It’s not a new concept – but it has taken time to get there


Drivers of team-based care

IHI Triple Aim Initiative
Better Care for Individuals, Better Health for Populations, and Lower Per Capita Costs

WHO definition of Health

Core Competencies for Interprofessional Collaborative Practice
Sponsored by the Interprofessional Education Collaborative®
New models of care

• Goal: provide patients with more comprehensive, accessible, coordinated and high quality care at lower costs

✓ Emphasis on primary, preventive and “upstream” care

✓ Care is integrated between:

  ✓ Primary care, medical sub-specialties, home health agencies and nursing homes

  ✓ Health care system and community-based social services

✓ EMRs used to monitor patient and population health – increased use of data for risk-stratification and hot spotting

✓ Interventions focused on both patient and population levels
Today: Everyone is on the team, including patients, families, and communities
Definitions

• **Population health** – the health status of a group of individuals, including the distribution of such outcomes within the group.

• Successful population health managers divide patients into 3 groups:
  • **Low risk patients** – 75% of patients; healthy or have a well-managed chronic condition; typically looking for convenient access to services they need most.
  • **Rising-risk patients** – 20% of patients; have multiple risk factors that could push them into high-risk category if left unaddressed.
  • **High-risk patients** – 5% of patients; have at least 1 complex illness, multiple comorbidities, and psychosocial problems.
Definitions

• **Interprofessional education** “occurs when two or more professions learn about, with, and from each other to enable effective collaboration and improve health outcomes.”

• **Interprofessional, collaborative practice** “occurs when multiple health workers and students from different professional backgrounds provide comprehensive health services by working with patients, their families, caregivers, and communities to deliver the highest quality of care across settings.”
Definitions

• **Patient centered medical home** - a model of care that emphasizes care coordination and communication to transform primary care into “what patients want it to be.”

• **Care coordination** – the deliberate coordination of patient care activities between 2 or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of comprehensive health care services.
Definitions

• **Patient and family-centered care** – the planning, delivery, and evaluation of health care that is grounded in a mutually defined partnership among patients, families and providers that recognizes the importance of the family in the patient’s life – and organized around the needs/wants of the patient.

• **Quality improvement** – systematic actions that lead to measurable improvement in health care services and the health status of the targeted patient groups.
Definitions

• **Accountable care organizations** – groups of physicians, hospitals and other health care providers who accept accountability for measuring and managing the quality and cost of healthcare services for a group of patients.

• **Regional care organizations (RCOs)** - organizations of health care providers that contract with the Medicaid Agency to provide a comprehensive package of Medicaid benefits to Medicaid beneficiaries in a defined region of the state and that meets the requirements set forth in this act. (Act 2013-261 passed by Alabama State Legislature and signed by Governor Bentley May 17, 2013)
Definitions

• **Value-based payment** – a system where payment for services is variably adjusted up or down from a standard payment based on performance using predetermined metrics intended to define quality of care and/or healthcare outcomes.

• **Telehealth** - a collection of means or methods for enhancing health care, public health, and health education delivery and support using telecommunications technologies; it encompasses a broad variety of technologies and tactics to deliver virtual medical, health, and education services.
Educational game changers

IPEC Competency Domains:

1. Values & ethics for interprofessional practice
2. Roles and responsibilities
3. Interprofessional communication
4. Teams and teamwork
National Center for Interprofessional Practice and Education

• **Vision:** We believe high-functioning teams can improve the experience, outcomes and costs of health care.

• **Goal:** To provide leadership, evidence and resources needed to guide the nation on the use of interprofessional practice and education as a way to enhance the experience of health care, improve population health, and reduce the overall cost of care.

