Team Care – Spread the Jellybeans!

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Don Berwick

"The source of energy at work is not in control, it is in connection to purpose."

It Cannot be Done Alone

- *A primary care physician with a panel of 2500 average patients will spend:*
  - ***7.4 hours per day*** *doing recommended preventive care [Yarnall et al. Am J Public Health 2003;93:635]*
  - ***10.6 hours per day*** *doing recommended chronic care [Ostbye et al. Annals of Fam Med 2005;3:209]*

= 18 hrs per day, with no time to address the patient's agenda

From "Cup Runneth Over"...

Provider

Medical Assistant/Care Coordinator

Nurse

Behavioral Health

Clinical Pharmacist

Physical Therapist

Traditional Work Flow

Preventive Med Intervention

Chronic Disease Monitoring

Medication Refill

New Acute Complaint

Test Results

Provider

Case Manager

Mental Health Provider

Referral to Specialist after Assessment

Certified Medical Assistant

Healthcare Support Team

Southcentral Foundation

Parallel Work Flow Redesign

Medication Refill

Chronic Disease Monitoring

Test Results

New Acute Complaint

Preventive Med Intervention

Point of Care Testing

Acute Mental Health Complaint

Chronic Disease Compliance Barriers

Healthcare Support Team

Case Manager

Provider

Certified Medical Assistant

Behavioral Health Consultant

Southcentral Foundation

To "Share the Care"

Provider

Medical Assistant/Care Coordinator

Nurse

LCSW/Behavioral Health

Physical Therapist

Clinical Pharmacist

Stanford Coordinated Care Team

2.0 FTE MD (300 pt/FTE), 1 RN CNS, 1 LCSW, 0.6 FTE PT, 1 clinic manager, 1 receptionist, 4 care coordinators/medical assistants (120 pt/cc)

SCC Wonderful Care Coordinators!

SCC patients want one person they can count on who can manage communication with the team.

From MA to Care Coordinator

- ***CREATE NEW JOB CATEGORY AND PAYSCALE to reflect greater skills and responsibility***
- **RESPONSIBILITY** for patients in their panel rather than simply perform a set of TASKS
- **STAY WITH PATIENT** throughout the entire MD visit
- **DOCUMENT THE VISIT**
- **PERFORM ASSESSMENTS**
- **BUILD A RELATIONSHIP WITH PATIENTS**
- **CASE PRESENTATION BY CC** at team meeting
  - Build skill of hearing/telling the patient's story
  - Build skill of patient assessment using SCC tools

Four MA Levels at Stanford MA1

- **MA1** *8 out of 8 functions*
  - Patient Rooming
  - Vital Signs
  - Preparing Medical Records
  - Patient Phone Calls
  - Stocking of clinic area
  - Medication and supply ordering
  - Check-in/Check-out
  - Record Retrieval

Four MA Levels at Stanford: MA 2

- **MA2** *Meets MA1 Responsibilities PLUS 8 out of 10 functions listed below*
  - Specimen collection/Point of Care Testing
  - Customer relationship management
  - MyHealth and inbox message management
  - Injections and other in-clinic procedures
  - Assist with physican procedures
  - Assist with billing and referral inquiries
  - Disability paperwork management
  - Patient phone calls
(including scheduling or discharge phone calls)
  - Rx Refill
  - Processing Prior Authorization
  - Abstraction

Four MA Levels at Stanford: MA 3

- **MA3** *Meets MA2 Responsibilties PLUS 7 of the 8 functions listed below*
- Care Coordination for a panel of patient needs, which includes tracking that patient referrals and testing are completed
- Schedule management responsibilities for a patient panel
- Patient outreach to address gaps in care & follow-up
- Precepting new Medical Assistants
- Internal Clinic audits
- Surgery Scheduling for Practice
- Expedite communication between patient & provider
- **Process Improvement work**
(at least 3 A3s submitted each year)
- MA Certification completion
- Health Coaching

