Interview Results – Wisconsin's Health Care Systems Use of Team-Based Care for Chronic Disease Management

TRANSCRIPT OF TEAM-BASED CARE PRESENTATION

Welcome! This is Gina Dennick-Champion, and I am the executive director of the Wisconsin Nurses Association and we're very pleased to bring this webinar to you. WNA has been involved in looking at the concept of patient centered team based care in Wisconsin. We've developed a conceptual model; the model focuses on existing and emerging work from many partners in Wisconsin. We've looked at national pieces of information that begin to look at this whole issue of healthcare transformation. We find that patient centered team based care is one of those models that is beginning to gain traction in Wisconsin. WNA, in collaboration with the community of partners and reviewers, developed a model where we would like to share the findings with you the findings of an interview we conducted with a variety of health system leaders (1:00) to look and identify their work related to team based care in Wisconsin related to chronic disease management. I am pleased to present our presenter. Pamela Myhre. Pam has a Master's degree in Nursing. She is an Advanced Practice Nurse Prescriber and a Certified Diabetes Educator. She serves as the grant consultant to WNA on this very important work. Without further ado, I welcome you to the webinar.

*NOTE: NS=New slide

Welcome, my name is Pam Myhre – I'm a Nurse practitioner and certified diabetes educator and I've been a nurse for about 30 years. I've done about everything in nursing from outpatient to inpatient Med-Surg, emergency room, and endocrinology/diabetes specialty.

NS-We'll going to talk today about the interview results of Wisconsin healthcare systems use of team based care for chronic disease management. (2:00) As we look at the talk today were going to talk about team based care in-depth interviews with a number of Wisconsin health systems. We'll follow a background and overview, a definition of team-based care, the interview findings, next steps, and some discussion and questions.

NS-In terms of background and overview, the purpose of doing these interviews was to get a snapshot of team-based care across the state. We developed a semi-structured interview guide with primarily open ended questions. These questions looked at a high level overview of the health system and the interviewee's role, team based care in general, and how it is utilized, a health system specific way of looking at team based care implementation. We hoped to capture the how, why and to what extent team based care is being utilized in the different healthcare systems. Our timeline started at the end of March and into April when we developed and finalized the semi-structured interview guide with complementary handouts and worksheets. In early May, we piloted the interviews with a physician and nurse practitioner who did a team based care diabetes project (3:00) in the family practice setting. Then we went about to recruit and interview 8 health systems. We developed the interview format and this included an in person interview which was audio recorded and notes taken during the interview. The average interviews lasted approximately 2 hours. We took notes during the interview and post interview, these notes were checked for thoroughness and completion and a compiled summary was

done. This power point is part of that compiled summary. The interviews were done using a grounded approach coding. As we did this project, we looked at a definition of team based care provided by Mitchell et. al. 2012.

NS-Mitchell explains that team based care means "The provision of health services to individuals, family, and/or their communities by at least (4:00) 2 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."

It was interesting to note that, as we conducted the interviews, to find out that most of the health systems truly didn't have an identified definition of team based care. So the responses tended to vary. Many people think that team based care just means working together. Others may think that it means access for anybody.

NS-So, as we looked at our findings, we have these main four categories: Barriers and factors related to team based care, successes and benefits, team members that are involved, and the work flow and design.

NS-Let's start with the barriers and factors when implementing team based care. As you know, barriers can be small, just like in the photograph and they can be very large. (5:00) One thing to note as we go forward in the presentation, the black and bulleted items are the main themes that came across in many of the interviews. The smaller blue text is examples of what those themes are comprised of. It was so interesting to note that many of these themes were consistent across interviews. So some of the barriers: Lack of standardization and evidence-based protocols. Lacking in that uniformity, evidence and definition, how things roll in terms of having specific roles, structure, care, work flow and the care team. Another theme was having that team culture and having care team relationships. So much of our healthcare right now is a hierarchical structure, and sometimes physicians have trouble relinquishing work. The importance of building that trust and collaboration. And historically healthcare has been very siloed. One of our participants said "silos of care do nothing but perpetuate error. We have to have team based care. We can't have just one physician providing his care, (6:00) one nurse providing that care, a pharmacist in his pharmacy providing care. It has to be a collaborative approach. People on the care team definitely feel more like partners and not subservient. We can provide care to patients with all the minds and all the wisdom together versus one. There's also some difference in training and education and the importance of having that mutual respect and the entire team engagement.

