Partnerships for Care

HIV TAC TEAM

Multi-Disciplinary Team Based Care
Session #1, Community of Practice

Presenter: Steven Bromer, MD

26 July 2016

Disclaimer

This project was supported by a cooperative agreement from the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) with $3,946,256 (0% financed with nongovernmental sources). The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, HRSA, HHS or the U.S. Government.

HRSA Health Center Program

AETC AIDS Education & Training Center Program

Multi-Disciplinary Team Based Care:
Community of Practice

Steven Bromer, MD
Clinical Director
Pacific AIDS Education and Training Center

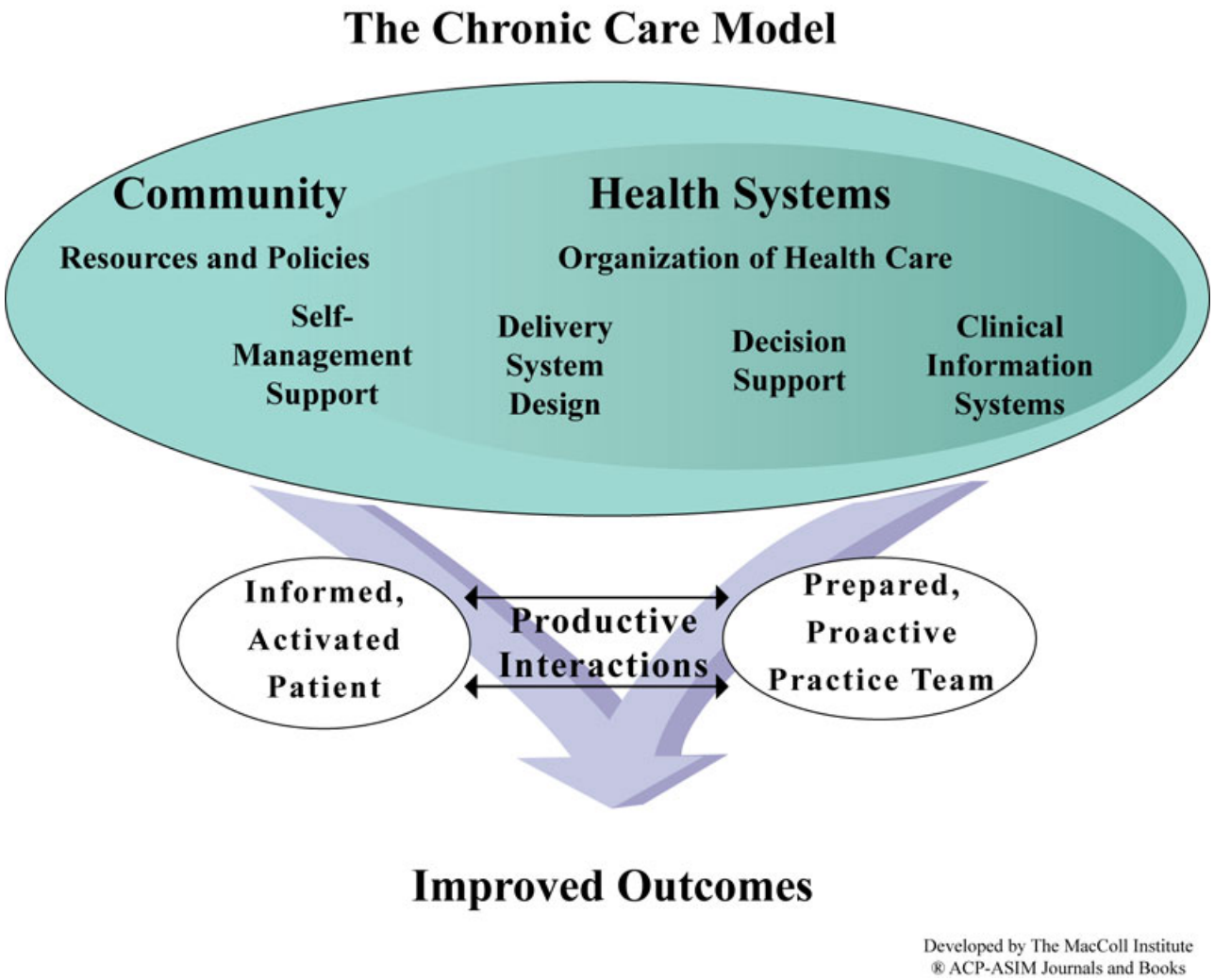
Goals

- Review importance of Multi-disciplinary Teams in Primary Care and HIV Care
- Review meaning of Team-based care in HIV settings
- Identify key domains of effective teams
- Assess your own practice on several domains of team based care
- Agree to do Share-the-Care exercise with your team

Your presenter

- Clinical Director, PAETC
- Co-investigator SPNS Workforce Development Initiative
- Family Physician with HIV practice Sebastopol Community Health Center

Chronic Care Model



PCMH Standards

PCMH 2014
(6 standards/27 elements/100 points)

1) Patient-Centered Access (10)
- A) *Patient-Centered Appointment Access
- B) 24/7 Access to Clinical Advice
- C) Electronic Access

2) Team-Based Care (12)
- A) Continuity
- B) Medical Home Responsibilities
- C) Culturally and Linguistically Appropriate Services
- D) *The Practice Team

3) Population Health Management (20)
- A) Patient Information
- B) Clinical Data
- C) Comprehensive Health Assessment
- D) *Use Data for Population Management
- E) Implement Evidence-Based Decision Support

* Must-pass

4) Care Management and Support (20)
- A) Identify Patients for Care Management
- B) *Care Planning and Self-Care Support
- C) Medication Management
- D) Use Electronic Prescribing
- E) Support Self-Care & Shared Decision Making

5) Care Coordination and Care Transitions (18)
- A) Test Tracking and Follow-Up
- B) *Referral Tracking and Follow-Up
- C) Coordinate Care Transitions

6) Performance Measurement and Quality Improvement (20)
- A) Measure Clinical Quality Performance

Measure Resource Use and Care Coordination
- A) Measure Patient/Family Experience
- B) *Implement Continuous Quality Improvement
- C) Demonstrate Continuous Quality Improvement
- D) Report Performance
- E) Use Certified EHR Technology

NCQA Measuring quality. Improving health care.

