Team-Based Primary Care to Treat the Whole Person

Wendy Bradley, LPC, CAADC
Cindy Hupke, RN, BS, MBA
Mara Laderman, MSPH
Jerry Langley, MS
Bellin Health Representative
PanCare Inc. Representatives

December 7th, 2015
8:30 AM – 4:00 PM

Session Objectives

- Describe the key changes needed to implement team-based primary care that integrates behavioral health
- Identify and start to build the necessary skills to support integrated, team-based primary care
- Develop an action plan to implement integrated, team-based primary care at your organization
Today's Agenda

<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30 AM - 8:45 AM</td>
<td>Welcome and introductions; review objectives and day’s agenda</td>
</tr>
<tr>
<td>8:45 AM - 9:00 AM</td>
<td>Making the case for team-based primary care and behavioral health integration</td>
</tr>
<tr>
<td>9:00 AM - 9:45 AM</td>
<td>Exercise: Integration assessment</td>
</tr>
<tr>
<td>9:45 AM - 10:15 AM</td>
<td>Brief case studies</td>
</tr>
<tr>
<td>10:15 AM - 10:30 AM</td>
<td>Break</td>
</tr>
<tr>
<td>10:30 AM - 12:00 PM</td>
<td>The foundational elements</td>
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<tr>
<td>12:00 PM - 1:00 PM</td>
<td>Lunch</td>
</tr>
<tr>
<td>1:00 PM - 2:00 PM</td>
<td>What changes can we make? Team-based relationships</td>
</tr>
<tr>
<td>2:00 PM - 3:15 PM</td>
<td>What changes can we make? Behavioral health integration Group exercise and discussion (+ break)</td>
</tr>
<tr>
<td>3:15 PM - 3:50 PM</td>
<td>Tabletop Exercise: Identifying Opportunities and Approaches for Improvement</td>
</tr>
<tr>
<td>3:50 PM - 4:00 PM</td>
<td>Summary and wrap up</td>
</tr>
</tbody>
</table>

Your Guides

Wendy Bradley, LPC, CCSAC
Cindy Hupke, BSN, MBA
Jerry Langley, MS
Mara Laderman, MSPH

Bellin Health:
Kathy Kerscher

PanCare, Inc.
Bill Kuzbyt
Stephanie Hofrichter
Sandy Ford
MAKING THE CASE – TEAM-BASED CARE AND BEHAVIORAL HEALTH INTEGRATION

Mary

- 69 year old retired female who owns her own home, is on Medicare, and has a monthly income of $1000 a month.
- Married to a husband with disabilities who frequently requires her assistance with activities of daily living
- Has one grandchild in area and babysits often
- Considered the “glue of the family” and feels responsible for everyone else
- Uncontrolled hypertension, possible depression
- 1 hospitalization and 2 ER visits in the last year
- Engages with health care mostly when sick. She agrees to do what her doctor tells her during the visit but has difficulty with follow through
- No alcohol, limited fresh food, moderate smoker, no exercise
- Attends church and enjoys participating in church based activities.
- Worries: What will happen to her family if she is not here, financial limitation
Contributions to premature mortality

What Determines Health?
What is behavioral health?

Behavioral health includes:
- Mental health, e.g. depression, anxiety
- Substance abuse
- Health behaviors, e.g. exercise, healthy eating, medication adherence, stress management

Behavioral health services include:
- Assessment of behavioral health needs, including screening for mental illness, substance abuse, and barriers to managing chronic health conditions
- Brief interventions for identified behavioral health issues
- Support for healthy behavior change and self-management
- Connections with community-based services and specialty mental health care if needed

Integration and Triple Aim Outcomes

Population Health

Experience of Care

Per Capita Cost
Integration and Triple Aim Outcomes

- **Population Health**
  - Better chronic disease management and treatment
  - Improvements in overall functioning
  - Improved medical and mental health outcomes

- **Experience of Care**
  - Improved patient satisfaction
  - Improved provider satisfaction

- **Per Capita Cost**
  - Improved medical and mental health outcomes
Integration and Triple Aim Outcomes

Population Health
Better chronic disease management and treatment
Improvements in overall functioning
Improved medical and mental health outcomes

Experience of Care
Improved patient satisfaction
Improved provider satisfaction

Per Capita Cost
3 of the 5 top conditions driving overall health costs are related to BH (depression, anxiety, obesity)

Use of specialty and emergency care
Save 5 to 10% of total health care costs over a 2 to 4 year period; $26 – 48 billion total (Milliman, 2014)

Medical + behavioral comorbidities are costly

Medical + behavioral comorbidities are costly

Robert Graham Center, 'Why there must be room for mental health in the medical home; NBGH: An Employers’ Guide to Behavioral Health Services
Why primary care?

- 59% of patients with behavioral health conditions receive no treatment for their condition.

- ~50% of visits for behavioral health conditions are treated in primary care, but 67% of primary care physicians are unable to access outpatient behavioral health services for their patients.

- 15-30% of patients who receive a referral do not make their first behavioral health appointment.

- Stigma prevents many from seeking behavioral health care – but they go see their primary care provider.

Behavioral Health Integration - Defined

- The care that results from a practice team of primary care and behavioral health clinicians, working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population.

- This care may address mental health, substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.
Why now?

