Division of TennCare

STATE OF TENNESSEE

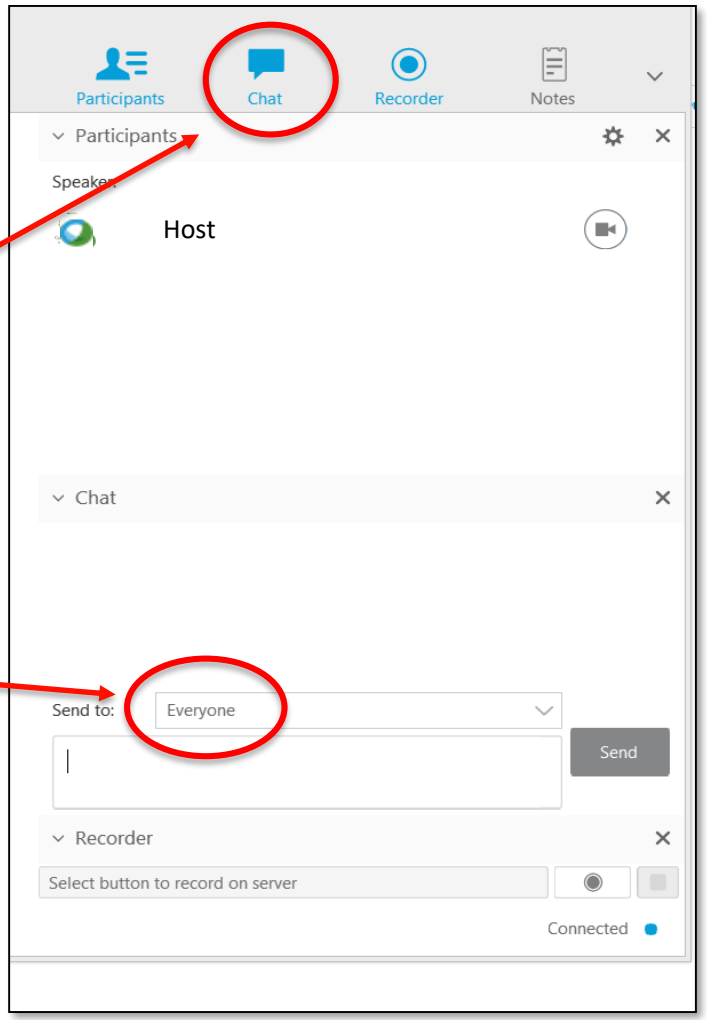
Keeping the Care Team Engaged: Involvement, Taking Ownership, and Training

July 17, 2019

Interactive Webinar

Communicating during the webinar:

- For questions or comments during the presentation, please click on the **chat box** function
- Select “Everyone” and enter your question or comment
- This will also be used during all Q&A portions of the presentation



Presenters

Wanda Rodgers, LMSW, has more than 20 years experience in healthcare. In her current role with Navigant, she provides technical assistance and coaching to clinical practices in developing patient-centered transformation strategies required for NCQA recognition. Her key areas of specialty are in healthcare compliance, program development, and revenue management.

Ripal Patel, MHA, currently works as Practice Administrator for-Darsalud Care, PLLC, which has two clinics, a primary care clinic and a multi-specialty clinic, LifeDOC. Ripal led both clinics in achieving PCMH recognition this year. She has worked with the Patient-Centered Medical Home Initiative for the past four years.