Another barrier and factor involved is the staff capacity. Do we have the quantity of staff needed? With the correct skills and knowledge? Do we have the roles and positions that we need? Many of the participants talked about a lack of training in LEAN processes and flow. Because we can't do this team based care without looking at those items. It is important from a barrier standpoint to demonstrate value. Payers, providers, the parent organization, all clinical and nonclinical staff are going to be important in demonstrating that value.

NS-another barrier is that mentality of "If it's not broke we're not going to fix it". (7:00) "Team based care-we already do that1" "We've ALWAYS done team based care". We have to look at buy-in. From stakeholders, from leaders, from the providers, administrators, nurses, clinical and nonclinical staff, even patients, everyone – from top down and even from the bottom up. From the standpoint of patients, one of the participants noted that some patients don't want to see anyone else. They want their provider to take care of everything in one visit. Others noted that for patients, it might be about the money. It might be about their time. For some patients, the barrier is their time and travel. For others, it might be that need for prior authorization - especially things like diabetes self-management. Another one of the barriers is that we are "paid for episodes of care and not longitudinal well-coordinated care delivery." Another barrier is that investment and financial piece. (8:00) How do we put the money into team based care and provide good care with that. Payment structure and reimbursement is also important as we just noted. One of the participants noted that "we have to have a model that rewards the team" also. So that we can align incentives to reward the team and not just one provider. One of our systems has a model where everything is aligned, and when quality, cost, and satisfaction are met, the entire team is rewarded-financially. Everybody buys into it then. And you're noting that there are lot a barriers and factors, but these themes consistently came up.

NS-Another barrier, another factor is organizational structure. The expectation for how many patients per physician are seen. Thinking about the ACO (Accountable Care Organization). Resources, training capacity, EHR/EMR access and availability - and hiring resources are important. (9:00) Communication is a VERY important factor when we are looking at team based care. How often we communicate, HOW we communicate, using that inclusivity and exclusivity - and transparency in communications. One person noted "people are social creatures and we need to give them chances to talk to each other – and being in closer proximity increases communication." Several of the participants noted that they have co-location of the team members, so that RN and the provider and the MA are all in close proximity. It made a big difference in their care delivery. We also need to think about the physical layout and environment. Sharing working spaces, and access to computers, and an area dedicated for communication. (Not recorded: Other factors in team based care: including the patient – always in goal setting. Viewing metrics with the whole team – sharing goal levels).

NS-Let's move on to some successes and benefits. When we think about the successes, the predominant themes that came out were staff and team satisfaction, patient outcomes and quality metrics, patient care and satisfaction, and communication. (10:00) When we think about staff and team satisfaction, most of the participants noted that increased clinical and nonclinical staff satisfaction - "when you have people working and taking care of patients on a team, you have a sustainable worklife, and you don't have to be that 'Atlas' with all the world on your back". Another participant said "It's more fun!" You have happier clinicians. And when you have happier clinicians, everyone together in the workplace feels better. Another provider noted that RN satisfaction, provider satisfaction, physician satisfaction ALL improved, and they saw an improvement in disease management scores, improved patient outcomes and improved accomplishment of needed testing. One team based care pilot actually

showed physician productivity go up by 30%. They had better patient buy in and better services with decreased wait time. (11:00) One of the patients noted that it didn't seem like they were ever waiting for anyone because they were always with someone on the care team - throughout their whole visit. When we think about patient outcomes and quality metrics, we see improved patient health outcomes for each patient and transparency understood by the entire team. Most of the health systems that did the team-based care shared their metrics with the entire team. "Give them the data…. Ask the questions… What happened? Why are we succeeding? Why are we doing less well? What are the reasons?" They looked at that data – they looked at those metrics and provided the best practice. Those reports – those metrics go all the way from top – to the bottom – so that each person on the care team has a voice in understanding what's going on. And troubleshooting any problems.

