MiCMRC
Provider Delivered Care Management Online Course

Team Based Care

The Michigan Care Management Resource Center

Introduction of the PDCM Online Course

- The purpose of the Provider Delivered Care Management (PDCM) Online Course is to provide a curriculum focused on evidence based care management in the ambulatory care setting. The curriculum is designed to assist Qualified Health Professionals and Care Managers in their role as a member of the care management team in Primary Care and Specialty practices.

PDCM Online Course

The PDCM Online Course consists of seven self-study lessons to be completed at your own pace. Each lesson is a recorded webinar:

1. Team Based Care
2. Medication Reconciliation
3. Transitions of Care
4. The Medical Neighborhood
5. Care Management in the PCMH
6. The Chronic Care Model, PCMH, and Accountable Care Organizations
7. PDCM for Primary and Specialty Care

Please refer to the PDCM Online Course webpage: http://micmrc.org/training/pdcm-online-course regarding steps to complete the course as well as information regarding certificate of completion or Continuing Education Contact Hours (CE's).

Learning Objectives

- Define team based care in the ambulatory care setting
- Describe goals of team based care
- Explain opportunities to overcome barriers to team based care

Team Based Care

- The provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient - to accomplish shared goals within and across settings to achieve coordinated, high-quality care

https://www.pcmh.ahrq.gov/page/creating-patient-centered-team-based-primary-care#fig1

Care Management Team

- The care management team must consist of at least one individual who functions as a lead care manager.
- This lead care manager must:
  - Be a licensed allied practitioner of one of the following disciplines: registered nurse, licensed masters of social work, certified nurse practitioner, or physician assistant; and
  - Accept responsibility for ensuring that PDCM services being delivered by any care management team member are appropriate and aligned with the patient's overall plan of care, as applicable.

Provider Delivered Care Management Payment Policy and Billing Guidelines for Blue Cross Blue Shield of Michigan Commercial, June, 2016

Care Management Team

In addition to the care manager, additional allied health practitioners of any of the following disciplines may be on the care management team:

- registered nurse
- masters of social work
- certified nurse practitioner
- physician assistant
- licensed practical nurses
- certified diabetes educators
- registered dietitians
- masters of science trained nutritionists
- clinical pharmacists
- respiratory therapists
- certified asthma educators
- certified health educator specialists (bachelor's degree, or higher, in health education)
- licensed professional counselors
- licensed mental health counselors

Care Management Team

Every care management team member delivering PDCM services must:

- Function within their defined scope of practice;
- Work collaboratively with the patient's clinical management; and
- Work in concert with BCBSM care management nurses as appropriate.

Benefits of Team Based Care

- Practices with a team based environment report:
  - Increased office efficiency (63%)
  - Improved quality of care (53%)
  - Increased patient satisfaction (50%)
  - Increased staff satisfaction (36%)
  - Improved financial outcomes (19%)

