadPath: 10.0%
- Surg: 11.0%
- MedSpec: 30.0%
Stressful worklife

- Survey of 422 general internists and family physicians 2001-2005
  - 48%: work pace is chaotic
  - 78%: little control over the work
  - 27%: definitely burning out
  - 30%: likely to leave the practice within 2 years

Adult Care: Projected Generalist Supply vs Pop Growth + Aging

Demand: adult pop’n growth/aging

Supply, Family Med, Gen’l Internal Med

Colwill et al., Health Affairs, 2008:w232-241
Primary care physician with panel of 2500 average patients will spend 7.4 hours per day doing recommended *preventive care* [Yarnall et al. Am J Public Health 2003;93:635]

Primary care physician with panel of 2500 average patients will spend 10.6 hours per day doing recommended *chronic care* [Ostbye et al. Annals of Fam Med 2005;3:209]

Average panel size in US: 2300
The dilemma

- The shortage will get worse
- Panel sizes will go up
- This will reduce access, reduce quality, and increase clinician dissatisfaction
- As clinician dissatisfaction increases, fewer MDs/NPs/PAs will enter primary care
The Patient-Centered Medical Home (PCMH) can make the care experience better for practitioners, staff, and patients.
Neighborhood context

- Payment reform: change from fee-for-service
- Accountable Care Organizations
- Coordinated neighborhoods that value a strong primary care base
Fundamentals of the PCMH

Priority #1: Continuity

Requires Empanelment

Leads to Panel size

Determines Access

Requires Teams

Culture:
Agree that continuity comes first
Start with continuity of care

- Continuity of care is associated with
  - Improved preventive care
  - Improved chronic care outcomes
  - Better physician-patient relationship
  - Reduced unnecessary hospitalizations
  - Reduced overall costs of care
    - Saultz and Lochner, Ann Fam Med 2005;3:159

- Continuity over time is related to patient satisfaction
  - Adler et al, Fam Pract 2010;27:171

- For older adults, continuity with a PCP is associated with reductions in mortality (adjusting for many other factors)
  - Wolinsky et al, J Gerontology 2010;65:421
Start with continuity of care

- To achieve and to measure continuity, patients must be **empaneled** to a clinician or team
- Measuring continuity:
  - % of a patient’s visits that are visits to the patient’s personal clinician
  - or
  - % of a patient’s visits that are visits to the patient’s team
- Your goal:
  - 100%? 85%?
  - Doing better than you’re doing now
Continuity and access can be in conflict

Clinic culture:
- What does the front desk offer patients when they call to be seen?
- Each clinic must create its own culture: is continuity a primary goal or not?
Continuity, access and panel size

- We have large panel sizes
  - Shortage of PCPs
  - Financial stability

- The larger the panel size = less access

- To achieve continuity and access with large panel sizes, we must have teams

- Teams are a necessity now
Continuity and teams

- Continuity is redefined as continuity with a team rather than with a clinician
- Stable teams
- Small teams (teamlets)
Primary Care Teams

Teams:

a group of diverse clinicians who participate in, and communicate with each other regularly about the care of a defined group (panel) of patients.
Teamwork?
The Frantic Bubble

- How Teams Work— Or Don’t— In Primary Care: A Field Study on Internal Medicine Practices
  - Chesluk and Holmboe. Health Affairs May 2010. Reinventing Primary Care issue.
Re-building Primary Care Teams

- Attitudes toward re-distributing the work
  - Attitude #1:
    - Offload tasks from the clinicians to RNs/MAs
    - Will create resentment in the team: This isn’t my job description, I already have too much to do
  - Attitude #2:
    - Entire team is responsible for health of our panel
    - Different people on the team will have different responsibilities
    - Re-distributing work is not delegating tasks from clinicians to other team members; it is sharing responsibilities
Tasks vs. Responsibilities

- **Delegating tasks**
  - Do this EKG.
  - Check that patient’s blood sugar
  - Call the pharmacy to refill the metformin

- **Re-distributing responsibilities**
  - **Panel management.** The MA is responsible for working the registry to make sure that all patients in the panel receive their chronic and preventive care services on time
  - **Health coaching.** RN or MA responsible to assist patients with chronic conditions to gain the knowledge, skills, and confidence to self-manage their condition
Team roles

Panel management

Got Pap?

