Innovative Team Based Care

DECEMBER 17, 2021

MARYLAND
Health Care
Commission

AGENDA

- Overview of the Maryland Model

  Tequila Terry

- Team-Based Care Approaches to Facilitate Improved Health Outcomes

  Siobhan Kirksey, MSN, RN, AATMC, CDP

- Population Health Management Models and Team-Based Care

  Ashley Kinder, M.D.

- Q&A

CME and Disclosures

- This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of MedChi, The Maryland State Medical Society and the Maryland Health Care Commission (MHCC). MedChi is accredited by the ACCME to provide continuing medical education for physicians
- MedChi designates this virtual online educational activity for a maximum of 1 AMA PRA Category 1 Credits™
- Physicians should claim only the credit commensurate with the extent of their participation in the activity
- The following presenters and planners have reported no relevant relationships to disclose: Siobhan Kirksey, Melanie Cavaliere, Anene Onyeabo
- The following presenter, Dr. Ashley Kinder, has reported the following relevant relationship: UnitedHealthcare Community Plan, Maryland Provider Advisory Council. Physician representative. Stipend for PAC meeting attendance.
- All relevant relationships listed for this individual have been mitigated.

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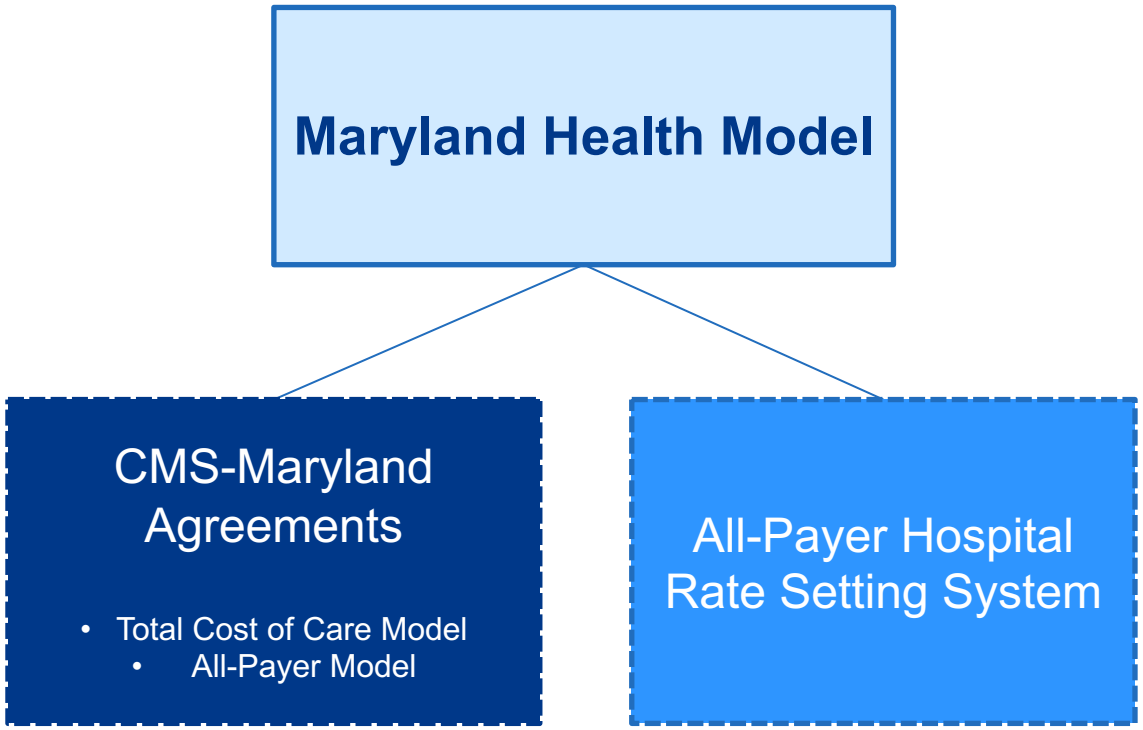
The Maryland Health Model