- Health systems are acquiring primary care practices
- ACO formation
- More organizations are taking capitated funds
- “One-stop shopping” is desirable to consumers
- Payment reform – rewards and penalties
- Medicaid expansion – influx of patients with behavioral health needs
- Shortage of primary care and behavioral health providers

Remember Mary?

On Tuesday, she visits her PCP.
- BP 186/110
- On 3 anti-hypertensives: states she is taking them but unable to describe
- Screens positive for depression
- High intake of processed foods
- Stressed due to illness of grandchild and caregiver responsibilities
- No care for 14 months due to no shows
- Teary and says, “I am exhausted”
Mary’s visit in an integrated setting

- Seen initially by PCP for hypertension
- PCP introduces behavioral health consultant (BHC) and BHC completes brief intervention in the exam room.
- BHC uncovers that the depression score has more to do with high stress and insomnia, and she has had no time to pick up refills.
- PCP and BHC co-develop a plan to address insomnia, medication needs, and self-care, including stress management.
- BHC connects her with mail order pharmacy services and caregiver respite services to help care for her husband.
- Mary agrees to follow up with the team in one week. She will get BP checked and see BHC to follow up on sleep, stress, and medication adherence at the same visit.
- PCP gets updates on Mary’s progress in team huddles and intervenes or provides direction to the team as need.

A new trajectory for Mary

- Without a visit from the BHC, many of Mary’s most pressing issues and barriers to better health would have gone un-noticed and unresolved.

- Multiple concerns were addressed in one visit – medical, behavioral, social.

- She has a plan to address persistent problems that are commonly seen in primary care that adversely affect her health, her quality of life and happiness, and make her more likely to require more expensive care in the future.
# EXERCISE: INTEGRATION ASSESSMENT

## Six Approaches to Behavioral Health Integration (Core Descriptions)

<table>
<thead>
<tr>
<th>Coordinated Key Element: Communication</th>
<th>Co-located Key Element: Physical Proximity</th>
<th>Integrated Key Element: Practice Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collaboration: Minimal Collaboration</td>
<td>Co-located: Basic Collaboration at a Distance</td>
<td>Co-located to Integrated: Close Collaboration Online with Some System Integration</td>
</tr>
<tr>
<td>Behavioral health, primary care and other health care providers work:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In separate facilities, where they:</td>
<td>In same facility (in person or virtually), not necessarily same offices, where they:</td>
<td>In same space within the same facility (in person or virtually), where they:</td>
</tr>
<tr>
<td>- Have separate systems</td>
<td>- Have separate systems</td>
<td>- Have resolved most or all system issues, functioning as one integrated system</td>
</tr>
<tr>
<td>- Communicate about cases only rarely and under compelling circumstances:</td>
<td>- Communicate regularly about shared patients, by phone or e-mail</td>
<td>- Communicate consistently at the system, team and individual levels</td>
</tr>
<tr>
<td>- Communicate, driven by provider need</td>
<td>- Collaborate, driven by need for each other's services, and more reliable referral</td>
<td>- Collaborate, driven by need for consultation and coordinated plans for difficult patients</td>
</tr>
<tr>
<td>- May never meet in person</td>
<td>- Meet occasionally to discuss cases due to close proximity</td>
<td>- Have regular face-to-face interactions about some patients</td>
</tr>
<tr>
<td>- Have limited understanding of each other's roles and resources</td>
<td>- Feel part of a larger yet non-formal team</td>
<td>- Have a basic understanding of roles and culture</td>
</tr>
</tbody>
</table>

## Co-located Key Element: Physical Proximity

- Collaborate, driven by need for each other's services, and more reliable referral. When co-located providers share offices, they can easily communicate and coordinate care, facilitating seamless integration. This setup is highly beneficial for managing patient care efficiently and ensuring that all team members are aware of patient needs and treatment plans. Co-location promotes frequent face-to-face interactions, which are crucial for establishing strong collaborative relationships, and it allows for quicker response times to patient needs. This model is particularly effective in promoting a unified care approach, where all providers are physically close, enabling them to work together smoothly and efficiently.
Integration Assessment

- Review the description for each level and select the number (1-10) that thinks best corresponds to your current practice.
- To get your composite score and identify your current level of integration, take the average of your scores for each section.
  - There are twelve total questions across the five domains.
  - You may choose to assess your current level within each domain (sum total divided by the number of questions in that domain) and/or overall (sum total divided by 12).
- Assessment is a starting point for discussion and goal setting.
- The assessment and levels are not linear.

Complete Assessment (10 minutes)

- Take 10 minutes to complete the assessment.
- If some of your team is here, complete as a team.
- Faculty will circulate if you have questions.
Group Discussion (30 minutes)

- 15 minutes: break into groups of 3-4 to discuss one key finding from your assessment.
- 15 minutes: small groups report out + larger group discussion

Discussion questions:
- What are our strengths and challenges in moving forward?
- Who could provide state/regional support?
- Who else do we need to bring into the effort?
- How can IHI provide support?

CASE STUDIES

Bellin Health

PanCare, Inc.
Thriving on Change and Improvement – Team Based Care

Why-Integrate Behavioral Health into Primary Care?
Vision and Strategy

• **Vision**
The people in our region will be the healthiest in the nation, resulting in improved economic vitality in the communities we serve.

• **One of Three Breakthrough Initiatives**
Deliver Reliable Customer Experiences
How Are We Doing This?

Team Based Care

• Uniquely skilled individuals working together as a team to meet the health care needs of the patient in an efficient and comprehensive matter
The Primary Care Team:

- Office based staff involved with the office visit, the pre and post office visit work and in-between visit management.