From the patient standpoint, one of the providers noted that the patients started to take things more seriously when there was another person who wanted to talk with them about their diabetes or their hypertension. (12:00) Kind of like "Whoa, this must be serious. This must be real. Because my provider just met with me, and now I'm meeting with somebody else – to talk more about my control, about how I'm going to do this." Several of the health care systems had RN care coordinators, who support patient self-management. The patient gets connected with that RN Coordinator, usually at a provider visit, and if not at that time, at another time – either individualized or face-to-face. At this time, most of the systems are doing that for free. As a bonus to patients, they can just come in and just see that RN Coordinator, and get very individualized care. The RN coordinators use motivational interviewing and they follow-up on mutually set goals. Oftentimes, they touch base monthly on these goals.

Another success and benefit is the communication. Most of the health care systems noted that they had improved communication between the health care team and patients and also amongst the health care team members. (13:00) One of the ways they did this was to utilize a dashboard. So that they can see, or so that every member on the care team can see how the patients are doing in terms of getting the preventative care needed and on getting their regular diagnostics such as A1c's, different labs that are due, different immunizations that are due, and what follow-up is needed.

NS-Some more successes and benefits included increased and more comprehensive tests and timely tests being accomplished. Those screenings, those labs that are needed and preventative tests that are needed.

A consistent message – across the board – was making sure that we're utilizing top-of-license practice for ALL providers. With top-of-license, it's important that we make sure to provide further education and training, that we have advanced credentialing achieved as much as possible. Several of the participants noted that they are "growing their staff," some of the CNAs have gone on to nursing school, some of the nurses have gone on to become Nurse Practitioners or enrolled in medical school. (14:00) RNs find that they are working with more complex needs in self-management, especially in diabetes and hypertension.

When we're thinking about top-of-license and thinking about maximizing practice, at one of the health care systems, any patient on insulin that comes up with a higher than goal A1c, gets an automatic referral to the pharmacist for insulin titration and management. At another facility, they get an automatic referral to the care manager or the CDE so that diabetes management is constantly being adjusted and improved.

Another success and benefit is interprofessional collaboration. Examples include: workgroups, interaction and communication that is established or enhanced among multidisciplinary health professionals. One of the participants had an idea – with a very high level vision - of providing Nurse Practitioner Hospital services in a small rural hospital. Despite resistance, they were able to take this high level vision, and implement it – with the use of team-based care. (15:00)

Some other successes and benefits had to do with standardization of care, bridging behavioral health, including the depth of roles, and discussions of Patient-Centered Medical Home Certification and Recognition. Many of the facilities that we interviewed already have Patient-Centered Medical Home Certification and they utilize this – and think about this – particularly when we are looking at team-based care. A very common theme was bridging in Behavioral Health. As this becomes such an important part of supporting patients in their outpatient care.

Another success and benefit is looking at the EMR and EHR and the Health Information Systems and looking at those advancements. And utilizing our EMR so that we can help patients get better care. We looked at "best practice alerts" that are built into the electronic medical record. Several people said that the tools are amazing, and we can't do it without the tools. (16:00) There are other places that are looking at new ways to use the patient portal. How can we enter in diabetes data? How can we enter in blood glucose results? Can we get those clinical alerts to the patient? Some of the facilities are doing that. In one health system, we actually had a patient who said "would you please document my foot exam?" because she continued to get this clinical alert on her "my patient" portal. The My Chart advancements are also coming forward. We're looking at changing "My Chart" access. In one of the health systems, they looked at My Chart – from only being available – unfiltered – to the provider. To now being available to the whole health care team (this provider's team). The volume of questions addressed by CMAs, RNs and other providers, cut down the volume by 50% to the provider. And thus – now they have a success – that the My Chart inquiries are now addressed within 24 hours. This is a huge advancement by just utilizing team-based care. (17:00)

When we look at patient registries, it's another advancement with the electronic medical record that certainly helps with team based care. However, one of the providers noted that the registry can be a positive and a negative. For example, a patient might have had normal blood pressure. It's been a number of years since that patient has been in. Now with the registry, staff are recognizing that patients haven't been in, they're contacting them and pulling them into the system. And now there's hypertension present. So it can be deceiving, because now it looks like we've got a lot of numbers of people that aren't controlled. Actually, we're identifying these people earlier, we're getting them into

the system. It's also important when we're thinking about that registry and thinking about that EMR to make sure that we clean the data. We need to think about the fact that the numbers can look poor when there are people in your system that are no longer patients. Another way to use the EMR is to build in systems and build in protocols. (18:00) One of the health systems has a protocol built in - so when the physician (provider) enters the diagnosis of diabetes, the EMR cues up Diabetes Education for three visits automatically. This way – to use the EMR – definitely benefits the patient, the provider and the whole health care team.

