Cambridge Health Alliance Model of Team-Based Care
Implementation Guide and Toolkit

We would like to especially acknowledge Tom Bodenheimer and Ed Wagner, whose work serves as the foundation for all of our work on team-based care. Our model of care has also benefitted greatly from what we have learned from other teams going through patient-centered medical home transformation in the Safety Net Medical Home Initiative, the Massachusetts Patient-Centered Medical Home Initiative and in the Robert Wood Johnson Pursuing Perfection program.

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A. The Cambridge Health Alliance (CHA) Team-Based Model of Care

The current infrastructure for primary care is grossly insufficient to meet the population management needs of a primary care patient panel. In a study of primary care provider work hours required to meet existing guidelines for acute, preventative, and chronic care, McGlynn et al estimated in 1993 that it would take a primary care physician 22.6 hours a day to effectively meet the needs of a panel of 2500 patients: 4.6 hours for acute care, 7.4 hours for preventative care, and 10.6 hours for chronic care (McGlynn et al, NEJM 2003).[1] Not surprisingly, this same study found that adults in the United States only receive an average of 54.9% of recommended care in each of these areas. Despite this predictably poor performance, numerous studies have shown that the absence of primary care leads to dramatic worsening of population health outcomes, increased mortality, and increased costs. It is not possible to achieve improved population health outcomes for members of the Commonwealth without substantially strengthening the infrastructure of primary care.

It is not surprising that we find ourselves in the midst of a major primary care workforce crisis in the United States, unfortunately just as we have expanded access to patients. A number of medical home efforts have focused on both strengthening primary care, developing a team model of care, and developing team-based accountability for improving patient experience, population health and cost. In the context of healthcare reform with its increased demand for primary care access, however, this does not seem to be a tenable solution. Especially for safety net providers, who have historically provided access to some of the most vulnerable patients in the Commonwealth, closing panels is simply not a desirable option in the context of healthcare expansion for low income patients.

The foundation to achieving the Triple Aim outcomes of a patient-centered medical home is the primary care team. This team needs to have the capacity to deal effectively with the patient's acute care needs, preventative health needs, and chronic care needs to achieve effective population health outcomes. In addition, this team needs to be highly effective in coordinating care and providing complex care management to high risk patients.

At Cambridge Health Alliance, we have been working to discover how to provide effective population health to a safety net, underserved population for over a decade and to discover how this care differs from that of the commercial population. Over the last ten years, we have systematically implemented processes to improve population health. We began to develop a team model of care for chronic disease management 10 years ago to manage diabetes and asthma more effectively as part of the Robert Wood Johnson Foundation Pursuing Perfection Initiative. This effort has led to dramatic improvements in our care, the most notable of which has been the dramatic improvement in pediatric asthma outcomes, with >90% reduction in emergency room visits and inpatient admissions.[2] More recently, we have been learning how to improve complex care management for our Medicaid managed care population. We have learned some valuable lessons about what is needed to improve population health in the safety net as a result, and have developed the following foundational principles for our model of care:

1) It is critical to have a team model of care to sustainably meet the acute care, preventative care, and chronic care needs of our safety net patient population. This involves both creating an expanded primary care team and clearly defining roles, responsibilities, and workflows so that the care needs of the population can be met. In addition, there needs to be sufficient attention to training team members to function at the top of their license or scope of practice and to developing tools to help them provide care effectively. Above all, the team model of care needs to facilitate the development of a trusted relationship between the consumer and key care team members.

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[1] McGlynn, E et al. 1993.

2. Bielaszka-Duvernay C. Mar 2011. "Toward The Triple Aim: INNOVATION PROFILE: Taking Public Health Approaches To Care In Massachusetts" Health Affairs 30:3435-438; doi:10.1377/hlthaff.2011.0162

2) Unlicensed but engaging, culturally competent members from the communities we serve can have a profound impact on improving health outcomes if they receive appropriate training and monitoring. We have demonstrated improvements in diabetes and preventative health outcomes through the role of the Planned Care Coordinator (see Charts 1 and 2). These team members are of extraordinarily high value in improving the health of our community, and help to stretch more expensive clinical resources over a larger amount of the population.

3) The need to reinforce basic health literacy in our diverse safety net patient population is dramatic and can easily be impacted. This includes basic information about how the health care system works, the role of primary care, the role of patients in their own health, basic information about medications and refills, and about how to remain insured.

4) In the safety net patient population, given the incredibly high prevalence of mental health and social health issues as well as physical health issues, it is essential that we address mental, physical and social issues together in an integrated way. This requires close coordination among the providers of mental health and primary care. In addition, a population health approach to this patient population requires providers who have a different mix of skill sets in providing care management. A poorly controlled diabetic who is in denial about their presents a very different care management challenge from a patient with mental illness and homelessness who has poorly controlled diabetes because they lack the place and skills to store and take medications effectively. These differences are essential to consider in designing effective care management services for this population.

5) Care management for both routine and complex patients, who have needs in more than one of these areas, therefore requires a team approach. According to a recent IHI white paper on care coordination for patients with multiple health and social needs, the care management team needs to have the capacity to effectively address mental health, medical frailty or complexity, and social instability or lack of social support.[3] We have envisioned care management occurring as a dynamic interplay between the usual care team and the complex care team depending on the complexity of the patient at that moment.