- Consists of: Physician/Physician Assistant or Nurse Practitioner, Clinic RN, CMA/LPN (Care Team Coordinator), Scheduler, new member Behavioral Health Consultant
Team Based Care Keys for Success:

- Colocation of core team members
  - Improves communication
  - Creates team culture
- Huddles
  - Core team meet daily for 5-10 minutes to anticipate patient needs
- Care team weekly meetings
  - Update on high risk patients

BHC New Member to Core Team

- Pilot started 9/21
  - Screening PHQ9 score 10 or greater
  - Warm handoff from provider during visit
    - Anxiety
    - Depression
    - Substance abuse
    - Behavioral issues with children
  - Chronic diseases uncontrolled or engaged
What are our Successes and Opportunities?

Successes

• Empower staff to work to the level of their skillset resulting in an increased staff satisfaction
• Patient feedback
• Patient outcomes
• Improved quality measures
Opportunities

- Billing for to all payers for all services
- Integrating to one chart and housed in primary care

Team Based Care Prototype
Results
Financial Results – Win for the System

<table>
<thead>
<tr>
<th>Care Team</th>
<th>Operating Margin prior to Go-live</th>
<th>Operating Margin Target</th>
<th>Operating Margin Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>-2.2</td>
<td>3.3</td>
<td>5.7</td>
</tr>
<tr>
<td>2</td>
<td>10.5</td>
<td>10.4</td>
<td>17</td>
</tr>
<tr>
<td>3</td>
<td>7.9</td>
<td>8.4</td>
<td>18.1</td>
</tr>
<tr>
<td>4</td>
<td>9.5</td>
<td>4.8</td>
<td>-11.1</td>
</tr>
<tr>
<td>5</td>
<td>-9.5</td>
<td>-1.2</td>
<td>-4.6</td>
</tr>
<tr>
<td>6</td>
<td>49.2</td>
<td>50.3</td>
<td>46.1</td>
</tr>
</tbody>
</table>
### Quality Results – Win for the Patient, Care Team, and System

<table>
<thead>
<tr>
<th>Measure</th>
<th>Baseline</th>
<th>Actual</th>
<th>Percentage Improvement</th>
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</thead>
<tbody>
<tr>
<td>Breast</td>
<td>55.37%</td>
<td>64.01%</td>
<td>8.64%</td>
</tr>
<tr>
<td>Cervical</td>
<td>69.61%</td>
<td>77.57%</td>
<td>8.26%</td>
</tr>
<tr>
<td>Colorectal</td>
<td>79.71%</td>
<td>84.38%</td>
<td>7.97%</td>
</tr>
<tr>
<td>LDL @ TARGET (&lt;100)</td>
<td>65.79%</td>
<td>65.43%</td>
<td>.36%</td>
</tr>
<tr>
<td>BLOOD PRESSURE @ TARGET (&lt;140/80)</td>
<td>50%</td>
<td>50.53%</td>
<td>.53%</td>
</tr>
<tr>
<td>A1C @ TARGET</td>
<td>48.95%</td>
<td>57.98%</td>
<td>9.03%</td>
</tr>
<tr>
<td>A1C POOR CONTROL (&gt;9%)</td>
<td>6.11%</td>
<td>4.37%</td>
<td>1.74%</td>
</tr>
<tr>
<td>RENAL PROTECTION</td>
<td>62.11%</td>
<td>68.62%</td>
<td>7.40%</td>
</tr>
<tr>
<td>FOOT EXAM</td>
<td>21.05%</td>
<td>73.94%</td>
<td>52.89%</td>
</tr>
<tr>
<td>RETINAL EXAM</td>
<td>32.63%</td>
<td>38.30%</td>
<td>5.67%</td>
</tr>
<tr>
<td>PNEUMOVAX COMPLETED</td>
<td>54.21%</td>
<td>64.89%</td>
<td>10.68%</td>
</tr>
<tr>
<td>HEP B COMPLETED</td>
<td>6.32%</td>
<td>7.45%</td>
<td>1.13%</td>
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</table>
PanCare of Florida, Inc. (PanCare) is a 501(c)3 non-profit organization which operates Federally Qualified Health Centers (FQHCs) in Bay, Calhoun, Holmes, Liberty, Walton, and Washington counties in the Florida panhandle.

PanCare serves approximately 10,300 patients through 33,706 visits annually.
PANCARE PATIENTS (PAYOR MIX)

- Medicaid: 53%
- Medicare: 34%
- Uninsured: 10%
- Private Insurance: 3%

TEAM SUPPORT

- Mike Hill, Chief Executive Officer is the Executive Sponsor.
  The team is comprised of:
  - Robert Thompson, Chief Operating Officer
  - Sandi Ford, ARNP, FNP-BC, CNS Adult Mental Health
  - Stephanie Hofrichter, MSW, LCSW
  - Elena Leahey, LPN
  - Teresa Johnson, Medical Administrative Assistant
  - Will Hill, IT Support
  - William Kuzbyt, Psy.D., Consultant

- The team meets weekly to review clinical data, successes, and operational challenges.

- Face to face meetings, telephone, and email communication methods are used to communicate with the Sponsor. In addition, routine reporting mechanisms are utilized to keep the Sponsor abreast of the project’s progress.
**PANCARE AIM & GOALS**

**June 2015**

**Aim**
In one year, PanCare will develop a systematic model for integrated behavioral health care that will result in the patients being treated by a care team. This will result in improved clinical outcomes, easier access to care, increased support for complex patients, and greater input from staff regarding daily operations of the practice.