Health coaching
Practice of the future

- Clinicians (MD/NP/PA) no longer see all the patients for all their problems
- Depending on people’s problems, the appropriate team member addresses the problem
- Many routine preventive and chronic care issues can be handled by RNs, LVNs, MAs
- This creates time for clinicians to spend adequate time with complex patients
The patient-centered medical home requires a culture shift

- **Present:**
  - the doctor (sometimes NP or PA) assumes all the responsibility, makes the decisions, and orders others to perform tasks

- **Future:**
  - Entire team assumes responsibility for a panel of patients
  - Team members share the responsibility to make that panel of patients as healthy as possible
  - Tasks are linked to a sense of responsibility and purpose
Culture shift: I to We

**From:** How can the clinician (I) see today’s scheduled patients, do the non-face-to-face-visit tasks, and get home at reasonable hour?

<table>
<thead>
<tr>
<th>Monday</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00AM</td>
<td>Sr. Rojas</td>
</tr>
<tr>
<td>8:15AM</td>
<td>Ms. Johnson</td>
</tr>
<tr>
<td>8:30AM</td>
<td>Mr. Anderson</td>
</tr>
<tr>
<td>8:45AM</td>
<td>Sra. Garcia</td>
</tr>
</tbody>
</table>

**To:** What can the team (We) do today to make the panel of patients as healthy as possible, and get home at a reasonable hour?
Creating teams

- Well-functioning large teams are difficult
  - Lots of energy and time taken up with multiple team members having to communicate information and coordinate tasks with each other
  - If one person on the team is not cooperative, the entire team can fail
  - “The best team size is a team of one.” Dr. Harold Wise, *Making Health Teams Work*, 1974
- Smaller teams are easier
  - Divide the practice into small teams with each team responsible for a panel of patients
  - Create 2-person teamlets (MD/RN, NP/LVN, MD/MA)
  - 4-person teamlets are a new experiment
  - VA: 4 person teamlets (MD/NP, RN, LVN, clerk) responsible for 1200 patient panel
Creating teams and teamlets

- Common goals
- Implementing systems to achieve the goals
- Clear division of labor
- Training
- Communication
- Ground rules
Creating teams and teamlets

Ground rules

How are team meetings run (facilitator, time keeper, note taker)

How are meeting minutes written up and distributed?

Are decisions by consensus, by leader, by vote?

How to deal with tardiness, excessive absences?

Conflict resolution
Monograph on primary care teams

NCQA Patient Centered Medical Home
Element 1G: The Practice Team

The care team manages patient care in the following ways:

1. Defines roles for all team members including clinical and non-clinical practice staff.
2. Has regular team meetings and a communication process (e.g. daily huddle, email or instant messaging, messages in chart)
3. Uses standing orders for medication refills, tests, routine preventive services
4. Care team are assigned and trained to coordinate care (tests, referrals, community based services)
5. Care team assigned and trained to support patient/family in self-management, self efficacy and behavior change (e.g. weight reduction, smoking cessation, stress reduction)
6. Care team assigned and trained to manage populations of patients
7. Care team assigned and trained in communication skills with vulnerable populations
8. Care team involved in performance evaluation and improvement
Preventive services: old way

- Mammogram for 55-year-old healthy woman
- Old way:
  - Clinician gets reminder that mammo is due
  - At next visit, clinician orders mammo
  - Clinician gets result, (sometimes) notifies patient
Preventive services: new way

- MA in role as panel manager checks registry every month
- If due for mammo, MA sends mammo order to patient by mail or e-mail
- Result comes to MA
- If normal, MA notifies patient
- If abnormal MA notifies clinician and appointment made
- For most patients, clinician is not involved
- Similar for FOBT, pneumovax, flu shots
Chronic care: hypertension: old way

- Clinician sees today’s blood pressure
- Clinician refills meds or changes meds
- Clinician makes f/u appointment
- Often blood pressures are not adequately controlled
Chronic care: hypertension
new way

- LVN/MA in role as panel manager checks registry q month
- Patients with abnormal BP contacted to come for LVN or RN visit
- LVN or RN in health coach role does education on HBP and meds, med-rec, med adherence/lifestyle discussion
- Patient is taught home BP monitoring
- If BP elevated and patient is med adherent, RN intensifies meds by standing orders
- If questions, quick clinician consult
- LVN or RN in health coach role f/u by phone or e-mail if patient does home BP monitoring or by return visit
- Clinician barely involved
- Processes, outcomes, patient involvement improved by panel management and health coaching
Chronic pain: old way

- Clinician negotiates pain contract with patient
- Patient comes every month to get refill
- If clinician is not available on the day that refill is needed
  - In disorganized systems, big mess
  - In organized systems, another clinician writes the refill
Chronic pain: new way

