

WEBINAR VIDEO TRANSCRIPT

Partnership for Care HIV TAC

Multi-Disciplinary Team-Based Care Session #2, Community of Practice

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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 number two, Community of Practice webinar. This webinar is brought to you by the Partnerships for Care, HIV Training, Technical Assistance, and Collaboration Center, HIV TAC. The Partnerships for Care project is a three year multi-agency project funded by the Secretary's Minority AIDS Initiative Fund, and the Affordable Care.

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 at the Department of Family and Community Medicine at the University of San Francisco, California. He is a Clinical Director of the Pacific AIDS Education and Training Center, and co-investigator in the system level work risk capacity building for integrating HIV primary care in community health care settings, special projects of national significance. And he currently has a HIV practice in the Sebastopol Community Health Center.

Please join me in welcoming Dr. Bromer.

STEVEN BROMER: Great, thanks. It's really nice to be back with you guys again after our session about a month ago. Last time I did most of the talking, or maybe all of the talking. So today I'm hopeful that we can have somewhat of a dialogue because thinking about team based care is-- teams are very complex. Our organizations are very complex. And there aren't really simple solutions to the kinds of challenges you're facing. And there's a lot that we can learn from each other about how to make teams work.

I'm going to review the nine elements of successful teams that have come out of the research on successful teams. A lot of that's been done at UCSF, but by other investigators as well. And



then talk about some of the key questions to ask ourselves about those areas-- about those elements. And then I wanted to check in.

We talked last time and I gave you a handout for a Share the Care exercise. Now believe me, I understand how busy work is in community health centers. I used to be the clinical director-- the medical director of a FQHC. Actually it's the agency where I still work, but I'm no longer the medical director. But for about five years I was the medical director of that agency. And I understand how busy people are and what we're taking on. So if people didn't have time to do the exercise, I understand completely.

But if you did, I'd like to have people have a chance to talk for minute about what they learned from it. So I thought I would ask, if people would use the raise the hand feature now to let us know if they had time, with their team or with some subset of their team, to do the Share the Care exercise? So if you could just take a minute to raise your hand.

STEVE LUCKABAUGH: OK. So if you did the exercise, please raise your hands.

STEVEN BROMER: And again, there's no penalty for not doing it. Right. What are we seeing Steve?

STEVE LUCKABAUGH: And I'm not seeing any hands.

STEVEN BROMER: OK. That's fine. That's fine. That's good to know. Then we're sort of all on the same page. And we're going to do some modified version of it today. And have a chance to talk about it. And maybe then you'll keep it in your back pocket. And think about when it's appropriate to use in the work you're doing, a strategic planning meeting, with your leadership team, or-- it's a really quite transformative exercise. And helps people see what's really happening at that their site around teams.

Great. So this is just me. The only point I wanted to make is that-- I said this last time too, there are three initiatives that I know, including yours, that are really looking at how to build capacity for HIV care and community health centers. And it's just very exciting to be working with you. I think yours is one of the most exciting initiatives that there is. So it's really a pleasure to work with you.

This is a chance to really try to understand what we've learned about HIV, into community health centers. And then help the HIV practice really learn what the kinds of advances that we've made in primary care, as well, I think is an exciting opportunity.

And the model that I have used, and I talked a little bit about last time, is the building blocks of high performing primary care. That's the model I use to think about transformation. And that's just showing the foundational building blocks that teams or agencies have in place to really be the foundation for the kinds of other advances in the care that we want to make.



One of the questions that we had last time was how do we get people to be patient centered. And being patient centered is a quality, right. It's a perspective. It's a way you approach your work. But it's also dependent on things working well.

It's impossible-- someone can want to be as patient centered as-- it could be their value to be patient centered, but if we don't have the system's working so that they can actually operationalize that, it's just a set-up for burnout. Which is something I know I've seen in the community health center world. People come in with real high hopes about wanting to serve the community and leave after a few years feeling quite burned out. And it's when the mission and the vision doesn't match what our capacity is that we're set-up for burnout.