PCMH 2014 19

Article on Team Structure and Culture

ORIGINAL RESEARCH

Team Structure and Culture Are Associated With Lower Burnout in Primary Care

Rachel Willard-Grace, MPH, Danielle Hessler, PhD, MS, Elizabeth Rogers, MD, Kate Dubé, BA, Thomas Bodenheimer, MD, MPH, and Kevin Grumbach, MD

Purpose: **Burnout is a threat to the primary care workforce. We investigated the relationship between team structure, team culture, and emotional exhaustion of clinicians and staff in primary care practices.**

Methods: **We surveyed 231 clinicians and 280 staff members of 10 public and 6 university-run primary care clinics in San Francisco in 2012. Predictor variables included team structure, such as working in a tight teamlet, and perception of team culture. The outcome variable was the Maslach emotional exhaustion scale. Generalized estimation equation models were used to account for clustering at the clinic level.**

Results: **Working in a tight team structure and perceptions of a greater team culture were associated with less clinician exhaustion. Team structure and team culture interacted to predict exhaustion: among clinicians reporting low team culture, team structure seemed to have little effect on exhaustion, whereas among clinicians reporting high team culture, tighter team structure was associated with less exhaustion. Greater team culture was associated with less exhaustion among staff. However, unlike for clinicians, team structure failed to predict exhaustion among staff.**

Conclusions: **Fostering team culture may be an important strategy to protect against exhaustion in**

Teams, Team Culture and Burnout

- Surveyed 231 clinicians/280 staff in 16 clinics
- Hypothesized that tight team structure would be protective against against emotional exhaustion
- Team culture would be protective against emotional exhaustion
- Measured degree teams are stable (work with same provider/staff team)
- Measured team culture with validated 7 item tool
- Measured burnout with the Maslach Burnout Inventory

Willard-Grace R, Hessler D, Rogers E, Dubé K, Bodenheimer T, Grumbach K. Team structure and culture are associated with lower burnout in primary care. *J Am Board Fam Med*. 2014;27(2):229-238.

Teams, Team Culture and Burnout (2)

Burnout associated with:

- Increase in medical errors
- Reduced quality of care
- Poor communication with patients
- Longer recovery time from hospitalizations
- Poor patient adherence to care plans
- Lower patient satisfaction

Willard-Grace R, Hessler D, Rogers E, Dubé K, Bodenheimer T, Grumbach K. Team structure and culture are associated with lower burnout in primary care. *J Am Board Fam Med*. 2014;27(2):229-238.

Teams, Team Culture and Burnout (3)

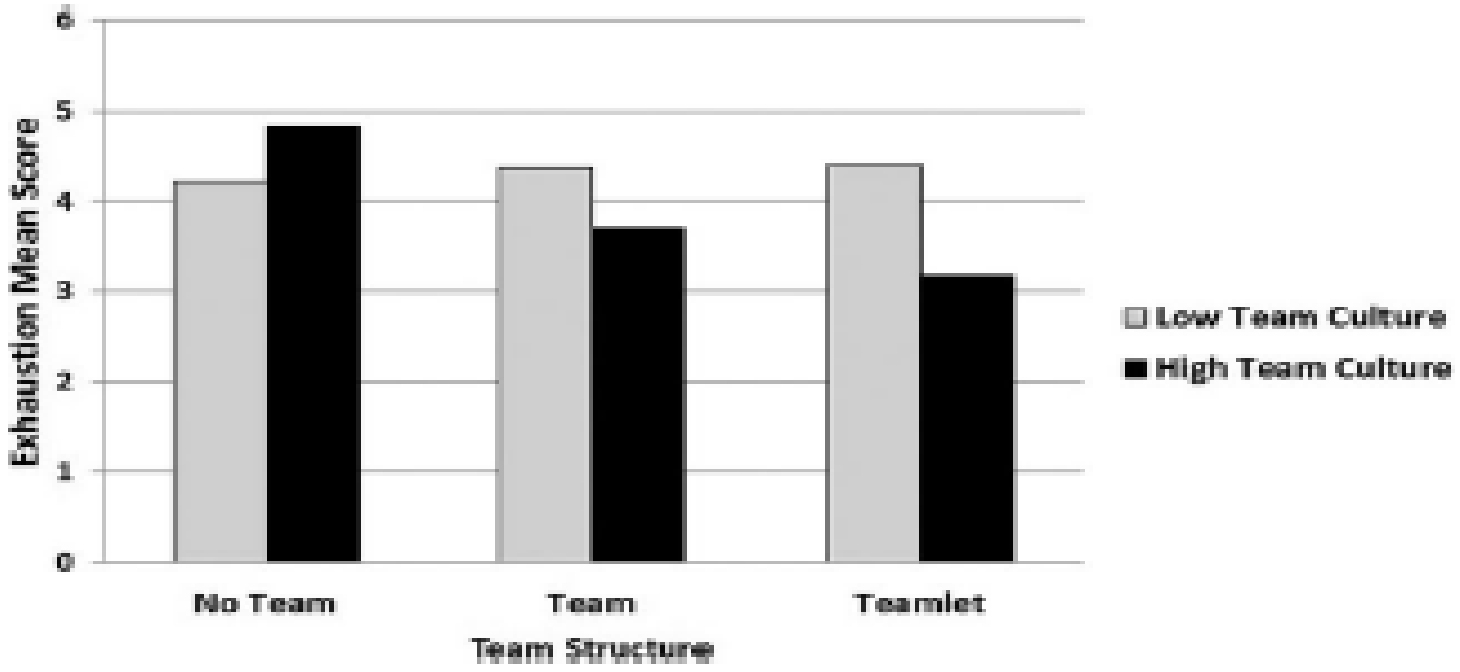
Table 1. Team Culture Scale

Item	Mean	Median	Standard Deviation	Range	Factor Loading
The group of staff and providers I work with most regularly work well together as a team.	7.09	7.00	2.35	1–10	0.80
My most important task in clinic is to manage patient flow.*	6.52	7.00	2.71	1–10	0.20
We have a "we are in it together" attitude at my clinic.	6.42	7.00	2.60	1–10	0.87
I feel unprepared for many of the tasks that I am asked to do every day.†‡	7.76	9.00	2.47	1–10	0.35
My professional skills are used to the fullest at my clinic.	6.39	7.00	2.96	1–10	0.64
It is hard to get things to change in my clinic.†	4.77	5.00	2.56	1–10	0.60
I can rely on other people at my clinic to do their jobs well.	6.66	7.00	2.25	1–10	0.72
We regularly take time to consider ways to improve how we do things at my clinic.	6.87	7.00	2.47	1–10	0.69

*This item was removed from the final scale.
†These items were reverse-coded to develop a composite score. The results presented here are reverse-coded.
‡The factor loading score for this item is low, but removal of this item did not improve the Cronbach α, and it was retained in the final scale.