Learning Objectives

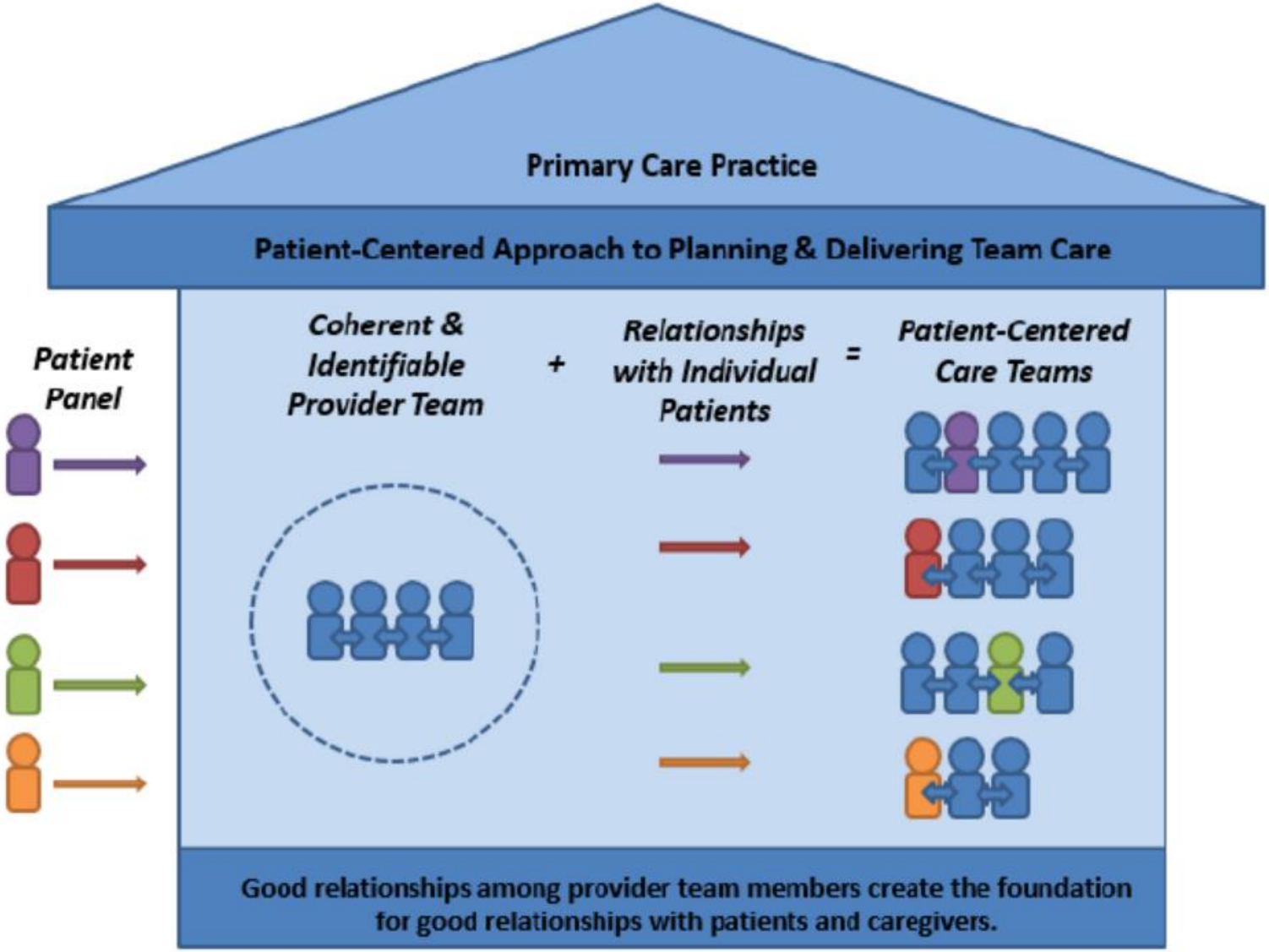
At the end of this webinar you will be able to:

1. Identify strategies for engaging the PCMH care team
2. Identify strategies for promoting a sense of ownership among the care team
3. Identify key elements for training the care team

Quick Review:
PCMH 2017 Terminology

Today's Concepts:

TC : Team-Based Care and Practice Organization



https://pcmh.ahrq.gov/page/creating-patient-centered-team-based-primary-care

Team-Based Care

Defined by the National Academy of Medicine:

> *The provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient—to accomplish shared goals within and across settings to achieve coordinated, high-quality care.*

Source: https://pcmh.ahrq.gov/page/creating-patient-centered-team-based-primary-care

Advantages of Team-Based Care

- Expands access
- Improves delivery of:
  - Patient education
  - Behavioral health
  - Self-management support
  - Care coordination
- Increased job satisfaction
- Promotes staff to working at the top of license and ability
- Increases likelihood of patients receiving the care they need
- Engages team members in data-driven continuous quality improvement

Source: https://pcmh.ahrq.gov/page/creating-patient-centered-team-based-primary-care

What are Elements of a Successful Care Team Environment?