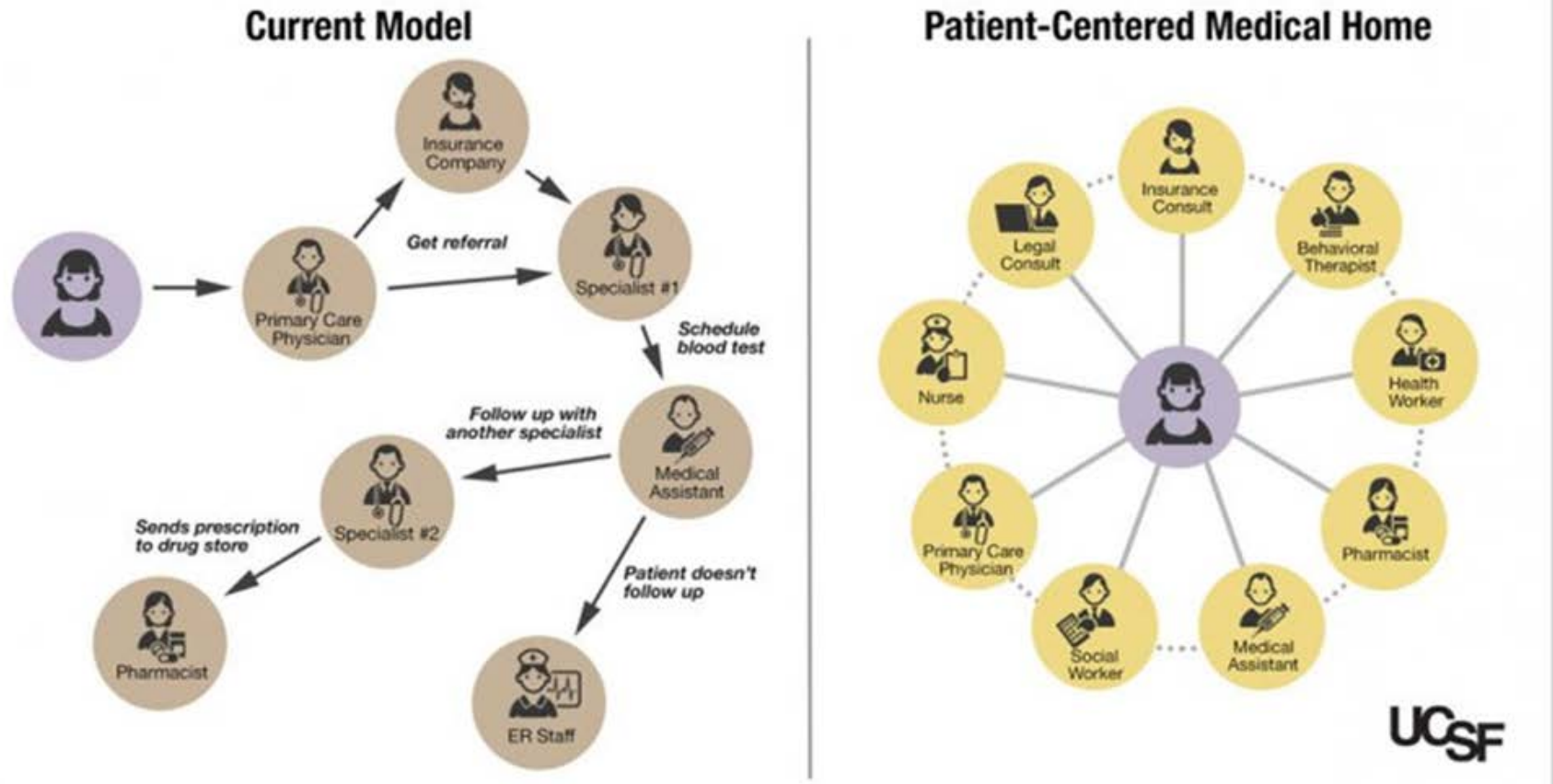
Journal of the American College of Cardiology Mar 2011, 57 (9) 1123-1125; DOI: 10.1016/j.jacc.2011.02.003

Goals of Team Based Care

- Well-implemented team based care has the potential to improve:
  - Comprehensiveness
  - Coordination
  - Efficiency
  - Effectiveness
  - Value of care
  - Satisfaction of patients and providers

Rethinking Primary Care

Clear communication and effective coordination among health care providers are vital for patient health, but the current primary care structure makes collaboration incredibly difficult. See the difference:



https://www.ucsf.edu/news/2014/08/116856/team-based-approach-primary-care

Keys to Establishing a Primary Care Team Model

1. Determine if there is a desire among your current office to pursue these changes
2. Identify a leader for this change
3. Seek input from the whole team to develop a mission statement
4. Commit to regular team meetings at a minimum of twice a month
5. Establish standing orders and protocols for chronic and preventative care
6. Optimize current EHR and Registries
7. Educate, cross-train and provide opportunities for advancement of staff
8. Allow for open discussion of processes and protocols to ensure buy in throughout practice.