**Goals**
By the end of the project period PanCare will:
- Screen 95% of all patients aged 12 and older with the PHQ-9.
- Have 0.5 FTE Psychiatric ARNP on staff.
- Ensure that 90% of those screened positive for depression have a face to face encounter with the LCSW within 2 days.

---

**PANCARE AIM & GOALS**

**December 2015**

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**Goals**
By the end of the project period PanCare will:
- Screen 95% of all patients aged 12 and older with the PHQ-9.
- Ensure that 90% of those screened positive for depression have a face to face encounter with the LCSW within 2 days.
- By November 1, 2016 PanCare will improve performance measures and response rate of patients surveys though process improvements related to survey methodology and automation for data extrapolation.
- By November 1, 2016 though PDSAs, ongoing testing and adjustment PanCare will demonstrate improvement in performance outcomes as indicated by reaching the established goals for at least 2 consecutive months.
- By November 1, 2016 the remaining performance measures relative to Depression will be automatically extrapolated from MicroMd, calculated, graphed and reported for at least 5 consecutive months. These measures include Screening with the PHQ9 tool, Follow up by Provider, Treatment, and Improvement.
"How confident are you that you can control and manage most of your health problems?"

Goal > 70%

"I was able to get all of my health needs met by my MEDICAL HOME TEAM"

Goal > 4.24
“In general, would you say your health is: Excellent, Very Good, Good, Fair, or Poor?”

Percentage reporting Excellent or very good health

Month/year

<table>
<thead>
<tr>
<th>Month/Year</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>Aug-15</td>
<td>64.71</td>
</tr>
<tr>
<td>Sep-15</td>
<td>81.82</td>
</tr>
<tr>
<td>Oct-15</td>
<td>35.29</td>
</tr>
<tr>
<td>Nov-15</td>
<td>64</td>
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</table>

“In general, would you say your health is: Excellent, Very Good, Good, Fair, or Poor?”

Average score

Month/Year

<table>
<thead>
<tr>
<th>Month/Year</th>
<th>Average Score</th>
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<tbody>
<tr>
<td>Aug-15</td>
<td>4.2</td>
</tr>
<tr>
<td>Sep-15</td>
<td>4.36</td>
</tr>
<tr>
<td>Oct-15</td>
<td>4.41</td>
</tr>
<tr>
<td>Nov-15</td>
<td>4.95</td>
</tr>
</tbody>
</table>

“For today’s visit, your care team was well organized, efficient, and did not waste your time”
Challenges for Implementation

- Electronic Health Record
  - Data harvest for PHQ9
  - Seamless merging of behavioral health records
- Staffing
Benefits of Participating in the IHI Collaborative

• Increased Team building
• Increased Awareness of need for changes in “routine practices”
• Increased use of PDSA cycles
• Huddles

Medical Provider’s Perspective: Evolutionary and Dynamic

• Primary Care Evaluation
  • Patient Health Questionnaire 9 (PHQ9)
• Warm Handoff
• Medication Therapy
• Medical and Behavioral Integration
• Collaboration with Patient
• Evaluate-Treat-Re-Evaluate
89% of the patients surveyed in November 2015 Strongly Agree that there is a 
*Seamless Transition between Medical and Behavioral Health*
BREAK

THE FOUNDATIONAL ELEMENTS
“Teamwork, Teamwork, Teamwork”

Edward H. Wagner, MD, MPH
Group Health Research Institute
Senior Investigator
Director (Emeritus), MacColl Center

WHAT CHANGES CAN WE MAKE?
TEAM-BASED RELATIONSHIPS

The next hour….

- Why care teams?
- Assessing your population’s needs
- Building and supporting a team culture and workspace
- Determining the composition of the care team
- Building effective care teams
**Why a Primary Care Team?**

- Increasing numbers needing access
- Decreasing number of PCPs
- 10.6 additional hours to manage chronic conditions

**Problems and Barriers**

- Transaction costs (handoffs, safety issues, etc.)
- Scope of work dilemmas
- Challenges of human relationships and personalities
- Need for collaborative decision making
- Economic disincentives

As delineated in *Building Teams in Primary Care: Lessons Learned* (California Healthcare Foundation)

[Building Teams in Primary Care: Lessons Learned](http://www.chcf.org/~/media/Files/PDF/B/PDF_BuildingTeamsInPrimaryCareLessons.pdf)
Develop the team based on the population that you serve, their outstanding needs, and high-volume diagnoses.

- Assess your practice and the population you serve
  - The Green Book: [www.clinicalmicrosystem.org](http://www.clinicalmicrosystem.org)

- Think seriously about diversity and matching your care team to reflect the population served and the culture of the community.

- Measure team and patient satisfaction while making changes

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### Microsystem Assessment of Data Sources and Data Collection Actions

With your interdisciplinary team, review the Assess, Diagnose and Treat workbook. "The Greenbook". Use this form to collate the data you've collected and determine what data is needed. Don't need to use the current versions of the worksheets. Be sure the data is current and not months old. Determine which worksheets will be used. Plan who, when and how the worksheets will be completed. Decide who oversees the compilation of each worksheet or alternative data source.