Teams, Team Culture and Burnout (4)

- For clinicians team culture associated with less burnout if associated with team structure

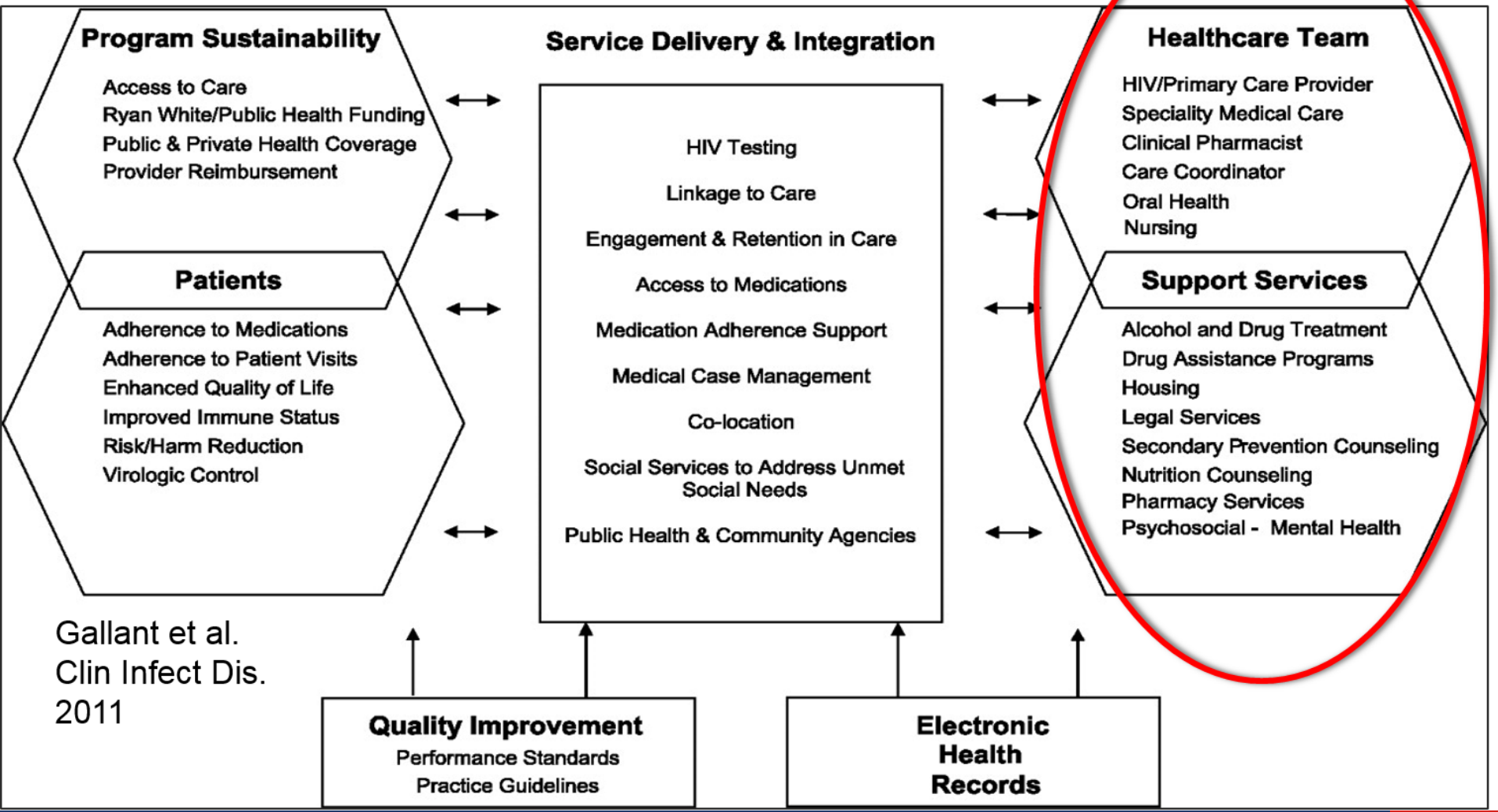


Teams, Team Culture and Burnout (5)

- For staff, team culture associated with less burnout but team structure is not.
- “The finding that culture trumps structure for staff is consistent with our experience that when members of a team do not get along or communicate well, team structure alone does not improve the quality of work life. “

Willard-Grace R, Hessler D, Rogers E, Dubé K, Bodenheimer T, Grumbach K. Team structure and culture are associated with lower burnout in primary care. *J Am Board Fam Med*. 2014;27(2):229-238.

Ryan White Care Team Model



Gallant et al.
Clin Infect Dis.
2011

Ryan White Clinics

- Robust model of comprehensive care
- Deep understanding of different roles on the care team
- Case management and Care Plans
- Adherence Counseling, Risk Reduction Counseling, Linkage to Care, Peer Navigator

Safety-Net Medical Home Change Concepts

10 Building Blocks of High-Performing Primary Care

Building Teams in Primary Care

Building Teams in Primary Care:
Lessons Learned

Building Teams in Primary Care: Lessons from 15 Case Studies

- General agreement that strengthening primary care is essential part of health care reform
- Not enough time in the day to do the work expected of PCP with average size panel
- Building effective teams one solution
- Studied 15 different practices implementing team based care in primary care settings

2007 California HealthCare Foundation report by Thomas Bodenheimer, MD

Features of Successful Teams

- Organizational culture supporting teams
- Stable Teams (Teamlets)
- Co-location
- Communication strategies
- Staffing ratios
- Defined roles and responsibilities
- Standing Orders/Protocols
- Training on roles/skills checklists