Qualities of Team Based Care

Table 1: Six Qualities of Team-based Care

Qualities	Description
1. Physician as Servant Leader	The servant leader needs to value and support the team and set the climate. Leaders must foster a "can do" attitude and a spirit of understanding instead of blame when struggles arise.
2. Mission and Established Goals	The mission is the foundation for a successful team and allows team members to have a professional compass to turn to during challenging times and the ability to refocus during times of growth. Additionally, the team needs to identify goals to evaluate and address performance.
3. Clearly Defined Roles	It is important to determine who has ownership of specific tasks and functions. There is a risk that staff members may feel that increased work is being delegated to them; therefore, it is critical that the team is empowered with the concept of sharing the care.
4. Team Communication	Successful communication will determine whether the team flourishes or flounders. Daily team huddles and regularly scheduled staff meetings are needed to foster teamwork. These meetings are a forum for each team member to have an equal voice and to discuss current practices and future initiatives.
5. System Improvement	As teams develop, a census needs to be taken of current systems and processes. These can be clinical pathways, patient flow and administrative functions. The team should evaluate what is working well and what needs to be changed to be more effective.
6. Enhanced Training	Successful primary care teams have trained their LPNs, care managers and medical assistants to work at the upper scope of their practice.

http://www.acog.org/Resources-And-Publications/Task-Force-and-Work-Group-Reports/Collaboration-in-Practice-Implementing-Team-Based-Care

Challenges of Team Based Care

- The largest barrier to team care is finding the time, energy and resources to make the changes necessary to transform a practice into an effective team.

- A second barrier is the lack of financial resources and reimbursement for coordinated care in our current healthcare delivery system.
  - Dr. Bodenheimer states “Without a multidisciplinary team, consistently good chronic care is impossible…without payment reform, such teams are impossible.”

- A third barrier is physician openness to the team based care concept.

- A fourth barrier is having the wrong “who’s” on your team.
  - Team based care is not for every physician or staff member. It takes a strong belief and commitment that together a team can optimize patient care greater than any individual effort.

The American Congress of Obstetricians and Gynecologists. 2016.Collaboration in Practice: Implementing Team-Based Care.

CHALLENGE	OPPORTUNITY FOR CHANGE
Difficult to control costs in the current health care system	1. Practices, payers, hospitals, policy makers and health care providers should support the team based care model allowing costs to decrease while outcomes improve in the context of achieving the triple aim.
Lack of understanding which health care providers may be needed on the team	1. Assess the needs of the patients and patient populations. 2. Team composition should include qualified personnel to meet the needs of the populations being serviced. 3. Establish a team that functions within the greater context of regionalization and clinical integration.
Lack of knowledge and appreciation of education, skills, clinical capabilities and health care provider overlap among health professionals	1. Leadership should actively educate all team members on the education, skills, and clinical capabilities of each member. 2. Emphasizing the overlap and difference among provider types.
Lack of shared vision and goals among team members	1. Leadership should establish shared, clearly articulated goals for the process and outcomes of care. 2. Goals should be mutually decided on by the patient and health care team.