NS-How Now – Brown Cow???

So what's the advice that we take from these team based interviews. I know that this is a busy slide – there's a lot of excellent information in here.

We want to communicate effectively. We want to think about process, goals, strategies, and best practices. It's important to share wins, quickly and often. Use stories. We want to strategically plan and gain knowledge. Talk with others, pilot test things and start small - and this was consistently heard across the health care systems. (19:00) Start small, start slowly, and develop a team-based care definition beforehand, and develop goals and purpose as well as metrics and successes that you might expect.

Almost all of the health systems established a workgroup or committee to start things off. A steering committee, advisory board and paid attention to formal and informal leaders. It was consistently stated to engage and seek input from everyone - leadership, financing, providers, patients, all the healthcare professionals, and team members. Get buy-in from everyone also. Again, those same people. And establish that 2-way communication. Communication was just consistently noted. One of the participants noted that team members are scripted to talk about preventative measures, and to talk about the importance of the diagnostics that we do, such as the A1c. "What does it mean when that A1c is lower?" They find out that that way – we're all talking about the same thing, and patients are impressed that the MA, the RN, the LPN, and then the provider-all are talking about that A1c and why it so important. (20:00) And why it should come down. The same thing with hypertension. A participant also noted that it is so important to have "candor with respect" and notes that they regularly thank the MA, the RN, the lab person – in front of the patient. Again – showing respect – showing an impressive team.

In terms of getting buy-in from everyone, it's important that we value employees, "they are the greatest asset". We now are beginning to think about physicians as a "precious resource". (This was also shared by a participant).

Another participant noted that the recipe for quality is to engage patients, engage caregivers and you get HIGH QUALITY OUTCOMES.

Lastly, educate and inform. Everyone that is on the team, and everyone is going to be around the team. Educate about the team-based care concept, what changes we're going to do, highlight the successes again. Share the wins. At every stage at every… Provide the strategic plan, make sure you do training and follow-up.

NS-so next, in the interview process, we asked about team members and who was actually engaged in team-based care. (21:00) We are going to see those team members listed on one of the slight coming up. The team members varied by each health system and it ranged from 9-33 team members for each of the different health systems. We provided a handout and a list of team members to reference, with the ability to add additional team members if needed. When you are looking at the slide, the least were 1-2 health systems identified these personnel, some were 3-4 health systems, most were 5-7 health systems and all were all 8 health systems. If you think back to that team-based care definition from Mitchell, it's noted that team based care is provided by at least 2 health providers. So in some of the cases, team-based care was simply a pharmacist and physician, or a physician and a physician assistant, or a physician and a CMA.

NS- (22:00) Next we looked at workflow and design, and the types of things that are needed to support team-based care implementation. One of the things that we needed to look at was: "What is the current model?" And again, we don't have a model that incentivizes or rewards team-based care.

When we think about work flow and design, we look at work groups – inter-professional groups or committee's with a focus. The hypertension population provides us with a great focus for work groups, made up of clinical staff, physicians, pharmacists, analytics, and EMR designers. There is a high-risk patient focus in many of the facilities, that is led by care coordinators and made of up RNs, pharmacists and social workers with the physician or the provider component added.

When you think about workflow and design, the protocols and standards of care make the team-based care work. Thinking about things like evidence based guidelines. The fact that the use of a certified diabetes educator is evidence based. (23:00) Evidence shows us that involvement of a certified diabetes educator can get a 1.5% reduction in the A1c without addition of medication, just from the education and counseling and coaching involved. (And as a side note, that's not just because I happen to be a diabetes educator!)

When we think about protocols, we think about hypertension readings, new diabetes diagnoses, and protocols for referrals to behavioral health. These protocols and standards are needed. There's other protocols for anticoagulation and refill protocols that can be run by nurses and pharmacists with oversight - so we can take some of that load off of the provider.