Maryland Health Care Commission Innovative Care Symposium

December 17, 2021

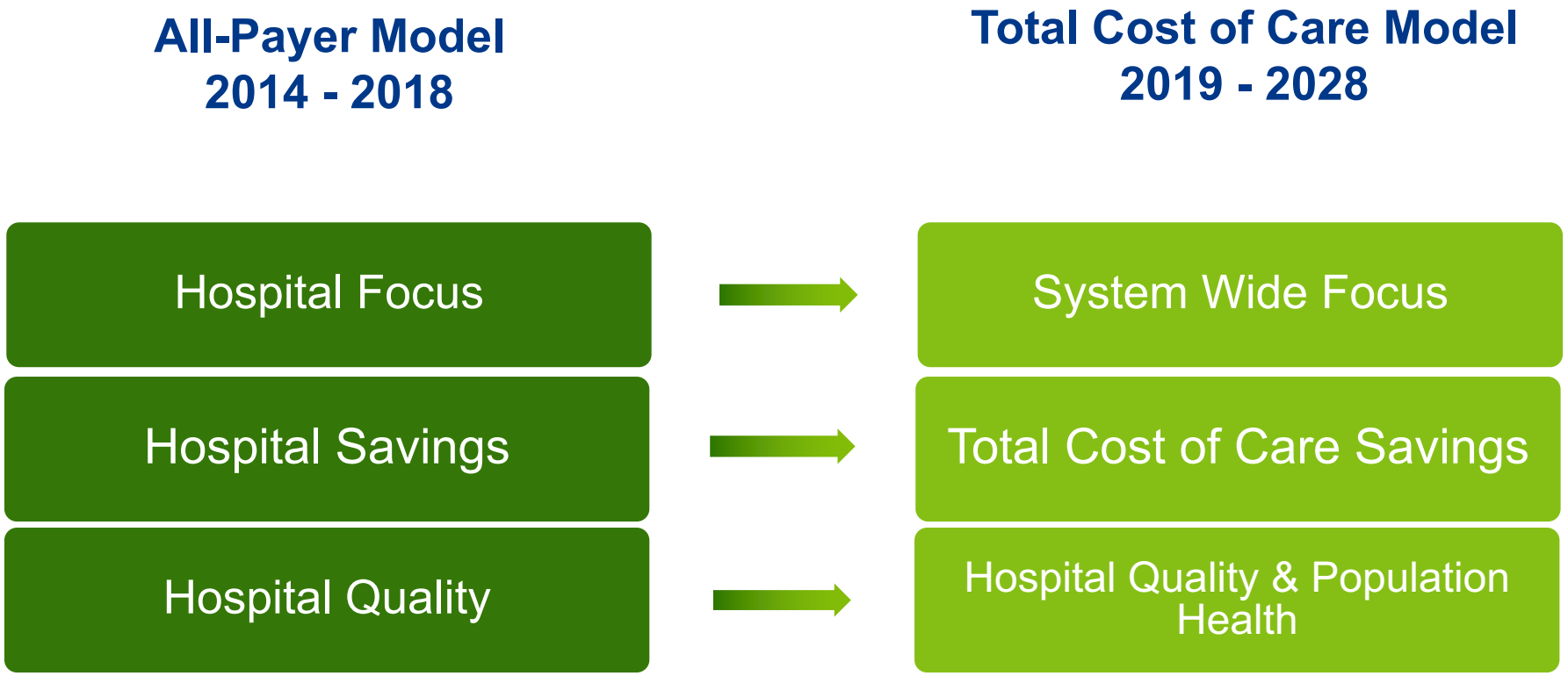
Tequila Terry

Maryland's Unique Healthcare Payment System



- Maryland's approach:
  - Enables cost containment for the public
  - Incentivizes better all-payer health outcomes through pay-for-performance programs
  - Avoids cost shifting across payers and provides equitable rates to self-pay customers
  - Guarantees equitable funding of uncompensated care
  - Creates a stable and predictable system for hospitals
  - Funds investments in population health
  - Establishes Maryland as a leader in linking quality and payment
  - Provides support for state healthcare infrastructure and subject matter expertise

Transitioning from All-Payer Model to the Total Cost of Care Model



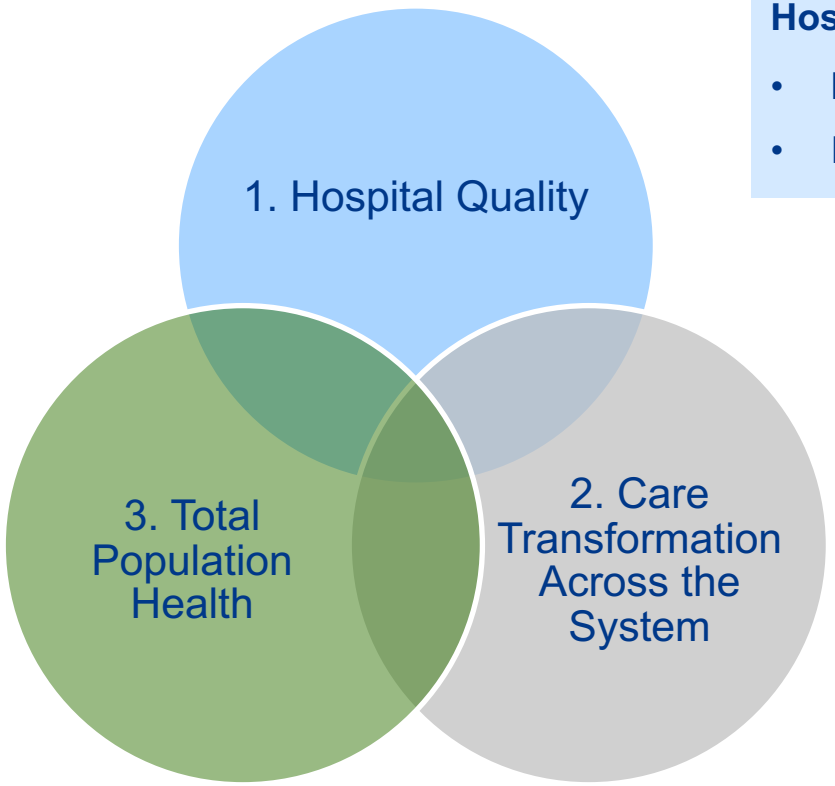
Strategies for TCOC Model Implementation

Total Cost of Care Model (2019-2028)

Maryland can succeed under the TCOC Model with the following strategies:

Foster Accountability	• Support providers as they take responsibility for the care and health outcomes of defined populations
Align Incentives	• Ensure providers, payers, and health care consumers are working together to achieve common goals
Transform Care	• Coordinate care for patients across both hospital and non-hospital settings to improve health outcomes and constrain the growth of costs
Improve Population Health	• Encourage statewide coordination to address Maryland's highly prevalent chronic conditions

Statewide Goals Across Three Domains



Hospital Quality

- Reduce avoidable admissions
- Improve Readmission Rates by Reducing Within-Hospital Disparities

Care Transformation

- Increase the amount of Medicare TCOC or number of Medicare beneficiaries under value-based care models*
- Improve care coordination for patients with chronic conditions

Total Population Health

- Diabetes: Reduce the mean BMI for adult Maryland residents
- Opioids: Improve overdose mortality
- Maternal and Child Health:
  - Reduce severe maternal morbidity rate
  - Decrease asthma-related emergency department visit rates for ages 2-17

*Value-based models including the Care Redesign Program, Care Transformation Initiatives, and qualifying successor models.

TCOC Model: What's Next?

To show success in the TCOC Model, Maryland must demonstrate progress in the following areas:

Thank you!

Tequila Terry

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Team-Based Care Approaches to Facilitate Improved Health Outcomes

Presented By: Siobhan D. Kirksey, MSN, RN

AGENDA

Why is Team-Based Care Important

Integration of Team-Based Care

Reporting to Support Team-Based Care and Improve Health Outcomes

Why is Team-Based Care Important?