[3] Craig, C, Eby, D, and Whittington, J. Care Coordination Model: Better Care at Lower Cost for People with Multiple Health and Social Needs. IHI Innovation Series white paper. Cambridge, Massachusetts: Institute for Healthcare Improvement; 2011. (Available on www.ihi.org)

What is a team?
A team is a group of people working together to achieve a common purpose for which they hold themselves mutually accountable.

What is teamwork?
- Teamwork is the interaction or relationship of 2 or more health professionals who work interdependently to provide care for patients.
- Teamwork means members of the team*:*
    - Respect and value each others work
    - Demonstrate competency in their work
    - Work collaboratively for patient-centered care and improved outcomes
    - Benefit from working collaboratively
    - Participate in shared decision-making
    - Know when teamwork should be used to optimize care

Why Patient Care Teams?
- To provide safe, timely, effective, efficient, equitable, patient-centered care* in a systematic way
    - *Remember that the patient is the "captain" of their team! Patient-centered care teams deliver care that is respectful of and responsive to individual patient preferences, needs, and values and ensure that patient values guide all clinical decisions
- To be able to care for each and every patient, a panel and the population – tailored to the patient needs.
- A healthcare system that supports effective teamwork can:
    - Improve the quality of patients care
    - Improve efficiency
    - Enhance patient safety
    - Reduce unbalanced workloads and
    - Improve employee satisfaction

Key Principles of Team-Based Care at CHA:
1. Every patient is assigned to a care team that, at the very least, includes a primary care provider, nurse, medical assistant and receptionist.
2. The team huddles daily to care for patients in a proactive way.
3. The teams meet at least monthly to proactively manage the work of population health and to discuss high risk patients. At most sites, teams meet weekly or biweekly.
4. The usual care team interfaces seamlessly with the complex care management team.

What is a team? Who's on the team?
1. Session Team – The team that is seeing the patient on any given day (at the very least, includes the Provider and MA working together that day; ideally includes the RN and receptionist). Participates in the daily huddle. Ideally, the session team would be the same people as the Planned care team.
2. Patient's Planned Care Team – The patient's "go to" team. This team is accountable to and for a panel of patients and manages all of the care of the 95% of usual care patients.
3. Coverage Team or Pod – a structure to support a higher level of access and continuity for patients and sharing of staff; usually contains one-three planned care teams. When the patient's PCP is not available, the patient may see another provider in this group.
4. Complex Care Management Team – The team who is responsible for managing the care of the top 5% highest risk patients in collaboration with patient's planned care team.

Getting Started

What are the steps to build a Patient Care Team at our site?

1. ***Define Goals and develop a shared aim***. Create a sense that these are *our* patients
   Examples:
   - Improvement of patient's and community's health based through evidence-based practice
   - Improvement in access to care
   - Improvement in service to patients
   - Provider and staff satisfaction and joy in work
   - Improvement in practice's financial performance

2. ***Define specific, measurable outcomes and objectives***
   Examples:
   - At least 90% of patients with diabetes will have ≥ 2 HgbA1c per 12 months
   - At least 80% of female patients between 40-69 years will receive a mammogram
   - Each team member will achieve an explicitly defined goal for personal professional development
   - Members of the assigned team will attend at least 80% of scheduled team meetings
3. ***Assign roles for each team member and define and delegate functions and tasks***
   - Determine which people on the team are best qualified to perform the tasks within the clinical and administrative systems of the practice (efficiency)
   - Introduce team members so they know who each other are
   - Introduce each members role (skills) so members on the team know what each other *does* and *can do* in their role
   - Maximize the role of each team member within the scope of their licensure and skills
   - Ensure that the *right* person is doing the *right* task for the *right* patient at the *right* time (is the team efficient in their workflow?)

4. ***Ensure that each team member is competent to perform their defined and delegated functions and tasks***
   - Provide education and training for the functions and tasks that each team member performs
   - Provide adequate IT training. Include EPIC, Outlook, and StaffNet (intranet)
   - Provide education and cross-training to substitute for other roles (in cases of absences, vacations, or periodic heavy demands on one part of the team
   - Provide all team members with communication training for effective teamwork
   - Assess competency of team members at least once each year (performance review) and have team members set goals which contribute to team performance
     - ✓ Communicate each member's competencies to the other team members!

5. ***Ensure that clinical and administrative systems support team members in their defined work***
   Examples:
   - Procedures for providing prescription refills
   - Procedures for informing patients of laboratory results
   - Procedures for making patient appointments
   - Policies on how decisions are made in the practice
   - Work schedules allow time for team members to perform all parts of their job
   - Adequate level of permissions in EPIC which allow teams to perform

6. ***Create communication structures and processes***
   Examples*:*
   - Schedule team meetings and/or "huddles"
   - Hold team members accountable for attending and participating in team meetings and "huddles"
   - Clearly communicate expectations, assignments, tasks, roles to all team members

- In between team meetings, routinely communicate through electronic information (i.e. EPIC In Basket and Outlook). These communications will help team members know the work is getting done.
- In between meetings, share important information through brief verbal interactions among team members
- Provide feedback to care team members on a daily basis re: work well done and opportunities for improvement
- Decide on a process for conflict resolution among team members and implement the process

7. *Use data to assess <u>team</u> progress and performance at least every month, ideally every week.*
   - Are we accomplishing the work we set out to do as a care team?
   - Are we meeting our goals and objectives?
   - Where are our opportunities for improvement? What will we test to see if it results in an improvement?

