

WEBINAR VIDEO TRANSCRIPT

Partnership for Care HIV TAC

Multi-Disciplinary Team-Based Care

Session #1, Community of Practice

Speaker: Dr. Steven Bromer, M.D.

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STEVE LUCKABAUGH: Good afternoon. My name is Steve Luckabaugh, and I'd like to welcome you to the Multi-Disciplinary Team-Based Care, Session #1, Community of Practice webinar. This webinar as brought to you by the Partnerships for Care, HIV Training, Technical Assistance, and Collaboration Center, HIV TAC. Partnerships for Care Project is a three-year multi-agency project funded by the Secretary's Minority AIDS Initiative Fund and the Affordable Care Act. The goals of the project are to one, expand provision of HIV testing, prevention, care, and treatment in health centers serving communities highly impacted by HIV. Two, to build sustainable partnerships between health centers and their state health department.

And three, to improve health outcomes among people living with HIV, especially among racial and ethnic minorities. The project is supported by the HIV Training Technical Assistance and Collaboration Center, HIV TAC. Our speaker today is Dr. Steven Bromer. Dr. Bromer is an associate professor in the Department of Family and Community Medicine at the University of San Francisco, California. He is the clinical director of the Pacific AIDS Education and Training Center, and a co-investigator in the system level workforce capacity building for integrating HIV primary care and community health care settings, special projects of national significance. And he currently has an HIV practice in the Sebastopol Community Health Center. Please join me in welcoming Dr. Bromer.

DR. STEVEN BROMER: Thank you very much for the introduction. I appreciate it, and it's really a pleasure to be here today to talk to you about team-based care. I think I'm going to actually ask you, this is a huge topic, team-based care, and it's going to help if you can identify what it is that you're hoping to get out of the webinar today. So I'm going to ask to go ahead and use that question feature. To go ahead and think about are there things that you really hope to get out of our time together today? Go ahead and put those in the question field, so that that will help me organize what we emphasize in the webinar. These are roughly the goals that I wanted-- We have roughly 50 minutes together so, these are the goals.

I want to review the importance of multidisciplinary teams, in both primary care and HIV care, and then talk about what team-based care really means in an HIV setting. But the most important thing is the third point there, to identify some key domains of effective teams. Really



think about a structure of what are the key things that we have to look at to see if our teams are working well. And then you'll have an opportunity to assess your own practice on a couple of these domains. And then I'm very much hoping to convince you to do the share of the care exercise with your team, and then share what you've learned from that in the next webinar. I'll talk more about this share the care exercise a little bit later in the webinar. I'm already been introduced, but I thought I would just say a little bit more personally about myself to try to explain why I'm interested in this area. And I will say I work on two projects that have similar goals to the project that you're working on.

As the clinical director for Pacific AETC, we were just, in this past year, given the mandate to work with clinics, community health centers, FQHCs, to help them integrate HIV care into their practice. And then the SPNS project that I work on also has a similar focus of looking at how to integrate HIV care in community health settings. They're not all FQHCs, but a lot of them are. A lot of times in those settings I'm actually working though with the HIV providers. And so I'm actually very excited to be talking to you as a workforce that's based in the FQHC world. I trained at San Francisco General Hospital at UCSF in San Francisco in the middle 90s. And so I learned HIV care in the hospital setting, where that was most of what we were doing.

And, of course, in the middle 90s, when I was an intern, we admitted people every night that were never going to leave the hospital. And shortly after that, the world dramatically changed with the introduction of protease inhibitors and effective antiretroviral therapy. And HIV care, of course, moved to the outpatient setting. And I continued to do HIV care, but in San Francisco where I was working, it was, as a family physician, harder to be involved in the outpatient care, oddly enough. And I ended up really taking a job, leaving the university and taking a job, in a community health center in a rural area north of San Francisco that had an integrated HIV program within the FQHC. My goal there was to really just get more clinical experience. But in that process I really fell in love with the community health center, and the whole communal health center movement, and what it meant.

In that setting I had the opportunity to see the real benefit of having an integrated HIV program within the setting of an FQHC. So this is the work that's been interesting to me in the last period of time. So this a slide that I'm sure you're all familiar with, the chronic care model. I'm showing you this slide because it really-- To me, when I was working in primary care, the way I was trained was to be the person that had the solutions to people's problems. I was the person that patients would come in, I had 15 minutes with them, I was supposed to find out what's wrong, write the prescriptions that we're going to fix them, and then they would leave. And, of course, this is the whole health care system that's organized around acute problems. And that's not who we're seeing in health care.