[www.nexusipe.org](http://www.nexusipe.org)
National Center for Interprofessional Practice and Education

Transformed Health System: Our Vision

- Improving quality of experience for people, families, communities and learners
- Sharing responsibility for achieving health outcomes and improving education
- Reducing cost and adding value in health care delivery and education
• Effective interprofessional collaboration promotes the **active participation** of each discipline in patient care, where all disciplines are **working together** and fully **engaging patients** and those who support them, and leadership on the team **adapts based on patient needs**.
Effective interprofessional collaboration enhances patient- and family-centered goals and values, provides mechanisms for continuous communication among caregivers, and optimizes participation in clinical decision-making within and across disciplines. It fosters respect for the disciplinary contributions of all professionals.
Success factors in promising IP collaboration practices

• Put patients first
• Demonstrate leadership commitment to IP practice as an organizational priority through words and actions
• Create a level playing field that enables team members to work at the top of their license, know their roles, and understand the value they contribute
Success factors in promising IP collaboration practices

• Cultivate effective team communication
• Explore the use of organizational structure to hardwire IP practice
• Train different disciplines together so they learn how to work together

“Those with whom we met reported how their efforts have improved patient and provider satisfaction, created a safer environment, enhanced the quality of care, and aligned efforts in a way that helps get work done more effectively and efficiently.”
So how do we really accomplish team-based care? *One example*

1. Implement a model in which nurses and other health professionals become competent at interprofessional collaborative practice.

2. Demonstrate the efficacy of the Chronic Care Model in providing continuity of care and chronic disease management to a medically underserved population.

3. Integrate nursing and other health professions students into the IPCP model in order to gain experience with team-based care and the healthcare needs of vulnerable populations.

Supported by HRSA NEPQR UD7HP25047 (2012-2015)
PATH Clinic IPCP Staffing Plan

**Tuesday Team**
- Endocrinologist
- 2 Nurse Practitioners (NP)
- Registered Nurse (RN)
- RN Care Manager
- Dietitian
- PAP Coordinator
- Pharmacist
- Students

**Wednesday Team**
- Internist
- 2 NPs
- Optometrist
- 1 Psych/MHNP
- Psychiatrist
- RN
- RN Care Manager
- Dietitian
- PAP Coordinator
- Pharmacist
- Students

**Thursday Team**
- Internist with medical residents
- 1 NP
- RN
- RN Care Manager
- Dietitian
- PAP Coordinator
- Pharmacist
- Students
IPCP Team Development

Honeymoon (ing)
Pre-team formation optimism/pessimism

Forming
Team acquaints and establishes ground rules. Formalities are preserved and members are treated as strangers.

Storming
Members start to communicate their feelings but still view themselves as individuals rather than part of the team. They resist control by group leaders and show hostility.

Norming
People feel part of the team and realize that they can achieve work if they accept other viewpoints.

Performing
The team works in an open and trusting atmosphere where flexibility is the key and hierarchy is of little importance.

Adjourning
The team conducts an assessment of the year and implements a plan for transitioning roles and recognizing members’ contributions.
PATH Clinic morning huddles

• Each morning begins with a huddle
• All providers, staff, and students attend except triage nurses
• Patient list reviewed (time reduced to 15 min)
  • New patients versus established patients
• Discuss potential issues with flow (staffing issues, dispensary issues, medication availability)
PATH Clinic afternoon post-conferences

- Post-conference with all providers, staff, students
- Originally discussed each patient, now focus on high priority patients
- Patient Assistance Program coordinator works with providers so patients receive certain meds that are expensive
- Nurse care manager follows up with any missed appointments, necessary referrals, etc.
Lots of evaluation!

- Annual structured interviews of clinicians
- Team Fitness Test (TFT)
- Survey of the Organizational Attributes of Primary Care (SOAP-C)
- Assessment of Interprofessional Team Collaboration Scale (AITCS)
- End of clinic surveys (stopped after 9 months)
- Patient experience surveys
What did we learn?

• The road to true team-based care is steep and long
• Experienced clinicians lack understanding of the roles/responsibilities of professions other than their own
• It takes time to learn to function as a team (Tuckman’s stages of team formation: forming, storming, norming, performing)
• Unexpected feeling of “leaderlessness”
• Ultimate success! teamwork, holistic approach to care, and patient benefit
Clinician quotes at the end of year 3

• “I have worked in healthcare for 30 years and believe that this is the way it should be.”