8. *Practice teamwork! Be innovative and try new things!*

9. *Share your learning with other care teams at your site and at other health centers!*

Considerations in Forming Teams

How many teams should be organized at my site? One per panel.
HINT: Let the number of PATIENTS per team be your guide……..

- Consider Planned Care Teams as the smallest number of people who can accountably be responsible for achieving the population health outcomes for patients.
- Consider forming coverage teams as pairs or clusters of providers and staff who can cover for each other during planned and unplanned absences. This can help the covering teams know the patients.
- Each care team at a particular site should have a balanced patient population in order to balance the workload
- Some teams have organized around a language of a patient population, especially if team members speak that particular language.
- A RN, MA, Front Desk, RD, SW, etc. may be on more that one team depending on the number of staff at a site
- One team may have more than one RN, MA, Front Desk, RD, SW, etc. depending on the number of staff at a site.

  HINT: Assign everyone at your site to a team!
- Schedules of team members may influence who is on the team. In order to facilitate communication, consider overlap of schedules among team members
- Literature suggests that $\leq$ six team members is the optimal size and teams with greater that twelve members are too large.

  HINT: If the team is too large:
  - There may be too many hand-offs which can increase the risk of errors (of omission)
  - Communication among larger teams may require more effort

  HINT: if the team is too small:
  - There may be staff who touch the patient who are not included in the team's planning, communication, or work effort leading to redundancies, inefficiencies, and missed opportunities

Team members and their roles:

Provider	• Prepares for, attends and participates in team meetings and huddle(s): see table • Collaborates in developing team priorities and patient goals and care plans • Keeps problem list, medication list and patient care plan updated for team members • Approves orders and referrals for health maintenance
Nurse	• Prepares for, attends and participates in team meetings and huddle(s): see table • Collaborates in developing team priorities and patient goals & care plans • Active in patient education, goal setting, self management teaching & coaching • Medication reconciliation and education • Chronic disease care management
Medical Assistant	• Prepares for, attends and participates in team meetings and huddle(s): see table *Team Huddles* • Responsible for patient flow on day of visit: o Completes required pre-visit and visit preparation using the MA Standards of Care checklist o Reviews and completes any overdue health maintenance and open orders at every visit o Completes appropriate documentation of questionnaires o Completes follow up work after visit • Completes planned care team outreach assignments between visits • Maintains room stocking
Medical Receptionist	• Prepares for, attends and participates in team meetings and huddles: see table *Team Huddles* • Completes team outreach assignments including but not limited to follow up phone contact, appointment scheduling, and letters.
Planned Care Coordinator	• Facilitates team meetings and participates in follow up. • Provides a bridge between patients and their healthcare team • Manages dashboard, prepares reports for team meetings and tracks results. • Provides support and coaching for patient /planned care teams • Works with team members to organize group visits for patients with chronic diseases
Clinical Pharmacist	• Attends team meetings for chronic disease management and participates in development of patient care plans • Collaborates with providers on medication management • Reviews medical record and status of patient health and makes suggestions to other team members regarding med management • Completes patient visits for medication review and management, makes recommendations for medication adjustments to providers and patients, educates patients about use of their medications
Volunteer Health Advisor	• Assists in outreach calls for health maintenance issues and chronic disease management. • Participates in peer-led group visits, community-based health fairs, reminder calls

Mental Health Specialist	• Assists patients with resources • Provides counseling, facilitates support groups for patients living with chronic conditions. • Provides expert consultation and supports the work of the primary care teams
Community Resource Specialist	• Works closely with patients and their planned care teams to facilitate community connections and access to a range of psychosocial resources both within and beyond CHA's immediate network. • Performs a wide range of functions which safely, effectively, and efficiently support CHA patients to address their personalized health goals. • Includes direct interface with patients and members of site based care teams with the purpose of facilitating access to resources and removing barriers to social supports

	that facilitate patient health and safety • In the context of a supportive, short-term, problem-solving relationship with patients effective resource utilization will improve patient experience of care, promote population health and wellness and ensure patient engagement and empowerment.
Nutritionist	• Assists patients with nutritional counseling • Facilitates and participates in group visits for patients living with chronic disease conditions • Provides expert consultation and supports the work of the primary care relationship and overall health of the patient.
Complex Care Manager-Nursing	• Receives Complex Care Management referrals, assesses appropriateness for Complex Care, works with patient/caregiver/co-learner to develop goals, informs care team if inappropriate for complex care and makes recommendations for care plan in usual care team • Attends team meetings • Provides clinical support and direct care management including patient education, goal setting, self management teaching and coaching for the care team's top 5% highest risk patients • Provides care coordination, follow up, and population management • Assess readiness for transition back to usual care team or to more intensive level of care such as ESP, SNF • Works in coordination with CCM Social Worker
Complex Care Manager-Social Work	• Receives Complex Care Management referrals, assesses appropriateness for Complex Care, works with patient/caregiver/co-learner to develop goals, informs care team if inappropriate for complex care and makes recommendations for care plan in usual care team • Attends team meetings • Provides mental health support, linkage to ongoing mental health treatment, direct care management including patient education, goal setting, self-management teaching & coaching for the care team's top 5% highest risk patients. • Assess readiness for transition back to usual care team or to more intensive level of care such as ESP, SNF

Who is on a care team? What is their role? What are their functions and tasks?