So the chronic care model was the first attempt that I saw that helped us reframe what we were doing. And at the core of the chronic care model is the prepared, proactive, practice team that gets to interact with activated patients to get the outcomes that we want. So team-based care really was different from the first efforts at looking to try to understand, how do we take care of people with chronic conditions? Team-based care was an important part of it. When you



think about all the things that we learned in the early work, and I'm sure a lot of you participated in disease collaboratives with IHI, where we worked on the chronic care model, then if you take the chronic care model and add really the core features of primary care, which are comprehensive, patient-centered, continuous, coordinated care, you add that to the chronic care model and you really come up with this model of the patient center medical home, which is part of what's guided a lot of us in our work recently. And I just want to point out that team-based based care is an essential part of the patients center medical home as well, as I'm sure you're all aware.

This is a quote from an article in 2004. And I'll just say a word about when I read this article, I was working in this little community health center north of San Francisco. And I love the work it. It was challenging but I loved it. But I would say I spent regularly two to three hours after clinic every night trying to get through the list of refills, reviewing labs, and writing letters, and all the work that had to happen. One night I remember I was determined to get through all of my piles of papers that had been building up. It was getting to be 9:00 o'clock, 10:00 o'clock, and I finally had the one last pile of paper. But somewhere in the middle there I started making a list of what are the things I'm doing now that I didn't have to be doing? That it wasn't me that had to do them, that this could have been done by somebody else that I was working with.

And because I knew it didn't make sense, I was going to have to get up at 6:00 in the morning to go around on people in the hospital. It just makes sense for me to be in that clinic until 11 o'clock at night every night. I got through all my piles that night, and the last pile was my mail. And in the mail was JAMA, and this article on team-based based care from, actually, one of the docs that I had worked with at San Francisco General, Dr. Brumbach. It's when I read that article that I got the idea that, really, the solution to this problem was to figure out how to have effective teams. Now in that article he wrote the sentence, the notion of the health care team is as rarely challenged in principle as it is achieved in practice. So that was 12 years ago. And so what I wanted to do is just do a poll and get your sense of where do you stand on that?

So if you strongly disagree with that statement, then you would be saying that actually we figured out how to make teams work. Really we should be doing this webinar. Or if you strongly agree with the statement, you're saying, really, we're still just trying to figure it out. We want teams but we don't really know how to make it work. So where do you stand? I'm going to have you go ahead and vote now. Where do you stand in that? Strongly agree, meaning really we hardly figured out teams yet. Strongly disagree with this statement would be that we've got it figured out. Let's go on ahead and let people vote. Great. So we've got 10% of people that feel like they really feel pretty confident with how their teams are working. Then another 40%, so half of us feel like we've really made significant progress. That's interesting. We're really kind of all just split down the middle. Half of you feel like you've made a lot of progress, and I think that's great. Because I think we have made a lot of progress in how to make teams work. In my experience, there's still a lot to figure out, and it's always an ongoing process.

This is a study that was done recently by the research group at San Francisco General, that was looking at team structure and team culture to see if they're associated it with a lower burnout.



And this is in primary care settings. So this looked at 231 clinicians, 280 staff, so roughly the same amount of clinicians as staff, in 16 different clinics. Some were academics clinics, some were FQHC's primary care clinics, and they hypothesized that both a tight team structure and team culture would be protective against emotional exhaustion or burnout. And so they measured the degree that teams were stable, that they worked with the same people day in and day out. And then they measured also the team culture of the organization and with a validated seven item tool. And then they measured burnout with a particular inventory.

So we know that burnout is important to look at because it's associated with increased medical errors, reduced quality of care, poor communication with patients, longer recovery time from hospitalizations, poor patient adherence to care plans, and lower patient satisfaction. We know that burnout is associated with all of these bad outcomes for patients. And it's also, of course, going to be associated with a higher turnover of providers. And losing providers in our settings is a very expensive proposition. So burnout is important. So this is just an example of the scale that was used to measure the team culture. And just asks questions. We have quote, we are in it together attitude at my clinic. And this was a particular way of measuring team culture. And these are the results. It's very interesting.