Four MA Levels at Stanford: MA4

- **MA4** *Meets MA3 Responsibilities PLUS 4 out of 5 functions listed below*
- Home Visits
- In clinic patient flow management including clinical documentation in partnership with physician
- Accompany patients to visits outside of the clinic
- Manages own patient panel & schedule of patients
- Serve as "lead" for clinic

Stay With the Patient Throughout the Entire Clinic Visit and Document the Visit

- Flow of the clinic visit
- Vital signs, “What bothers you the most?”
- Health maintenance and chronic disease monitoring tests
- Scribing the visit:
  - The patient’s story listed by problem
  - Physical exam
  - Plan: initial entry of medications, diagnostic studies, referrals
  - After visit summary, planning follow up and support

Perform Assessments

- At the visit:
  - Point of care testing like A1C, glucose, urine dipstick, Hct
  - Lining up health maintenance and chronic disease monitoring
- Between visits:
  - Health maintenance
  - Studies to monitor health conditions

Let’s see the model at work at Bellin

- Youtube.com Bellin Team Care The Office Visit 3 min 31 sec

Care Coordinators Build a Relationship With Patients

- Patients with chronic conditions want an accessible single point of contact they can trust: care coordinator

  - During office visits
  - Contact between visits based on patient need
  - Fielding incoming phone calls and e-mails
  - Supporting with depression/anxiety or crises

  - Nastasia’s stories

Responsibility for Patients in Their Panel

- Authorizations
- Diagnostics
- Procedures
- Consults
- Medication refills and adherence
- ***Establish goals and follow up of action plans with patients with chronic health conditions***

Protocols to Address Care Gaps Independently

- Immunizations
- Diabetes planned care
- Health maintenance
- Asthma care
- Chronic condition monitoring

- Protocols available at http://med.stanford.edu/cerc/education/team-training.html

HEDIS: SCC Results

Welcome | Performance View | Population View | Patient View | Panel Mgmt | Panel Stats

STANFORD HOSPITAL & CLINICS

Primary Care

Filters

Year Thru Date	Today
Service Area	SH&C
Location	HOOVER
Department	STANFORD COO
Provider	

Reset Filters

Overall Composite	Diabetes Composite	Cardio Composite	Preventative Composite	Meds Mgmt Composite
79%	87%	68%	74%	90%
Patients: 373	Patients: 87	Patients: 19	Patients: 373	Patients: 123

Distance from Goal | Internal Comparisons

Measure	Percentage to Goal	Current Rate	Goal	Patients	Patients to Goal	Percentile Ranking (Estimated)
Composite						
• Overall	28.8%	79.3%	50.5%	373	n/a	
• Diabetes	12.6%	87.4%	74.8%	87	n/a	
• Cardio	14.7%	68.4%	53.7%	19	n/a	
• Preventative	33.1%	74.0%	40.9%	373	n/a	
• Meds Mgmt	-3.5%	90.2%	93.7%	123	n/a	
Diabetes						
• HbA1c Screening	5.9%	98.9%	93.0%	87	0	
• HbA1c Control	5.2%	86.2%	81.0%	87	0	
• LDL Screening	3.0%	92.0%	89.0%	87	0	
• LDL Control	6.5%	62.1%	55.6%	87	0	
• Nephropathy Monitoring	7.4%	95.4%	88.0%	87	0	
• BP Control	8.1%	89.7%	81.6%	87	0	
Cardio						
• LDL Screening	-2.5%	89.5%	92.0%	19	1	
• LDL Control	10.2%	47.4%	37.2%	19	0	
Preventative						
• Flu Immunization	-2.9%	58.1%	61.0%	372	11	
• Pneumococcal Immunization	11.4%	96.1%	84.7%	76	0	
• Chlamydia Screening	8.7%	66.7%	58.0%	3	0	
• Cervical Cancer Screening (EB)	0.4%	82.4%	82.0%	165	0	
• Breast Cancer Screening	7.1%	87.1%	80.0%	139	0	
• Colorectal Cancer Screening	8.8%	78.8%	70.0%	231	0	
Medications Management						
• ACE/ARB/Diuretic/Digoxin	-3.8%	90.2%	94.0%	123	5	

