SESSION OBJECTIVES

At the end of the session participants will be able to:

1. Create care team roles and responsibilities
2. Identify core care team competencies
3. Connect care team training with NCQA PCMH standards
4. Develop care team training programs founded in PCMH principles
5. Understand what existing training resources are available in the marketplace

NCQA PCMH STANDARD: 1G

Element C: The Practice Team

The practice uses a team to provide a range of patient care services by:

- Yes
- No

1. Defining roles for clinical and nonclinical team members
2. Having regular team meetings or a structured communication process
3. Using standing orders for services
4. Training and assigning care teams to coordinate care for individual patients
5. Training and assigning care teams to support patients and families in self-management, self-efficacy and behavior change
6. Training and assigning care teams for patient population management
7. Training and designing care team members in communication skills
8. Involving care team staff in the practice’s performance evaluation and quality improvement activities
CARE TEAM SUPPORT & PHM: TIERS

Case Load

- PCMH 3B, 3C, 3D, 4A
- New, high-risk patients

- Clinical Care Management
  - Logical
  - Clinical Monitoring
  - Self Mgmt Support
  - Medication Mgmt

- Clinical Follow-up Care
  - Logical
  - Clinical Monitoring
  - Self Mgmt Support

- Care Coordination
  - Logical

MacColl Institute for Healthcare Innovation, Group Health Research Institute 2011

Why Teams Are Important in Patient-Centered Care Primary Care?

“Improving the quality of primary care is a key objective of health care reform. Central to the improvement of primary care is the development of effective primary care teams,” Ed Wagner, MD, MPH, MacColl Center for Health Care Innovation at Group Health Research Institute

The Patient-Centered Medical Home: Team Based Care

Key Features:

1. Engaged leadership
2. Quality improvement strategy
3. Empanelment
4. Patient-centered interactions
5. Organized, evidence-based care
6. Care coordination
7. Enhanced access
8. Continuous, team-based health relationships

http://www.improvingchroniccare.org
Primary Care practices handle such a wide array of patients it is difficult to routinize what happens each day. Tremendous diversity in primary care settings across the country. The central institution of primary care is the 15-minute physician visit. Too much work and too little time to do it. Challenges of human relationships and personalities. Reliance on part-time providers. Team-based care is a huge paradigm shift for teams and for patients. Authoritative leadership style embedded vs. facilitative leadership. Misalignment of vision.

42% of primary care physicians report not having enough time to spend with patients. 50% of patients leave without understanding what advice their provider gave. 23% of physicians interrupt patient’s communication about their concerns after 23 seconds. 25% of patients expressed they were never able to express their concerns during the patient visit. 9% of patients felt they were involved in decisions affecting them.

Sources:
Center for Studying Health System Change Physician Survey
Studies of doctor-patient interaction. Annual Review of Public Health
Soliciting the Patient Agenda: Have We Improved? JAMA
HOW TO APPROACH THE CHALLENGE

- High Function Teams: Creation of high-functioning well trained primary care teams with non-provider team members taking on clinical tasks that providers have insufficient time to perform, and that focus several people on each patient’s problems.
- Effective Systems: Standing orders and protocols to direct clinical support staff. Many primary care visits, especially for chronic disease, involve relatively simple matters that could be handled by non-physician team members via protocols or standing orders.
- Rewards: Performance-Based

DEVELOPING COHESIVE HEALTH CARE TEAMS

5 key characteristics:
- Clear goals with measurable outcomes,
- Clinical and administrative systems,
- Division of labor,
- Training of all team members
- Effective communication.

DEFINING CARE TEAM ROLES AND RESPONSIBILITIES

- The right staff doing the right things at the right time
- Traditional job descriptions vs. team based job descriptions
Let's practice optimizing roles through this work analysis exercise.

**Work Analysis Worksheet**

<table>
<thead>
<tr>
<th>Team</th>
<th>Job Classification</th>
<th>Tasks</th>
<th>Hours/Day</th>
<th>In a perfect world who would do this?</th>
<th>What's not getting done that I should be doing?</th>
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**READY TO MOVE ON?**

**STRUCTURED CARE TEAM COMMUNICATION PROCESSES**

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**EFFECTIVE HUDDLING**
QUESTIONS ANYONE?

TRAINING: COORDINATING CARE FOR INDIVIDUAL PATIENTS
TRAINING: PERFORMANCE IMPROVEMENT (QUALITY OF CARE AND SERVICES)

Documenting Care Team Training

DOMAINS OF PCMH COMPETENCY: ESSENTIAL SKILLS

- Patient Centered/Whole person care
- System-based care
- Practice-based learning
- Communication & Professionalism
- Teamwork
- Chronic disease management
- Practice & Population Management
- Coordination & Transitions of Care
- Integration of Care
- Quality, Performance, & Practice Improvement
- Information Technology
- Behavioral Health
CARE TEAM COMPETENCY EVALUATION: KEY AREAS

- Values and Ethics
- Roles and Responsibilities
- Communication
- Team and Teamwork


EXAMPLE: CARE TEAM COMPETENCY ASSESSMENT

RESOURCES

- Tennessee Primary Care Association
- Health Team Works [www.healthteamworks.com](http://www.healthteamworks.com)
- National Association for Quality Assurance – [www.ncqa.org](http://www.ncqa.org)
- Institute for Health Improvement – PCMH Assessment, [www.ihi.org](http://www.ihi.org)
- Agency for Healthcare Research and Quality, [www.ahrq.org](http://www.ahrq.org)
- National Transitions of Care Coalition - [www.ntocc.org](http://www.ntocc.org)
- Merck PCMH Overview [www.ncqa.org](http://www.ncqa.org)

[Tennessee Primary Care Association](http://www.healthteamworks.com)

[Health Team Works](http://www.healthteamworks.com)

[National Association for Quality Assurance](http://www.ncqa.org)

[Institute for Health Improvement](http://www.ihi.org)

[Agency for Healthcare Research and Quality](http://www.ahrq.org)

[National Transitions of Care Coalition](http://www.ntocc.org)

[AAFP PCMH Videos](http://www.aafp.org/practicemanagement/pcmh/overview/videos.html)

[Merck PCMH Overview](http://www.ncqa.org)

[Motivational Interviewing](http://www.motivationalinterview.org/)
RESOURCES
- Huddle Video
  http://www.youtube.com/watch?v=WttXm7Jahb4
- Motivational Interview Video
  http://www.youtube.com/watch?v=dm-rJJPCuTE
- Patient Centered Primary Care Collaborative
  www.pcpcc.net
- Safety Net Medical Home Initiative -
  http://www.safetynetmedicalhome.org/change-concepts
- Institute for Healthcare Improvement -www.ihi.org

QUESTIONS ANYONE?