So if you look on those three groups of results and on the bottom going across, we have no teams, so there's no team structure, in the middle section you have team structure, and then on the far right you have that teamlet structure, which is a tighter structure that I'll talk about in a little bit, where the functional team is paired. But and then the white and the black bars are looking at culture. So it's very interesting that, in the setting, and then of course on the scale on the left, it's exhaustion, or the burnout score. So the lower the bar, the less burnout there is. The higher the bar, the more burnout. So it's interesting that the highest burnout score is in the group that has no structure for teams but has a high team culture. I think that's very interesting. And then you see a lower burnout scores where there is a team structure, and the sites that have high team culture had lower burnout than the ones without the high team culture. And then when you look at that the teamlet model, you have the lowest burnout scores in the setting with the high team culture. Having a teamlet is not protective if there is no team culture is what you see on that slide.

So these are just the conclusions. That for staff, team culture is associated with less burnout, but team structure is not. I think the finding that culture trumps structure for staff is consistent with the experience that, when members of the team do not get along or communicate well, team structure alone does not improve the quality of work life. I think those are important things for us to think about. So now this is a little bit of a confusing slide. It is from an article in 2011 that described what is the model of care that's been developed in HIV care. The area that I've circled is, who is on the care team in an HIV care setting? And I just wanted to emphasize the kinds of roles that are considered part of HIV care. And so, obviously, primary care, HIV care, specialty medical care, pharmacist care coordinators, oral health, nursing, those are all parts of the care team in a Ryan White setting. And then there's the support services that are listed below that.



I show the slide really just both to make the point that there's an understanding of what works in HIV care, what we think has worked. And to get a sense of the breath of what the care team looks like in some HIV care settings. And I think in Ryan White clinics, there really is this robust model of comprehensive care. There is a deep understanding of the different roles that the care team can play. There is often dedicated case management with development of care plans. Adherence counseling, risk reduction counseling, linkage to care and navigation are all parts of that. It can be a little overwhelming if you're in a primary care setting thinking, how are you going to integrate all those things into the work? I think though this is a huge accomplishment. And for me, it's been one of the benefits of having an HIV practice within an FQHC, is that there's been this real opportunity to learn some of the lessons that we have been figured out HIV care and apply those to primary care setting.

But I just want to make the point that it actually goes both ways. When you look at the Ryan White setting or the HIV practices, it's not all figured out. We don't have the outcomes we want. We know that from looking at the care continuum. We don't have the outcomes that we want. And also, a lot of times this work ends up being siloed. I think one of the people asked in their questions, the work ends up in a siloed. Even something like adherence counseling that you think would be really integrated into the flow of the team ends up being siloed in a particular role that's been funded by separate funding, and it isn't necessarily the function, it isn't necessarily integrated into the team. So I think there's a lot to learn from both sides about how to make teams work.

This is a slide from the Safety-Net Medical Home, the change concepts. And this is an excellent resource if people are not familiar with it, the qualis. They've worked in supporting clinics to develop the competencies connected to being a patient centered medical home. And they've identified these eight domains as being key. And, obviously, continuous team healing relationships, or team-based care, is one of the major domains. And they have an excellent monograph about team-based care and have a lot of resources connected with team-based care. So I just wanted you to be aware of what's in the primary care world, connected to team development. And then on the next line, this is the 10 building blocks of high-performing primary care, which is the model that I work with and will be referencing through the rest of the webinar. You look at the checklist of the NCQA that I showed earlier, they're really looking at, how do you show that you are patients in medical home, or that you have high-performing teams? How do you show that?

The Safety-Net Medical Home, the slide just before this, they've worked with coaching practices to increase their capacity for team-based care, and those are the domains that they developed. This is Tom Bodenheimer, at UCSF, studied 20-some practices that were considered high-performing and looked at what they did, and tried to identify the key, the things they had in common that they all did, that made them high-performing. And so, the bottom row of the building blocks engaged leadership, data-driven improvement, and empanelment, and team-based care were really the foundational building blocks, or domains, that all the high-performing practices had figured out significant competencies. And so they looked at what made it successful practices and came up with these concepts. And it's very interesting that

there's such alignment between what the [INAUDIBLE] uses to decide whether you're patients are in a medical home, what the Safety-Net Medical Home team works with in terms of trying to coach practices, and then looking at successful practices and what makes them successful.