And so stepping back and thinking about the foundational building blocks is an important part of really building the operations that will work for what we want. And when we think about team based care, it really-- the first three that come before that end up being quite important to be able to make it work.

And in some ways you can't really-- one of the places that we often start with is access because access is-- for most of us we're in settings where we're aware of how long it takes a new appointment for a patient. And we're aware of the demand for our services. And we want to do something about it. We're not trying to keep the doors closed, we're trying to keep the doors open so people could come in. And yet our capacity often is not there.

And so a lot of times we want to start at access and figure out how do we improve access. But if you don't step back and really get these other foundational steps in place, you really can't do it. And so making teams work, for me, is really an essential part of being patient centered and having accessible patient centered care.

And this is just the report that some of the work is based on. And this is a map showing the different health centers and practices that were studied by these two groups, by Bodenheimer and Sinsky, to learn, like what were the key elements from what they're calling bright spots. Centers that had effective work going on.

So these are the nine elements that we reviewed at the last webinar. And what I've done today is-- actually what I'd like to do now is just check in with you about what questions you have. What question do you have? Why are you on this today? What would you like to really learn so that you can take your next step and make your teams work better?

And I'll give people a chance to go ahead and type in those questions. Why are you here today? What prompted you to sign up for this webinar? What's the kind of problem on your mind that you're trying to sort through with making your teams work better?

I would just remind people of the questions we had last time when I asked this was, how do we get people on the same page? Or how do we break down silos? How do people be patient centered? And then how do we address the issue of it's not my job? And are there other

questions that you want to have answered today? The reason I'm asking is because I think we could go in depth in any one of these nine elements. And I'd like to sort of focus more on the ones that are going to help you answer your questions.

STEVE LUCKABAUGH: All right. So if one of these jump up at you folks, you can type it into the questions pane. Then we can focus on those items. Or if you want to raise your hand and speak up, we'd love to hear from you.

STEVEN BROMER: And Steve, will I see the questions show up as they're typed in?

STEVE LUCKABAUGH: No. If they pop up, I'll read them out.

STEVEN BROMER: Oh, ok. Ok.

STEVE LUCKABAUGH: OK. We did get one. Training seems to be a one and done offered at the beginning, but no ongoing training to sustain development. How do you get leadership to buy in to ongoing training?

STEVEN BROMER: What a great question. Wow. That's a great question. Yeah. Let's keep collecting some questions. If that's the pressing question for folks, we can go right to that. But let's see what else is on people's minds.

STEVE LUCKABAUGH: OK.

STEVEN BROMER: That's a really important, good question.

STEVE LUCKABAUGH: It seems like every single day more is asked from the teams. How do you motivate the teams to keep them focused?

STEVEN BROMER: Great.

STEVE LUCKABAUGH: Team based care seems to be driven by one person here. How do you develop other champions?

STEVEN BROMER: Ah. Interesting. Wow. Good questions. So keep typing them in as you want. But let's start talking about some of these. And let's go ahead and start with the last question. The question about how do you develop champions, is a really great question. And it actually ties in somewhat to the training question.

Because if you don't have other champions it's going to be very hard to spread what you're doing. And the mistake that I think a lot of us make is that we see a successful team-- we see something that's working and then we figure out, oh look, they meet on Friday's at 9:30 in the morning. And so that must be important, and they have these number of people on the team.



And so then we try to recreate the structure of what they're doing, and apply that to other teams. And then we're sort of baffled that it doesn't work when we do that.

And this issue of a champion ends up being a hugely important issue. And it's really a leadership issue. And leadership is not just the-- actually the leadership ends up being involved in a bunch of the questions that you asked. So if you have that one champion, that's the place to start. And figuring out what motivates them. What do they get that other people don't get? Or what's their vision? And then, are they in a team that's working well? Have they figured out something that works? Are they an example for other teams or for other parts of the agency? I think those are questions to ask yourself.

And then to ask, how did this champion get developed? Is it just an accident or did they go to an IHI? Or were they involved in some of the chronic disease collaboratives? Or what was their development? How did they become a champion?