Medication Refill Protocol

	Medication (generic name)	Medication (Brand name)	Condition	Refill	Appt	Labs
3	acarbose	Precose	Diabetes	6 months	< 6 months	A1c < 6 mo; Lipid panel & CMP < 12 mo; Urine Microalb < 12 mo
4	acyclovir ointment or oral	Zovirax		12 months	< 12 months	
5	albuterol	Proventil	Asthma	12 months	< 12 months	
6	albuterol	Ventolin	Asthma	12 months	< 12 months	
7	alendronate	Fosamax	Bone Density	12 months	< 12 months	
8	allopurinol	Aloprim	Gout	12 months	< 12 months	BMP, Uric Acid
9	[illegible]	[illegible]	[illegible]			[illegible]
10	amiodarone	Cordarone	Atrial Fibrillation	6 months	< 9 months	AST, AST, TSH < 12 mo
11	amlodipine	Norvasc	Hypertension	12 months	< 12 months	BMP < 12 mo
12	amlodipine and benazepril	Lotrel	Hypertension	12 months	< 12 months	BMP < 12 mo
13	atenolol	Tenormin	Hypertension	24 months	< 12 months	BMP < 12 mo
14	atorvastatin	Lipitor	Cholesterol	12 months	< 12 months	Fasting Lipid Profile, AST, ALT < 12 mo
15	benazepril	Lotensin	Hypertension	12 months	< 12 months	BMP < 12 mo
16	benazepril with hydrochlorothiazide	Lotensin HCT	Hypertension	12 months	< 12 months	BMP < 12 mo
17	budesonide	Pulmicort	Respiratory Agent	12 months	< 12 months	
18	budesonide	Rhinocort Aqua	Allergies	12 months	< 12 months	
19	bupropion	Wellbutrin SR	Depression	12 months	< 12 months	
20	bupropion	Zyban	Depression	6 months	< 6 months	
21	candesartan	Atacand	Hypertension	12 months	< 12 months	BMP < 12 mo
22	candesartan and hydrochlorothiazide	Atacand HCT	Hypertension	12 months	< 12 months	BMP < 12 mo
23	captopril	Capoten	Hypertension	12 months	< 12 months	BMP < 12 mo
24	carvedilol	Coreg, Coreg CR	Hypertension	12 months	< 12 months	BMP < 12 mo
25	[illegible]	[illegible]	[illegible]			[illegible]

Analytics Risk Dashboard

Monthly “Speed Dating”