What is Team-Based Care?

The Institute of Medicine (IOM) defines **team-based care** as "the provision of health services to individuals, families, and/or communities by at least two healthcare 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 (ANA, 2016)."

The need for Team-Based Care

- As primary care in the United States evolves from volume-driven to a value-based reimbursement system, care delivery models for community-based practice must also evolve to ensure continuity of care.
- The patient-centered medical home was originally described by the American Academy of Pediatrics and was designed to help achieve the triple aim of improving health outcomes, improving patient experience, and controlling cost.
- Certain elements of the patient-centered medical home, such as team-based care, have improved outcomes, including quality of care and provider satisfaction (ANA, 2016).

Provider Burnout

Factors contributing to burnout and dissatisfaction are:

- Use of Electronic Health Records
- Increased needs to see more complex patients
- Change fatigue

One study found that physicians spend only 27 percent of their time providing direct, face-to-face care to patients and more than half their time on the EHR or desk work (Smith et al., 2018)

Statistics

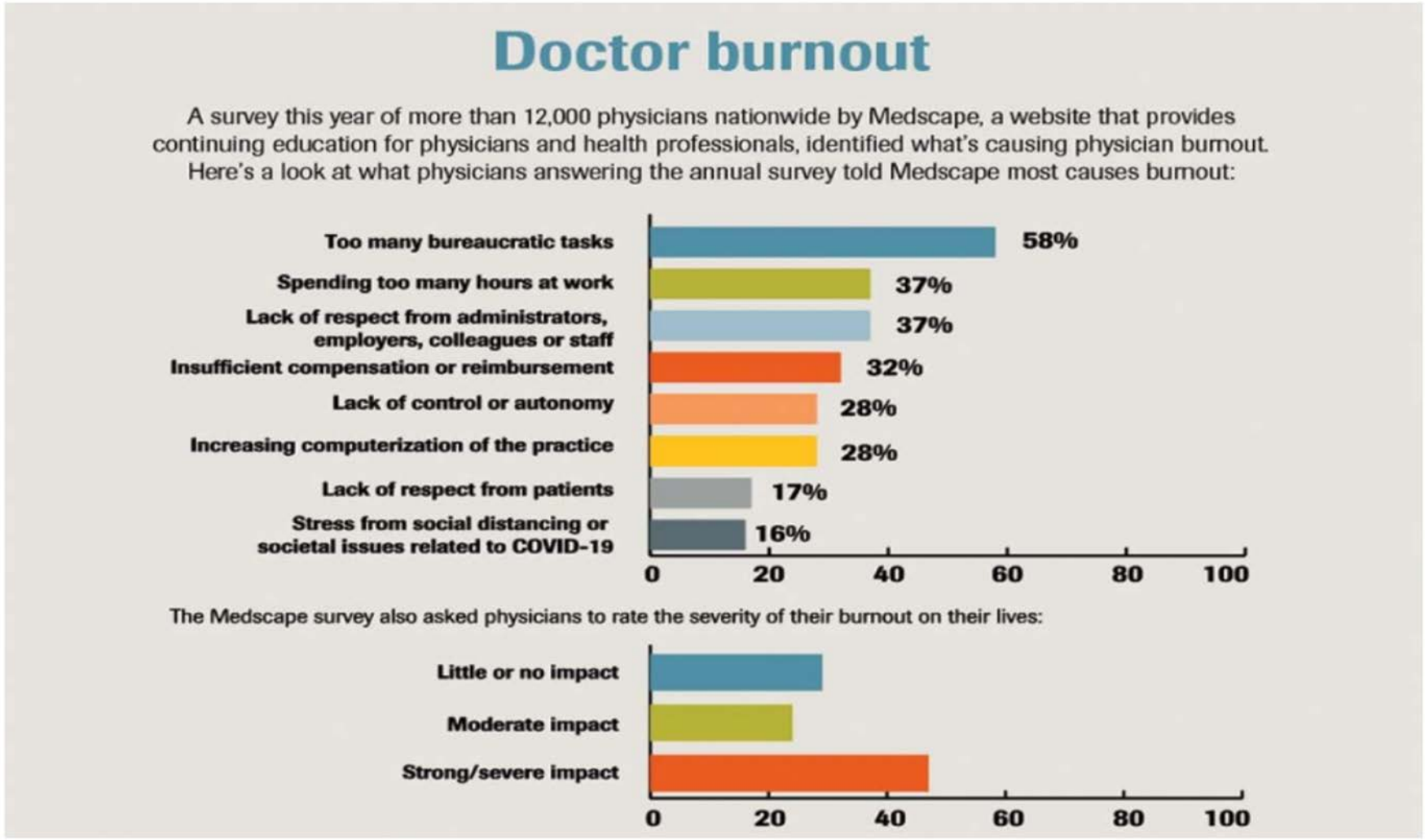

Image retrieved on 11/30/2021 from https://mibiz.com/sections/health-care/new-program-to-address-burnout-among-health-care-workers

Can Team-Based Care Help?

- Team-based care model can improve the following:
  - Increased visit volume and patient access
  - Improved clinical quality
  - Reduce provider burnout in half

Team-based care allows each member of the healthcare team to function at the top of his or her license, thereby improving efficiency of patient care and ultimately the well-being and engagement of all members of the team (Sinsky & Rajcevich, 2015).

Integration of Team-Based Care

Change Management Team

To get started, bring together a multi-disciplinary change team of nurses, medical assistants, physicians, administrators, and IT team with a physician leader who has enough authority within the practice or organization to empower the process.