- ✓ A culture of trust
- ✓ Clearly defined roles and responsibilities
- ✓ Strong leadership
- ✓ Respectful and empathetic open communication
- ✓ Appreciation of diversity
- ✓ Equal participation among all team members
- ✓ Established common goals
- ✓ Consensus decision making
- ✓ Solution-focused problem solving
- ✓ Ongoing evaluation

Source: https://www.aap.org/en-us/professional-resources/practice-transformation/Implementation-Guide/Pages/Team-Based-Cared.aspx

Involving Care Teams

- ✓ Involve staff in the development of the mission statement as equal participants on the team
- ✓ Define goals and develop a shared aim
  - ✓ Define specific, measurable outcomes and objectives
- ✓ Assign roles for each team member and define and delegate functions and tasks
- ✓ Ensure that each team member is competent to perform their defined and delegated tasks
- ✓ Involved each team member in the development of the team
- ✓ Ensuring quality and outcomes of care are important components of good team-based care
  - ✓ Include team members in QI efforts
  - ✓ Rotate team members on QI teams

Sources:
https://www.aap.org/en-us/professional-resources/practice-transformation/Implementation-Guide/Pages/Team-Based-Cared.aspx
https://www.integration.samhsa.gov/workforce/team-members/Cambridge_Health_Alliance_Team-Based_Care_Toolkit.pdf

Boosting Team Engagement

- Recognize individual and team accomplishments
- Prioritize learning and development
- Deliver feedback that integrates learning opportunities early and often
- Start engagement activities early (e.g., include new team members in QI activities upon hire)
- Align team goals with organizational goals
- Use succession planning to create career paths

In healthcare, a happy staff makes for healthy patients

Source: https://www.cornerstoneondemand.com/rework/healthcare-happy-staff-makes-healthy-patients

Taking Ownership: Building Coherence Among the Team

Promote a sense of egalitarianism, unity, and collective responsibility among team members:

- Provide a team structure in which one team member might serve as the "lead" for a patient to ensure smooth communication among the team; with the understanding that this person is not the sole decision maker, and may or may not be a physician, nurse practitioner, or physician assistant
- Acknowledge and examine power structures that interfere with developing collaborative relationships, encourage partnership approach to decision making

Source:
https://www.ahrq.gov/teamstepps/officebasedcare/classroom.html

Promoting Team to Patients

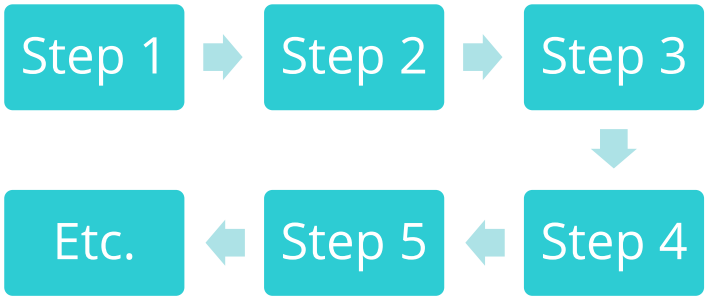
Making patients aware of the team-based approach increases each team member's sense of belonging and value to the team:

- Introduce patients to all team members and explain their roles
- Create visual cues (e.g., blue team)
- Reiterate "team-ness" to patients
- Demonstrate respect among team members
- Demonstrate patient information sharing among the team

Source: https://www.ahrq.gov/teamstepps/officebasedcare/classroom.html

Develop Team Workflows

- Workflow mapping is a way of making the invisible “visible” to a practice so they can look for ways to improve their processes to increase efficiency, reduce errors, and improve outcomes
- Workflows represent how work actually gets done, not the protocols that have been established to do the work
- Engage the entire team in developing workflows
- Review and update workflows regularly

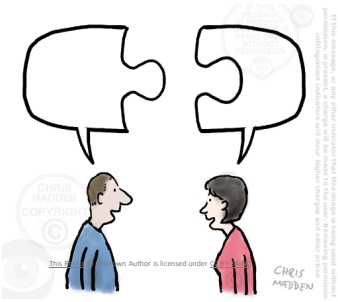


Source: https://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/mod5.html

Communication

The following strategies promote strong communication among team members:

- Written information sharing
  - Shared medical record system
  - Shared care plans
  - Using real-time communicating methods (IM, text, etc.)
- Verbal information sharing
  - Co-locating staff
  - Team members work at the same time or have overlapping schedules
  - Daily huddles
  - Scheduled time to review processes, fine tune roles, QI, etc.