• “I didn’t realize the richness that having multiple perspectives could bring to patient care. I now think this is a good way to practice rather than a difficult way to practice.”

• “IPCP helps to eliminate confusion by being able to talk directly to other clinicians instead of sending notes back and forth.”
Clinician quotes at the end of year 3

• “Overall I think the collegial relationship between the providers has improved some patient outcomes.”

• “I think that the different professional perspectives positively reinforce discussions with patients... I think the patients hearing things more than once helps and patients hearing things in different terminologies helps.”
Clinician quotes at the end of year 3

• “The main thing, which is very joyful actually, is the time we spend together processing how the patients are doing and coordinating the different specialties. You know, processing time. We just don’t have that in private practice.”

• “I guess the most important lesson would be that if I had my choice for my next (practice) site it would definitely be an interprofessional practice.”
Video

Promising Interprofessional Collaboration Practices
(Robert Wood Johnson Foundation)

https://nexusipe.org/informing/resource-center/lessons-from-the-field
Behavioral Health Integration

• Care resulting from a **practice team** of primary care and behavioral health clinicians, **working together with patients** and **families**, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health, substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.
Why Integrate Behavioral Health?

1. **High prevalence** of behavioral health problems in primary care (needing long-term follow-up)
2. **High burden** of behavioral health in primary care
3. **High cost** of unmet behavioral health needs
4. **Lower cost** when behavioral health needs are met
5. **Better health** outcomes
6. **Improved satisfaction** for patients and providers

Behavioral health integration helps achieve the **triple aim**.
Prevalence

As physical health worsens, the odds of having mental illness increase.

![Graph showing the relationship between the number of physical disorders and adjusted OR of comorbid mental health disorders.](image)
Unmet Behavioral Health Needs

- **67% of individuals with a behavioral health disorder** do not get behavioral health treatment
- **30-50% of referrals** to behavioral health from primary care don’t make first appointment
- Two-thirds of primary care physicians reported **not being able to access** outpatient behavioral health for their patients due to:
  - Shortages of mental health care providers
  - Health plan barriers
  - Lack of coverage or inadequate coverage
- **Depression goes undetected** in >50% of primary care patients
- **Only 20-40% of patients improve** substantially in 6 months without specialty assistance
High Cost of Unmet Behavioral Health Needs

- Annual healthcare costs are much greater for diabetes and heart disease patients with depression

- Untreated mental disorders in chronic illness are projected to cost commercial and Medicare purchasers between $130 and $350 billion annually

- Approximately 217 million days of work are lost annually to related mental illness and substance use disorders (costing employers $17 billion/year)
### SAMHSA-HRSA Six Levels of Collaboration/Integration

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Key Elements</th>
<th>Behavioral Health, Primary Care and Other Healthcare Providers Work</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Minimal Collaboration</td>
<td>Communication</td>
<td>In separate facilities, where they: Have separate systems. Communicate about cases only rarely under compelling circumstances. Communicate, driven by provider need. May never meet in person. Have limited understanding of each other's roles.</td>
</tr>
<tr>
<td>2</td>
<td>Basic Collaboration at a Distance</td>
<td>Communication</td>
<td>In separate facilities, where they: Have separate systems. Communicate periodically about shared patients. Communicate, driven by specific patient issues. May meet as part of larger community. Appreciate each other's roles as resources.</td>
</tr>
<tr>
<td>3</td>
<td>Basic Collaboration Onsite</td>
<td>Physical Proximity</td>
<td>In same facility not necessarily same offices, where they: Have separate systems. Communicate regularly about shared patients, by phone or e-mail. Collaborate, driven by need for each other's services and more reliable referral. May meet occasionally to discuss cases due to close proximity. Feel part of a larger yet ill-defined team.</td>
</tr>
<tr>
<td>4</td>
<td>Close Collaboration Onsite with Some System Integration</td>
<td>Physical Proximity</td>
<td>In same facility within the same facility, where they: Share some systems, like scheduling or medical records. Communicate in person as needed. Collaborate, driven by need for consultation and coordinated plans for difficult patients. Have regular face-to-face interactions about some patients. Have a basic understanding of roles and culture.</td>
</tr>
<tr>
<td>5</td>
<td>Close Collaboration Approaching an Integrated Practice</td>
<td>Practice Change</td>
<td>In same space within the same facility (some shared space), where they: Actively seek system solutions together or develop work-arounds. Communicate frequently in person. Collaborate, driven by desire to be a member of the care team. Have regular team meetings to discuss overall patient care and specific patient issues. Have an in-depth understanding of roles and culture.</td>
</tr>
<tr>
<td>6</td>
<td>Full Collaboration in a Transformed/Merged Integrated Practice</td>
<td>Practice Change</td>
<td>In same space within the same facility, sharing all practice space, where they: Have resolved most or all system issues, functioning as one integrated system. Communicate consistently at the system, team and individual levels. Collaborate, driven by shared concept of team care. Have formal and informal meetings to support integrated model of care. Have roles and cultures that blur or blend.</td>
</tr>
</tbody>
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The UAB NEPQR Story