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#### Primary Care Practice Profile

- **Pages 6-8, Know Your Patients**

#### Data Source/Data Collection Action

<table>
<thead>
<tr>
<th>Page/Type of Data</th>
<th>Purpose</th>
<th>Data Source/Data Collection Action</th>
<th>Date/Owner</th>
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<tbody>
<tr>
<td>Page 6 A. Know Your Patients</td>
<td><strong>A. Purpose:</strong></td>
<td>Why does your practice exist?</td>
<td>Site Name: Site Contact: Date:</td>
</tr>
<tr>
<td>B. Estimated Age Distribution of Patients</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>C. Estimated Age Distribution of Patients in Patients</td>
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<tr>
<td>D. Sex, Specific Health Outcomes</td>
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<tr>
<td>E. List Your Top Diagnoses/Conditions</td>
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<tr>
<td>F. Top Providers</td>
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<td>G. Patients Who Present Frequent</td>
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<tr>
<td>H. Regional Microsystem</td>
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<tr>
<td>I. Patient Satisfaction (CDC Patient Survey pg 11)</td>
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<td>J. Chronic Care Survey pg 10</td>
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<td>K. Patient Population Census</td>
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<tr>
<td>L. Walk Through (pg 9)</td>
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<tr>
<td>M. Out of Practice Days</td>
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<tr>
<td>N. Page 6 C Know Your Professionals</td>
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<tr>
<td>O. Site Name: Site Contact: Date:</td>
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<tr>
<td>P. Estimated # (unique) pts. In Practice</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Q. % Females of Practice</td>
<td></td>
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<tr>
<td>R. Outcomes</td>
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<td></td>
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<tr>
<td>S. Practice Est.</td>
<td></td>
<td></td>
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<tr>
<td>T. Site Name: Site Contact: Date:</td>
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**Primary Care Practice Profile**

- **Complete "Through the Eyes of Your Patient" pg 9**

- **Complete "Metrics that Matter", pgs 23-24**

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**Important…:**

- Complete the Core and Supporting Process Assessment Tool
  
  1. **E1.** Most Significant Pattern
  2. **E2.** Successful Change
  3. **E3.** Use the following template to create a comprehensive picture of the patient population that you serve.
Identify the leadership for teams and start building a team culture

- Ensure that formal and informal practice leaders repeatedly voice clear and strong support for team-based care, and act consistently in a way that signals their support for this model.
- Dedicate resources for team-building exercises to help team members begin developing trust and a coordinated way of working together.
- Encourage daily huddles and meetings to organize the work and solve problems together.
- Flatten the hierarchy by encouraging all member of the team to have a voice in discussions.
- Redesign work spaces to support Team-Based Care.

Goals and Example for work area design at Neighborhood Clinics, Ravenna Clinic

- Develop work areas that promote coordination and communication between team members,
- Design spaces that are patient-friendly, reducing patient anxiety by ensuring privacy, comfort, and engagement,
- Design a flexible space that can accommodate day-to-day variations as well as long-term changes in primary care models,
- Use space efficiently to reduce waste and cost,
- Promote patient safety and decrease error through standardization in design and equipment and by placing needed equipment in exam rooms,
- Integrate appropriate technology.

1. On-stage areas optimized for patient flow.
2. Standardize exam rooms
3. Off-stage areas that put team members near one another.
1. On-stage areas optimized for patient flow.
2. Standardize exam rooms
3. Off-stage areas that put team members near one another.
1. On-stage areas optimized for patient flow.
2. Standardize exam rooms
3. Off-stage areas that put team members near one another.
Architecture to Support Teams
Clinica Family Health, Team Based Care

Develop a core team structure or structures that you think will meet the needs of your patients and providers.

http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/PDF%20BuildingTeamsInPrimaryCareCaseStudies.pdf
Case Studies

1. Dr. Kwabena Adubofour: Expanding the Role of Medical Assistants in a Solo Private Practice
2. Dr. Charles Burger: Innovative Team Roles in Private Practice
3. Clinica Campesina: Using Space and Financial Incentives to Enhance Team Functioning
4. Harbor-UCLA Medical Center’s Family Health Center: A Community-Based Promotora Team
5. San Francisco General Hospital: The Family Health Center Teamlet Project
6. Santa Clara Valley Health and Hospitals System: A Planned care Center for Chronic Conditions Supports Primary Care
7. Cambridge Health Alliance: Using Multilingual Health Workers for Population Management
8. Kaiser Permanente Northern California: A Team Role for Panel Management
9. St. Peter Family Medicine Residency Program: Training Medical Assistants as Diabetes Care Managers
10. Palo Alto Medical Foundation: Optimal Utilization of the RN in Primary Care
11. Harvard Vanguard Medical Associates:

http://improvingprimarycare.org/team
The Primary Care Team

- Patient linked with specific provider(s):
  - Provider
  - MA/LPN
  - RN
  - Health Coach or Patient Service Rep.

