Innovative Team Based Care

DECEMBER 17, 2021
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.
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- 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.
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

**All-Payer Model**
*2014 - 2018*

- Hospital Focus
- Hospital Savings
- Hospital Quality

**Total Cost of Care Model**
*2019 - 2028*

- System Wide Focus
- Total Cost of Care Savings
- Hospital Quality & Population Health
Strategies for TCOC Model Implementation

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

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

2. Care Transformation Across the System
   - Increase the amount of Medicare TCOC or number of Medicare beneficiaries under value-based care models*
   - Improve care coordination for patients with chronic conditions

3. 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:

- Sustain and improve high quality care under the hospital finance model
- Achieve annual cost saving targets
- Demonstrate healthcare system transformation
- Advance quality, care transformation, and population health through SIHIS
Thank you!

Tequila Terry
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Health Services Cost Review Commission
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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?
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

A survey this year of more than 12,000 physicians nationwide by Medscape, a website that provides continuing education for physicians and health professionals, identified what’s causing physician burnout. Here’s a look at what physicians answering the annual survey told Medscape most causes burnout:

- Too many bureaucratic tasks: 58%
- Spending too many hours at work: 37%
- Lack of respect from administrators, employers, colleagues or staff: 37%
- Insufficient compensation or reimbursement: 32%
- Lack of control or autonomy: 28%
- Increasing computerization of the practice: 28%
- Lack of respect from patients: 17%
- Stress from social distancing or societal issues related to COVID-19: 16%

The Medscape survey also asked physicians to rate the severity of their burnout on their lives:

- Little or no impact
- Moderate impact
- Strong/severe impact
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 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.

<table>
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<tr>
<th>Final Risk Stratification Cohort</th>
<th>Values</th>
<th>3 - High</th>
<th>2 - Medium</th>
<th>1 - Low</th>
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<th>Total %</th>
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<td>%</td>
<td>%</td>
<td></td>
<td>%</td>
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<td>4 - Complex</td>
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<td>3%</td>
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<td>1,591</td>
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<td>4%</td>
<td>49%</td>
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<td>3%</td>
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<td>39%</td>
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<td>Grand Total</td>
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<td>40%</td>
<td>6,887</td>
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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.

<table>
<thead>
<tr>
<th>Appt. Date</th>
<th>Appt. Time</th>
<th>Provider</th>
<th>Patient</th>
<th>Patient DOB</th>
<th>Age</th>
<th>Language</th>
<th>Sex</th>
<th>Race</th>
<th>Attributed</th>
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<tbody>
<tr>
<td>12/8/2021</td>
<td>09:30:00</td>
<td>WALK-IN SCHEDULE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>F</td>
<td>White</td>
<td>Attributed</td>
</tr>
</tbody>
</table>

**Appointment Details:**
- Last Appointment Date: 2021-12-02
- ED Visit: 3
- Cancelled (past 12 mo): 2
- Open Referral: No Shows (past 12 mo): 0

**Appointment Notes:**
- Booster shot -> MB

**Patient Details:**
- Primary Insurance: United
- AWV:
- 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 BMI: 26.90 2021-12-02
- Weight Change: -6.50 lbs (last 6 months)

**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%

<table>
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<tr>
<th>CareCenter</th>
<th>POD</th>
<th>February</th>
<th>August</th>
<th>September</th>
<th>Overall Change YTD</th>
<th>February</th>
<th>August</th>
<th>September</th>
<th>Overall Change YTD</th>
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<tbody>
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<tr>
<td>48.72%</td>
<td>17.20%</td>
<td>14.57%</td>
<td>-34.15%</td>
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<td>72.41%</td>
<td>88.32%</td>
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<td>26.73%</td>
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<td>-30.52%</td>
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<td>91.54%</td>
<td>89.70%</td>
<td>89.12%</td>
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<td>59.70%</td>
<td>19.43%</td>
<td>17.47%</td>
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<td>88.94%</td>
<td>16.10%</td>
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<td>6.81%</td>
<td>-39.02%</td>
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<td>88.76%</td>
<td>88.11%</td>
<td>10.17%</td>
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<tr>
<td>78.95%</td>
<td>40.07%</td>
<td>36.72%</td>
<td>-42.23%</td>
<td></td>
<td></td>
<td>69.27%</td>
<td>88.37%</td>
<td>87.30%</td>
<td>18.03%</td>
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<tr>
<td>50.00%</td>
<td>32.94%</td>
<td>30.68%</td>
<td>-19.32%</td>
<td></td>
<td></td>
<td>75.68%</td>
<td>87.63%</td>
<td>86.24%</td>
<td>10.56%</td>
</tr>
<tr>
<td>64.62%</td>
<td>29.58%</td>
<td>27.24%</td>
<td>-37.38%</td>
<td></td>
<td></td>
<td>72.01%</td>
<td>84.04%</td>
<td>85.38%</td>
<td>13.37%</td>
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<td>79.31%</td>
<td>39.66%</td>
<td>42.76%</td>
<td>-36.65%</td>
<td></td>
<td></td>
<td>70.19%</td>
<td>85.28%</td>
<td>84.66%</td>
<td>14.47%</td>
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<tr>
<td>56.72%</td>
<td>27.74%</td>
<td>23.51%</td>
<td>-33.21%</td>
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<td>69.16%</td>
<td>80.35%</td>
<td>82.94%</td>
<td>13.78%</td>
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<td>67.12%</td>
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<td>20.39%</td>
<td>-46.73%</td>
<td></td>
<td></td>
<td>51.45%</td>
<td>78.94%</td>
<td>82.31%</td>
<td>30.86%</td>
</tr>
</tbody>
</table>
**Program Dashboard**