- Clinician negotiates pain contract with patient
- Clinician and LVN/MA or RN discuss with patient how med refills will work
- Regular LVN or RN refill visits are scheduled
- At refill visit LVN or RN assesses pain, may do tox screen
  - If pain stable, LVN or RN asks clinician for secure rx
  - If pain not stable, brief clinician consult
- LVN/RN does patient education on alternatives to narcotics
Patients with complex healthcare needs: old way

- Clinician sees the patient every month for 30 minutes
- Often the visit plus care coordination takes longer than 30 minutes and clinician
  - Doesn’t provide the best care, or
  - Is running behind because the patient took an hour, or
  - Both
Patients with complex healthcare needs: new way

- Initial hour meeting with patient/family with care team (MD, RN, SW, behaviorist and/or pharmacist)
- Clinician, not worrying about preventive services or non-complex chronic care, has time
- Care plan made with team and patient/family
- RN care manager responsible for implementing and assessing care plan, teaching about meds, red flags
- RN does phone, home-visit f/u, care coordination, consults with MD or other team members as needed
- Regular MD /team visits
- **This will not work unless the other changes are made to free up MD for complex patients**
Team-based care responsibilities

- Panel management
- Health coaching for self management support and navigation
- Medication reconciliation and titration management
- Complex care management
- Mental health and behavioral health integration
- Management of simple problems
- Lab follow up
Redesign necessities for team care

- Staffing and training
- Electronic tools
- Workflows and algorithms
- Communication methods
- Risk stratification of patients
- Visit types
Culture shift: I to We

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To: What can the team (We) do today to make the panel of patients as healthy as possible, and get home at a reasonable hour?
<table>
<thead>
<tr>
<th>Time</th>
<th>Primary care physician</th>
<th>Medical assistant</th>
<th>Nurse</th>
<th>Nurse Practitioner</th>
<th>Medical assistant</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00</td>
<td>Patient A</td>
<td>Assist with Patient A</td>
<td>Triage</td>
<td>Patient H</td>
<td>Assist with Patient H</td>
</tr>
<tr>
<td>8:15</td>
<td>Patient B</td>
<td>Assist with Patient B</td>
<td>Injections</td>
<td>Patient I</td>
<td>Assist with Patient I</td>
</tr>
<tr>
<td>8:30</td>
<td>Patient C</td>
<td>Assist with Patient C</td>
<td>Wounds</td>
<td>Patient J</td>
<td>Assist with Patient J</td>
</tr>
<tr>
<td>8:45</td>
<td>Patient D</td>
<td>Assist with Patient D</td>
<td>A bit of time left for patient education</td>
<td>Patient K</td>
<td>Assist with Patient K</td>
</tr>
<tr>
<td>9:00</td>
<td>Patient E</td>
<td>Assist with Patient E</td>
<td></td>
<td>Patient L</td>
<td>Assist with Patient L</td>
</tr>
<tr>
<td>9:15</td>
<td>Patient F</td>
<td>Assist with Patient F</td>
<td></td>
<td>Patient M</td>
<td>Assist with Patient M</td>
</tr>
<tr>
<td>9:30</td>
<td>Patient G</td>
<td>Assist with Patient G</td>
<td></td>
<td>Patient N</td>
<td>Assist with Patient N</td>
</tr>
</tbody>
</table>
### Template of the Future

<table>
<thead>
<tr>
<th>Time</th>
<th>Primary care physician</th>
<th>Medical assistant 1</th>
<th>RN</th>
<th>Nurse Practitioner</th>
<th>Medical Assistant 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00-8:10</td>
<td>Huddle</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8:10-8:30</td>
<td>E-visits and phone</td>
<td>Panel management</td>
<td></td>
<td></td>
<td>Acute patients</td>
</tr>
<tr>
<td>8:30-9:00</td>
<td>visits</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9:00-9:30</td>
<td>Complex patient</td>
<td></td>
<td></td>
<td>Complex patient</td>
<td></td>
</tr>
<tr>
<td>9:30-10:00</td>
<td>Huddle with RN, NP</td>
<td>Blood pressure</td>
<td></td>
<td>Huddle with MD</td>
<td>Panel management</td>
</tr>
<tr>
<td></td>
<td></td>
<td>coaching clinic</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10:00-10:30</td>
<td>Coordinate with hospitalists and specialists</td>
<td>Care management</td>
<td></td>
<td>E-visits and phone visits</td>
<td>Panel management</td>
</tr>
<tr>
<td>10:30-11:00</td>
<td>Complex patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

About 30 patients contacted/seen in 3 hours
Teams can transform and revitalize primary care.

- Care for large panels while improving quality and access
- Engage staff in meaningful work, sharing responsibility for the health of a panel of patients
- Allow clinician to lead a team rather than individually see one patient after another