How is the work of a Care Team Organized?
The work of care teams to deliver proactive, population-based, patient-centered primary care is divided into 3 domains of work: pre-visit, visit, and between visit work.

Care Team tasks:	**Who?**
<u>Previsit</u>	
• Assist patient to prepare for visit:	MA, receptionist via letter
o bring medications to visit	
o prepare questions to ask provider	
o come in for pre-visit lab tests	
o invite family member to visit if patient prefers	
o do previsit questionnaires on MyChart	
• Confirm need for interpreter	Receptionist
On the day before/of the visit—before the patient arrives	
• Make sure all rooms are stocked per standards with supplies, including printer paper.	MA

• Prepare intake packet in advance for each patient and place at the reception desk. o Previsit forms to identify patient goals for the visit o Medication lists o Patient-specific screens (PHQ9, PEDS/PSC, ACT questionnaire, etc)	MA or receptionist
Place orders in advance in EPIC for anticipated labs, radiology, immunizations	MA/provider depending on whether standing orders exist
• Huddle	Provider-MA (minimum); RN and receptionist strongly preferred

On the Day of the Visit – After the Patient Has Arrived	**Who?**
• Verify address and phone number	Receptionist
• Verify MyCHArt and text message preferences	Receptionist
• Give med reconciliation list to patient and verify pharmacy	Receptionist/MA
• Give intake form(s) to the patient: meds, allergies, family history, past medical history and encourage patient to fill out in the waiting room.	Receptionist
On the Day of the Visit--In the Exam Room Before the Provider Has Arrived	
• Complete vitals and previsit work per MA Standards.	MA
• Review health maintenance needs and close as many gaps as possible	MA
o Obtain healthcare proxies and pend order	MA
• Visibly place FOBT cards in exam room for patient overdue for colorectal cancer screening	MA
o Schedule mammogram, eye exam, colorectal screening, etc. as health maintenance needs are identified; update HM	MA/receptionist
• Administer PHQ-9/other mental health patient self-assessment for patients being screened or monitored for mental health disorders	MA
• Place monofilament on counter and have patients take their shoes off if they have diabetes	MA
• Administer ACT questionnaire for patients with asthma	MA
• Complete falls assessment for elderly patients	MA
• Complete all age-specific assessments (eg, hearing and vision screening)	MA
• Help patients identify their goals for the visit and for their health	MA, CRS (Community Resource Specialist)
• Review and reconcile medications and identify refill needs	MA and Provider
• Assess for tobacco use and domestic violence	MA
• Review EPIC Snapshot and lock on exam room computer screen	MA
• Provide prescriptions for medications that are due to expire	Provider
• Update problem list	Provider
• Assess patient's educational needs	All team members

• Create care plan as needed for patients who are at higher risk (eg, diabetics with A1C >= 8, persistent asthmatics, patients with depression PHQ9 >= 15, patients perceived by the team as high risk)	Provider, RN, complex care manager
• Share care plan with patient	Provider, RN
• Provide appropriate educational/self-management tools for patient	MA, RN, Provider
• Administer immunizations	RN or LPN
• Give after visit summary to patient and review with the patient	Provider, MA
• Schedule patient for primary care follow-up, specialty appointments	Receptionist, MA
Between visits	
• Follow-up on test results	Provider
• Monitor Health Maintenance and use Planned Care outreach process to help patients address gaps.	MA, receptionist, Planned Care Coordinator, Community Resource Specialist
• Normal Pap, Mammogram tracking	MA
• Track all important appointments to completion	Receptionist or referral coordinator, community resource specialist
• Follow-up on missed appointments (primary care/specialty/radiology)	Receptionist, referral coordinator
• Schedule additional primary care and specialty appointments	Receptionist, referral coordinator, MA
• Utilize prescription renewal as opportunity to manage patient's care	RN/Provider
• Routine Care Management	RN
o follow-up with patients with ED and inpatient discharges	Team RN
o follow-up with patient for abnormal cancer screening	RN with team support
o follow-up with patients with newly diagnosed or poorly controlled chronic diseases, such as diabetes and depression	RN
o Provide coaching and support with patients enrolled in care management; revise treatment plan as needed; adjust treatment per guidelines or per provider recommendations; communicate treatment changes to PCP; continue follow-up until patient meets goals or opts out of care management	Team RN, Provider, RD, MA
o proactively outreach by phone (and/or mail) re: chronic illness care and health maintenance needs; review progress toward goals; reinforce self-management goals	Team RN, CCM-depending on needs, pharmacist
o proactively outreach by phone (and/or mail) re: chronic illness care and health maintenance needs	Team RN/nurse care manager depending on complexity

What is the difference between a Team "Meeting" and a "Huddle"?