PCP Name	Care Co-ordinator	Measure	Measure Value	Measure Dat
GLASEROFF, ALAN MARTIN	CURIEL, MONICA	PAM Score	1	5/30/13
		PHQ9 Score	24	5/30/13
VOLLRATH, KATHAN HICKEY	POSO, NASTASIA	LDL	169.00	5/27/14
VOLLRATH, KATHAN HICKEY	POSO, NASTASIA	LDL	158.00	10/2/13
		PHQ9 Score	19	3/17/14
LINDSAY, ANN D	POSO, NASTASIA	BMI	40.60	9/17/14
VOLLRATH, KATHAN HICKEY	CURIEL, MONICA	LDL	130.00	6/10/14
VOLLRATH, KATHAN HICKEY	COLEMAN, DELILA	BMI	41.19	12/17/14
LINDSAY, ANN D	CURIEL, MONICA	A/C Ratio	238.00	4/26/13
VOLLRATH, KATHAN HICKEY	CURIEL, MONICA	LDL	133.00	6/30/14
		PHQ9 Score	15	9/24/14
GLASEROFF, ALAN MARTIN	CURIEL, MONICA	BP (Systolic)	166	1/2/14
		Pain Score	8	8/1/14
VOLLRATH, KATHAN HICKEY	POSO, NASTASIA	A1c	14.00	11/10/14
		A/C Ratio	70.00	1/22/14
		LDL	131.00	11/12/14
LINDSAY, ANN D	POSO, NASTASIA	LDL	137.00	10/6/14
VOLLRATH, KATHAN HICKEY	CURIEL, MONICA	BMI	38.01	11/21/14
VOLLRATH, KATHAN HICKEY	CURIEL, MONICA	PAM Score	1	9/26/14
GLASEROFF, ALAN MARTIN	COLEMAN, DELILA	LDL	182.00	2/3/14
VOLLRATH, KATHAN HICKEY	POSO, NASTASIA	Pain Score	8	12/16/14
		Smoker	YES	12/16/14
VOLLRATH, KATHAN HICKEY	POSO, NASTASIA	BMI	40.73	12/1/14
		LDL	138.00	9/12/13
		Smoker	YES	4/2/14
LINDSAY, ANN D	POSO, NASTASIA	BMI	46.43	12/2/14
VOLLRATH, KATHAN HICKEY	POSO, NASTASIA	Pain Score	8	12/19/14
LINDSAY, ANN D	COLEMAN, DELILA	BMI	41.33	4/10/14
		LDL	157.00	12/11/13
LINDSAY, ANN D	CURIEL, MONICA	LDL	138.00	9/10/14
VOLLRATH, KATHAN HICKEY	CURIEL, MONICA	BMI	44.40	11/25/14
		PAM Score	1	11/25/14
GLASEROFF, ALAN MARTIN	COLEMAN, DELILA	LDL	191.00	6/21/12
GLASEROFF, ALAN MARTIN	COLEMAN, DELILA	PAM Score	1	11/25/14
GLASEROFF, ALAN MARTIN	COLEMAN, DELILA	LDL	154.00	6/3/14
GLASEROFF, ALAN MARTIN	COLEMAN, DELILA	A1c	9.90	10/1/14
NO PCP	Unassigned	LDL	278.00	4/23/14
LINDSAY, ANN D	COLEMAN, DELILA	BP (Systolic)	154	11/14/14
		PHQ9 Score	15	10/30/14
LINDSAY, ANN D	CURIEL, MONICA	BMI	35.12	11/19/14
GLASEROFF, ALAN MARTIN	CURIEL, MONICA	LDL	143.00	9/23/14
LINDSAY, ANN D	POSO, NASTASIA	BMI	40.41	9/17/14
		LDL	143.00	6/11/14
LINDSAY, ANN D	POSO, NASTASIA	BP (Systolic)	164	11/12/14
GLASEROFF, ALAN MARTIN	COLEMAN, DELILA	BMI	41.08	9/18/14
GLASEROFF, ALAN MARTIN	CURIEL, MONICA	LDL	164.00	12/2/14