Design Team-Based Care Workflow

Consider these Fundamentals

1. Pre-visit planning and/or Daily Huddle
2. Expanded rooming and discharge
3. Team documentation
4. Medication Management/Reconciliation
5. EHR in basket management
6. Reporting Dashboards
7. Patient Family Advisory Council (PFAC)

Pilot Team

It is important to set up your pilot team for success. When aligning the pilot team to the ideal team model developed by the change team, keep the following in mind:

- Role flexibility is part of practice culture
  - Practice culture will change from practice centric to patient centric
- Make time to learn new responsibilities
  - Prevents resistance to change
- Eliminate unnecessary activities and waste
  - Great opportunity to eliminate redundancy in workflow

Consider External Partnerships

- Hospital Transition of Care Team
- Community Pharmacist
- Behavioral Health Specialist
- Local Health Department

Reporting to Support Team-Based Care & Improve Health Outcomes

Risk Stratification Reports

Risk Stratification is an ongoing process of assigning all patients in a practice a particular risk status – risk status is. based on data reflecting vital health indicators, lifestyle and medical history of your adult or pediatric populations.

	Final Risk Stratification Cohort	Values								
	4 - Complex		3 - High		2 - Medium		1 - Low		Total Patients	Total %
Site	Patients	%	Patients	%	Patients	%	Patients	%		
	326	20%	368	23%	42	3%	855	54%	1,591	100%
	252	26%	196	21%	36	4%	471	49%	955	100%
	267	34%	164	21%	24	3%	338	43%	793	100%
	358	29%	297	24%	36	3%	523	43%	1,214	100%
	183	34%	108	20%	18	3%	237	43%	546	100%
	153	23%	165	25%	17	3%	335	50%	670	100%
	157	29%	131	25%	17	3%	228	43%	533	100%
	189	32%	143	24%	24	4%	229	39%	585	100%
Grand Total	1,885	32%	1,572	25%	214	2%	3,216	40%	6,887	100%

Huddle Reports

Huddle Reports are quick snapshots of pertinent information to help your team plan your day. The goal is proactive care for patients versus reactive.

Appt. Date	Appt. Time	Provider	Patient	Patient DOB	Age	Language	Sex	Race	Attributed
12/8/2021	09:30:00	WALK-IN SCHEDULE				English	F	White	Attributed

	Appointment Details: **Last Appointment Date:** 2021-12-02 **ED Visit:** **Open Referral:** **#Visits (past 12 mo):** 3 **#Cancelled (past 12 mo):** 2 **#No Shows (past 12 mo):** 0 **Appointment Notes:** Booster shot->MB
B	**Patient Detail:** **Primary Insurance:** United **AWV:** **Last BMI:** 26.90 2021-12-02 **Weight Change:** -6.50 lbs (last 6 months) **Last 3 BP:** 110/80 (2021-10-29) 100/70 (2021-06-09) 118/74 (2020-10-20) **Last 2 LDL:** 150 (2021-11-11) 106 (2020-12-11) **Last 3 HbAlc:** **Smoker:** Never **Last Colonoscopy:** **Last Mammo:** 2021-06-18 **Last Cervical Cancer Screening:** 2021-06-09 **Open Quality Gaps:** Screening for clinical depression and follow-up

Quality Measures

- Breast Cancer Screening
- Colorectal Cancer Screening
- Controlling High Blood Pressure
- Depression Screening and Follow-Up
  - Depression Remission at Twelve Months
- Diabetes
  - Hemoglobin A1c Poor Control (>8%)
  - Eye Exam for Retinopathy
  - Kidney Disease Screening and Treatment (Urine micro albumin/eGFR)
- Falls: Screening for Future Fall Risk
- Influenza Immunization
- Statin Therapy for the Prevention and Treatment of Cardiovascular Disease/Diabetes
- Tobacco Use: Screening and Cessation Intervention

Sample Dashboards

		Diabetes: HbA1c Poor Control (>9%) 80th: 19.03% 50th: 33.97%					Hypertension: Controlling HBP 80th: 76.92%. 50th: 65.65%			
CareCenter	POD	February	August	September	Overall Change YTD		February	August	September	Overall Change YTD
		48.72%	17.20%	14.57%	-34.15%		72.41%	88.32%	89.36%	16.95%
		54.05%	26.73%	23.53%	-30.52%		91.54%	89.70%	89.12%	-2.42%
		59.70%	19.43%	17.47%	-42.23%		72.84%	87.78%	88.94%	16.10%
		45.83%	8.51%	6.81%	-39.02%		77.94%	88.76%	88.11%	10.17%
		78.95%	40.07%	36.72%	-42.23%		69.27%	88.37%	87.30%	18.03%
		50.00%	32.94%	30.68%	-19.32%		75.68%	87.63%	86.24%	10.56%
		64.62%	29.58%	27.24%	-37.38%		72.01%	84.04%	85.38%	13.37%
		79.31%	39.66%	42.76%	-36.55%		70.19%	85.28%	84.66%	14.47%
		56.72%	27.74%	23.51%	-33.21%		69.16%	80.35%	82.94%	13.78%
		67.12%	21.29%	20.39%	-46.73%		51.45%	78.94%	82.31%	30.86%

Program Dashboard

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Diabetes Management: Performance

Care Center Performance:

	Diabetes Patients	A1c (<8%)	BP (<140/90)	Nephro. Screening	Lipid Mgmt.	Bundled Complete	Bundled Pass
	1,026	78%	72%	93%	85%	69%	51%
Washington Northwest	1,276	76%	74%	91%	82%	67%	49%
Mid-Atlantic	40,249	72%	77%	90%	85%	71%	47%
National	90,394	71%	77%	91%	84%	74%	46%
Privia							
Market Goal		92%	92%	96%	91%	88%	81%

Areas of Improvement:

	A1c (<8%)	BP (<140/90)			Single-Gap Patient Count	
Uncontrolled:	100	139				
Not Tested:	127	149			**327**	

- Dashboards can be used to compare goals with providers national average or with slight modifications compare providers
- This type of dashboard includes a patient list so MA, office managers or even scheduling team can play a role in improving outcomes.

Takeaways

3 Things to Remember

1. Communication is important to developing a team based model.
2. Collaboration and partnerships are key to success.
3. Be patient, nurture your new vision and watch how it changes how you deliver care to your patients.

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Thank you!