- Centralized Resources:
  - RN Care Managers
  - Lay Caregivers: CHW, Pt. Navigators
  - Administrative Staff: QI, EHR Specialists
  - Pharmacists
  - BH Specialists

Provided through links with outside organizations

What has Changed in the Care Team at Bellin?
OLD MODEL OF PATIENT CARE

NEW MODEL OF CARE
### Old vs New Care Team Models

<table>
<thead>
<tr>
<th>Old</th>
<th>New</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider: MA Ratio = 1:1</td>
<td>1 provider to 2 Care Team Coordinators (CTC)</td>
</tr>
<tr>
<td>MA – room patients</td>
<td>CTC – rooming patients, agenda setting, team documenter, close out visit, result management</td>
</tr>
<tr>
<td>Clinic RN – 100% on the phones</td>
<td>Clinic RN – 50% on phones 50% patient care – Medicare wellness Visits, Diabetic Education, BP rechecks</td>
</tr>
<tr>
<td></td>
<td>Behavioral Health Consultant (BHC) – 10 &gt; PHQ-9 or warm handoff from care team</td>
</tr>
</tbody>
</table>

---

**Develop clear roles and responsibilities for every member of the team**

**Ensure That each team member is working to the top of their skillset and credentials**

*Team Visualization Exercise*

www.ihi.org/IHI/Topics/OfficePractices/Access/Changes/OptimizetheCareTeam
Share the Care: Assessment of Team Roles and Task Distribution

This is an example of a planning tool, to assess who is currently doing what tasks in your practice and then who should be doing each task, based on how we learned that LEAP sites define clear roles and responsibilities. There is no “right answer” — task distribution will vary from practice to practice, based on contextual and internal factors. The tool is in the discussion about roles that this worksheet can stimulate. Your practice may be able to redistribute the tasks in a way that better fits your workforce and patients.

Instructions:
1. Modify the worksheet so that the columns reflect all care team roles and the rows contain the most important tasks in your practice. (Note: we use the term “lay person” to mean someone without medical background, so this may include lay caregivers such as Community Health Workers or administrative staff members such as Front Desk staff).
2. Gather a group of staff members who are engaged in redesigning care roles, representing all the roles on the care team.
3. Assess your practice at the current time, for each task. The tasks are organized by categories, such as “communications with patients, outside of the patient office visit.” PLACE(X) in boxes to indicate “Who does it now?”
4. Next, use the worksheet to think about “Who Should Do It?” Discuss which roles are capable of doing each task and how well the work is distributed across roles. Use a check mark to indicate where you think that tasks can be redistributed for improvements to everyone’s workload.

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<table>
<thead>
<tr>
<th></th>
<th>MA</th>
<th>LPN</th>
<th>RN</th>
<th>Provider</th>
<th>PharmD</th>
<th>BH specialist</th>
<th>CM</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication with patients, outside of patient office visit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Answer phones, triage calls</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Help manage/ triage provider electronic inbox</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Serve as primary point of contact for patients</td>
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<tr>
<td>Conduct patient outreach for outstanding labs, etc.</td>
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<tr>
<td>Follow-up by phone or email after visits to ensure instructions understood</td>
<td></td>
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<tr>
<td>Follow-up with patients after hospital discharge</td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Follow-up with patients after Emergency Department visit</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Respond to patient calls requiring clinical assessment and decision-making</td>
<td></td>
<td></td>
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<tr>
<td>Community-based efforts to connect new patients to the practice</td>
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<tr>
<td>Notify patients about normal lab results</td>
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<td></td>
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<tr>
<td>Notify patients about abnormal lab results</td>
<td></td>
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</tr>
</tbody>
</table>

http://improvingprimarycare.org/team/practice-team

Step 4 Encourage and enable staff to work independently

- Develop standard work processes for the delivery of common services, and incorporate them into practice workflows and into the Electronic Health Record.
  - Systematizing expanded roles in standard work helps reduce variation and prevent backsliding.
- Maximize the use of standing orders.
  - Standing orders enable staff to independently perform key clinical tasks without having to involve the provider.
Lessons Learned: Nursing/MA/PharmD Protocols

- Pick the right protocol
- Review the Board requirements
- Include when to ask for help
- Demonstrate documentation & billing
- Plan for ad hoc updates
- Assure annual review
- Retrain after review

Carolyn Shepherd, M.D.
Leibig Shepherd

http://improvingprimarycare.org/team/practice-team

High Leverage Change

Provide team members with regular, dedicated time to meet about patient care, quality improvement, and to facilitate strong working relationships.
Resources for Huddles

Guide

Extended Huddle for Complex Patients

Time: Weekly. Morning meeting: 8 – 9 AM (or other as decided at site)

Attendees: Team members including PCPs (physician, NP, PA), medical assistants, PSR, BHC, care coordinator/care navigator, administrator, student and/or pharmacist. (A typical Extended Huddle may include 2-3 PCPs and 1-3 MAs, one or two PSRs, a BHC, pharmacist, administrator, health coach.)

The Objectives of Huddles:
- To bring a diversity of input to the care of complex patients who have not responded well to care thus far - usually patients with multiple and poorly controlled chronic conditions.
- Through discussion, to educate a diverse group of staff members on issues related to the care of our complex patients.
- To build understanding of the roles and responsibilities of various team members.
- To expand staff understanding of community medical and other resources and how to access them.
- To facilitate the integration of medical and behavioral health care.
- To carry out an activity that will meet expectations of some payers and granting agencies for a QA/QI program of certifying and granting agencies (i.e. patient centered medical home, Accountable Care Organization, Community health center program expectations)

Preparation:

I. General Rules
   a. Meet prior to morning and afternoon patient appointments
   b. Keep huddle to < 3 minutes
   c. Keep huddles a predictable and consistent part of the day

II. Review
   a. Review previous day and status of unfinished medical work (comu results, patient follow-up)
   b. Update clinic operations status (staffing, equipment and computer
   c. Unexpected hospital visits, meetings, special events/external factors