	TEAM MEETINGS	"HUDDLES"
Meeting Frequency	o Goal: weekly o Minimum: biweekly	Goal: before each session (AM & PM)) Minimum: once a day Ideal: In addition, post-session quick huddle for f/u tasks
Amount of Meeting Time	30-60 minutes depending on weekly/ biweekly *This meeting time should occur during a time when team members CAN ATTEND and coverage for their work is available. Team meetings are part of administrative time for providers.*	Average 10 minutes or less! * Who's coming in today: what do they need? * Who was in the hospital/ED and what is the plan for f/u?
Attendees	All assigned members of the Planned Care Team **Required participants:** Provider, Nurse, Medical Assistant, Medical Receptionist, Planned Care Coordinator, and Complex Care Managers (for high risk case discussions) **Support team participants:** Clinical Pharmacist, Nutrition, Mental/Behavioral Health, Social Work, Patient Navigators, Community Resource Specialists	• A provider and the MA who are working • together to see the patient that day. • The receptionist joins the team if at all possible to assist with scheduling of appointments. • The team RN connects with this team either during the huddle or sometime during the day to review the hospital/ED f/us.
Focus of meeting	Planning for care of a *panel/population* of patients. This includes patients who touch the health care system regularly (during appointments and phone contacts) and those who do not touch the health care system regularly. Includes planning for their: o Health Maintenance issues o Chronic Care issues o Social and Resource issues o High risk patients	Planning for care of the patients scheduled *to receive care* during the session/day by the provider. Includes planning for flow of the session *(i.e. provider informs RN that this patient on the schedule will be a quick follow up and an add on can be double booked in this slot)* Includes planning for patient's: o Health Maintenance issues o Chronic Care issues o Urgent Care issues *(i.e.provider informs MA that this patient will need an EKG, this one a throat culture, etc.)*

Huddle Strategies and Checklist

A good huddle can be done in as little as 10 minutes. It does require everyone to show up on time, which means, if your first appointment is at 8:30 am everyone on the patient care team must show up at 8:15 am to begin the huddle. Most teams build their huddle time into their work schedules.

What is needed for a successful huddle?

1. All team members present (typical teams include the provider, MA, and Nurse) added benefit to have other members: team receptionist, pharmacist, nutrition, covering PA/NP, behavioral health
2. Everyone is on time!
3. A place for the team to meet with a couple of computers available for the team to use
4. Intense and purposeful focus. No interruptions! Do not be distracted by phone calls, emails, or other staff.
5. Proximity! A team shouldn't spread out in a room sitting in chairs to huddle. Imagine how sports teams huddle. They get up close, heads together, and speak to each other with focus and energy. Try to mimic this kind of huddle.

Team Huddle Guidelines:

1. Occur twice a day- before each session
2. Be kept to less than 10 minutes
3. Become a daily clinic practice routine

The Goal of Huddles is for everyone to feel calm: It is so much calmer planning for these bumps before they happen rather than dealing with them in the midst of seeing patients, isn't it?

What do you talk about? You discuss the patients that are coming in that day for their appointment and people you may need to worry about:

1. Patients with chronic disease: administering PHQ-9's for depression, Asthma questionnaire/Peak Flow, or removal of shoes and socks for Diabetics
2. Patients who are often late, problematic or have high service needs
3. Canceled appointments
4. Patients who need follow-up from the hospital or ED
5. Team communicates about future/standing immunization, lab, and radiology orders and Provider places those future/standing orders not covered under CHA Standing Order Policies
6. Confirm which patients may need an interpreter for their visit
7. Population Health: those who will need FOBT cards, mammography, pap smear, PSA

What determines "an effective" huddle:

1. Everyone contributes
2. Team anticipates as much as it can
3. Strategies are developed to handle potential problems or scenarios

More strategies for effective huddle and high performing team:

1. Do a quick check in with everyone
    A. How is everyone feeling today?
    B. Is anyone leaving early?
    C. Is anyone out today?
    D. How can we support each other through the session?
2. Know the status of each team member because everyone is critical to the success of the team.

Team Huddle Assessment Tool:

Purpose: Huddling seems variable by teams within and across the system. We are looking for best practices around huddling. This tool is for use by members of the team in team self-evluation.

Huddle defined: Discussing the days care

	Every session	Most sessions	Some sessions	rarely
Do you huddle with a provider?				
Do you huddle with a nurse?				
Do you huddle with a medical assistant?				
Do you huddle with a receptionist?				
Do you discuss admitted patients, ER admits, or recently discharged patients with your care team?				
Do you huddle with other clinic staff?				

	always	sometimes	rarely
Do you discuss admitted patients with your care team			
Do you discuss patients recently discharged with your care team			
Do you discuss patients recently discharged from the ED with your care team			

Huddling with the MA is good because:
Could be better if:

Huddling with the RN is good because:
Could be better if:

Huddling with the front desk is good because:
Could be better if:

If a member of your team had information about patients admitted to non CHA hospitals or being discharged from non CHA ED's do you have a system to address the needs of the patient in transition?