References

Dera, J., D. (2019). Risk Stratification: A Two-Step Process for Identifying Your Sickest Patients. *Family Practice Management, 26(3)*, 21-26. https://www.aafp.org/fpm/2019/0500/p21.html

Sinsky, C., & Rajcevich, E. (2015, October 7). Team-Based Care Improve Patient Care and Team Engagement Through Collaboration and Streamlined Processes. AMA ED Hub. Retrieved November 29, 2021, from https://edhub.ama-assn.org/steps-forward/module/2702513

Sanchez, M. (2021, April 25). New program to address burnout among health care workers. MiBiz. Retrieved November 29,2021, from https://mibiz.com/sections/health-care/new-program-to-address-burnout-among-health-care-workers

Lyon, C., English, A., F., & Smith, P., C. (2018). A Team-Based Care Model that Improves Job Satisfaction. American Academy of Family Physicians. Retrieved November 29, 2021, from https://www.aafp.org/fpm/2018/0300/fpm20180300p6.pdf

American Nurse Association. (2016). Promoting Patient-Centered Team-Based Health Care. Nursing World. Retrieved November 17, 2021, from https://www.aafp.org/fpm/2018/0300/fpm20180300p6.pdf

Mitchell, J. D., Haag, J., D., Klavetter, E., Beldo, R., Shah, N., D., Baumbach, L., J., Sobolik, G., J., Rutten, L., R., Stroebel, R., J. (2019). Development and Implementation of a Team-Based, Primary Care Delivery Model: Challenges and Opportunities. *Mayo Clinic Proceedings, (94)7*, 1298-1303. https://doi.org/10.1016/j.mayocp.2019.01.038.

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Population Health Management Models and Team-Based Care

Approaches for Coordinating Care Across the Medical Neighborhood

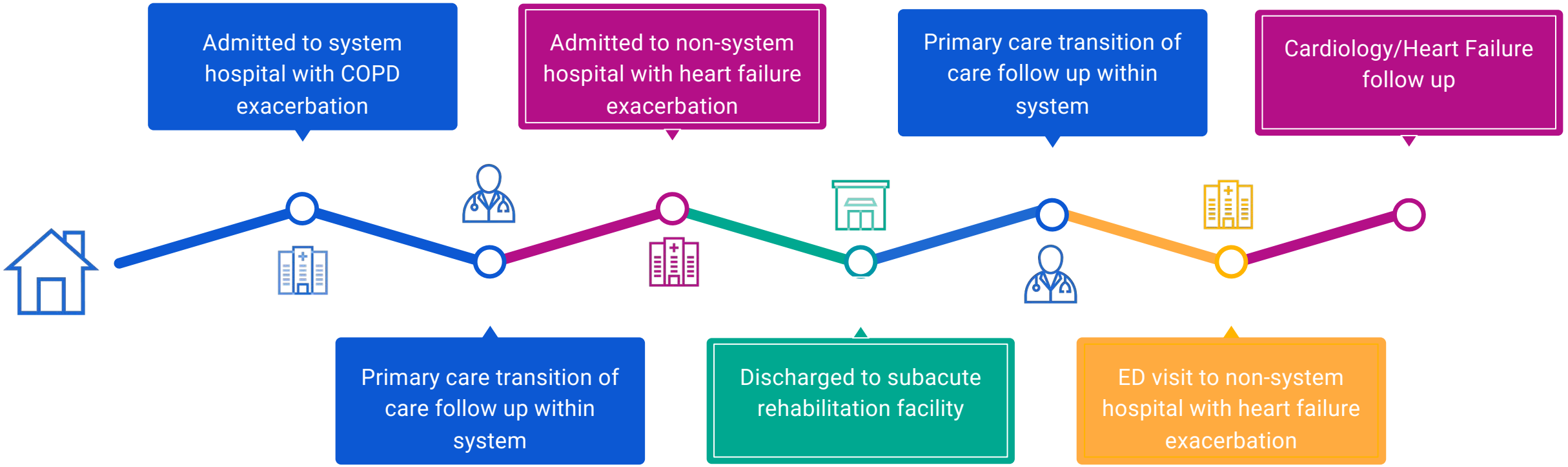
Ashley Kinder, MD
December 17, 2021

Ascension

Learning Objectives

- Review barriers to effective care coordination across the continuum of care
- Describe strategies to promote patient-centered team-based care delivery
- Recognize the role of strategic partnerships and community engagement in successful population health management