III. Identification
   a. Identify patients with chronic disease
   b. Identify potential patient "bottleneck", tardy patients or schedule
   c. Update canceled appointments (hospitalized patient, etc)
   d. Identify patients with special needs (age, disability, personality, language)
   e. Identify patients for whom the provider will need assistance

IV. Preparation
   a. Discuss special patient issues
   b. Discuss possible constraints to visit (language, disability, stress, personality)
   c. Discuss contingencies to deal with issues and patient needs
   d. Define necessary work for specific patient
   e. Discuss need for testing or questionnaire prior to provider encounter
   f. Discuss any specific expectations for the day

V. Growth
   a. Develop a team spirit and maintain positive attitude

http://improvingprimarycare.org/search?keyword=huddles&=Search

Anatomy of a Huddle

Planned Care Huddle
(3.25 min.)
http://www.youtube.com/watch?v=Wttxm7jAnb4

Army Medical Department PCMH
Huddle Video
(8.5 minutes)
https://www.youtube.com/watch?v=q84aAeMV4C4
1. **Purpose:** Team work approach to patient care

2. **When:** Each Morning beginning at 8am for 15 minutes

3. **Participants:** Primary Care Provider (leader), Behavior Health Provider, LPN, and Medical Administrative Assistant

4. **Content:** Coverage specific patient updates from the previous day, assignments/ updates, Clinic facility issues

5. **What Survey process on Huddles has been done?**
   Impromptu testing with the key questions (next slides) related to process, benefits and suggestions for improvement to the Huddles.
**Change to be evaluated:**

Will a morning Huddle practice prevent gaps or delays in service delivery? Does this increase in communication improve job satisfaction?

**Objective for this PDSA Cycle:**

Increase information flow across care team members to prevent gaps or delays in service delivery at all levels while improving job satisfaction.

**PLAN**

- On June 22, 2015 Implement Huddles at 2 pilot sites each morning at 8am with PCP leading, Admin transcribing, and all players signing minutes.

- Survey of the Process will be conducted quarterly for feedback continuous improvement.

- Staff survey related to service delivery, job stress, overall job satisfaction and perceived employee performance. (Likert scale of 5)

- Open ended staff survey question asking suggestions for improvement of the Huddles.
1. Morning Huddles will open team communication and decrease delays relative to Quality Care through information sharing, group discussion and decision making.

2. Morning Huddles will acknowledge the worth of each Care Team Member and their contribution to the Team approach which will improve employee satisfaction with their job and in turn improve their perceived job performance.

3. Morning Huddles will prevent delays in referrals and medication delivery
RESULTS

Impact of Huddle

- New Information: Jul-15 100, Nov-15 100
- Improved Overall Communication: Jul-15 100, Nov-15 100
- Improved ability to do Job: Jul-15 80, Nov-15 100
- Lowers Job Stress: Jul-15 40, Nov-15 75

THIS PRESENTATION MADE POSSIBLE THROUGH

Act | Plan
---|---
Study | Do
Building Effective Care Teams

1. Identify the leadership for teams and start building a team culture
2. Develop a core team structure or structures that you think will meet the needs of your patients and providers, AND TEST IT
3. Develop clear roles and responsibilities for every member of the team
4. Encourage and enable staff to work independently.
5. Engage patients as a member of the care team and help them understand what they can expect in a team-based model of care.
6. Provide team members with regular, dedicated time to meet about patient care, quality improvement, and to facilitate strong working relationships.
7. Provide training so that staff members learn new tasks and how to coordinate with team members.
8. Develop career ladders for staff members in all roles.

http://improvingprimarycare.org/team/practice-team

WHAT CHANGES CAN WE MAKE?
BEHAVIORAL HEALTH INTEGRATION
Integrated Behavioral Health and Primary Care

Collect key information to guide program direction, staffing, and determine approach to integration.

Develop reliable operations and processes to support integrated care.

Make the business case for integration.

Redesign care delivery using the core principles of integrated care.

---

BHI core components

1. Define the behavioral health needs you need and want to address.
2. Choose a behavioral health integration approach.
3. Identify how to make the business case for integration.
4. Select the behavioral health providers and organizations with whom to collaborate.
5. Develop and train the workforce.
6. Develop a process for how patients will access behavioral health care.
7. Redesign clinical and operational workflows.
8. Track patient and integration program outcomes.
9. Enhance the capacity to provide evidence-based care.
1. Collect key information + program planning

1. Collect key information

- Collect key information to guide program direction, staffing, and determine approach to integration:
  - Patient needs
  - Clinic/organizational characteristics
  - Policy & financial environment
  - Existing data & measurement system
- Define the behavioral health needs you need and want to address.
- Choose a behavioral health integration strategy.
- Define how you will make the business case for integration.