Source:
https://www.ahrq.gov/teamstepps/officebasedcare/classroom.html

Handoffs

The transfer of information (along with authority and responsibility) during transitions in patient care:

- Includes an opportunity to ask questions, clarify, and confirm
- Transfers authority and responsibility

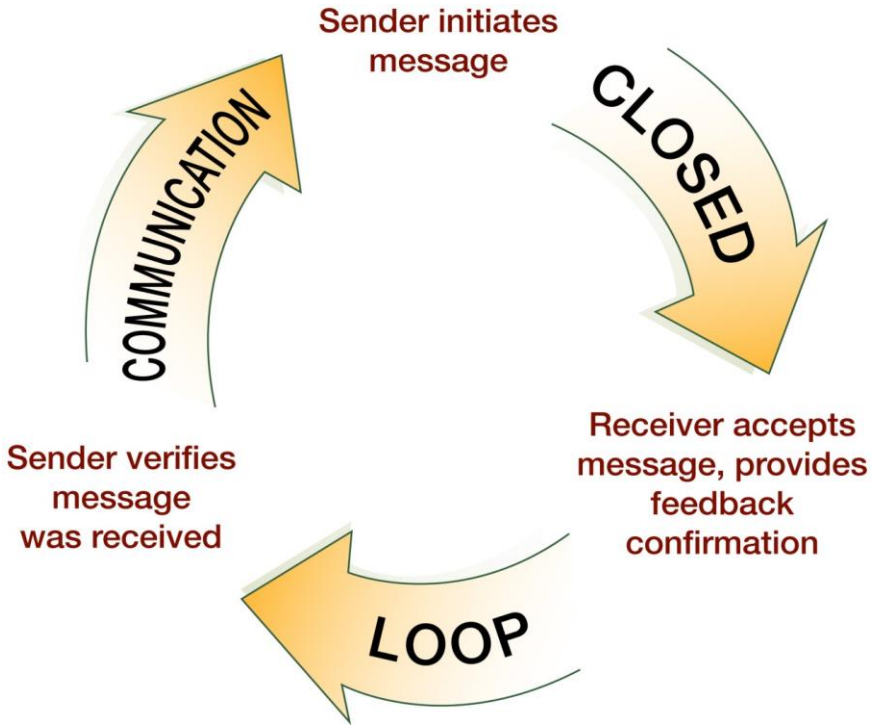
A proper handoff includes the following components:

- Responsibility: Person is aware of assuming responsibility
- Accountability: You are accountable until both parties are aware of the transfer
- Uncertainty: Clear up all ambiguity before the transfer is complete
- Communicate verbally: Clarification and follow up
- Acknowledged: Ensure that the handoff is understood and accepted
- Opportunity: Evaluate the situation for both safety and quality

Source:
https://www.ahrq.gov/teamstepps/officebasedcare/classroom.html

Check-Back

A closed-loop communication strategy verifies and validates the exchange of information with members of the team



Source: https://www.ahrq.gov/teamstepps/officebasedcare/classroom.html

Policies and Procedures to Support the Care Team

Ensuring that clinical and administrative systems support team members in their defined work helps promote engaged care teams and promotes a sense of ownership

Examples:

- Procedures for
  - Providing prescription refills
  - Informing patients of laboratory results
  - Making patient appointments
- Policies on how decisions are made in the practice
- Work schedules that allow time for team members to perform all parts of their job
- Adequate level of permissions in EMR to allow teams to perform their jobs

Source: https://www.integration.samhsa.gov/workforce/team-members/Cambridge_Health_Alliance_Team-Based_Care_Toolkit.pdf

Tips for Developing Training for the Care Team

- Outline all responsibilities and tasks that need to be performed to provide high quality, accessible, family-centered, continuous, coordinated, and comprehensive care to patients and their families
- Determine the tools and resources needed to carry out each task
- Match team roles to scope of practice, licensure, training, and capabilities fostering team care

Source: https://www.aap.org/en-us/professional-resources/practice-transformation/Implementation-Guide/Pages/Team-Based-Cared.aspx

Tips for Developing Training for the Care Team (continued)

- Create a training manual with clear, step-by-step guidance on each task
  - Include job descriptions for each team member
  - Include step-by-step procedures for each task required to fulfill the responsibilities as noted by their job description
  - Once staff roles and responsibilities are defined, review with staff to obtain input and to identify areas where additional training is needed
  - Revise job descriptions as needed

Source: https://www.aap.org/en-us/professional-resources/practice-transformation/Implementation-Guide/Pages/Team-Based-Cared.aspx

We utilize CARE TEAM APPROACH for our integrated model which helps us prevent progression of underlying conditions.