Systems are Fragmented



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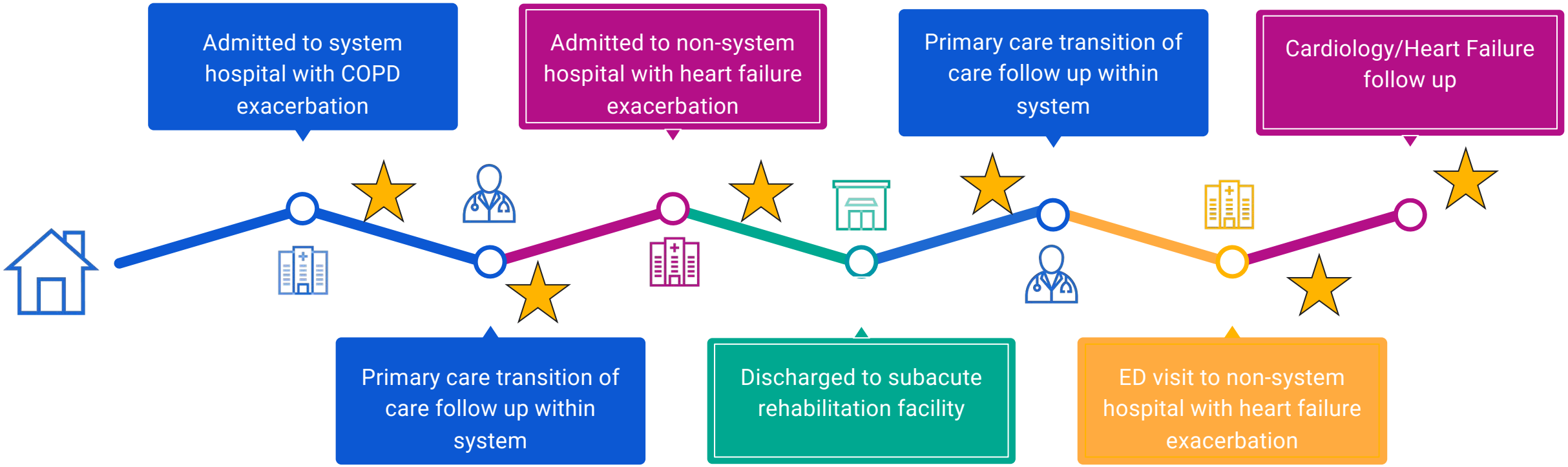
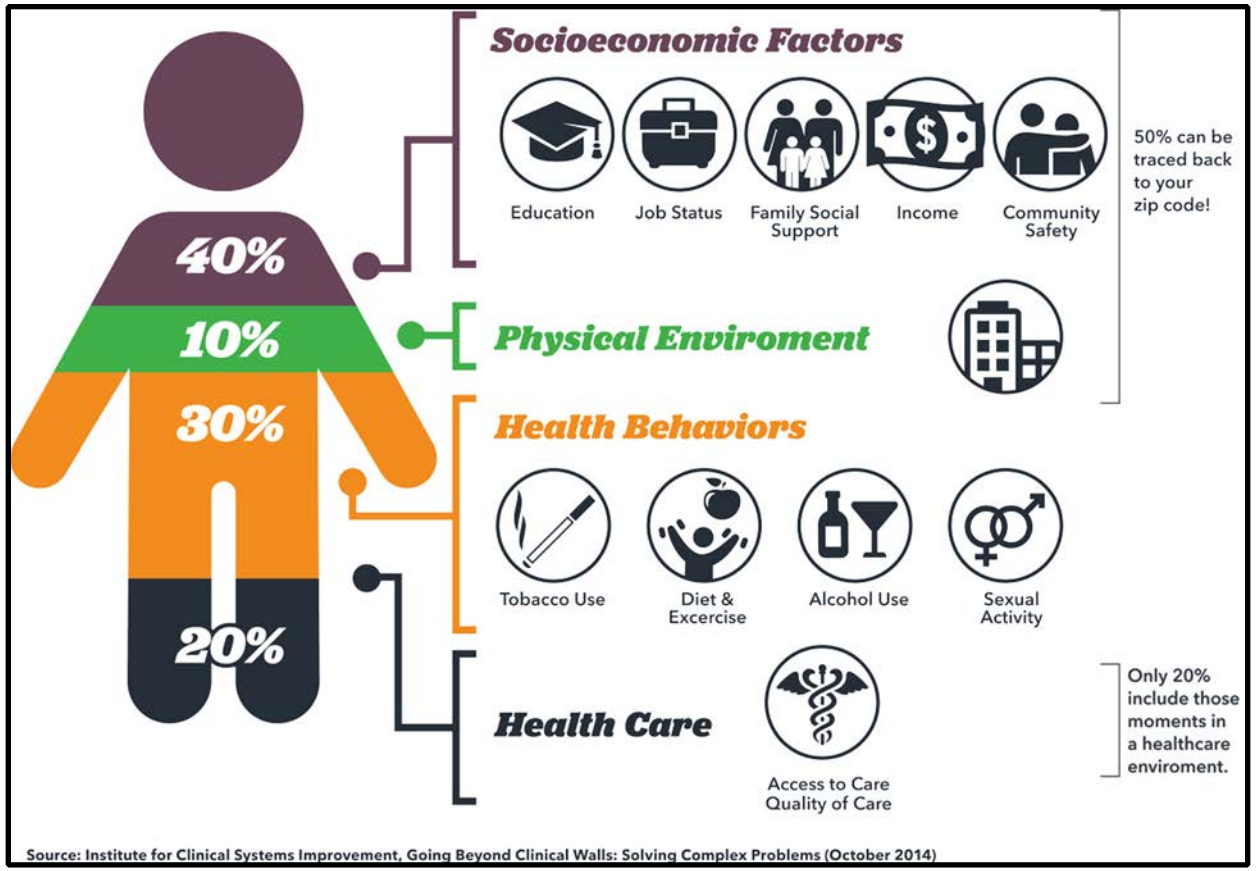


Transitional Care Teams- Each System
Primary Care Ambulatory Care Management
Payor Based Care Management
Disease Specific Care Navigation Programs

Much of this work is outside of the health system

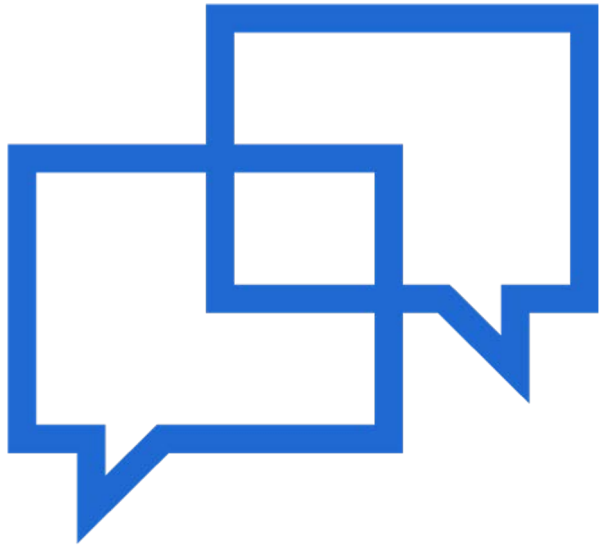
- Most of what determines health outcomes is *not* healthcare [1]
  - Impact of ZIP code
  - Variation in what is modifiable at the individual level versus policy/population level
- COVID pandemic exacerbating existing healthcare disparities and SDOH needs[2]



[2]*Shah, G. H., Shankar, P., Schwind, J. S., & Sittaramane, V. (2020). The Detrimental Impact of the COVID-19 Crisis on Health Equity and Social Determinants of Health. Journal of public health management and practice : JPHMP, 26(4), 317–319.https://doi.org/10.1097/PHH.0000000000001200*