And then rather than focusing on making a bunch of other teams happen, it may make sense to step back and say, how can I develop another cadre of champions? Or cohort of champions for different teams? Who's a likely candidate in this team to get this work? And how can I get those people together so that you're developing-- leadership happens at all levels.

And obviously you can't do that if you don't have the leadership buy in from the top. Assuming you have that, then focusing on development of some champions would make a lot of sense. Because then you've got somebody-- I guess in my experience, teams are about-- I mean you have to think about the structure and all the issues that we've talked about, but you also have to think about relationships. And somebody has to be in charge of thinking about how is this team working, what's getting in the way, and what can we do to make it go better.

And it boils down to relationships. And there is no one solution. So you have to train people to be thoughtful and creative and have strengths in addressing those kind of interpersonal issues. And the champion is exactly the correct model I think. Or it's one model anyway that works.

I'm just curious if people have ever worked-- do any of the agencies have meetings, for example, team leads or something? Who leads your teams? Who have you decided is kind of the leader of your-- and by team I think we mean a care team. A team that's charged with taking care of a panel of patients. Who do you think is the leader of that? Have you identified a physician, a provider, is it the nurse, a case manager, is it a behavioral health specialist, or a medical assistant? Who have you identified as the official champion of the teams?

STEVE LUCKABAUGH: OK. Cindy Cabales would like to speak up. Go ahead Cindy, you're unmuted.

CINDY CABALES: Hi. So to answer your question about who we've designated as team leaders, we have 9 care teams that just started at the beginning of this year. And each care team as a



facilitator. And it looks like all the facilitators, for the most part, come from senior management.

And I guess that ties to one of my other questions then, it seems like we're very top heavy in terms of team management. And I'm just curious if there's any experience of other organizations developing team leaders or champions from outside of the management or the executive level? And I can go offline again. Thank you.

STEVEN BROMER: Great questions. So I would just say at my health center, Sebastopol Community Health Center, we actually have the medical assistants as our leads for the care team, for running the huddle, and keeping us on track with our quality goals. So each of our teams have-- we have daily huddles and then we have a quality improvement project that we're working on. And we have the medical assistant as the lead for that.

And that has taken-- that gets into the training question. Because you can't just throw people into that. It's a whole culture shift for one thing, because a lot of providers just sort of think that we are the ones that are supposed to be leading the team. And it's been a culture shift to sit back and figure out how can-- as a provider how can I add something to the team, but not run it.

And so we've had to then train the-- it's part of the training of medical assistants. And then they get some coaching around running the teams, particularly around running the huddle. That's the most kind of affects or daily role that they have in running the team. So they get coaching around how to do that.

And then periodically, senior management will come in on a huddle and just observe and see what's going on. And use that to inform the trainings and the individual coaching for the medical assistants. So that's one model we've tried.

And it also gets to the question of it's not my job. That was a question from last time. And it's often medical assistants. I know people have different names for medical assistants, med techs. So I'm not sure in your state what they're called. But it's often the medical assistant that is being asked to do more things than was in their job description initially.

I mean when I first started practice, a medical assistant basically roomed a patient, took their vitals, and maybe drew blood at the end of the visit, or did something-- a task that closed up the visit. And that was about it. And now we have medical assistants doing population management, doing depression screening, doing the diabetic foot exam, closing care gaps. We have been doing a whole host of things, leading the huddles. And it's a big culture shift.

But what I've seen happen, and it's not always smooth-- it doesn't always work, believe me. But what I've seen happen is that people have really grown into the role and are excited about having-- because it's not Dr. Bromer's panel of patients. It's the team's panel of patients. And like Cruise, my medical assistant, it's his job to make sure that people have had their labs every

six months. Their HIV labs every six months, let's say. And so he actually has a kind of pride in that.

And that's why I'm not a big fan of the concept of task shifting. Because I think if that's your metaphor, that you're shifting tasks onto people, I mean that's just not very attractive. I mean, I would also push back and say, look, I have enough work to do. I don't want to do that.