Organizational Culture Supporting Team-based Care

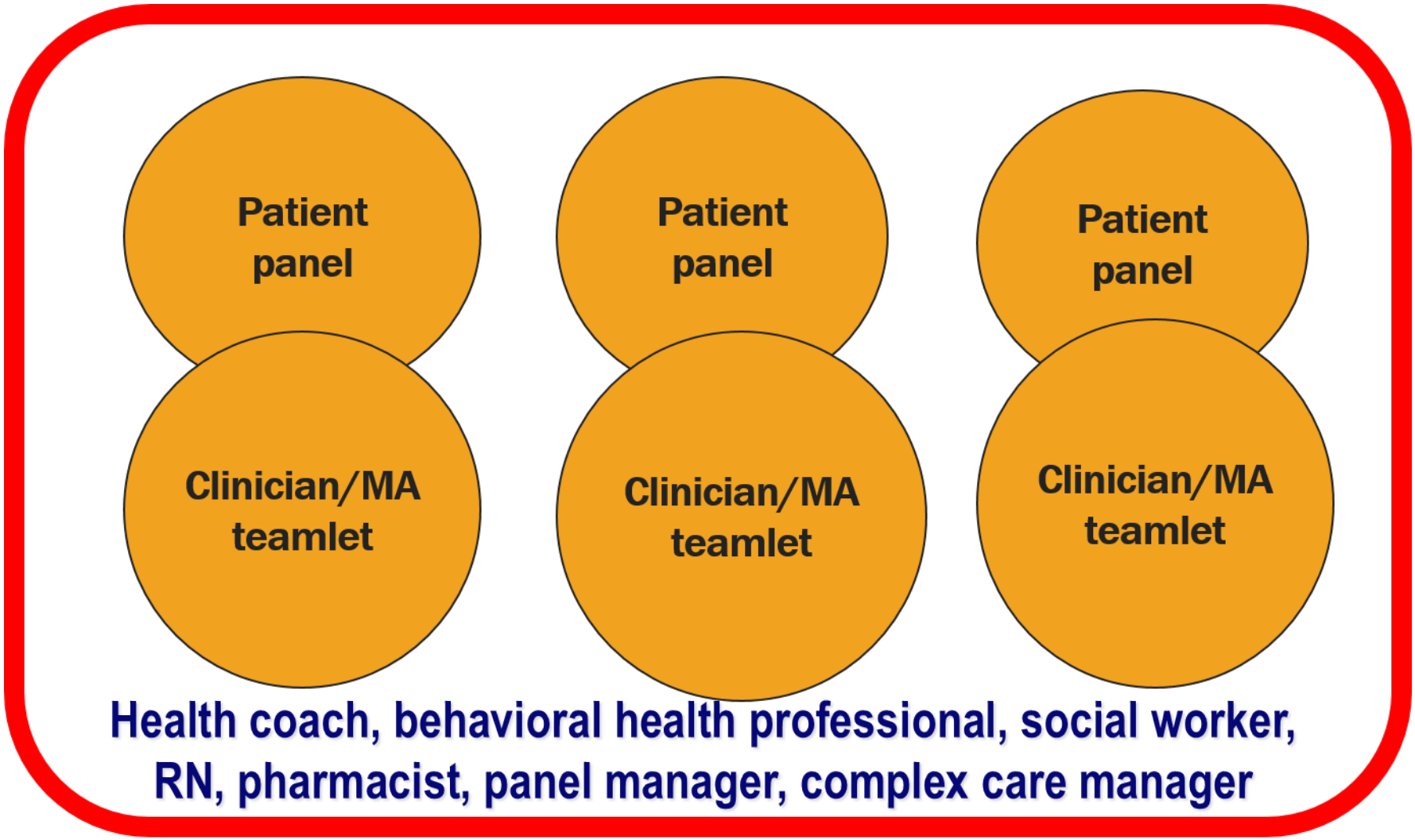
- Leadership aligned to support teams
- Task-shifting vs. “Share the Care”
- Everyone work at the top of license
- Deep understanding of value of all roles
- Everyone on a Quality Improvement team
- Become a “learning organization”

Shift in core beliefs for providers

Lone Provider	Provider as Part of a Highly Functioning Team
Self-sacrifice	Building Relationships
Provider-driven care	Collaborative health workers
Individual Hero	Well-being of all team members
Ownership: “ My patient”	Collaborative responsibility: “Our care”
Full control	Shared control
Physician as lone expert	Team expertise

George Saba et al. The Mythology of the Lone Physician: Towards a Collaborative Alternative. *Ann Fam Med March/April 2012 vol. 10 no. 2 169-173.*