NEPQR #1
PATH Clinic
Starting teams

NEPQR #2
HF Clinic
Making teams work

NEPQR #3
BHI
Integrating behavioral health
Transitional Care Coordination IPCP Model
Across the Hospital, Clinic, Home, and Community

Leveraging Resources of Academic-Practice Partnership
Faculty/Staff Expertise, Clinical Integration, and Rapid Cycle Improvement

Behavioral Health Services
Wrap Around Process

Heart Failure and Diabetes
Underserved Population
Patient/Family Centered Care and Engagement

Population Health

Outcomes

Patient Experience

Cost per Capita
BHI Staff Hired

- Psych/Mental Health NP (one day per week each clinic)
- Psychiatrist (one day per month each clinic)
- BHI Care Coordinator (25 hours per week)
- Medical Social Worker (20 hours per week)
- Exercise Physiologist (4 hours per week) – unique approach to patients with depression
BHI Process

• All patients receive PHQ-9 plus tobacco and SBIRT screening questions prior to seeing medical clinician (every patient, every visit).
• Patients with PHQ-9 > 9 receive screen for mood disorder.
• Medical provider reviews results. Those who screen + for SBIRT questions are asked additional screening questions about alcohol/drug use (6-item UNCOPE).
• Patients who screen + for tobacco use are advised and referred (Ask, Advise, Refer).
PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: ________________________________ DATE:__________________________

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use “✓” to indicate your answer)

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several Days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead, or of hurting yourself</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

(Hospitality professional: For interpretation of TOTAL, please refer to accompanying scoring card.)

TOTAL: ____________________________

10. If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

<table>
<thead>
<tr>
<th></th>
<th>Not difficult at all</th>
<th>Somewhat difficult</th>
<th>Very difficult</th>
<th>Extremely difficult</th>
</tr>
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<td></td>
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</table>

Tobacco and SBIRT Screening

1. Do you currently smoke cigarettes or use other tobacco products? _______ Yes _______ No
2. Do you sometimes drink beer, wine or liquor? _______ Yes _______ No
3. If you are a man, how many times in the last 12 months have you had 5 or more drinks in one day? ________
4. If you are a woman, how many times in the last 12 months have you had 4 or more drinks in one day? ________
5. How many times in the last year have you used an illegal drug or used a prescription medication for nonmedical reasons? ________
BHI Process

• Patients who screen positive for a BHI concern see the BHI care coordinator prior to leaving the clinic.
• The BHI care coordinator schedules the patient for the appropriate BHI provider (sometimes the same day).
• Patients who screen positive for substance use are referred to Aletheia House for more thorough evaluation (appointment within 3 days).
• Patients receive ongoing care at the clinic.
Daniel’s Story, produced by the AIMS Center, provides an introduction to Collaborative Care.
Questions?