Page 1/10

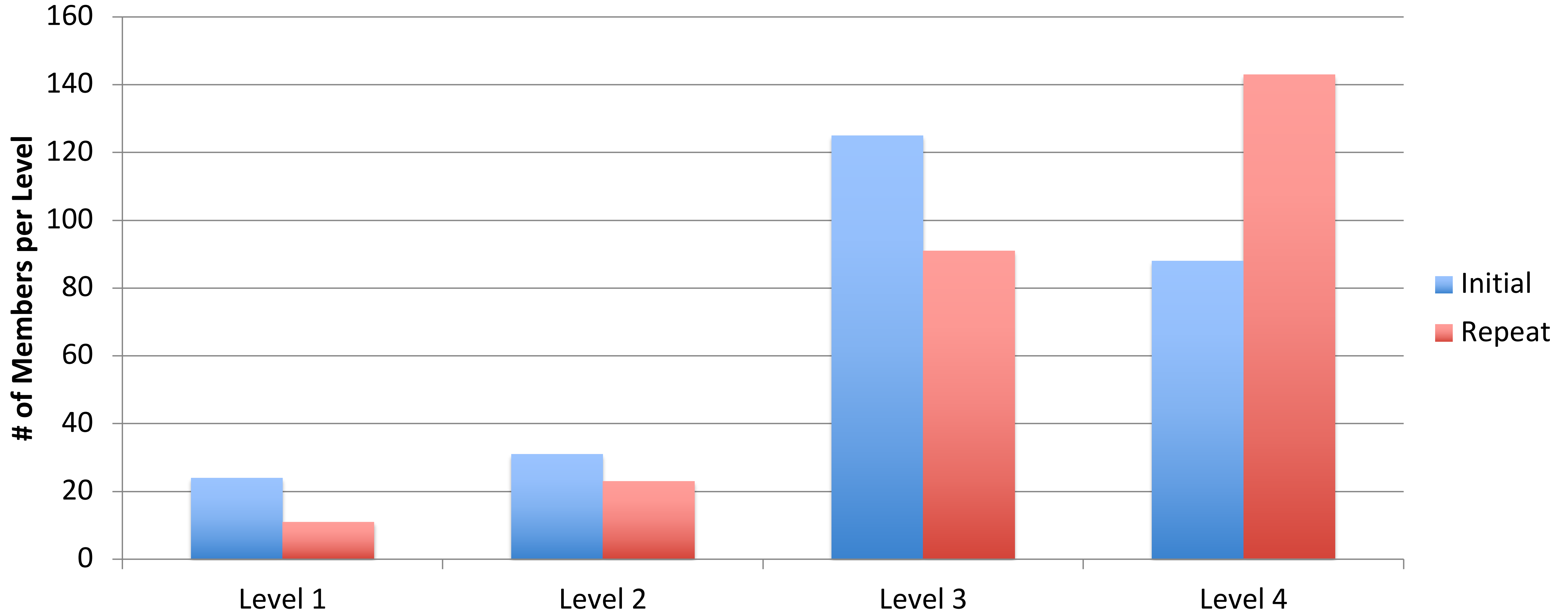
- Each care coordinator conferences with relevant clinician on CC panel they share
  - Each CC works with each clinician – allows for cross-coverage
  - Focus on “red” areas – immediate risk for poor outcome
  - CC panel ~100
  - No one “falls through the cracks”
  - Care gaps also addressed

Time for Questions and Comments

Patient Activation Measure: 13 Question Survey

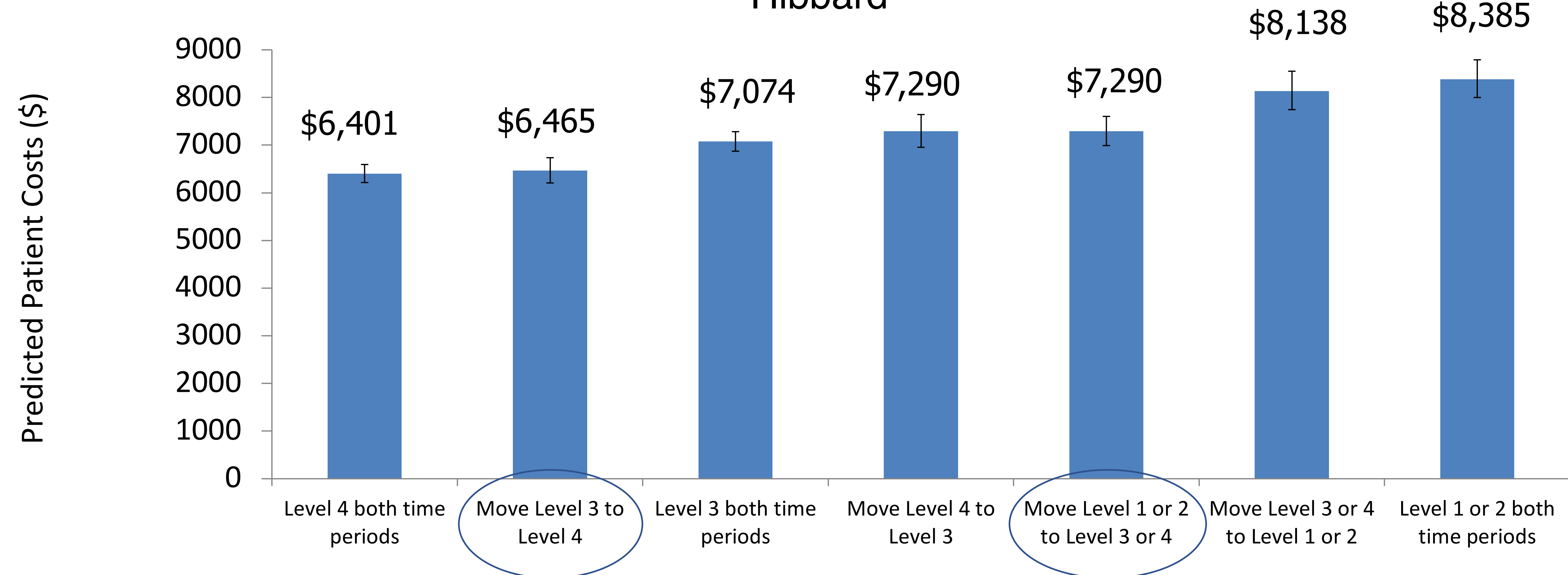
- Guides interactions with patients
- Outcome measure for the program