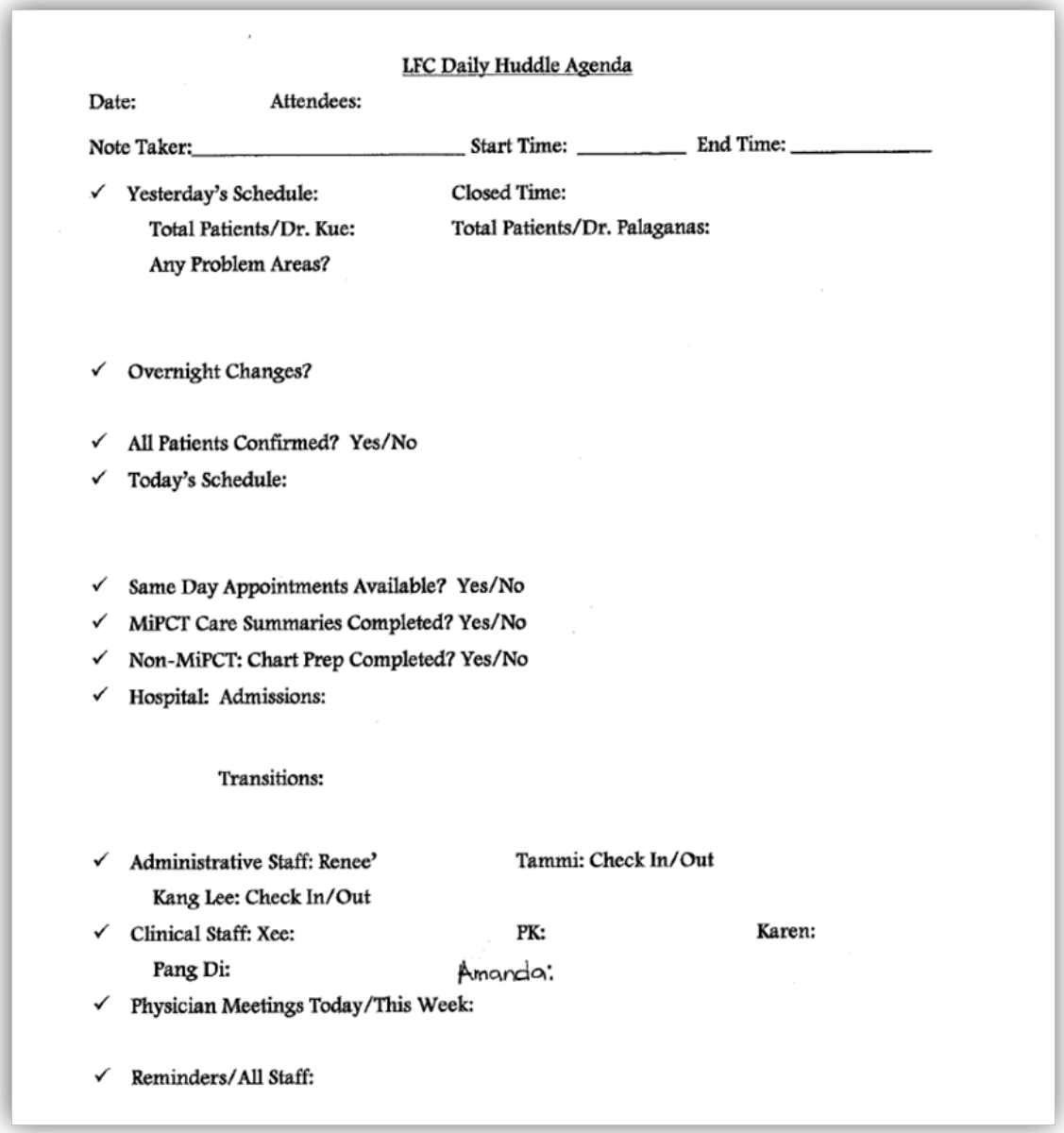
The American Congress of Obstetricians and Gynecologists. 2016.Collaboration in Practice: Implementing Team-Based Care.

CHALLENGE	OPPORTUNITY FOR CHANGE
Lack of role clarity among health care providers	1. Each team member should clearly communicate his/her role to the other team members (including patients and families) 2. All providers should work to the top of their scope 3. Practices should develop or seek out clear evidence based protocols.
A patient is unaware of the role of each team member (clinical or non-clinical) or confused about team member roles	1. Practices should ensure that patients and families can easily understand team member's role and identify which provider is responsible for various aspects of their care. 2. Each team member should consistently and clearly communicate their role to the patient.
Patient is unaware of his/her role on the team and is unaware of his other ability to shape their clinical goals and outcomes	1. Clinical information should be presented in terms that are easily understood and culturally relevant. 2. Patients should receive complete and timely care about their care and changes in this care.

The American Congress of Obstetricians and Gynecologists. 2016.Collaboration in Practice: Implementing Team-Based Care.

Team Communication-Huddles

- Huddles are short, daily meetings in which a team reviews their patient list for the day.
- They usually last no more than 10 minutes.
- Huddles enable a team to anticipate care needs and special situations, so that members of the care team can support each other through the day.