But if it's a perspective of, how do we work together to get what our panel needs? And then Cruise also has-- we look at our different panels. And how are we doing on TB screening? How are we doing on STI screening or whatever? He doesn't want us to lag behind the other teams. And so there's a certain pride in our team functioning well that he takes.

And putting the MA in charge of that, in charge of the huddle and some aspects of the team, has made a big difference in shifting that culture.

STEVE LUCKABAUGH: OK. We had another comment came in. We have patient care navigators identified as the care team lead. They're medical assistants and function as a site based team lead. There are multiple providers at each site, and creating provider based care teams was not a good fit. Especially because our providers may also switch between sites. They do a large component of the pre-visit planning and they facilitate the daily huddles.

STEVEN BROMER: That's great. And I think that brings up a really important point that you can't just try to apply some model to your practice. And that's why I think the elements are helpful. Because one of the elements of effective teams is looking at you're staffing ratios. And it sounds like what the site did was to look and see who is really one to one with a patient panel. And it wasn't the provider. And so it doesn't make sense to organize the panels around the provider. It made sense to organize them around the patient navigator, which is an effective strategy.

And I've seen that in a number of practices, where it's the case manager that it's actually organized around. And what I mean by organized around is, that the panel is defined by who they see and who they're responsible for. And it sounds like in this case, the providers are actually maybe seeing patients on several different panels because of just the resource. There isn't a one to one ratio with the care navigator. And so then it makes sense to develop that leadership.

Can I ask that site what has been some of the successes that have come out of that? And what have been some of the challenges? If you'd be willing to share. If you're willing to be unmuted and share that, that would be great.

STEVE LUCKABAUGH: OK. Andrea, I will unmute you. Go ahead.

ANDREA BROOKS: Yeah. Sure. So some of the successes-- I think definitely the-- one think that you talked about was the creation of the training and the coaching of them of how to deliver

the conversation. How to focus on what was the most important thing during a huddle. But it definitely helped us to build. We went through that process as a team.

We have a PCMH implementation committee. And we decided what were the things that we want to be discussed during a particular huddle. So sharing that conversation, having the navigators be a part of that discussion, as well as the provider. And a senior leadership team made it-- helped to get the buy in across the board. So everyone knew that it wasn't sort of a dictatorship. Like because I'm the boss, I'm telling you to do what needs to be discussed.

Versus, we looked at what are some our performance measures that we want to do better on? Are there ways that we can identify those things before the patients get here? And can we address those things during the huddle? For instance, we added-- the suggestion to add a reminder or an alert for patients who were do for a colorectal cancer screening or for a tobacco cessation intervention. Those things came out of the committees, were suggested to the team, and we decided what was the best way to put it onto the huddle list.

I think the challenge was getting other people to-- I know you were talking about, who's the lead? Who's the team sort of built around? Again, one, helping the navigators understand the importance of their role regardless of their title. And so it required our organization to shift our thinking about, what's the responsibilities of that person? They may be a patient care navigator, but when they're facilitating the huddle, they're the person who's responsible for transmitting some of the information and/or facilitating discussion. It took us a while to get adjusted to that.

My formal role is the performance improvement manager, as well as the project lead for this. So one of the things that I also do now, is I do sort of spot checks at the huddles to make sure that it's not just one person talking, but that there's a facilitation of discussion. There's some operational things that need to be discussed, in addition to the clinical things. So that's been helpful coming up with the structure of the huddle, with the team deciding who should be the lead and why. And helping everyone understand that during that particular time this is their role and responsibility.

STEVEN BROMER: Thank you. That's really helpful and inspiring. And I just want to highlight one thing you said which was, you do these spot checks. And I think that that's really a key thing for success because-- just because huddles work for a while doesn't mean they're going to keep working. And it's a dynamic process.

And you need to assess, why are things going off if they're going off? Why is it getting kind of like people aren't engaged? Or whatever comes up for people. So I think having an ongoing process for checking in and then being able to do course corrections is really, really important to making that work.

And we're talking about huddles a bunch, but the same applies for teams. It's just huddles end up being one of the ways that the team interacts formally together. That it's easy, it pulls together the issues in a nice way. Thank you for sharing that. That's really helpful.



