TEAM-BASED CARE TOOLS

SOUTH DAKOTA
CARDIOVASCULAR
COLLABORATIVE

GETTING STARTED WITH TEAM-BASED CARE

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Levels of Team-Based Care

Adapted from: Cambridge Health Alliance Model of Team-Based Care Implementation Guide and Toolkit
https://www.integration.samhsa.gov/workforce/team-members/Cambridge_Health_Alliance_Team-Based_Care_Toolkit.pdf

Level	Who is on the team as a caregiver?	What supportive team structures are in place?	What kind of work is done as a team?	Team-based access	Who leads/is responsible for the team?	How does the team improve its work?
1	Provider alone	Meets less than monthly as a team to discuss panel of patients.	Little or none.	Patients identify with their provider alone; messages come to provider triaged by RN, who are not empowered to resolve. Providers have access/training to use quality reports.	Provider; Planned Care Coordinators help to lead the quality work but primarily serve as outreach workers.	No structured process for team member suggestions to come through – general "if you have an idea" send it your way.
2	Provider and MA	Pre-session huddles routine between at least the provider and MA; meet at least monthly to pro-actively discuss Planned Care.	Quality/population health work; flow work.	Patients begin to identify both their provider and their MA. MAs and medical receptionists receive access to registries/tools to manage patients.	MAs become the captains of flow and lead achievement of Planned Care goals during the visit, before the doctor has seen the patient.	Formal process for team members to make suggestions to improve the practice based on what they've learned (suggestion box, suggestion sheet).
3	Provider, MA and RN or receptionist	Pre-session huddles routine with RN or receptionist; meets weekly as a team to do Planned Care.	Daily work and population health work; some outreach by team RN to high risk patients.	Team-based scheduling to assure continuity of care.	MA emerges as the leader for the routine Planned Care work. Receptionist emerges as leader for referral work.	Practice Improvement Team (PIT) formed that includes frontline staff, patients, and a leadership supporter.

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4	Provider, MA, RN and receptionist	Pre-session huddles routine with RN and receptionist; co-scheduling or colocation of part of the team (at least provider-MA during session).	All core work is done as a team; RN plays an increasingly important role as a chronic disease manager; may be supported by LPN.	Calls routed to the care team; improved first call resolution. Team-based scheduling to assure continuity of care through visits, portal, etc.	RN emerges as the leader for chronic disease management work.	Seamless process of care teams communicating improvement suggestions to leadership and PIT.
5	Provider, MA, RN, receptionist, complex care manager (CCM)	Pre-session huddles for the whole team. CCM part of weekly team meetings to discuss high risk patients. Co-scheduling and colocation of the clinical care team.	Team works with complex care management team to connect usual care to complex care.	Team accesses patient at home and throughout the continuum of care; telephone and portal f/u common.	CCM emerges as the leader for the highest risk work.	Culture of continuous quality improvement, measurement, and rigorous process of spread that permeates how the practice does its work (beyond care teams).
6	Provider, MA, RN, receptionist, CCM, integrated mental health specialist	Pre-session huddles for the whole team including a mental health clinician; CCM part of weekly team meetings to discuss high risk patients. Mental health clinician joins team meetings to discuss patients with MH issues. Co-scheduling and colocation of the core clinical care team.	Patients move seamlessly between usual care, chronic disease management, and complex care management, with support of a whole person orientation that integrates physical and mental health.	Telemedicine, e-visits, phone visits routine between patient and their care team.	Every team member knows what part of the work they lead and feels competent, empowered and accountable for achieving the needed outcomes with others on their team.	Culture of continuous quality improvement, measurement, and rigorous process of spread that permeates how the practice does its work (beyond care teams).

Core Principles for Team-Based Care

Fundamental truths that serve as the foundation for a system of beliefs or behaviors

1. **Put the Patient First:** Providing comprehensive high quality team-based care to our patients and to our community is our guiding principle.
2. **Build Team Culture:** A team is an organization entity that together accomplishes more than can be accomplished individually. This mindset must be ingrained in all team members to allow us to provide the very best care for our patients.
3. **Empower Staff:** All team members should work at the top of their skill set and should be proactive in finding ways to help care for our patients. This develops trust between team members and enhances work life satisfaction for each team member, as they realize the key role they play in providing care for our patients.

4. **Encourage Critical Thinking:** All team members should be continually looking for ways to anticipate the needs of both patients and other team members, therefore, proactively meeting these needs. This strives for the highest quality patient care, and increases effective team dynamics.