Medical Services

- Pediatrics
- Family Medicine
- Internal Medicine
- Endocrinology
- Cardiology
- Cardiac-Lab
- Ultrasound Unit
- Wellness Program (Diet, Nutrition and Exercise)
- Laboratory and Imaging Services
- Full Optometry Center
- E/R Diversion Unit

Support

- Referral Coordinators
- Care Coordination Specialist
- Wellness and Exercise Coach
- Patient Engagement Center
- Vida Plus Membership
- Fully Implemented cloud-based EMR
- Motivational coaching and mental health support
- Multi-lingual support
- Clinical Research Unit

Care Team Approach at Darsalud Care

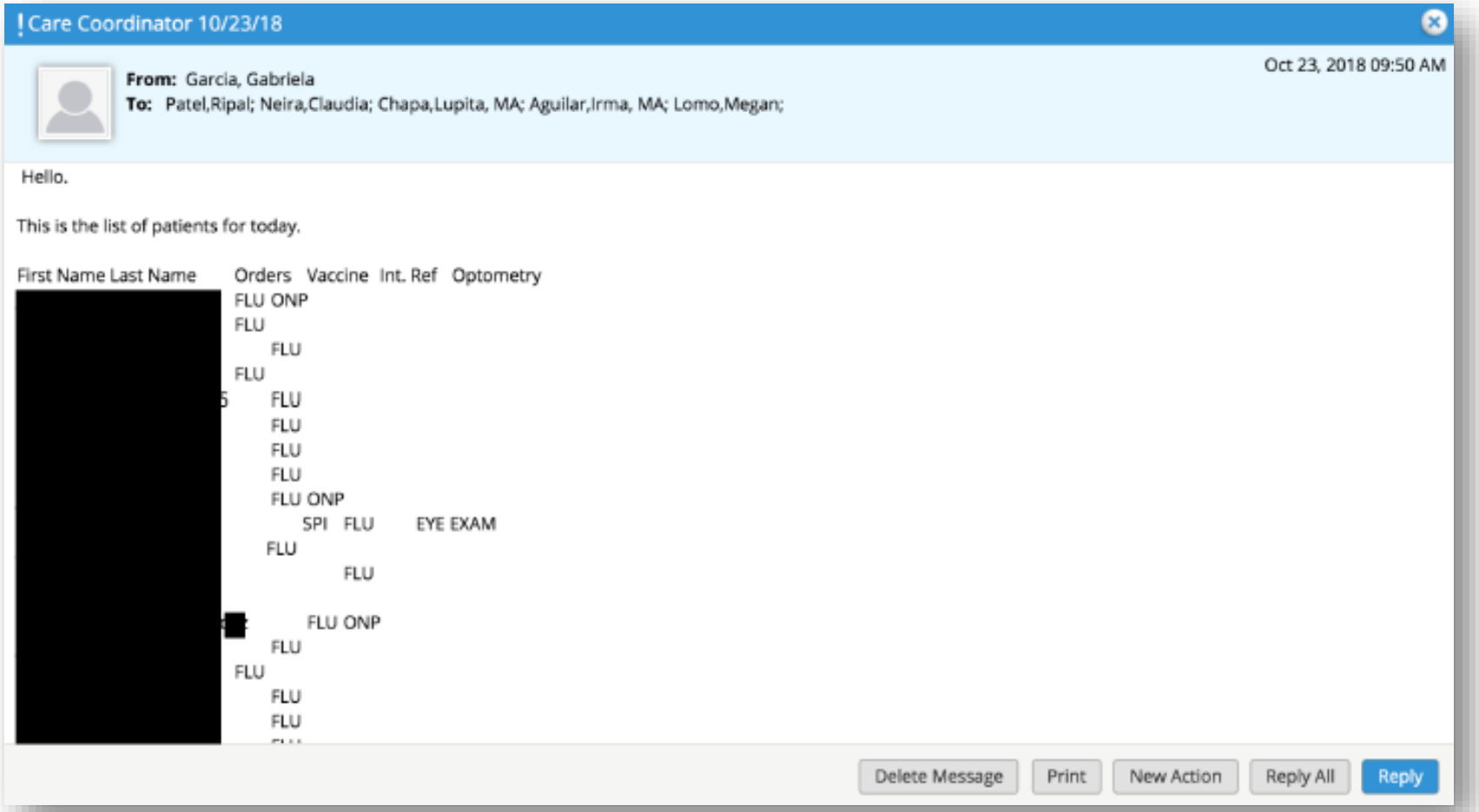
A Care Coordinator is essential for addressing and tracking clinical gaps for patients