Stable Teamlets

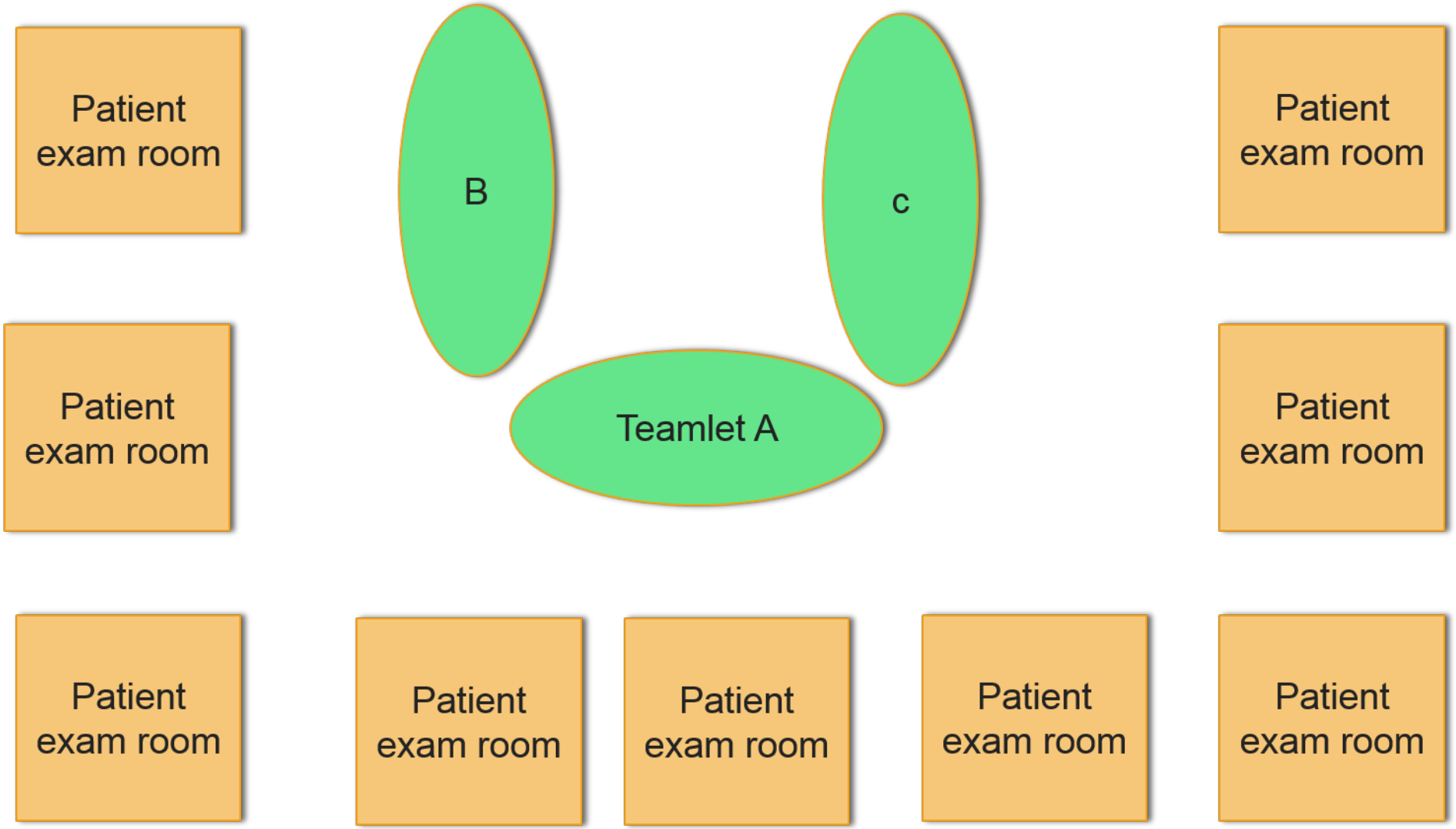


1 team, 3 teamlets

Co-location

- Architecture is important
- Physical proximity facilitates communication
- Technology can be used to create virtual co-location