5. **Know Your Population:** This consists of analyzing the composition and risk profile of a practice population. This determines the anticipation of resources required for high quality and comprehensive patient care, and allows for the development and improvement of measures to ensure this care is delivered as effectively as possible.

Source: Bellin Health Systems, Inc. ("Bellin"). (09/01/2014).

Core Concepts for Team-Based Care

Notions or statements of an idea expressing how something might be accomplished

1. **Planned Care Principles:** Includes principles such as obtaining pre-visit labs, and advanced access. These are necessary in order to deliver effective and efficient team based care.

2. **Expanded Standard Rooming Processes:** In addition to usual rooming procedures including standard and accurate vital signs and proper exam room preparation; enhanced processes include patient functional status and behavioral health screening, agenda setting, medication reconciliation, choosing a template, and beginning documentation. This ensures that patient needs are anticipated and met, and improves the quality of care and efficiency of the office visit.

3. **Co-Location:** The core team, including the Provider, the Care Team Coordinators, and preferably the RN and the Patient Access Representative, work together in a space that allows for ongoing and continuous communication between these team members. This is essential for effective team functioning and ongoing communication, which leads to a significant decrease in the need for electronic messaging.

4. **Daily Huddles:** Brief daily check-ins of the core team to review the day's schedule. This improves the efficiency of the work day by allowing the team to anticipate needs of that day's patients, emphasizes the availability of all necessary records, allows for the review of options for add on appointments, and helps build team culture.

5. **Regular Care Team Meeting:** Meetings of the Core Team and the Extended Care Team occur typically on a weekly or biweekly basis. This allows for communication between all team members involved in the care of complex or high risk patients, as well as focused discussion on the care gaps of all patients, resulting in coordinated, effective care.

6. **Maximize use of Warm Handoffs:** Verbal communication about the patient between team members, often in the presence of the patient. This enhances engagement of the patient in their own care, and demonstrates effective communication between team members regarding the patient's ongoing needs.

7. **Standard Documentation and Communication:** Using tools such as standard messaging, standard smart sets and templates leads to consistent and accurate communication and health record documentation. This standardization decreases the chance for errors and improves the quality of the patient record.

8. **Effective Use of the Extended Care Team:** The extended care team members, including Case Managers, Central Care Managers, Clinical Pharmacists, Diabetes Educators, and RN Care Coordinators, among others, play a key role in helping to care for our highest risk and most complex patients. Using members of this team whenever appropriate greatly enhances the care of these patients, leading to improved health outcomes.

9. **Team Approach to In-Between Visit Work:** There are many patient needs that arise at times other than their office visit. These include things like test results, triage issues, patient questions, refills, forms, and care gap issues. An empowered, critically thinking team is the most efficient way to deal with this work leading to highest quality care for our patients.

10. **Start on Time:** Each half day seeing patients should start on time. This minimizes stress on the core team, respects the time of the RN or Extended Care Team members who may be planning on seeing the patient, and respects the time taken by the patient to come in for the visit.

Source: Bellin Health Systems, Inc. ("Bellin"). (09/01/2014).

Suggested Steps to Build a Patient Care Team

1. **Define goals and develop a shared aim. Create a sense that these are our patients.**

   Example goals:
   - Improve patients' and the community's health through evidence-based practice.
   - Improve access to care.
   - Improve service to patients.
   - Improve provider and staff satisfaction and joy in work.
   - Improve the practice's financial performance.

2. **Define specific, measurable outcomes and objectives.**

   Example measures:
   - At least 90% of patients with diabetes will have ≥ 2 HgbA1c per 12 months.
   - At least 80% of female patients between 40-69 years will receive a mammogram.
   - Each team member will achieve an explicitly defined goal for personal professional development.
   - Members of the assigned team will attend at least 80% of scheduled team meetings.

3. **Assign roles for each team member and define and delegate functions and tasks.**
   - Determine which people on the team are best qualified to perform the tasks within the clinical and administrative systems of the practice (efficiency).
   - Introduce team members so they know each other.
   - Introduce each member's role (skills) so members on the team know what each other does and can do in their role.
   - Maximize the role of each team member within the scope of their licensure and skills.
   - Ensure that the right person is doing the right task for the right patient at the right time (the team is efficient in their workflow).