There's a lot of synergy between those concepts. But at the core of it, really, is team-based care. And one of the things that is important about the building blocks model is that the three blocks that come before that, engaged leadership, data-driven improvement, empanelment you can't really develop effective teams if you don't have those in place. And I think that's one of the helpful things about the building block models that explains that. So this is a study Dr. Bodenheimer is looking at it, which helped develop this model, the building block model. This looked at, what were the lessons we can learn from the affective team? So they looked at 15 case studies, and I'd recommend anyone reading this article from the California Healthcare Foundation. It's an excellent article. But they looked at 15 teams, and of course there's general agreement that strengthening primary care is an essential part of health care reform.

But there is a realization, just like my experience in my community health center, there's not enough time in the day to do the work that's expected of a primary care provider with an average panel size, and that building effective teams is one of the solutions. And so they studied 15 different ways of implementing these teams. And this is really the most important slide here, because these are kind of the eight domains that end up being your features, that end up being important to look at for effective teams. And we're going to talk about each one of them a bit. And actually any one of these could be its own webinar or more. There is a lot to cover in any one of these domains. So I'm really just going to give you the structure of, what are the areas we need to think about to make our teams affective?

So in terms of thinking about the organizational culture supporting teams, there are a lot of things to think about. And I guess the other thing, another point I want to make, is that there is no single recipe for how to make teams work. We all have gotten to where we are in our health centers by different paths. And we have our unique strengths and unique challenges. And when you try to apply one formula to it, it almost never works. I mean I've done webinars on huddles, for example, and people will try to say, what's the structure of the huddle? OK, so it's 15 minutes, and you have these people in it, and these are the questions you ask and this is what you do. And OK, so we did it. And surprise, surprise, it doesn't work. Because you can't just apply a structure, particularly with teams, you cannot apply someone else's structure to what you're doing and expect it to work. You have to look at what your strengths are and what are you building on to make that work. So in terms of thinking about, does the culture of the organization support team-based care?

So the leadership has to be aligned with supporting teams. And that's a simple little statement, but it's incredibly complicated. How well does your leadership really understand what life is like for, let's say, the provider or the medical assistant? Those kinds of questions are important to really have a aligned leadership and supporting team-based care. One of the reasons I presented the other study about burnout early in the webinar was, how many of us actually measure burnout? And that's a really, potentially, powerful tool and something you want to

know. Are your providers, are your MAs on the edge of being burnt out? We want to know that because then we need to think about what we can do to fix that. But so leadership being aligned to support teams is huge ongoing process. It's not like, oh yeah, we are. We got it. We think it's important, we're going to do it. It's really an ongoing process. And I think it's important to think about, really, what has been your story as a health center? How have teams evolved in your setting?

Within that story, you'll see some of the key strengths that you'll need to be playing on and some of the challenges that recur over and over again. I just want to encouraged to think about, what's your story? How have teams developed in your settings? So what we call things is important and we often I think have talked about task shifting. And so I personally don't think this is a very helpful metaphor, task shifting. It sounds like you're shifting the work from one person to someone else, and that doesn't look very attractive to me. If I were the person being shifted to, I would not find that attractive. But share the care is a different metaphor and, I think, is a more accurate description of what we're trying to do in making effective teams. We're trying to help teams, help everybody work at the top of their license, and work together to interact with our patients. And if you're sharing that care, then everyone is playing a role rather than doing someone else's work, which is what task-shifting can sound like.

So I think how you talk about it and how you frame it is an important part of having a leadership structure that is going to support team-based care. So, of course, there has to be a commitment to everyone working at the top of their license, and I think a deep understanding and respect for the value of everyone's role in the health center. And these are kind of easy words to say and they're hard things to actually address. But I'll just tell you a quick story about that emphasizes this point. Somebody came into our health center asking for an HIV vaccine to the front office. They said, I heard there's an HIV vaccine. I want the HIV vaccine. And the front office person could've said, well Vaccine Clinic is Tuesday night, come back then. Or there's no HIV vaccine, you're not our patient. We can't help you. Could've said any number of things that might have been appropriate. But they said, this is an unusual request. Let me ask the HIV nurse what's going on, what it is that we can do for this person. And turns out it was someone coming in who wanted a PEP, who was afraid that they had been exposed to HIV and they wanted PEP. And we were able to take them in as a patient.