Increasing Activation as an Outcome Measure



Cost Savings Potential with Increased PAM

Predicted Average Per-Capita Costs 2 Years Later by Change in PAM Level: Hibbard



Predicted costs are based upon regression models with log transformed costs that control for age, sex, chronic conditions, natural logarithm of income and percent of care that was received in-network. Costs were retransformed from log dollars using the Duan smear factor.

Demonstration of Higher Level MA Duties

- Youtube.com Bellin Team Based Care Between the visit work flow 4 min 45 sec

Clinic Huddle

Key points:

- Volume for the day
- Staffing for the day
- Quick review of yesterday
- Plus / Delta
- Announcements
- ED visits, overnight calls, admits

Guiding principles:

- Interactive
- Respect for People
- Hard on the process
- Continuous quality improvement

Ambulatory Care Daily Huddle Sheet

Stanford Coordinated Care
Date: Thu Facilitator:

HUDDLE AGENDA

1. Welcome / Introductions (1 Minute)
Introductions, Recognition, & Celebration
Opportunities for improvement
- POC audit findings

2. Today: Daily Flow (2 Minutes) Status/Escalate?
Daily Status: Census
- *# patients scheduled:* 10 total clinic appointments
- *# new patients scheduled:* 0
- *# open slots/rooms available today:* MD1: 10-11am, 1-5pm
- *# no-shows yesterday:* 1 (intake)

Patients Enrolled: Future Patients Scheduled: 3rd AVAILABLE NPV:
Panel Sizes: Physician Panel Sizes:
Daily Status: Staffing (including assignments for 2-patient identifiers, C-I-CARE rounds, EverReady checklist, etc.)

3. Topic of the Day (2 Minutes) Status/Escalate?

Monday	Tuesday	Wednesday	Thursday	Friday
Quality/QTRACS	Access	Business Ops	Quality/QTRACS	Service

- Check in on day ahead! (new daily topic)

4. Announcements (1 Minute) Status/Escalate?

C-I-CARE Readiness

Status Check on AIls/ Action Plans

Communication / Trust

- Unity around mission
- Team room
- Clear roles but mutual support
- Huddles
- Sharing interactions with patients
- Dashboard to plan support for patients
- Team meetings to present new patients and plan care
- Team operations meetings

Recruiting the Right Staff

- Consider group interviews with the team
- You cannot teach “empathy”
  - Ask for an example of when they went out of their way to help a patient.
  - Pose a scenario

SCC Story: Nastasia

How do you interview a candidate to make sure the person has empathy and will be a good team member?