- 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.

<table>
<thead>
<tr>
<th>Area of Improvement</th>
<th>A1c (&lt;8%)</th>
<th>BP (&lt;140/90)</th>
<th>Single-Gap Patient Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncontrolled</td>
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<td>139</td>
<td></td>
</tr>
<tr>
<td>Not Tested</td>
<td>127</td>
<td>149</td>
<td>327</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Care Center Performance:</th>
<th>Diabetes Patients</th>
<th>A1c (&lt;8%)</th>
<th>BP (&lt;140/90)</th>
<th>Nephro. Screening</th>
<th>Lipid Mgmt.</th>
<th>Bundled Complete</th>
<th>Bundled Pass</th>
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<tbody>
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<td>Washington Northwest</td>
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<td>76%</td>
<td>74%</td>
<td>91%</td>
<td>82%</td>
<td>67%</td>
<td>49%</td>
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<tr>
<td>Mid-Atlantic</td>
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<td>77%</td>
<td>90%</td>
<td>85%</td>
<td>71%</td>
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<td>84%</td>
<td>74%</td>
<td>46%</td>
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<tr>
<td>Privia</td>
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<td>92%</td>
<td>96%</td>
<td>91%</td>
<td>88%</td>
<td>81%</td>
</tr>
</tbody>
</table>
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.
Thank you!
References


Population Health Management Models and Team-Based Care

Approaches for Coordinating Care Across the Medical Neighborhood

Ashley Kinder, MD
December 17, 2021
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
Barriers to Effective Care Coordination

Systems are Fragmented

- Admitted to system hospital with COPD exacerbation
- Admitted to non-system hospital with heart failure exacerbation
- Primary care transition of care follow up within system
- Cardiology/Heart Failure follow up
- Primary care transition of care follow up within system
- Discharged to subacute rehabilitation facility
- ED visit to non-system hospital with heart failure exacerbation
Barriers to Effective Care Coordination

Systems are Fragmented

- Admitted to system hospital with COPD exacerbation
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Transitional Care Teams - Each System
Primary Care Ambulatory Care Management
Payor Based Care Management
Disease Specific Care Navigation Programs
Barriers to Effective Care Coordination

Much of this work is outside of the health system

- Most of what determines health outcomes is not healthcare
  - 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

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Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)
Many of us are still learning to work in multidisciplinary teams

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


Promoting Team Based Care

Breaking Down Silos: Shared Leadership

- VP Population Health
- Medical Director Population Health
- Ambulatory Quality and VBC
- Post Acute Programs
- Community Health, Engagement and Advocacy
- Inpatient Care Management & Utilization Review
- Ambulatory, ED, and Transitional Care Management
- Behavioral Health & SBIRT
Promoting Team Based Care

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
Promoting Team Based Care

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

Partnerships and Engagement

Engage Partners & Your Community

Who in my community is doing this work?

What are the needs of my population?

Partnerships and Engagement

Anthony Baddio, left, a nurse from Ascension St. Agnes Hospital, administers a Moderna vaccine, Brother’s Keeper, a Catholic Charities service center in the Livonia neighborhood of Detroit for the “next phase” of the vaccination campaign, when demand for the mass sites dips and the clinics within communities. (Barbara Haddock Taylor)
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
THANK YOU

Melanie Cavaliere
Chief of Innovative Care Delivery
melanie.cavaliere@maryland.gov