They weren't our patient. We were able to take them in and get them started on PEP, and then, subsequently, on PrEP. And this wouldn't have happened if the front office person hadn't actually seen that person, connected with them, realized that there was something that they wanted that they weren't able to directly ask for, and that's really a very sophisticated interaction. And you could know everything you want to know about PEP and PrEP, but if that didn't happen, you're not going to have an opportunity to work with this patient. And we have that opportunity. This is just a simple story to try to emphasize the importance of everyone working at the top of their license and respect for everyone's role. Another question is, is everyone in your organization on a quality improvement team?

I think that's a sign of an organization where the culture is really around supporting team-based care, because that respects everyone as being involved in improvement. And then, are we learning organizations? Are we a learning organization? I spent a bunch of time on that because I think those are really important cultural issues to think about as we build teams. And there's we all have a lot that we can figure out in this area. this is just a study, I'll go through it very quickly, that looked at, what are the kinds of shifts that are going to have to happen from a provider perspective to be able to work effectively in teams? When I trained, I got kudos for being the person that drew the blood, and carried it down to the lab myself, and handed it to the lab person, and wait until the results were there, and brought it back to the bedside.

That was being a good doctor. What you've done is just invalidated the work of all of your colleagues when you do that. And, unfortunately, a lot of us coming out of training, have that kind of individual hero role. That needs to be shifted to understanding how do we make teams work. So this just goes through a list of the kinds of cultural shifts that have to happen from a provider perspective. And it's not easy. I think that was it at the core of one of the questions someone was asking. But I think one of the key things to do is for the providers to start to understand that their job is to help facilitate a team rather than to lead the team. I'm going to go on to the next domain, which is stable teams, or teamlets. And there's really two concepts here. One is stable and one is teamlets. And so stable means that you work with the same people every day. That's all stable means. It means that when you come in to clinic, you're working with the same group of colleagues every day. And the teamlets is another concept that I think is a powerful concept. We talk about teams, but the teamlet is really what is the functional unit of getting the work done that day.

And so another way to think about what's the teamlet is to think about who is the patient panel? And which of the people that you work with in your whole center are actually one-to-one with that panel? What I mean is that, as a provider, I have a panel that I work with. My medical assistant has that same panel that they work with. And, in my case, the nurses also has that same panel of patients they work with. So the three of us really form the teamlet, because those patients, that panel, are ours. And so in this slide I would actually include a circle there for the nurse. But my other support, the other people that support me, let's say adherence counselors, a social worker, they actually interact with a bunch of different panels. So they're there to support the team. We work with them, they work with our patients, but they're not the teamlet. They're not the group that who only has the one panel as their responsibility. So this is an important concept in making. And back on the slide that looked at burnout, it definitely was the organizations that had understood this concept of, what is the teamlet? What is the effective unit that working in the clinic?

The organizations understood that, and emphasized that, and prioritized that actually had a lower burnout scores than any of the other teams. So a stable team. What is your current arrangement? So providers. So now we're talking about providers. They work in different pairings every day, meaning pairing with their medical assistant, or a nurse. Or two, are they arranged in teams but are frequently reassigned? Because somebody suddenly doesn't show up. It's more of that an assignment in principle but not in practice. That would be number two.

Or number three is, consistently work with a small group of providers or clinical staff and a team. The number four would be, consistently work with the same providers, clinical support staff, almost every day. So where you end up on this?

This is excellent. Yeah, great. So half of you really do have stable teams. So this is great. OK, excellent. And then another third are doing well but still have some things to figure out. Excellent. So we're talking just very briefly about co-location. And you just made the point that architecture is important, how our clinics are set up. Are they organized around teams is an important thing. And physical proximity definitely facilitates communication. But I want to say we don't always have the ability to change our set up, how our clinics are structured. And there, sometimes, are some technological solutions that can really make create, essentially, a virtual co-location. And I'll show you an example of that.