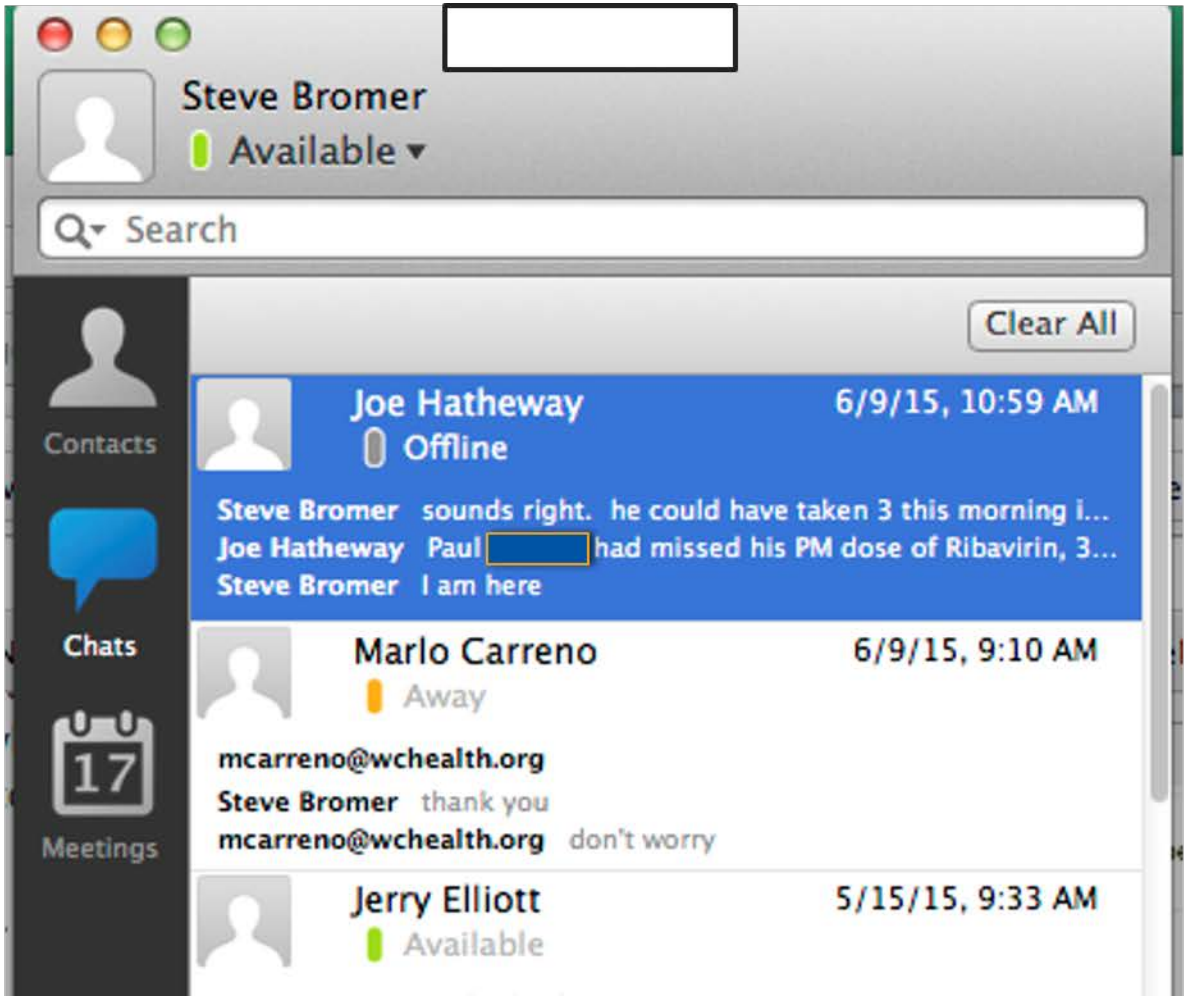
Co-Location Models



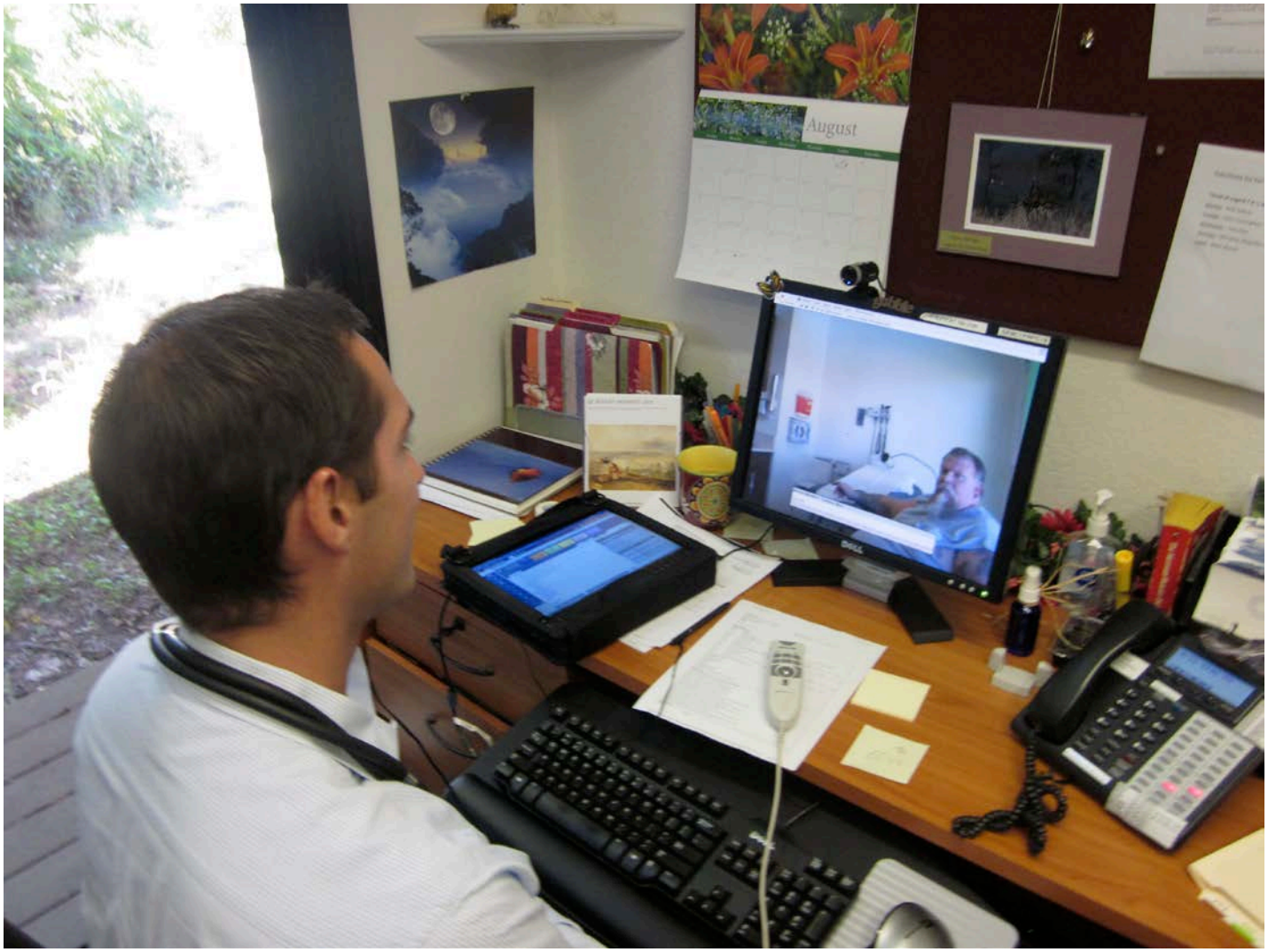
Clinica Family Health Services: Colorado

South Central Foundation: Alaska

Virtual Co-location



Picture of virtual co-location



Staffing Ratios Per Team

Benton

- 2 Provider
- 2 MA
- 1 RN
- 1 Health Navigator
- Shared Team Members:
  - Behaviorist
  - Clinical Pharmacist
  - Panel Manager
  - Health Navigator (depending on site)

Clinica Family Health Services

- 3 FTEs of Provider
- 3 FTEs of Medical Assistant
- 1 Nurse Team Manager
- 1 Case Manager
- 1 Behavioral Health Professional
- 2 Front Desk
- 1 Medical Records
- ½ Referral Case Manager
- Dental Hygienist
- Consulting Psychiatrist

3 Levels of Communication

- Structure for communication on goals, strategies, interface with larger organization: Team meetings
- Structure of getting on the same page around immediate work: pre and post clinic huddles
- Attention to minute-to-minute communication

Defined Roles and Responsibilities

Team Roles and Responsibilities
Core Team

Provider	PharmD	Team Assistant	Reception	Behavioral Health
Care Delivery • Medical/MH Dx • *Follows provider script* • Therapeutic plan for urgent/chronic problems • Determines clinical monitoring schedule • Determines need / schedule for tracking for high risk • Manages abnormal tests • Determine overall patient education needs • Decisions regarding comprehensive care to panel	Collaborative Practice • Collaborative drug therapy management • Medication therapy management • Consultation on complicated medication regimens • Controlled-substance agreements • Refill authorizations • Immunizations Education • Patient education about disease • Patient education about overall health and	• Monitors schedules in advance for problems and works collaboratively with care team to maximize access • Schedules appointments with team providers • Primary responsibility for reminder calls • No show f/u and mgmt • Acts as communication liaison between patients and providers & MA's to maximize efficiency and effectiveness of patient appointments • Makes f/u scheduling calls at providers' request,	• Confirms insurance coverage and schedules appointments as indicated with Eligibility or Outreach Eligibility Worker • Patient check-in for appts. • Collects, verifies, and updates demographic information and insurance coverage • Collects co-pays, payments on account balances • Distributes and explains client forms • Customer service	• As outlined in Behavioral Health (BH) charting guide • Determines BH intervention and treatment • Therapeutic plan for urgent/chronic BH problems • Determines need and recommends BH monitoring schedule • Provides consultation to providers and team regarding BH diagnosis and resources • Liaison with Mental Health (MH) and other programs at Health Services regarding MH / BH issues