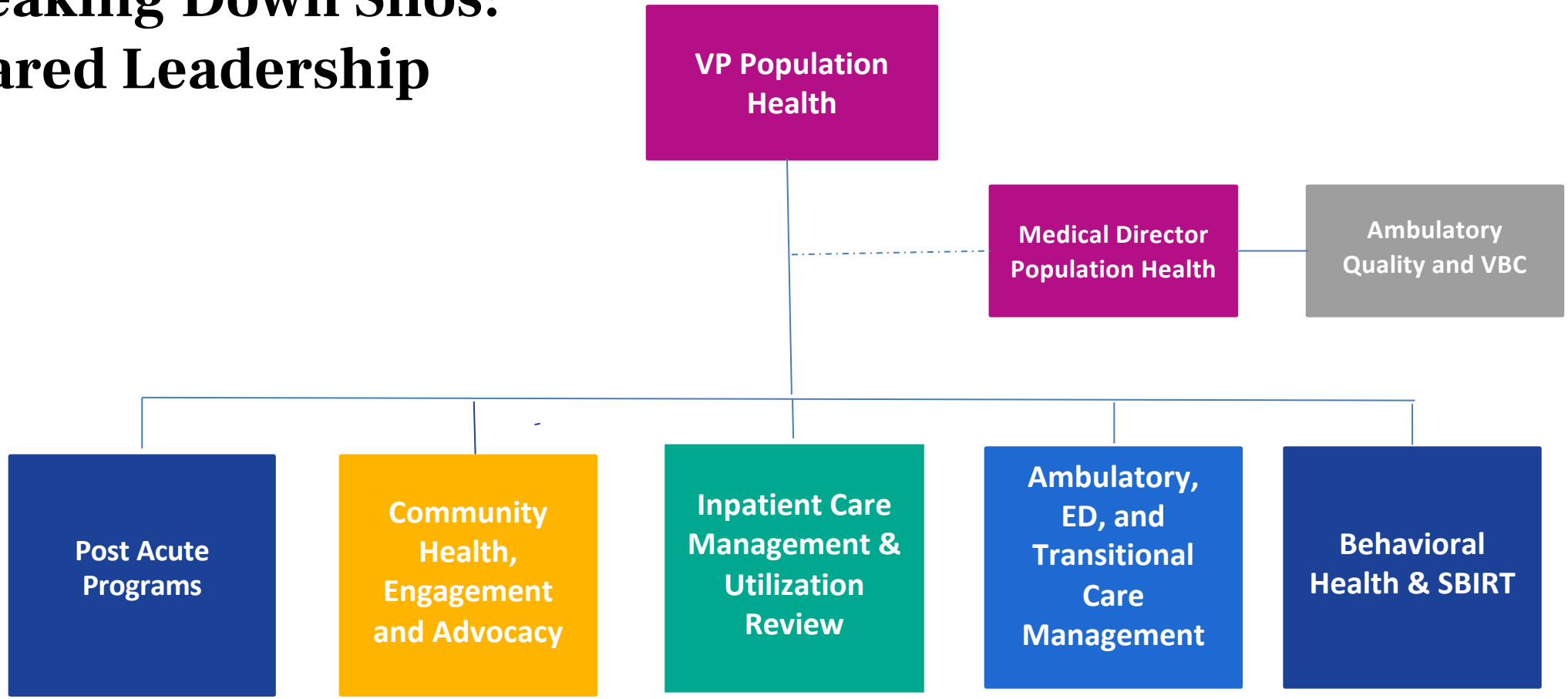
Many of us are still learning to work in multidisciplinary teams

- Review of Barriers [1]
  - Individual & Inter-individual (team)
  - Organizational & system
- Engaging clinicians [2]
- Tools to support → best to learn by doing [2]



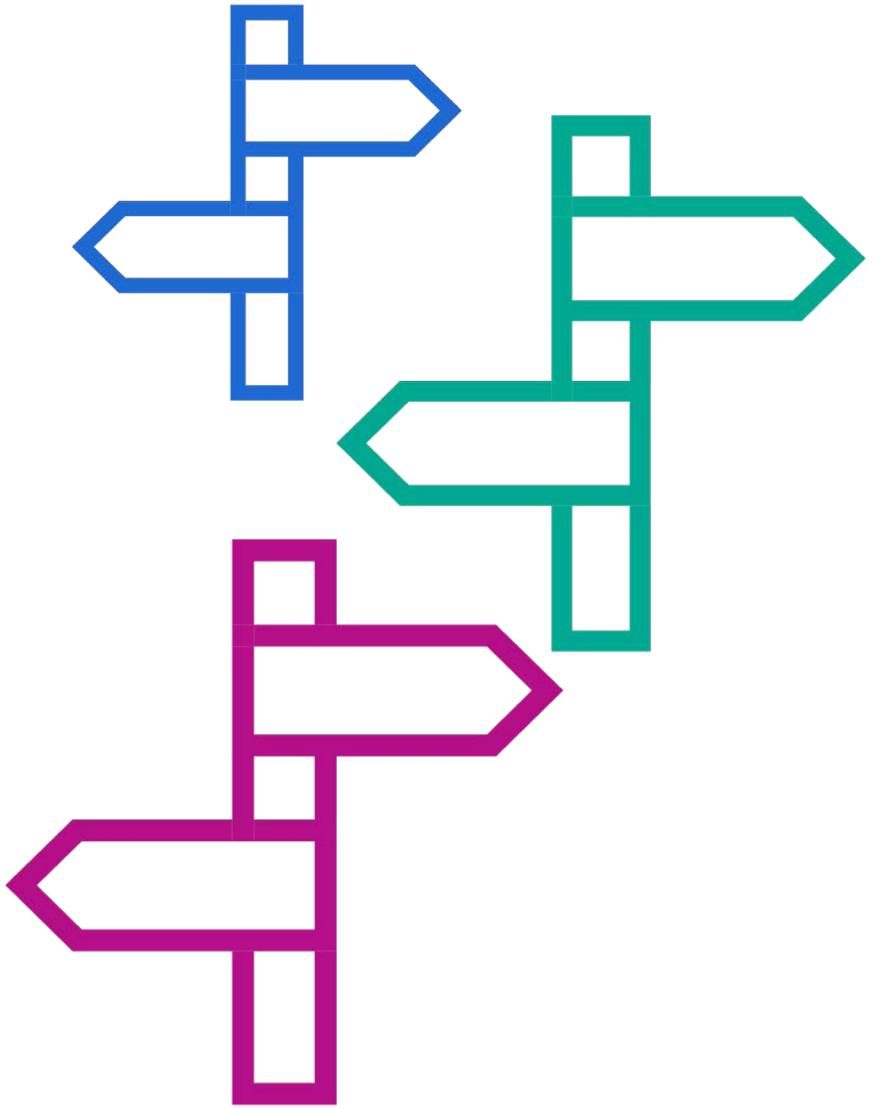
1 Rawlinson, C., Carron, T., Cohidon, C., Arditi, C., Hong, Q. N., Pluye, P., Peytremann-Bridevaux, I., & Gilles, I. (2021). An Overview of Reviews on Interprofessional Collaboration in Primary Care: Barriers and Facilitators. International journal of integrated care, 21(2), 32.https://www.ijic.org/article/10.5334/ijic.5589/
2 O'Reilly, P., Lee, S. H., O'Sullivan, M., Cullen, W., Kennedy, C., & MacFarlane, A. (2017). Assessing the facilitators and barriers of interdisciplinary team working in primary care using normalisation process theory: An integrative review. PloS one, 12(5), e0177026. https://pubmed.ncbi.nlm.nih.gov/28545038/