LFC Daily Huddle Agenda

Date: Attendees:

Note Taker:_____ Start Time: _____ End Time: _____

- ✓ Yesterday's Schedule: Closed Time:
  - Total Patients/Dr. Kue: Total Patients/Dr. Palaganas:
  - Any Problem Areas?
- ✓ Overnight Changes?
- ✓ All Patients Confirmed? Yes/No
- ✓ Today's Schedule:
- ✓ Same Day Appointments Available? Yes/No
- ✓ MiPCT Care Summaries Completed? Yes/No
- ✓ Non-MiPCT: Chart Prep Completed? Yes/No
- ✓ Hospital: Admissions:

  Transitions:
- ✓ Administrative Staff: Renee' Tammi: Check In/Out
  - Kang Lee: Check In/Out
- ✓ Clinical Staff: Xee: PK: Karen:
  - Pang Di: Amanda:
- ✓ Physician Meetings Today/This Week:
- ✓ Reminders/All Staff:

Team Huddle Template Example

2016 MiPCT Best Practice Winner- Lifetime Family Care

Evaluation of Team Based Care

What is Important to Evaluate?

- **Process**
  - Program Description
    - Who makes up the team?
    - What are the team's protocols and procedures?
    - What are the core components of the team's successes?
- **Process**
  - Engagement Description
    - How successful has our health system engagement been as it relates to expanding team based care?
    - What are the core components to integrating health care extenders into a clinical team?
- **Outcomes**
  - Clinical Outcomes
    - Blood pressure control
    - Hemoglobin A1C
    - Medication adherence
- **Outcomes**
  - Clinical Outcomes
    - Policies that promote a team approach
    - Systems that promote a team approach

https://www.ucsf.edu/news/2014/08/116856/team-based-approach-primary-care

Who is the Team?

- The provider team *may* include a range of clinical and non-clinical personnel
  - Physicians
  - Nurse Practitioners
  - Physician Assistants
  - Nurses
  - Care Managers
  - Dietitians
  - Pharmacists
  - Social Workers
  - Receptionists
  - Licensed Practical Nurse
  - Licensed Professional Counselor
  - Licensed Pharmacist
  - Bachelor's Social Worker
  - Certified Community Health Worker
  - Panel Manager
  - Social Services Technician

Panel Management

- Panel refers to the patient panel, or the patient population of the individual physician or practice.

- Panel management is the process of monitoring the patient population for important preventive and chronic care milestones based on guidelines determined by the practice.

Benefits of Panel Management

- Panel management is a proactive way to ensure that everyone assigned to a clinic is up to date on basic preventive care - like cancer screenings or immunizations - and that they receive extra help if they have lab numbers that are out of normal range.
  - Medical assistants, health workers, and nurses play a critical role in providing panel management.

Steps to Implement Panel Management

- Utilize a registry
  - A registry is a database with medical information about immunizations, cancer screenings and disease-specific lab results for the patients in your practice.
  - The registry can be searched to identify patients overdue for mammograms, pap smears, colorectal cancer screening, immunizations, HbA1c and cholesterol blood tests or diabetic eye exams.
  - Registries can be used to generate reports to help track if each clinician's patients are meeting preventive and chronic care measures.

Steps to Implement Panel Management

- Adopt clinical practice guidelines
  - Practices utilize clinical practice guidelines for preventive and chronic care services and establish target levels for selected health indicators.
- Train staff for panel management
  - An initial time investment will lead to better care for patients and improved efficiency in the practice.
  - Some practices may start with training one of two key staff members who then train their counterparts as the new process is adopted throughout the practice.