Standing Orders/Protocols

West County Health Centers
Caring for our Communities

CARE TEAM MEDICAL ASSISTANT STANDING ORDER

DIAGNOSIS:

- HIV/AIDS 042

Care Team Medical Assistants may, without consulting the Medical Provider, perform the following tasks:

- HIV RNA QT BDNA, 3rd Generation
  - No HIV RN QT BDNA **within the last 4 months**
- T-Lymph CD4/CD8
  - No T-Lymph CD4/CD8 **within the last 4 months**
- CBC Automated
  - No CBC **within the last 4 months**
- CMP
  - No CMP **within the last 4 months**
- RPR/Reflex TPPA (diagnosis)
  - RPR/Reflex TPPA (diagnosis) **within the last year**
- TB-Quantiferon Gold
  - No TB-Quantiferon Gold **within the last 2 years**
- LIPID Profile
  - No Lipid Profile **within the last year**
  - Use diagnosis code V58.69 *Medication exposure, long-term use high risk medication*

Training on Roles, Skills Checklists

Community Health Center
Phlebotomist and Lab Orientation Checklist
2010

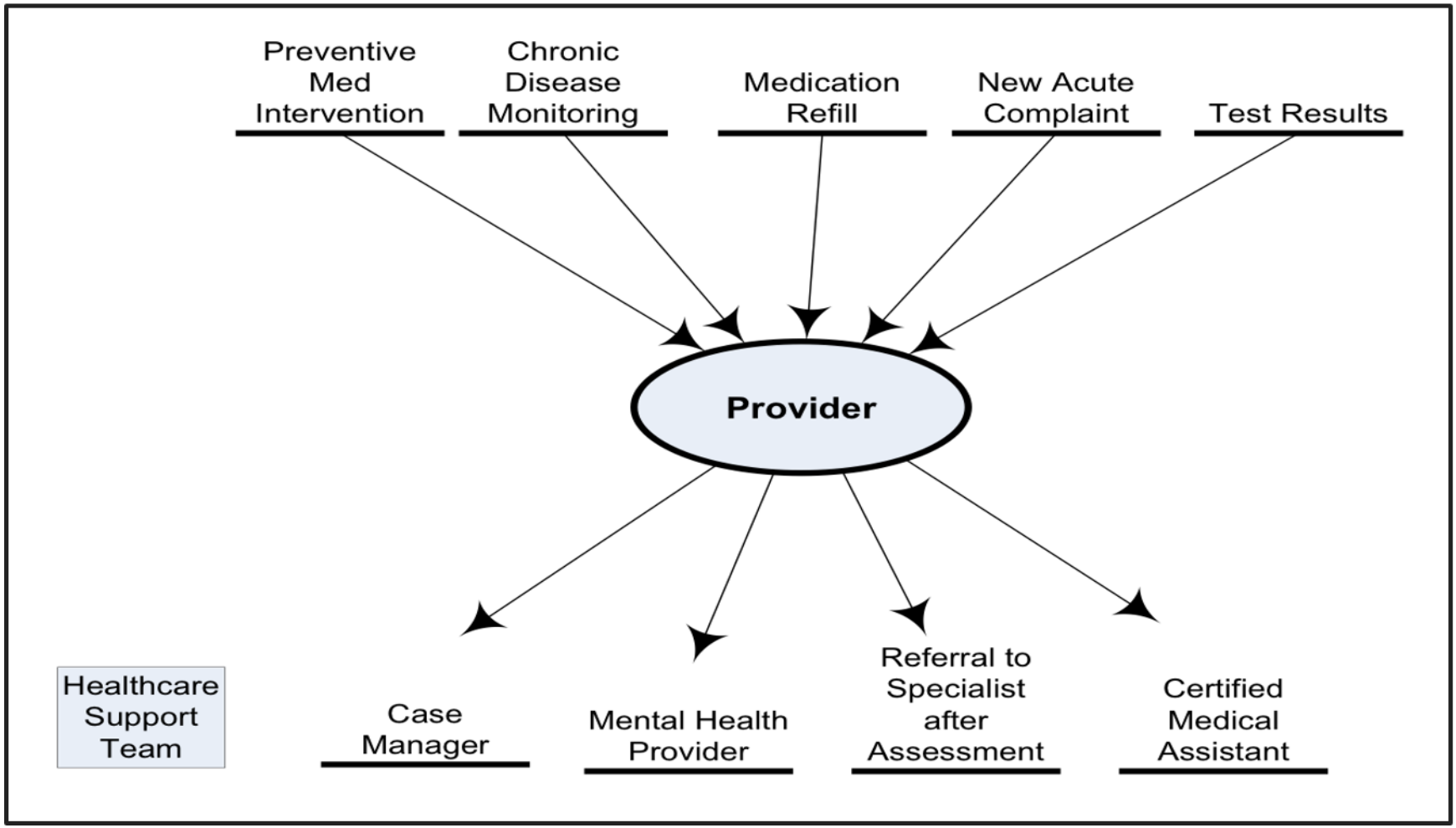
Employee Name: **Date:**

	Patient Care Tasks	Date Sign Off	Signature Approving Task		
1.	Venipuncture:				
A	Read venipuncture section of Manual				
B	Learn Blood draw technique				
C	What to do with different draws When to use a butterfly				
D	Correct tubes used and order of draws How much blood is needed				
E	What tests are fasting and what medications affect results				
F	Questions to ask patient before blood draw: DOB; Are they taking medication; fasting or not include type of liquid consumed				
G	Learn how to fill out forms & ICD9 codes needed				
H	Insurance, Special Fund decisions				
I	Reasons for rejections of the specimen – What tests are affected by hemolyzed or lipemic serum				
J	Where to look for information on specimen collection requirements				
K	How to use lab log				
L	How to evaluate & check off the lab results when they come in. What to do with abnormal results				
M	How to use label printer				
2.	Urinalysis				
A	Read Urinalysis Dip section of the Lab manual				
B	Learn how to read and understand multistix				
C	Learn QC				
D	Learn when sulfosalicylic acid test is used and how to interpret				