“Stopping the Line…”

- Addressing problems as they arise
- All staff empowered to call out problems and work on solutions (even when problems are caused by leadership
- RESPECT at all times!

A3 for Problem Solving

1. What is the problem or gap?
Phone calls from patients dropped

2. **What are the root causes?**
Front desk, especially lunch
Team room

3. Based on data, what are the causes in order of importance?
No coordination with senior care front desk staff
CC not always there to take direct calls

4. Which actions will address the most important causes?
Stagger front desk break with Sr Care front desk
CC take turns being “on” for team room calls

A3 for Problem Solving

1. What is the Problem or Gap?

-What goes in an action plan vs. what goes in patient instruction in clinic note?

•

2. What are the root causes?

- Action plans and follow up overlapping?
-Action plans not being updated/followed
-Old data in new clinic note
-Patient's dis-engaging or tired of action plans

3.Which Actions will address the most important causes?

-Standard work around updating action Plan and instructions at regular intervals
-Motivational interviewing practice
-Note review in speed dating once a Month with MD's

4. Based on data, what are the causes in order of importance?

1. Patient's losing interest/motivation around action plans
2. Standard work not being done around action plans and check in's
3. Action plan and patient instructions over lapping

Welcoming a New Team Member

- Team roles: shadow each team member
- Work along side experienced provider
- Review how to solve problems
- Welcome feedback: “New eyes” can teach you about your program!

Training/On-boarding

- **Mission of the team**
- Skills review
- Tools, including EMR
- Workflows
- Protocols
- Know what the business is
  - How the organization is supported
  - Insurance benefits
- Resources

Joy in Practice

Stressors

- Patient issues
- Worksite issues
- Personal issues

Compassion Satisfaction

- The pleasure we derive from being able to do our work well.
- A feeling, belief , and/or value that our professional role is a way we can assist or support people, perhaps humanity