Steps to Implement Panel Management

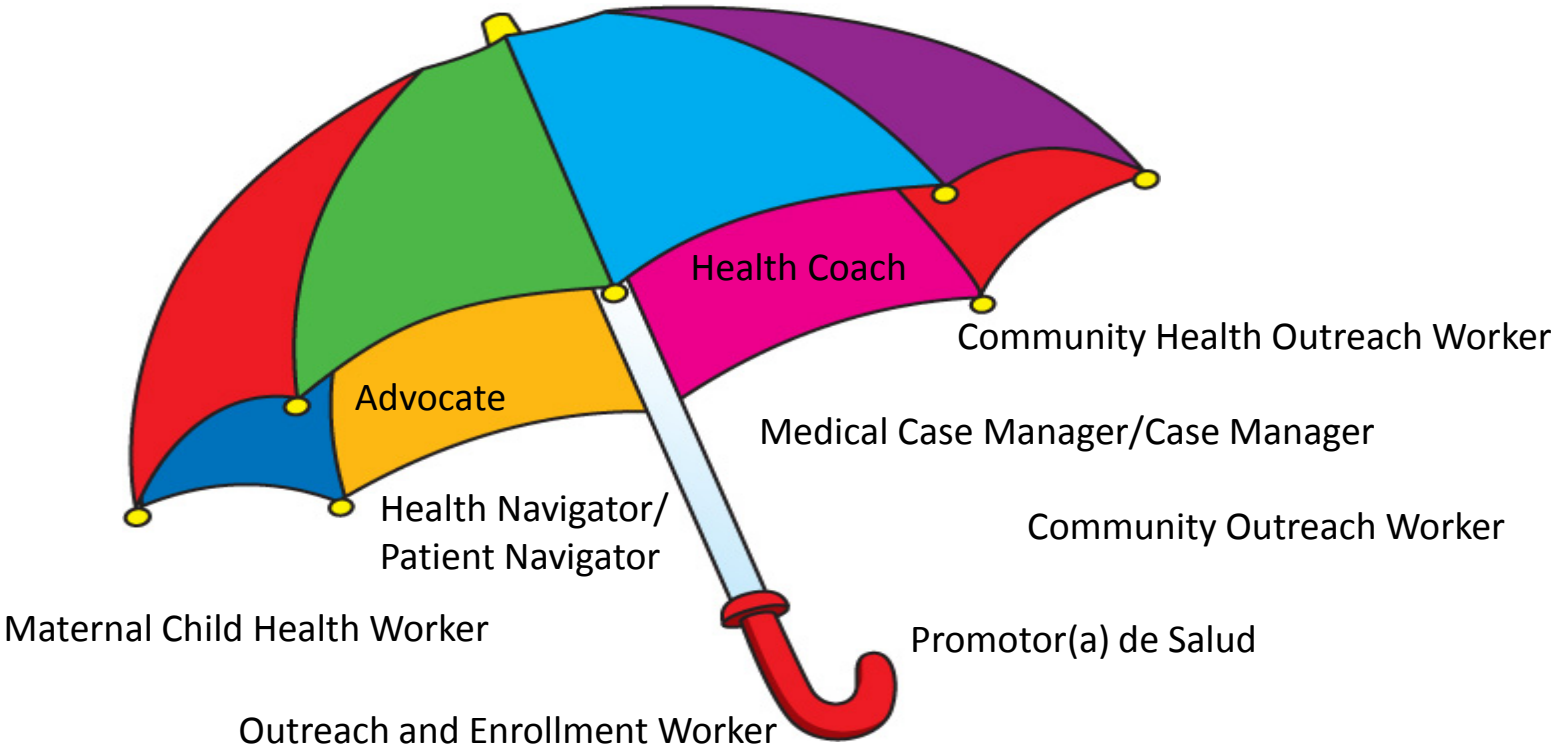
- Identify Gaps in Care
  - A gap in care exists when a patient is overdue for a service that should be done periodically (known as a process care gap) or when a patient is not meeting the goal range for a particular disease or condition, such as having an HbA1c greater than the recommended target (known as an outcome care gap).
- Close gaps in care
  - Close gaps through “in-reach” and “out-reach.”
    - In-reach is for patients who are physically present in the office—for instance, a nurse may identify a care gap during a visit and discuss the necessary treatment with the patient.
    - Out-reach is for patients who rarely come to the office or have fallen out of care and can be identified using the registry