STEVE LUCKABAUGH: OK.

STEVEN BROMER: Any other?

STEVE LUCKABAUGH: Yes. Edward Kayondo would like to speak up. Go ahead Edward. You're unmuted.

EDWARD KAYONDO: Yeah. Thanks a lot doctor. One thing we really also have knowledge on and I'm sure all community centers have this issue. Is that there are not that many incentives at community centers. And we always have continual movements of our medical assistants, in particular. Looking for new and better paying positions, both within the center or outside of the center. It seems that many times you find that you've trained team members just to-- two weeks down the road, to see that they have moved. And then you have to retrain them.

And I'd like the idea of the champion, but also this time try not to have champions who have no form of any kind of mentor, so they don't have anything really to show off in a way. And when they're identified as champions, it means basically that's more work for them in a way. We find that basically our medical assistants, you could find some other things with some of the trainings. And a nursing section whereby nurses can get certifications of some kind, like maybe diabetic educator behavioral health certified or something like that.

But for medical assistants there is even nothing really that in a form of recognized certification that they will be proud of and they could present as champions in a certain area. So you have HIV competing with a lot of other chronic care stuff that have to be done, diabetes, asthma, BMI and things like that. So maintaining this coherent team with a champion it's kind of like a serious struggle for some of the new sites that you're trying to implement all the services of. Thank you.

STEVEN BROMER: Yeah. Thanks for that comment. And there's a lot of important parts to that. And I think the point I want to emphasize again, is that when we talk about teams it's really important to assess where you are, and what your challenges are. Because it's different at each site. And you can't just apply a solution that somebody else has to your setting.

And the challenge with the medical assistants is a real one. It's the same thing that happens in our practice, actually. The HIV team has ended up being a training ground for leadership in the health center. I've lost, I think, four nurse case managers who have all stayed within agency, but moved onto-- one is the director of nursing, and one is running a prenatal program. I mean it's kind of comical almost. And then the same thing with the medical assistants. One of my medical assistants is now the director of quality for the whole agency.

And so I think when that's the situation, it's time to embrace the training. And embrace your role as training. This is an entry level position for a lot of people. It's their entry into the workforce. And you are really doing them a service by helping them develop skills that do make them attractive in other settings.



Now it's challenging to lose them. And so some of the strategies we've developed to keep people is to develop a tier system of medical assistants. So within the agency there's the entry level medical assistant, and then there's the medical assistant with population management. Sometimes we've included an additional level for language skills. Then if they do trainings and quality improvement we add that.

And so we've developed a tiered system and it does include pay raises. It's not a huge amount of money. It's not a huge incentive, but it is an incentive. And that's been one way we've tried to keep people within the system.

But I also just feel like community health centers-- we are often part of the economic engine of our communities. And it is, of course, a drag to lose people. But I also see it as a real service that we've trained people so that they are more able to support their families and have a stable job. But also they're doing good work in the community. I guess I try to have that bigger picture as well.

Somebody who became my medical assistant was working as a-- we have this thing in California, an in home supportive service worker. It's a program that's aimed at keeping people out of institutional settings that have a lot of health care needs at home. And so I had a patient who was quite ill and he had one of these workers.

And I met Sean and he was just so thoughtful and so passionate with this very challenging patient. And I encouraged him to apply-- when this patient passed way I encouraged him to apply to the health center. And he's just really flourished in our health center. And he's a dad with, I think, five children. So he doesn't have a lot of free time. But he is trying to get things in place to go to nursing school. And to me, that's an exciting part of the work that we do, that that can happen.

But I think a key thing is you've got to address the challenges that you have in front of you. And I think it's the same thing about providers leaving too. Part of it is trying to shift the culture so that community health centers aren't a place that people go to repay their loans and move on. It's a place that people go because for their careers. And that's part of the culture shift that I think we're talking about.

STEVE LUCKABAUGH: We had another comment that came in. We had that same challenge. And that was why we decided to create the patient care navigator position, as a separate position, where they can focus primarily on this function and it not be in addition to traditional medical assistant roles. Most of our PCN's transition from the role of medical assistant to PCN.