Another important factor in workflow and design is to have the support tools needed and have the EMR, the EHR or the Health information system available and help us with team-based care. Items like Smart Set, registries, telehealth, digiceuticals, and Health Link. (24:00) Evidence based algorithms that are built into the chart already make it easier for us to do our job.

NS- More on workflow and design. Thinking about role responsibility and "top of license" practice. What is the best use of that physician provider? What is the best use of the nurse provider? The APNP? The MA? The dietitian? The pharmacist? Utilizing each of those persons at top of license helps them utilize the top of their talent. Another participant noted we also want to think about the things that (people in) each of those categories love to do. Some nurses are going to be best doing triage. Some nurses are going to be best doing face-to-face with the patient, providing education. Both of them can be utilized at top of license, but just doing something that they're better at. In one of the health systems, the pharmacy leads and handles all hyperlipidemic, angiotensin receptor blockers, anticoagulation medications and insulin titration, based on protocols and based on top of their license practice. (25:00) Another facility talked about our and triage and teaching. Having that RN highly involved with Medicare annual wellness visit. Another talked about MA completion of a template according to the chronic care condition.

We want to think about team composition and dynamics. Thinking about having a psychologist available on site. Thinking about having that protocol for getting that behavioral care.

Pre-visit planning is another workflow and design issue. Many of the participants noted that they were able to provide chart review, and contacting patients ahead of time before an appointment - looking for gaps in care, and arranging for diagnostics to be done prior to the appointment, having orders pended and ready for the provider. Working as a team to get all of this done.

Consistent with many of the participants was the idea of "huddle". Sometimes with a huddle sheet, sometimes with a huddle board. Often these are done daily, sometimes at the beginning of each shift sometimes as issues arise. (26:00) Participation varies, from everyone in the clinic to only clinical staff, to sometimes, the remainder of the staff without physicians or providers. Other places have chronic disease huddles where an entire team, the provider, the RN, the pharmacist, meet monthly to look at one specific chronic disease. Many of the sites have a daily huddle, and in one of the clinics, it's noted "they ring a bell and everyone comes running."

Another important part is to involve the patient, and engage the patient and family and think about patient satisfaction. It is also important to think about what really is a patient goal? One of the participants questioned whether an A1c range is really a patient goal, or is that a medical goal or is that a system goal? In the lifestyle pilot for several of the systems (employee pilots) they have participants write their own goals and decide what it is THEY want to do. In one specific setting, they have participants write their own epithet. (27:00) That REALLY helps them identify their goals. Another system has it set in place that their policy is that every patient walks out the door has a diabetes self-management plan in their hand. The patient doesn't leave the exam room without a follow-up card and a plan.

In terms of workflow and design, transparency is important. Making sure that metrics, shared goals, patient outcomes are all shared – all the way across that team. It's important to celebrate successes.

Talking again about having "scripted" talk for lowering A1c, or for managing hypertension, everyone saying the same thing about the importance of getting that blood pressure down.

NS-So what are the next steps? What are we looking at next? It's important that we go forward and we utilize these interview findings. We want to continue the conversation. We want to continue to spread the news about team-based care across the state. (28:00) It's important to note that the findings of these interviews coincide with the patient centered team based care model from Wisconsin Nurses Association. We're going to stay engaged – we're going to keep informed.

We want to challenge each one of you to think about how you can take this information back and utilize it or integrate in your own work and health system.

As we go forward, we definitely want to say a HUGE THANK YOU to the interview participants. And these people are listed on the last slide.

<u>And just a little bit "frosting" for the cake – some of the little extras.</u>

"Believe in the unimaginable!" We did it!

TEAMSTEPPS was an effective team building program recommended in one of the health systems

Another system noted that Intermountain Healthcare was an amazing Behavioral Health Model for team based care (out of UTAH)

Another interesting thought was a grocery walk through utilizing a dietiecn. The patient and family are welcome to attend.

Another facility is doing a M33A Academy (29:00) – where they get information, education, speakers, updates, talk about burnout, vaccines and depression. The RN academy is next.

"Extraordinary health care – one patient at a time!"

"Treat employees as your most valuable asset and as precious commodities."

THANK YOU VERY MUCH FOR LISTENING.