Team Huddles: Making a game plan for today

	MA	Provider	RN	Receptionist
Prepare for the huddle.	o Review schedule of patients for the session, and reasons for visits o Review health maintenance needs o Review DM/asthma/ depression chronic care needs o Review open orders o Assist in preparation of intake packets	o Review specialist and hospitalist communications about patients coming in/in the hospital. o Review test results o Note if patients with complex/chronic disease need a care plan updated o Note any orders/referrals that are outstanding (incomplete) o Enter any orders you would like done in advance of rooming as future orders.	o Prepare list of team patients discharged from the hospital. o Prepare list of team patients in ED since last huddle. o Discuss risk and follow up with provider and team in preparation to call later. o Identify high risk patients on today's schedule for warm handoff to RN or to complex care manager. o Review immunization needs	o Note number of available appointments and requests for appointments. o Note who needs to be offered MyCHArt and text messaging. o Complete preparation of intake packets o Note any orders/referrals that are outstanding (incomplete) o Note which extended team members are present and availability
Review patients coming in today.	o Ask for clarification of priorities (How much can we get done today?) o Clarify open orders to complete o Proactively discuss likely issues with flow, lateness, or high service needs	o Suggest extended team members who might assist patients for possible warm handoffs o Proactively discuss likely issues with flow, lateness, or high service needs	o Suggest extended team members who might assist patients for possible warm handoffs	o Plan to assist with scheduling overdue referrals or tests. o Proactively discuss likely issues with flow, lateness, or high service needs
Review patients discharged from the hospital or ED		o Discuss when to see patients who have been in the ED or inpatient unit for follow-up.	o Discuss when to see patients who have been in the ED or inpatient unit for follow-up.	o Schedule these patients based on patient and team preferences.
Review major patient requests for letters, forms etc				o Review requests for referrals, forms, letters etc with the team.
Document individual patient plans for today in Snapshot Specialty field	**Documentation in EPIC:** Allows other staff to assist today if needed, for example during breaks or busy times Allows notes to remain in place for the future if patient misses or reschedules the appointment Serves as a reminder for today for each team member			

Structure of Care Management Program
All sites receive complex care management through our centralized and hospital-based complex care management teams. Additionally, we are in the process of implementing primary care-based complex care management to address the needs of the top 5% of our population. The remaining 95% of the population receives usual care management for management of chronic diseases, care transitions and social issues through the usual care team. At sites with primary care based care management

The complex care manager RN serves as the primary care manager for that top 5% of patients who have a variety of fundamental and high risk drivers of complexity of care. The duties include: receiving and seeking referrals from usual care teams of patients appropriate for complex care management, stratification of risk based on chart review and provider/team input, patient assessment, medication reconciliation, medication management, referral coordination, assist with patient/caregiver/co-learner goal setting and education. Social barriers to health care are supported by the community resource specialist/case worker supporting all of the patients in the practice. The complex care manager Social Worker is the primary care manager for patients with complex mental illness and secondary care manager for patients with complex medical illness with mental health (psychiatric illness)or behavioral health (behavioral impediment to health behaviors) co-morbidity.

The reasons for referral to complex care management are outlined below to assist primary care teams in making referrals.

Complex Care Management Referral Guide: Medical/Psychosocial Criteria

Higher Risk Drivers	Moderate Risk Drivers	Fundamental risk drivers
UTILIZATION: Inpatient or ED visits for medical or psychiatric reason in the past three months.	**DISENGAGEMENT:** Patient has **chronic conditions AND has been disengaged** from primary care > 1 year	**CHRONIC DISEASE:** Patient has one or more **uncontrolled/severe physical health conditions**
ACTIVE SUBSTANCE ABUSE DIAGNOSIS	**PHYSICAL/MENTAL/LEARNING DISABILITY:**	**CHRONIC PAIN** .
HOMELESSNESS	**PRESCRIPTION MEDICATIONS (EXCLUDING OTC)** Patient has **10or more active** prescription medications **OR** has newly prescribed, changed **OR** unstable high risk medications such as anticoagulants or insulin.	**PHQ 9 SCORE**>/= 15 over 2 screenings within the previous 6 months (Please submit a recent (< 6 mos.) score with referral.
MENTAL HEALTH CONDITION that is **severe, persistent, and/or uncontrolled.**	**SOCIAL SUPPORT:** Patient has no active social supports **OR** Patient has social supports that are inconsistent, chaotic or detrimental.	**PAYER RISK:** Patient has been identified by payer as "at risk" (If known).
	FEDERAL POVERTY PROGRAM INVOLVEMENT OR ELIGIBLITY	**SAFETY**: Patient/team has concerns for patient safety.
	LITERACY AND LANGUAGE NEEDS	**OTHER:** Issues or concerns not other specified.