2. Develop Reliable Operations and Processes to Support Integrated Care

1. Collect key information

2. Processes to Support Integration

- Select the behavioral health providers and organizations with whom to collaborative.
- Develop and train the workforce.
- Develop a process for how patients will access behavioral health care.
- Redesign clinical and operational workflows.
- Track patient and integration program outcomes.
- Space to support behavioral health care
3. The Business Case for Integration

1. Collect key information
2. Processes to Support Integration
3. Make the Business Case

- Identify existing policy incentives to support integrated care
- Know your cost: calculate expenditures
- Identify potential sustainable payment strategies, e.g. case rates, capitated payments, global payments
- Offsetting of costs
- Manage existing payment structure
- Find money-saving opportunities
- Supplemental income + funding sources
- Take calculated risks

Source: AHRQ Integration Academy Guidebook of Professional Practices for Behavioral Health and Primary Care Integration

4. Re-design Care Delivery

1. Collect key information
2. Processes to Support Integration
3. Make the Business Case
4. Redesign Care Delivery

- Develop clinical assessment methods, evidence-based interventions, and follow up guidelines for treatment of medical and behavioral health disorders
- BH expertise on care team tailored for patients and target population
- Shared care plan between PC and BH providers
- Treat to target
- Identify a stepped care approach
- Weekly huddles and case conferencing
- Enhancement approach
Small group discussion

Select a discussion group based the change concepts:
1. Define the behavioral health needs you need and want to address and choose a behavioral health integration approach.
2. How to make the business case for integration.
3. Select the behavioral health providers and organizations with whom to collaborate and develop and train the workforce.
4. Develop a process for how patients will access behavioral health care and redesign clinical and operational workflows.
5. Track patient and integration program outcomes.
6. Enhance the capacity to provide evidence-based care.

Exercise: Group discussion

- 25 minutes: Discuss key issues, major change ideas, expected barriers and strategies to overcome them. What successes have you had? What is missing?

- 25 minutes: groups report out
Identifying Opportunities and Approaches for Improvement

Your task for the next 30 minutes….

- Each table will work together on an opportunity for improvement.
- Clarify what you are trying to accomplish, i.e.;
  - Increase % of population with depression screening within the last 12 months.
  - Increase the percentage of patients with hypertension with blood pressure under control
  - Increase the percentage of people who test positive for depression or SMI receiving initial follow-up on the same day
- Set goals and timeline to achieve goals
- Use the worksheet to generate discussion and identify changes that will help you accomplish your goals.
- Report out to others.
### Quality Measurement and Improvement Worksheet

<table>
<thead>
<tr>
<th>What are we trying to accomplish?</th>
<th>Data Source or Measure(s)</th>
<th>Current Performance Level</th>
<th>Performance Goal and Dates</th>
<th>Proposed Changes to be Tested</th>
</tr>
</thead>
</table>
| Increase the number of people in the microsystem ≥ 18 yo with documented depression screening in the past 12 months. | Depression Screening | 40% | >70% by April 2016 | - Use of reminders and prompts from the EHR for patients coming in for a visit to identify patients needing screening to be utilized in huddle.  
- Perform a query on all patients in the panel to identify patients needing depression screening and test methods to reach those patients. (i.e.; dental visit opportunities)  
- Patient wellness handouts with reference to guidelines for depression screening, supporting and encouraging patients to take responsibility for their health and wellness.  
- Data on depression screening available to care team members with weekly review conducted by the care team to determine progress and identify opportunities for improvement.  
- Optimize the role of the MA to conduct screening with the PHQ2.2 and the role of the nurse to conduct a follow-up on positives with the PHQ-9.  
- Training for staff on new roles/responsibilities  
- Encourage the independence of care team members through the use of protocols and standing orders for screening and follow-up in patients over the age of 18. |
Your task for the next 30 minutes....

- Each table will work together on an opportunity for improvement.
- Clarify what you are trying to accomplish, i.e.:
  - Increase % of population with depression screening within the last 12 months.
  - Increase the percentage of patients with hypertension with blood pressure under control
  - Increase the percentage of people who test positive for depression or SMI receiving initial follow-up on the same day
- Set goals and timeline to achieve goals
- Use the worksheet to generate discussion and identify changes that will help you accomplish your goals.
- Report out to others.

Summary

- Describe the key changes needed to implement team-based primary care that integrates behavioral health
- Identify and start to build the necessary skills to support integrated, team-based primary care
- Develop an action plan to implement integrated, team-based primary care at your organization

<table>
<thead>
<tr>
<th>Time</th>
<th>Agenda Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:30 AM - 8:45 AM</td>
<td>Welcome and introductions; review objectives and day's agenda</td>
</tr>
<tr>
<td>8:45 AM - 9:00 AM</td>
<td>Making the case for team-based primary care and behavioral health integration</td>
</tr>
<tr>
<td>9:00 AM - 9:45 AM</td>
<td>Exercise; Integration assessment</td>
</tr>
<tr>
<td>8:45 AM - 10:15 AM</td>
<td>Brief case studies</td>
</tr>
<tr>
<td>10:15 AM - 10:30 AM</td>
<td>Break</td>
</tr>
<tr>
<td>10:30 AM - 12:00 PM</td>
<td>The foundational elements</td>
</tr>
<tr>
<td>12:00 PM - 1:00 PM</td>
<td>Lunch</td>
</tr>
<tr>
<td>1:00 PM - 2:00 PM</td>
<td>What changes can we make? Team-based relationships</td>
</tr>
<tr>
<td>2:00 PM - 3:15 PM</td>
<td>What changes can we make? Behavioral health integration</td>
</tr>
<tr>
<td>3:15 PM - 3:50 PM</td>
<td>Group exercise and discussion (+ break)</td>
</tr>
<tr>
<td>3:50 PM - 4:00 PM</td>
<td>Tabletop Exercise; Identifying Opportunities and Approaches for Improvement</td>
</tr>
<tr>
<td></td>
<td>Summary and wrap up</td>
</tr>
</tbody>
</table>