PTI Quarterly Convening, July 2017
Team Base Care Breakout Sessions

Northern California

Breakout A:

Ann Lindsay, MD
Stanford Coordinated Care

Background:

Dr. Ann Lindsay discussed how Stanford Coordinated Care implemented several key principles of team based care. The Stanford Coordinated Care clinic manages the care of several hundred patients with multiple complex chronic conditions. The clinic employees two MD's and 4 MA's, with the MAs acting as the primary point of contact for each patient.

Key Takeaways:

- Workflow Redesign
    - Reducing MD workload by having each member of the healthcare team working at the top of their license.
    - MAs acting as care coordinators for patients. MAs assigned a panel of patients to manage.
    - Created multiple tiers with the MA job description to provide career advancement opportunities. Helped reduce staff turnover.
- Medication Refill Protocol
    - Created a list of most commonly prescribed prescriptions within the clinic and developed standing orders for refills.
    - Certain medications were flagged for MD follow-up and MAs coordinated follow-up
- Care Gap Tool
    - Regularly used a care gap report to identify patients in need of screening, preventative care & medication refills.
    - Allowed MA's to complete necessary screenings prior to patient's appointment with MD

Northern California

Breakout B:

Kim Perris, RN
North Coast Improvement & Information Network (NCHIIN)

Background:

Kim once worked as an RN in a student center. There were never enough appointments and students kept presenting without appointments and with similar issues- pink eye, strep throat, needing Plan B or contraception, etc.. Kim saw the need and felt that team-based care could be the solution to provide a better method to meet the student's needs. This was based on knowing that other team members could remedy much of these issues without requiring the student see the clinician. Eventually, Kim and her team implemented team-based care in the student center and reduced wait times and met the needs of the students.

Key Takeaways:

- What hurdles did you encounter?
  - Large amounts of opposition from leadership
    - Overcame: Kim used literature to convince the lead clinician to buy-in. He became the champion and brought the others along.
  - Kim did not have the education to implement TBC
    - Overcame: Kim got her Master's and began to use the tools to which she was exposed; Predominantly Kim's persistence and constantly highlighting the need and potential solution – TBC – lead to the implementation of TBC.
- How did you know which standing protocols were needed?
  - Based on patient population and needs they present. Student clinic standing orders will look very different than, for example, a geriatric focused clinic.
  - Started with one protocol, then added on as time progressed
- How did you learn the Rules & Regulations around protocols?
  - There are many examples of standing protocols- Kim said she would share with the group her resources
- How did you know you were successful?
  - When students noticed the positive difference, and commented.

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Breakout A:

Lorrie Baird & James Dester
St. Joseph Health

Background:

St. Joe chose two pilot sites for TBC; one was predominantly managed care, the other was 90% FFS. St. Joe was very prescriptive in what was and was not allowed with the TBC model, and gave both sites very detailed directives similar to the 10BB. Each site received an additional RN and an embedded pharmacist. The RN focused mainly on access (flip visits, simple visits, protocols, etc.). The managed care site is still working and implementing the TBC, whereas the FFS site is no longer implementing TBC.

Key Takeaways:

- How did you measure ROIs to convey success?
  - Looked at PMPM costs and turnover costs, however access and utilization were the two main focus areas for measurement.
  - Cost is an outcome measure, not a process measure so St. joe focused first on Relative Value Units (RVUs).
- The FFS model did not benefit from TBC; are you abandoning TBC with FFS compensation model completely?
  - As of current, the FFS model is lucrative for these practices. Once MACRA hits, this will likely change and they may be more amenable to participating, especially given that St. Joe promises to keep them whole if the practice pilots TBC.
  - The two main conditions for which docs are inclined to participate are: 1) they are young and more willing to change or 2) they are overwhelmed and are willing to try anything that may work.
- How did you know the FFS model was a failure?
  - Patient satisfaction scores went down, clinicians' hours went up
- What would you do differently?
  - Ask the clinicians what their needs are, then help meet those needs
  - Keep in mind the three important components are: office culture, patient, and compensation model

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Breakout B:

Efrain Valladolid, MD
Sharp Community

Background:

Dr. Valladolid provided insights into his practice transformation journey within his medical practice. Dr. Valladolid began his transformation efforts over 3 years ago and has made several changes to his internal workflow to drive quality improvement across his practice.

Key Takeaways:

- Work flow redesign
    - Redesigned practice work-flow, placing a greater emphasis on the role and responsibilities of the each position within the practice. Requires detailed job descriptions for each role.
    - Also important to cross train all staff member, which helps maintain momentum when staff our out (vacation/sick) or turnover occurs.
    - There was initially some resistance from the practice staff which led to turnover.
- Team approach to quality improvment
    - To become successfully really required buy-in from the entire practice staff. Dr. V adopted a weekly quality improvement staff meeting and documented decisions and next steps to keep everyone accountable.
    - Importance of celebrating practice achievements. For example, Dr. V provides entire team with lunch during their weekly quality improvement meetings.
- Financial Viability
    - Took a significant amount of time, over 2 years, for new work flow patterns to become financially rewarding. However, the practice is now reaping the rewards of being a high performing practice and is able to monitor and improve/maintain performance over a range of quality improvement metrics.