So this is an example of how a clinic can be set up. So these are the patient rooms around the outside. And then there's tables where each teamlet sits. So teamlet B would sit at that table, and so the provider and the medical system and whoever else is on the teamlet would sit there and work, then be able to work their patient rooms. So this is an example of what co-location can look like. This might be, for example, in that clinic it might be the green team. But within the green team there are these 3 teamlets and how it's organized. So if any new people are building new buildings, it's a great opportunity to really rethink how we structure things. There's a couple of pictures if you want to go to the next slide. Clinica Family Health Services in Colorado. This is an example of how that works where they've got a provider and a medical assistant meeting in the middle there with their pods, and then their patient rooms are on the outside. And the next slide shows another picture of South Central Foundation, which is a really excellent health center. Check them out if you haven't before. They do really excellent work.

They have providers and their support staff all meeting together, and then have patient rooms in the back there. If rearranging your building isn't an option, this is one of the ways we try to do a work around when we can't always have everybody in exactly the same physical location. And so we use just an instant messaging program that my nurse or whoever can text me, and it will pop up on my computer screen and I can communicate. If I forgot to bring in the liquid nitrogen or something, I can ask my medical assistant to get that. Or we do this with behavioral health and ask if I'm going to do a warm handoff. I'm going to instant message the behavioral health person on call and get them to come over. And then this is an example of something else we do where, we don't have a room for the peer navigator, or patient advocate, to be physically in the clinic where we're seeing patients just because we just don't have the space. So they are in another building, meeting with the patient, and they will have worked with the patient for an hour, let's say, and developing health related goals. And then they will instant message their provider and say, you know, when you get a minute in between patients, touch base with us.

So the peer navigator has the time to hang out with the patient, work on goals, and then they summarize them very quickly. And then we connect by video. And so you get to talk by video between the provider and the patient, and just say, this is what we figured out. And the

provider gets a chance to really validate what they're doing and at give their words of support for it. It's a neat way of making virtual co-location happen. And I mean if you're interested, it also actually potentially in some settings becomes a goalable visit, if that's of interest to you, because you've essentially done a telehealth or telemedicine visit. I'll go through quickly through this. I think looking at staffing ratios and understanding what your staffing ratios are is important. It's essential actually in figuring out how you're going to organize your teams and what you're going to ask them to do. And how do you define what the teamlet is? How do you define what the wraparound team is? And what work are you asking each one to do? You have to know what the ratios are.

And then communication within teams is a huge, huge domain. And we can certainly do a whole webinar on this. There's several levels you have to think about with communication. And one level is their structure of communication on goals, strategies, and interface with a larger organization. And that's what we think of as team meetings. And, my organization, my team meeting us once a month. And then we have huddles every morning. And that's really about getting on the same page for the immediate work that needs to happen that day. We do a pre-clinic and a post-clinic check-in, depending how hard the day is. Sometimes we call it a cuddle depending on how hard the day is. But we do a pre- and a post-clinic huddle to just make sure we're all on the same page about what's happening. And then there's the minute-to-minute communication that I referenced before with instant messaging. And how do we make communication happen effectively just in real time? And so those are three levels to think about with communication. So this is just an example of flushing out the roles.

And this may seem totally obvious, but it's surprising how hard it is for teams to do this, to really flush out what are the roles that each of the people on the team are going to take. And what are they responsible for? And you can do this, just take any one, take something like adherence counseling. Where does this fall? Who's doing it? Who's doing which part of it? Sometimes we think we've done it, and then when we look at what we have done, we realize, oh that was for the job description and it's not really a workable document. I'll say, for me, we had huddles that were helpful, but when we define very clearly what the chart prep was for each of the roles involved in the huddle for the nurse, for me, for the provider, for the front office person, our huddle, and for the medical system, we define what those roles were, that's when our huddles really started working well. And we redefined what the chart really was for each different person on the team. That made a huge difference. You need to have some way of making the work functional, making it operational rather. And so standing orders, protocols, those kinds of tools are important.

I know, I have worked with some clinics in New York, and I know that standing orders don't work for medical assistance because of legal issues. But there's ways to figure out protocols that empower other team members to do pieces of the work that fall on providers. This is just an example of HIV standing orders for the kinds of labs that can be ordered in by a medical assistant. I think the last piece is really just training. And do we have flushed out checklists about, what are the things we're asking people to do? Have they actually been trained on it?