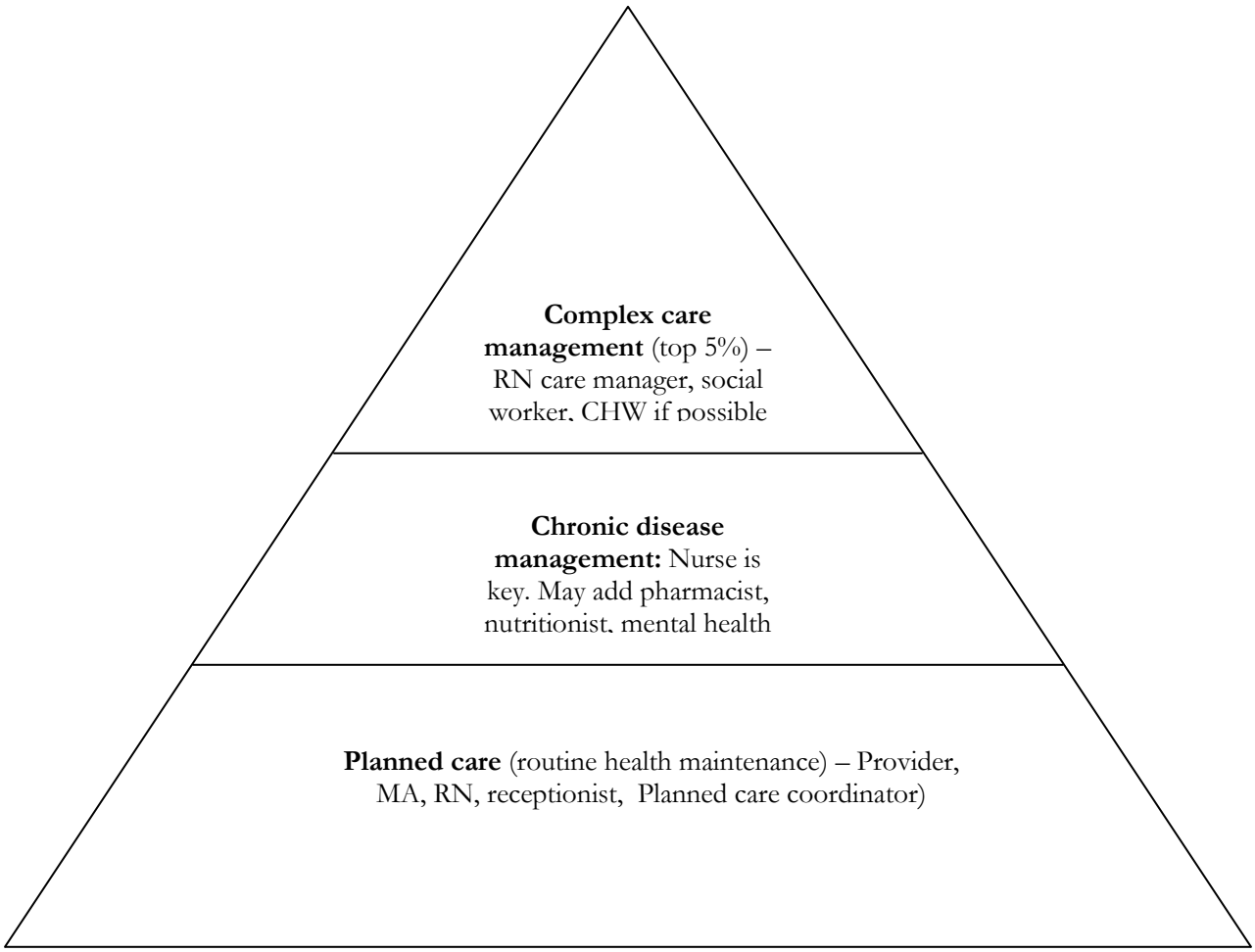
Once referred for Complex Care Management, active outreach by a care manager will take place. Next steps include:

1) Obtaining consent to participate in Complex Care Management
2) Assessment to determine impactability, engageability and care plan if appropriate
3) If a patient is determined to be not eligible, or unwilling to participate in complex care management, a care manager will advise the patient's team and include suggestions for care planning.

Patients **NOT** appropriate for Complex Care Management:

- Patient has Care Management at a Specialty Practice (cancer center, sickle cell clinic; complex behavioral health or addiction services)
- Patient involved with Elder Service Plan, Commonwealth Care Alliance or other well coordinated care management program
- Patients who need multiple basic needs for assistance with food, housing, literacy, transportation without other risk factors. Those needs are to be met by usual care at health center, especially if a relationship has been well established with community resource specialist or case worker. Complex Care Manager will be happy to consult with existing usual care staff.