Community Health Worker

- A community health worker (CHW) is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served, and acts as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery

http://www.michwa.org/what-is-a-chw/

Other Names for CHWs



Michigan Community Health Worker Employer Survey 2016: Final Evaluation Report for Public Use. Ann Arbor, Michigan: Michigan Community Health Worker Alliance (MiCHWA); June 30, 2016. Results available at http://www.michwa.org/about/evaluation/program-survey/

Benefits of Community Health Workers

- Many CHWs come from the communities they serve, and often speak the same language—literally or figuratively—as the patients living there

- They call upon that shared experience to build relationships with patients, and in turn use their knowledge of patients' neighborhoods and cultures to help providers fine-tune their approaches to the patients they serve
  - In this way, they differ from social workers, nurse care managers, or others tasked with helping people with complex needs

Benefits of Community Health Workers

Community health worker programs have led to more appropriate use of preventive and primary care. For example, CHWs have been shown to:

Community health worker programs have also been shown to help improve disease outcomes for patients with asthma, hypertension, diabetes, cancer, tuberculosis, HIV/AIDS, and depression, among other conditions.

Documented savings in CHW programs have been attributed to:

http://www.commonwealthfund.org/publications/newsletters/transforming-care/2015/december/in-focus

CHW's Improving Patient Experience

System navigation
CHWs assist patients in navigating the oftentimes confusing health care system. CHWs enhance patient experience through translating and interpreting health information, promoting and coaching in health literacy, addressing basic needs like food and shelter, and coordinating referrals and follow-ups.

Home-based support
Home-based support allows patients to get care in their home or community, eliminating transportation barriers to care. CHWs assist with home- based support by engaging family members in care, performing home visits and assessments, promoting health literacy for their patients, offering supportive counseling, coaching on problem solving, implementing care action plans, and promoting treatment adherence among their patients.

Case management & care coordination
CHWs can enhance patient experience through case management and care coordination. Tasks related to case management and care coordination include: engaging family members in health care, assessing patients individual strengths and needs, addressing basic needs like food and shelter, assisting patients with the creation of goals and action plans, and providing feedback to medical providers.

Health promotion & coaching
CHWs work with patients to help them gain knowledge, skills, tools, and confidence to become active participants in their care to help them reach their self-identified health goals. Specifically, CHWs assist with translating and interpreting health information, coaching in health promotion and prevention, problem solving, modeling behavioral change, and leading support groups.

http://www.michwa.org/wp-content/uploads/MiCHWA_CHW-ROI.pdf

Community Health Worker Roles

ROLE	DESCRIPTION AND RELATED TASKS
Case Management and Care Coordination	• Family engagement • Assessing individual strengths/needs • Addressing basic needs • Promoting health literacy • Coaching on problem solving • Developing goals and action plans • Coordinating referrals and follow-ups • Providing feedback to medical providers
Community-Cultural Liaison	• Community organizing • Advocacy • Translation and interpretation of information • Assessing community strengths and needs
Health Promotion and Health Coaching	• Translating and interpreting health information • Teaching health promotion and prevention behaviors • Coaching on problem solving • Modeling behavior change • Promoting health literacy • Reducing harm • Promoting treatment adherence • Leading support groups

http://www.michwa.org/wp-content/uploads/MiCHWA_CHW-ROI.pdf

Community Health Worker Roles

ROLE	DESCRIPTION AND RELATED TASKS
Home-Based Support	• Engaging family members in care • Home visiting and assessment • Promoting health literacy • Supportive counseling • Coaching on problem solving • Implementing care action plans • Promoting treatment adherence
Outreach and Community Mobilization	• Preparation and dissemination of materials • Case-finding and recruitment • Community strengthening/needs assessment • Promoting health literacy • Advocacy
Participatory Research	• Preparation and dissemination of materials • Facilitating translational research • Computerized data entry and web searches
System Navigation	• Translating and interpreting health information • Promoting health literacy • Patient navigation • Addressing basic needs like food and shelter • Coaching on problem solving • Coordinating referrals and follow ups