Features of Successful Teams

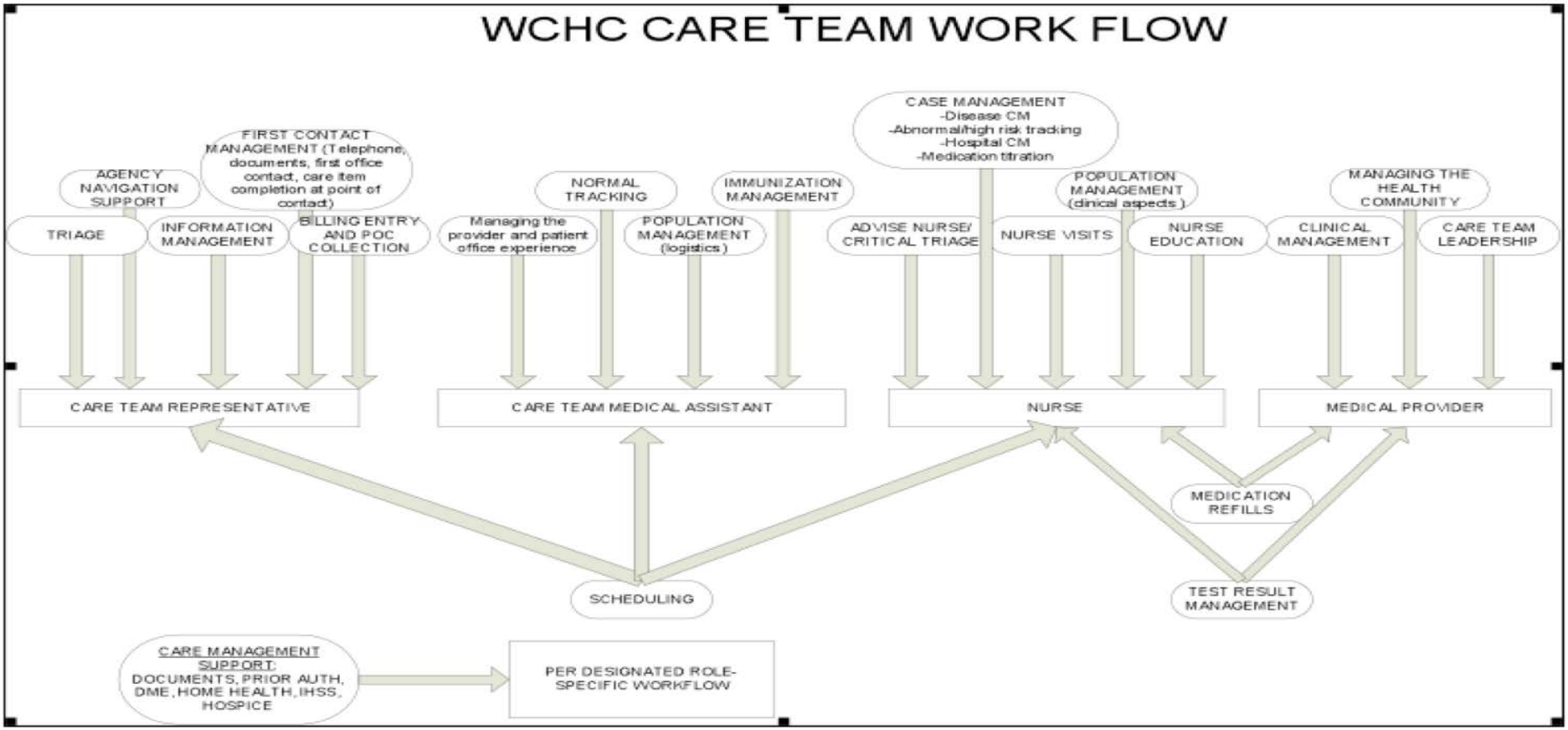
- Organizational culture supporting teams
- Stable Teams (Teamlets)
- Co-location
- Communication strategies
- Staffing ratios
- Defined roles and responsibilities
- Standing Orders/Protocols
- Training on roles/skills checklists

Share the Care



Share the Care (2)

Share the Care (3)



Homework: Share-the-Care Exercise

- Email with two sets of cards
- Task and responsibilities cards
- Role cards
- Meet with team and do the exercise twice, once as your team currently functions and again in the “ideal world”
- 3-4 sites to agree to share learnings from the Share-the-Care exercise on next Community of Practice

Teams in Primary Care Reading List

Anderson, P. and Halley, M.D. **A New Approach to Making Your Doctor-Nurse Team More Productive.** *Fam Pract Manag.* 2008;Jul-Aug;15(7):35-40.

Bodenheimer, T. **Building Teams in Primary Care: 15 Case Studies.** Report prepared for the California Healthcare Foundation. 2007; Available here.

Bodenheimer, T. **Building Teams in Primary Care: Lessons Learned.** Report prepared for the California Healthcare Foundation. 2007; Available here.

Teams in Primary Care Reading List (cont.)

- Bodenheimer, T and Laing, B.Y. **The teamlet model of primary care**. *Ann Fam Med.* 2007 Sep-Oct;5(5):457-61.

- Chen EH, Thom DH, Hessler DM, Phengrasamy L, Hammer H, Saba G, and Bodenheimer T**. Using the teamlet model to improve chronic care in an academic primary care practice.** *J Gen Intern Med*. 2010;25(Suppl 4):610-614.

- Ghorob, A. and Bodenheimer, T. 2012. **Share the Care™: Building Teams in Primary Care Practices.** *J Am Board Fam Med.* 2012 Mar-Apr;25(2):143-5.

- Ghorob, A. and Bodenheimer, T. **Sharing the Care to Improve Access to Primary Care.** *N Engl J Med.* 2012; 366(21).

Disclaimer

This project was supported by a cooperative agreement from the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) with $3,946,256 (0% financed with nongovernmental sources). The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement by, HRSA, HHS or the U.S. Government.