Have we checked in on how well they're doing it? And then I would just say the other piece of that is, do you have any resources for coaching people around when teams aren't working well?

And that's another piece I think of the training role is, to think of how do you identify teams that are not functioning well? And how do you coach them on it? These are the eight domains. And it's really a structure for you to think about how to make your teams work. And I want to go into share the care. Shows an image of the way a lot of things work in a lot of settings. Where you take whatever role there is and, somehow, the provider becomes a bottleneck. This is an image of what that ends up looking like if the provider is the bottleneck. We lose the ability to really provide effective access. The next slide is an example of what a workflow could look like if we figured out how to share the care. I think we sent via email, and then also you can download this share the care exercise. And I have to say this is an exercise I've done with lots of teams. And just across the board, people find it helpful. So I would love for you to figure out, 30 minutes or something with your team in the next couple weeks, to do this exercise.

There are instructions in the exercise, and I think you'll find some very interesting things about who does what. And it can be done in a number of different ways. But I would strongly encourage you to do that. And then we're going to ask some of you to share what kinds of things you figured out. Basically the exercise is very simple. There's a number of roles that are just cards that represent roles. And then there is responsibilities or tasks on separate cards. And you get to just decide in your organization who does what. So, let's say, prescribing anti-virals, who does that? Checking on adherence, who does that? And you put the cards next to the person who's primarily responsible for that task. And it's just very interesting. You learn a lot about your organization, about different people's perception of it. So I encourage you to do that exercise, and then we'll have some time in a couple weeks, I think three weeks it is, to check in on what you learned from that exercise. And there's also some resources listed here about teams. And I think we're ready for the wrap-up slides. Time for any particular questions. I'm happy to stay on if there's other questions that people want to make sure we get answered.

STEVE LUCKABAUGH: OK if anyone has any questions, please type them into the questions pane in the Go to Webinar Toolbar. And while we give folks a minute to do that, just show the rest of these references. And Victor, did you want to speak now?

VICTOR: Thank, Steve. I just want to get some advice of the people who are on the call today to take some time to go ahead and complete the exercise. Meanwhile what we want to do for the next session, which is August 16th, is to have maybe a couple of you share with the group what results you got from completing the exercise. I mean, we would like to make this as interactive that's possible. So take, like Dr. Bromer stated, take a lot of time. And again, on the 16th, if one or two can share the results of the exercise with the group, I think that would be extremely beneficial. So I'll be sending out messages to the Listserv in the upcoming weeks before the training on the 16th. Again, just reminding everybody here today, to please take time to do that, to complete exercise.



DR. STEVEN BROMER: Could I just add one thing? One of the questions was, how do you address this thing of it's not my job? And this, actually, this exercise this is a great way to do that because you get-- One of the teams I worked with decided that they did it by people in particular roles. All that MAs did it, and then the providers did it. And actually it was so interesting how different people thought of who did what. The MAs thought they did most of the things, providers thought they did most of the things. And then you brought people together and talked about it, figured out what was really going on. It's very helpful. Also helps in terms of breaking down silos. So I really would encourage people to do it.

STEVE LUCKABAUGH: I am not seeing any questions right now. If anyone has any questions, please type them into the questions pane.

DR. STEVEN BROMER: Well there's a lot to think about in terms of doing the share the care exercise. I think if people do that they'll end up with a lot of questions about, both a lot of observation, about their organization, and then questions that we can talk about on the next webinar.

STEVE LUCKABAUGH: We're not seeing any questions. So did you have any final thoughts before you wrap it up here?

DR. STEVEN BROMER: I think the one last thought I would say is that, really the process of building teams is knowing, as best you can, where you really are. Because then you know what the next step is. Because it can be overwhelming in terms of figuring out all of these different levels that we have to think about in making teams work. But understanding, really, where you are and what your strengths are, then you know what to build on. So, again, I think this share the care exercise is one of those tools that helps you understand a little bit better where you are. I very much appreciate the time and the chance to share these thoughts with you, and I look forward to hearing more.

STEVE LUCKABAUGH: Thank you again for participating in today's webinar. And thank you, Dr. Bromer, for that excellent presentation. If you have any additional questions for the P4C project, or for Dr. Bromer, please email us at P4CHIVTAC@myatech.com. Take care everybody, and we'll see you next time.