1. Daily activities include:
   a. Patients are seen by the care coordinator to address gaps in care such as HbA1cs, echocardiograms, stress tests, eye exams, wellness exams, etc.
   b. Once gaps are identified – structured communication occurs with the provider and MA team
   c. Communication with the clinical supervisor about the progress
2. Weekly reports are obtained to track gaps that need improvement or gaps that have been improved or closed
3. Monthly meetings including all MAs and providers to address any needed improvement
   a. Provide initiatives to accomplish gap goals

Structured Communication

- **EHR**
  - Every employee can be reached to communicate special instructions for patients and patient needs through out the day via EHR messaging
  - Overall team members have access to patient information through the secure portal of the EHR system
- **In person:**
  - Very important to communicate at the beginning of each day – our care coordinator reaches out to MAs and providers to share details about which of the patients coming in will need services that they have missed previously)
- **Telephone encounter** - internal communication message going straight to the person who will need to address the issue/concern in regards to the specific patient
  - Encourage clinical needs for patients to be addressed in 24 hours
- **DAILY COMMUNICATION IS THE KEY!**

Example of Structured Communication



Monthly Team Meeting

- As much as structured communication is important via EHR system it is also essential to communicate with your providers and medical assistant team with a meeting that is face-to-face in a group setting.
- Monthly meetings allow for:
  - Employees can give feedback for clinical improvements
  - Provide clinical education, e.g., care coordinator discusses the importance of closing care gaps.
  - Discuss feedback from other departments that directly interact and speak with the patients as well.
- FEEDBACK FROM EMPLOYEES **AND** FOR EMPLOYEES IS THE KEY!!

Things to Consider About YOUR Primary Care Team

- Who are the members on your team?
  - PCP
  - Clinician
  - Clinical support staff
  - Receptionist/administrative staff
  - Ancillary support staff
  - Others
- When do members of your team interact? How frequently?
- How does your team exchange critical patient information?
  - What is the quality of that information exchange?
  - Do team members have enough information to do their jobs and to ensure patient safety?
- What changes might your team contemplate to improve i exchange of patient information?

https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/education/curriculum-tools/teamstepps/officebasedcare/handouts/thinking.pdf

NCQA PCMH Standards: Team-Base Care and Practice Organization (TC)

The practice provides continuity of care; communicates its roles and responsibilities to patients/families/caregivers; and organizes and trains staff to work to the top of their license to provide patient-centered care as part of the medical home.

Competency A: The Practice's Organization.

- TC 01 (Core) PCMH Transformation Leads
- TC 02 (Core) Structure and Staff Responsibilities
- TC 03 External PCMH Collaborations
- TC 04 Patient/Family/Caregiver Involvement in Governance
- TC 05 Certified EHR System

Source: PCMH Standards and Guidelines (2017 Edition, Version 4)

NCQA PCMH Standards: Team-Base Care and Practice Organization (TC) (continued)

Competency B Team Communication

- TC 06 (Core) Individual Patient Care Meetings/Communication
- TC 07 (Core) Staff Involvement in Quality Improvement
- TC 08 Behavioral Health Care Manager

Competency C: Medical Home Responsibilities

- TC 09 (Core) Medical Home Information

Source: PCMH Standards and Guidelines (2017 Edition, Version 4)

Questions?

Contact Us

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