4. **Ensure that each team member is competent to perform their defined and delegated functions and tasks.**
   - Provide education and training for the functions and tasks that each team member performs.
   - Provide adequate IT training on systems such as the electronic health record (EHR), client email, intranet, etc.
   - Provide education and cross-training so team members can substitute for other roles (in cases of absences, vacations, or periodic heavy demands on one part of the team).
   - Provide all team members with communication training for effective teamwork.
   - Assess competency of team members at least once each year (performance review) and have team members set goals which contribute to team performance.
       - Communicate each member's competencies to the other team members.

5. **Ensure that clinical and administrative systems support team members in their defined work.**

   Example policies/procedures:
   - Procedures for providing prescription refills.
   - Procedures for informing patients of laboratory results.
   - Procedures for making patient appointments.
   - Policies on how decisions are made in the practice.
   - Work schedules allow time for team members to perform all parts of their job.
   - Adequate level of permissions in EHR which allow teams to perform.

6. **Create communication structures and processes.**

   Examples:

   - Schedule team meetings and/or "huddles."
   - Hold team members accountable for attending and participating in team meetings and "huddles."
   - Clearly communicate expectations, assignments, tasks, roles to all team members.
   - In between team meetings, routinely communicate through electronic information (i.e. EHR, email). These communications will help team members know the work is getting done.
   - In between meetings, share important information through brief verbal interactions among team members.
   - Provide feedback to care team members on a daily basis regarding work well done and opportunities for improvement.
   - Decide on a process for conflict resolution among team members and implement the process.

7. **Use data to assess team progress and performance at least every month, ideally every week.**

   Example questions to answer:

   - Are we accomplishing the work we set out to do as a care team?
   - Are we meeting our goals and objectives?
   - Where are our opportunities for improvement? What will we test to see if it results in an improvement?

8. **Practice teamwork! Be innovative and try new things.**

9. **Share your learning with other care teams at your site and at other health centers!**

Guide to Improving Patient Safety in Primary Care Settings by Engaging Patients and Families (AHRQ)

Adapted from AHRQ: https://www.ahrq.gov/professionals/quality-patient-safety/patient-family-engagement/pfeprimarycare/gettingstarted.html

Getting Started with Patient and Family Engagement in Primary Care

> **"Implementing the strategies will be like any quality or process improvement project. It requires commitment, leadership, and planning."**

The Agency for Healthcare Research and Quality provides tips for facilitating the quality improvement process in its Ambulatory Care Improvement Guide.

1. **Identify a Practice Champion and Secure Leadership Support**

   Strong leadership and staff engagement are important to any successful process improvement program.

   Identify a practice champion

   A practice champion is needed who can lead the implementation efforts. The practice champion should be dynamic and respected. The champion must work on team building and provide technical support for implementing the strategies. You may want to identify champions from both the administrative and clinical staff to encourage active engagement from all perspectives.

   Secure leadership support

   Strong leadership support is important to any successful patient safety improvement activity.

   Practice champions should orient leadership to:

   - The scope of the problem of patient safety in primary care in general and the practice specifically.
   - Available strategies to overcome patient safety challenges.

   An infographic (PDF, 525 KB) is available for the practice champion to use when seeking leadership support.

2. **Select the Strategies to Implement**

   Review the Guide strategies and select the strategy or strategies that address key patient safety threats for your practice. Use the selection guide to help guide your decisions.

3. **Plan Your Implementation Process**

   Once you have identified and prioritized the strategies for implementation, the next step is designing and planning a successful implementation.

   Identify your team

   Even the strongest practice champions cannot do it alone. A small multidisciplinary team can help the practice champion make important decisions about strategies, timeline, and evaluation metrics.

   Set a reasonable timeline

   Successfully implementing a sustainable practice improvement takes dedication and time. Multiple strategies should not be implemented at the same time. Each strategy should be implemented for at least 3 months before starting the next implementation. This approach will give the practice time to deploy the intervention and evaluate progress without distraction.

   Determine a standardized implementation process

   There is no one best approach to planning, implementing, and evaluating quality improvement strategies. If you already have an established approach for practice improvements, use this approach.

   A widely used approach for process improvement planning is the Model for Improvement. This approach seeks to accelerate change improvement efforts through a series of Plan-Do-Study-Act (PDSA) cycles. Each rotation of the cycle results in improvements to the process, and each revision of the process requires additional measurement and evaluation.

4. **Design Your Implementation**

   The practice champion will lead the implementation team through the process of designing the implementation of the selected strategies.

   Use the implementation quick start guides

   Each strategy has implementation guidance specific to that strategy within the Implementation Quick Start Guide. These Quick Start Guides are meant as the starting point for your implementation and should help you plan your strategy for adopting each intervention. The guide appendixes also provide strategy-specific implementation guidance.