STEVEN BROMER: So wait. So people start as medical assistants and become patient care navigators?

STEVE LUCKABAUGH: Correct. Yes.



STEVEN BROMER: Excellent. Yeah. That's lovely. That's great. And I'm assuming that you guys get a chance to share some of your successes and stuff at your in person meetings. But these are all-- what you're figuring out is really hugely important. And can be very helpful to teams as they're sorting through these issues.

I'll just make a quick point here. And I think we've already made it. But just to remember to think about defining your teams really as a functional unit. And the way that it makes sense to me-- because a lot of times we have all these players on the team, and they're all important. And it's not that the pharmacist, for example, is not hugely important. But I don't know of any health centers that have a one to one ratio with a panel and the pharmacist, it would be lovely. But I don't have that.

So I try to think about the teamlet as being the team members that have a one to one relationship with the panel. Meaning that, their responsibility is that panel. And so for me, that's my medical assistant, my nurse, and my front office person, and me. And I'm saying my, I shouldn't be doing that. But the front office person, the medical assistant, the provider, and the nurse. I think we're pretty lucky to have that large of a teamlet.

A lot of places it's really-- when you define it that way, it's the medical assistants and the provider that's really one to one. Everyone else is kind of in the-- is working with a lot of other teams. There are a lot of other patients in the center. So it's helpful to define that because then you have to put special attention on those relationships. The relationships of who's in the teamlet. Because to get through the day, those relationships have to work. The other perspectives are very important to have places where they can come in, but you need the teamlet to be able to focus their workflows and their responsibilities in a way that there working as a unit.

For me it's been very helpful to kind of pull that out because I know in a lot of Ryan White settings we have these large, large teams. And we don't work together as a team. It's everyone is off doing their own thing. They're in their own silo. And sometimes the patient has to go through that silo.

There are some HIV practices, or Ryan White practices, where an intake is like a half day event. People come in and then they meet with eligibility, then they meet with the social worker, and then they meet with the nurse case manager, then they meet with the adherence counselor, and they meet with a patient navigator. And then they go get their labs done. And then two weeks later they come and meet with the provider or something.

I mean that's fine, but it's not working as a team. That's still staying in silos. And so the whole purpose of breaking things down into a teamlet is so that we can really make those flows work well. So we have to think of our sites. And at our sites, really what is a teamlet. How we define that?



I'm going to move ahead to the Share the Care exercise. So I'm just going to give you a little taste of the Share the Care exercise. And this is kind of an example of it. And you just basically look at the column on the left and see the different tasks that are there. And then, the column on the right is just an example of different roles that exist, that are likely to exist in a health center. And yours may be different. You may not have an LPN, you may not have an RN, you have a patient navigator. Don't worry too much about that. But this is just an example of how it might be.

But then go through and look-- who in your organization orders mammograms for a healthy woman between 50 and 75 years old? And there, the issue is orders them. Who does that? And then who refills high blood pressure medications for patients that are stable and have well controlled hypertension? And who performs diabetic foot exams in your organization?

So go through those. I'm just curious-- and go ahead and mark. Maybe take a piece of paper and just mark the out of the-- and you can add a column if you want to patient navigator. Add a column to yours. Because I know a number of sites said they have patient navigators. So who does each of those tasks? And who cares for patients on complicated UTIs? Finds patients who are overdue for a LDL? Prescribes statins for patients with elevated LDL?

As you go through that-- so there are 10 tasks there. Who ends up with a column that has somewhere between seven and ten tasks ending up in that column? Either the medical assistant, the LVN, the RN, or the PCP or pharmacist? Do any of the sites end up with a seven or greater of those tasks falling to one team member? Is that no hands?

STEVE LUCKABAUGH: I'm not seeing any hands.

STEVEN BROMER: OK. What about, let's say, five to seven? Did any of you end up with one of the columns-- well, first of all, maybe I better check to make sure my directions were clear. It's always clear my head. It sometimes doesn't come out clearly when I give the directions. What we're doing is just marking, like in terms of let's say, who orders mammograms. Is it a PCP, an RN, an LVN, a medical assistant, or a pharmacist? I would tell you, in my organization, it's the PCP that orders a mammogram.