Breaking Down Silos: Shared Leadership



Air Traffic Control

- **Navigate the navigation!**
- Identifying patients
  - Lists
  - Disease specific teams
- Provider referrals
  - Make it easy!
- Hierarchy of intervention
- Assessing what we have tried and what we have not



Leverage IT systems…. but don't forget the importance of relationships

- Within system tools- EMR based, secure messaging → Standard of Work
- Across systems
  - Care alerts
- Huddles/Rounds

Maryland Patient Safety Center. (2016). Care Alerts: A novel solution to improve coordination of care. Drivers, standards, implementation, measurement. https://www.crisphealth.org/wp-content/uploads/2016/03/Care-Alerts-White-Paper-MPSC-final.pdf

Engage Partners & Your Community

Who in my community is doing this work?

What are the needs of my population?

[1]*U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (n.d.). Social determinants of health. Healthy People 2030. https://health.gov/healthypeople/objectives-and-data/social-determinants-health.*

Partnerships and Engagement

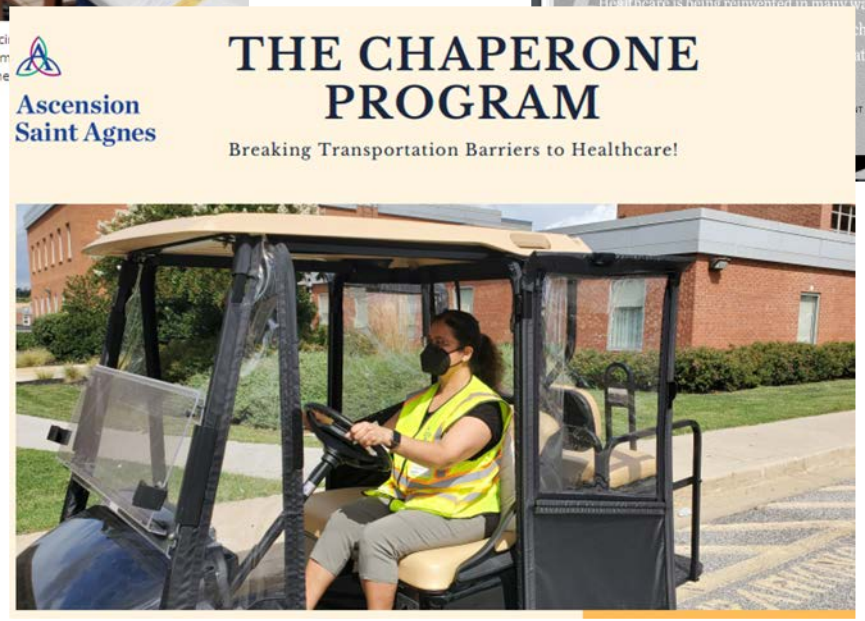
Anthony Bustillos, left, a nurse from Ascension St. Agnes Hospital, administers a Moderna vacci
My Brother's Keeper, a Catholic Charities service center in the Irvington neighborhood of Baltim
for the "next phase" of the vaccination campaign, when demand for the mass sites dips and the
clinics within communities. (Barbara Haddock Taylor)

Transforming healthcare as we know it

Our Advanced Strategic Direction

What do you do when your strategy has stood the test of time, but the world around you continues to evolve at a rapid pace? You review your Strategic Direction to ensure its focus is still right in both the current and projected future environment. That's the work the Strategy Ministry-wide Function has led this past year, partnering with leaders from across Ascension.

"As we look to the future, we see new competitors, regulatory changes, advances in science and medicine, and new expectations for how those we serve will access and receive care," said Eric Engler, Senior Vice President and Chief Strategy Officer, Ascension. "Our Advanced Strategic Direction must address this changing landscape while continuing to deliver on our Mission."



Ascension Saint Agnes

THE CHAPERONE PROGRAM

Breaking Transportation Barriers to Healthcare!

Learning Objectives

- Barriers to effective care coordination are significant and require innovative approaches
- Sometimes structural changes are needed to break down silos in our own institutions
- Even healthcare teams need navigation
- Don’t go it alone- Partner
- Listen to your community, your front line staff, and your patients

Ascension

THANK YOU

Melanie Cavaliere

Chief of Innovative Care Delivery

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