5. **Make Patients and Family Members Aware of the Changes**

   Inform patients and their families about what the practice is implementing and what the patients' and families' roles are in the process. Talk with patients about the importance of engagement and the practice's engagement efforts and reinforce the patients' and family members' roles in ensuring safe and effective care.

6. **Evaluate Implementation Effectiveness**

   Recognize your team's efforts and successes

   Talk about progress every chance you get. Tell success stories about using the intervention. Celebrate clinician and practice staff wins and publicly recognize efforts to improve patient safety. Ensure that the success of the interventions is seen in every aspect of your practice to help the changes gain solid footing.

   Establish evaluation measures

   There are several things to consider when selecting measurements to assess the effectiveness of any process improvement implementation:

   - Identify stakeholders and their data needs. This group includes internal stakeholders (e.g., patients, clinicians, practice staff, administrators, and leaders) and external stakeholders (e.g., payers, regulators). Ideally, you should select evaluation measures that meet the information needs of both internal and external stakeholder groups.

   - Identify global patient safety and patient and family engagement outcomes. These may include measures of patient safety or patient and family engagement tracked over time. These would be conducted less regularly than process implementation measures. Be sure to conduct a baseline evaluation of your global outcome measures to fully assess the impact of your practice changes.

   - Identify strategy-specific outcomes and implementation processes. Establish strategy-specific measures on both outcomes and processes to examine implementation success. These measures are often obtained through observation and self-report. The process-related measures should focus on whether the implementation was successful and how and why the implementation was successful (or not).

Monitor the impact of patient safety and patient engagement activities

Several surveys can assist office practices in monitoring the impact of patient safety and patient engagement activities at the practice level. The surveys and measures provided here are recommendations. You should select the measures that best reflect your implementation and practice environment.

- AHRQ Medical Office Survey on Patient Safety Culture. This AHRQ-sponsored survey is designed specifically for outpatient medical office providers and staff and asks for opinions about the culture of patient safety and healthcare quality in medical offices.
https://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/medical-office/index.html

- Clinician & Group Consumer Assessment of Healthcare Providers and Systems (CG-CAHPS). This survey assesses patients' experiences with healthcare providers and staff in doctors' offices.
http://www.ahrq.gov/cahps/surveys-guidance/cg/index.html

- CG-CAHPS Health Literacy Item Sets. The CAHPS Health Literacy Item Sets focus on assessing providers' activities to foster and improve patients' health literacy. Health literacy is commonly defined as patients' ability to obtain, process, and understand the basic health information and services they need to make appropriate health decisions. While health literacy depends in part on individuals' skills, it also depends on the complexity of health information and how it is communicated.
https://www.ahrq.gov/cahps/surveys-guidance/item-sets/literacy/index.html

- Patient measures of patient safety. Recently, several new measures of patient safety from the patient's perspective have been developed.

    These include:

    - Primary Care Patient Measure of Safety (PC PMOS), discussed in an article in BMJ Quality & Safety at http://qualitysafety.bmj.com/content/25/4/273

    - Patient Reported Experiences and Outcomes of Safety in Primary Care (PREOS-PC), discussed in an article in Annals of Family Medicine at http://www.annfammed.org/content/14/3/253.full

    - Patient Experience Assessment, part of the guide Improving Your Laboratory Testing Process, available at https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/quality-resources/tools/lab-testiing/lab-testing-toolkit.pdf.

Patients' Role on Health Care Teams

Adapted from Patients and Health Care Teams Forging Effective Partnerships
https://www.accp.com/docs/positions/misc/PatientsForgingEffectivePartnerships%20-%20IOM%20discussion%20paper%202014.pdf

Patients' Role in Relation to Team		
Care Recipient (to me) The patient receives services from members of the health care team.	**Care Participant (with me)** The team provides care and the patient cooperates on relevant care processes.	**Care Partner (by me)** The entire team, including the patient, agrees on each team member's responsibilities.
Information Flow		
Information Giving The patient provides information and receives instructions	**Information Sharing** Patients and team members each contribute information to guide care decisions.	**Information Exchange** Team members reflect back and explore shared information to achieve mutual understanding and clear expectations.
Decision Making		
Prescriptive Health professionals create a care plan and give to patient, who may or may not follow it.	**Shared** The care plan is developed together and includes patient goals, but lacks patient-focused roles and responsibilities.	**Partnership** There is mutual agreement on the care plan and related decisions, including shared accountability for outcomes.