http://www.michwa.org/wp-content/uploads/MiCHWA_CHW-ROI.pdf

Evidence and Outcomes

What did the CHW do?	Why did it matter?
• Provided pregnant women with health education, service navigation, and support	• Women in CHW group reported improved self-confidence (double that of non-CHW group), assistance with prenatal appointments, and transportation. (Migrant Health Promotion)
• Led individual and group sessions about prenatal and postnatal care, provided referrals for mothers and children in migrant camps.	• Increase in number of newborns that were breastfed; increase in children under five with current immunizations. (Outlaw et al., 2010)
• Visited homes of children with asthma; educated families about asthma and environmental triggers; created action plan to reduce environmental triggers.	• Statistically significant increase in lung function, less frequent asthma symptoms, and fewer unscheduled health visits for children with CHW visits. (Harvey et al, 2009)

http://www.michwa.org/wp-content/uploads/MiCHWA_CHWRoles_2014.pdf

Examples of Team Structures

- RN care manager with CHW care coordinator
- LMSW care manager with licensed pharmacist care manager
- NP care manager with registered dietitian and certified medical assistant care coordinator
- Care Coordination Teams: CHWs, MSWs, RNs

Practice Team Roles and Responsibilities	
Front Office Staff	Run Registry Report Monthly; Highlight appropriate patients on registry report; Participate in daily huddle to cross reference highlighted patient list with provider schedule for the day.
Medical Assistant	Highlight patients with gaps in care; Participate in daily huddle to cross reference highlighted patients with provider schedule for the day; Follow up with patients with gaps in care and patients identified as not appropriate for care management services (schedule tests per standing order or PCP appointment as appropriate).
Clinic / Triage Nurse	Participate in daily huddle to cross reference highlighted patients with provider schedule for the day; Conduct outreach to patients identified during huddle if there are identified patient needs beyond gaps in care; Collaborate with PCP to determine treatment plan and determine needed referrals as appropriate; Communicate patient progress to PCP regularly.
Care Manager	Conduct introductory phone call to patients identified during huddle; Provide care management services (medication reconciliation, assess barriers, provide disease management education and resources, assist with setting self-management goals); Participate in daily huddle to cross reference highlighted patients with provider schedule for the day; Collaborate with PCP to determine treatment plan and determine needed referrals as appropriate; Communicate patient progress to PCP regularly.
Panel Manager	Panel managers serve to enhance the team's success with population management and care coordination. Some of the Panel Manager functions may be performed at the PO or the practice level. Often this role involves follow-up and communication with patients to ensure patients receive appropriate tests and preventive services as ordered by the primary care physician.

Adapted from Compilation of Diabetes Best Practices by MiPCT Practices - documented by MiPCT Team BCBSM PGIP Quarterly Meeting 12.6.13

Practice Team Roles and Responsibilities (continued)	
Primary Care Provider	Provide leadership and clinical expertise to the practice team; Participate in daily huddle to cross reference highlighted patient list with provider schedule for the day; Provide necessary treatment regimen changes and referrals as appropriate.
CDE	Participate in daily huddle to cross reference highlighted patient list with provider schedule for the day; Provide teaching and resources to their licensure to appropriate patients after PCP referral; Collaborate with practice team during treatment to ensure clinical goals and patient self-management goals align
Pharm D	Participate in daily huddle to cross reference highlighted patient list with provider schedule for the day; Provide teaching and resources specific to their licensure after PCP referral; Collaborate with practice team during treatment to ensure clinical goals and patient self-management goals align
MSW	Participate in daily huddle to cross reference highlighted patient list with provider schedule for the day; Provide resources and support specific to their licensure after PCP referral; Assist patient with accessing appropriate community resources; Support patient in setting self-management goals; Collaborate with practice team during treatment to ensure clinical goals and patient self-management goals align
Registered Dietitian	Participate in daily huddle to cross reference highlighted patient list with provider schedule for the day; Provide teaching and resources specific to their licensure after PCP referral; Collaborate with practice team during treatment to ensure clinical goals and patient self-management goals align

Questions?

Contact micmrc-ccm-course@med.umich.edu