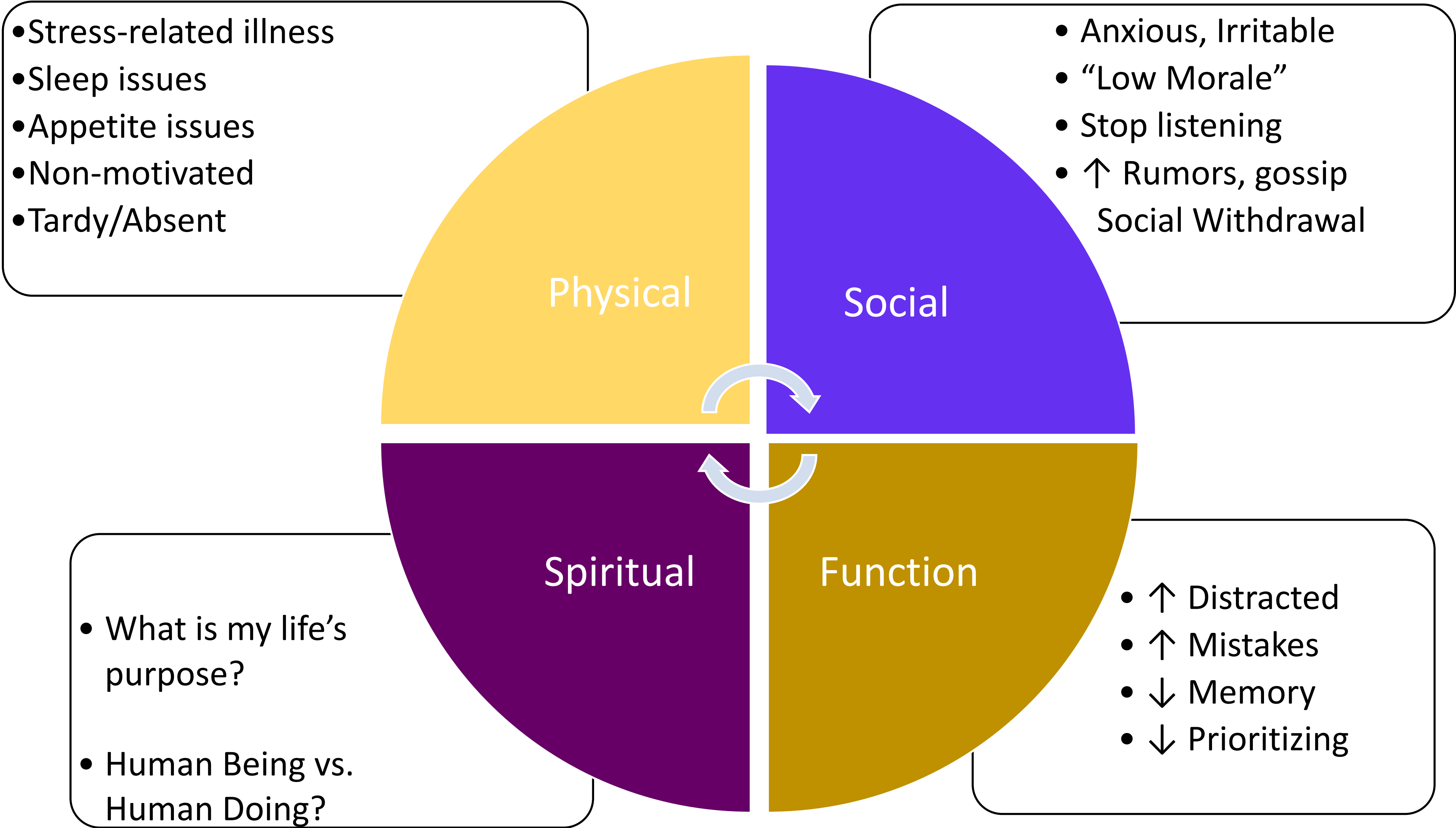
Compassion Fatigue

The cost of caring for others in emotional and physical pain

- Deep physical and emotional exhaustion
- Pronounced change in the Helper’s ability to feel empathy for their patients (as well as coworkers and loved ones)

What does compassion fatigue look like on the job?

Effects of Compassion Fatigue



Promoting Personal Resiliency

- Pay attention to how your past may be affecting your present
  - Vicarious or secondary trauma from past job
  - ACEs
  - Unrealistic expectations, etc
- Take care of yourself

Promoting Personal Resiliency

- Create boundaries
and thresholds with
entry and re-entry rituals

- Touchstones

Promoting Team Resiliency

- Enhanced MA role enhances “meaning” on the job
- MA scribing a big plus for providers and patients, “magic dust”
- RN role enhancement increases satisfaction

Promoting Team Resiliency

- Meet regularly
- Start staff meetings with the opportunity to breathe, become “present”
- SCC’s Team Jar for “thank you” notes
- Avoid “divide and conquer” undermining of team – *single team dialogue*
- **Do we have, or want to create, a work culture in which member of the team can compassionately tell a coworker that he or she may be showing signs of CF or burnout?**

Leaders Promoting Joy in Practice

- Open door/listening/learning communication skills
- Debriefing
- Team building and development
- Sustainable workload
- Increase participation in decision making and job control
- Supervision and mentoring
- Recognition, fairness, and justice
- Cross training and new skills
- Humor
- Promote good relationships within team

70% of Team Engagement is Due to the Team Leader

- Effective leaders know:
  - What their people are doing
  - How their people are feeling
  - Strengths of their people and how to support them

- Questions, comments?

- nposo@stanfordhealthcare.org
- adlindsa@stanford.edu

- Youtube: Bellin Team Based Care
- Protocols available at http://med.stanford.edu/cerc/education/team-training.html
- AMA Steps Forward

- Tune in for a follow up webinar on New RN Roles July 30 12-2 pm