Who refills high blood pressure medications for patients who are well controlled? And so you would just put an x in who does that the most in your agency. Performs diabetic foot exams. So for me, in my agency, it's the medical assistant because we've trained them in that. And it done as a screening exam that then I follow up on.

So are people finding that-- let's say, what sites have no more than three in any one category? Is there a site that has all these jobs kind of spread out among the different team members? So that if you totalled at the bottom, the PCP would be three, RN, would be no more than three, medical assistant no more than three. Are there any sites that have their tasks spread out all the way? And we're not seeing hands on that question either?



STEVE LUCKABAUGH: Not seeing any hands.

STEVEN BROMER: All right.

STEVE LUCKABAUGH: If you'd like to type in the questions pane, I can read it out here.

STEVEN BROMER: Yeah.

STEVE LUCKABAUGH: MA's and LPN's have a lot. We've created many of these tasks as standing orders where initial things happen with PCP, but followup is divided.

STEVEN BROMER: Oh nice. So some teams-- So some of you have really operationalized some of these tasks. That's great. And standing orders is a huge tool for making teams function. And it's one of those key kind of operational tools to make actually teams functional.

And I'll just tell you, some of the ways we've used this tool like this-- and I would encourage you to use, really, the full exercise. But some of the ways we've used it is to have, for example, have just medical assistants fill it out. And see what they think they do. And have just the providers fill it out. And see what they think they do. And then, you bring people together and talk about it. Because a lot of times they have very different perspectives.

I know one site I used it at, basically, everybody thought they did everything. And that was like a hugely important lesson. Because if everyone thinks they're doing everything, we clearly don't have our roles and responsibilities defined very well. And we identified with that that we needed a lot of work in defining the roles, but also in trust. Because the PCP was doing all those things, because they didn't actually trust that the medical assistant would do it. So it highlighted a bunch of issues that helped us make the teams were functional.

One of the things that a lot of people find out is that everybody-- a lot of these tasks end up falling on the PCP. When I have done this at meetings-- a few years ago we did it at one of the HIV medical resource center meetings. And about more than half the room said they had eight-- the PCP did eight of those tasks.

So it's a lot of times the-- there are many, many settings where the PCP is still really kind of a bottleneck for these things. And if that's happening, it's going to impact your ability to do all of the things you want, like increasing access, of being patient centered. You can't do that if the provider is the bottleneck for all this work. It will just getting in your way. So that's really, for me, one of the key reasons for making teams work.

Hey, so we're almost at the top of the hour. So I just want to check to see if there's any other final comments that people-- I appreciate your questions and your comments. I think the work you're doing is very exciting. And I'm a little jealous that you get a chance to share this with each other. It's a nice resource that you have. So any final comments or final questions that you want to make sure get addressed in a future webinar?



STEVE LUCKABAUGH: We have one. We are missing the case managers' work.

STEVEN BROMER: Oh. On this exercise. Yeah. Absolutely. And that's why with the exercise I sent you out, you have a whole bunch of options for the roles. And this, correct, this doesn't have the case manager on it.

And this was really geared towards primary care practices, actually. And this slide. And a lot of them don't have case managers. It's just a new thing for a lot of them. So that's why it's not on there. But you would want to include that in an HIV practice for sure. There's a bunch of roles that you would probably want to include. Yeah. Very good point.

And again, it's not prescriptive about what should be on a team. This is just an example of someone's team. Great. I just want to thank you again for letting me participate. I really appreciate it. I wish you the best of luck in the rest of this project. And look forward to hearing more and more about what you do.

STEVE LUCKABAUGH: All right. Thank you again for participating in today's webinar. And thank you Dr. Bromer for that excellent presentation. And we'd also like to thank the folks that spoke up and others who provided comments. If you have any additional comments for the P4C project or for Dr. Bromer, please email us at p4chivtac@mayatech.com. And take everybody. And we'll see you next time.