Figure 3: How Patients Receive Routine and Complex Care Management



How Chronic Disease Care Management takes place:

1. Visit at Clinic for Care Management (with one Care Management member or the patient may see a combination of : Team RN, Clinical Pharmacist, and/or Dietician)
2. Phone Contact for Care Management by Team RN and Clinical Pharmacists
   Team RN:
   - Diabetes (Initial Assessment and/or Follow Up)
   - Depression Outreach-
   - Abnormal Pap Smear Follow up
   - Abnormal Mammogram Follow up
   - ED and Post-hospitalization Follow up
   - Other patient related Chronic Disease follow up as requested/referred by Provider

   Clinical Pharmacists:
   - Diabetes Follow up
   - Asthma Follow up –teaching/consults
   - Anticoagulation Treatment- AMS program
   - Hypertension Follow up & lipids

Visit for Chronic Disease Care Management	**Who?**
• Review EPIC Snapshot and perform chart review	Team RN, Pharmacist, Nutrition
• Review and reconcile medications	Team RN, Pharmacist
• Administer PHQ-9 patient self-assessment (Diabetic and F/U Depression Patients)	Team RN
• Update problem list	MD RPh will do this when applicable
• Assess patient's educational needs	Team RN, Pharmacist, Nutrition
• Provide appropriate educational materials for patient	Team RN, Pharmacist, Nutrition
• Administer immunizations	Team RN, Pharmacist (limited Immunizations)
• Develop goals and coaching plan with patients	Team RN, Pharmacist, Nutrition
• Give after visit summary to patient	Team RN, Pharmacist, Nutrition
• Schedule patient for primary care follow-up, specialty appointments	Receptionist
Risk Stratification if CCM referral is necessary and route visit to PCP to communicate care plan	Team RN, Pharmacist
Post-visit from Level 2 Chronic Disease Care Management Visit	
• Review test results from care management visit	Team RN, Pharmacist, Nutrition
• Follow-up on test results	Provider; Pharmacist
• Schedule additional primary care and specialty appointments	Receptionist

• Follow up to see if patient has questions regarding care plan and future appointments	Team RN, Pharmacist, Nutrition
<u>Between visit from Chronic Disease Care Management or Provider Visit</u>	
• Chronic Disease Care management	Team RN, Pharmacist, Nutrition, CCM
o Provide coaching and support with patients enrolled in care management; Revise treatment plan as needed; Adjust treatment per guidelines or per provider recommendations; Communicate treatment changes to PCP; Continue follow-up until patient meets goals or opts out of care management	Team RN, Pharmacist, Nutrition, CCM
o proactively outreach by phone (and/or mail) re: chronic illness care and health maintenance needs; review progress toward goals; reinforce self-management goals	Team RN, CCM- depending on needs
• Utilize prescription renewal as opportunity to manage patient's care	Team RN, Provider, CCM-depending on needs
• Follow-up with all ED and inpatient discharges	Team RN, MA, Provider, CCM-depending on needs
• Follow-up on missed appointments (primary care/specialty/radiology)	Receptionist, referral coordinator

Cambridge Health Alliance Diabetes Management Services Program (DMSP) – An Example of How Chronic Disease Management Works

The CHA DMSP is designed to educate and support adult patients in successful self-management of diabetes. Core program elements include Medical Nutrition Therapy (MNT), pharmacotherapy inclusive of development and management of an insulin treatment plan for insulin dependent patients, and Diabetes Self-Management Education (DSME). The DMSP multidisciplinary team that works with the patient to engage and support them in achievement of their diabetes management goals includes nurses, pharmacists, dieticians, social workers, and physicians.

DSME is an on-going individualized process of facilitating the patient's knowledge, skills, and abilities necessary for diabetes self-care and incorporates use of Teach Back methodology and Motivational Interviewing techniques. This process includes *1*) assessment of the individual's specific education needs; *2*) identification of the individual's specific diabetes self-management goals; *3*) education and behavioral intervention directed toward helping the individual achieve identified self-management goals; *4*) evaluation of the individual's attainment of identified self-management goals (revised from *Report of the Task Force on the Delivery of Diabetes Self-Management Education and Medical Nutrition Therapy*, Diabetes Spectrum, Vol. 12, No. 1, 1999)

Pharmacotherapy is evidence-based medication management of diabetes related treatments by a clinical pharmacist. The services include medication initiation, titration or discontinuation, medication patient education, laboratory monitoring and treatment care planning. Patient specific treatment care plans are developed in collaboration with the patient and their multidisciplinary care teams to best manage glucose, blood pressure, lipids and renal insufficiency. Pharmacists provide DSME and reinforce ongoing training from other team members.

MNT is an evidence-based application of the Nutrition Care Process focused on prevention, delay or management of diseases and conditions. MNT involves an in-depth assessment, periodic re-assessment and intervention by a registered dietitian (American Dietetic Association Revised Standards of Practice and Standards of Professional Performance for Registered Dietitians, 2011). Most insurers cover at least 3 hours of MNT per year, and additional hours can be requested by PCP.

DMSP OBJECTIVES

The primary objectives of diabetes management include optimizing metabolic control, preventing disease progression, preventing and managing complications, and maximizing the patient's quality of life through a coordinated multidisciplinary team approach to engage, educate, and support the patient in self management of his/her care. The following DSM program elements were designed to assist the patient and multidisciplinary team in achievement of those objectives:

A. Continuous self management patient education and support
   - Provide detailed diabetes education related to pathophysiology of diabetes mellitus, goals for therapy, symptoms and management of hyperglycemia/hypoglycemia, short and long term complications of diabetes, proper foot care and sick day management
   - Counsel patient on purpose and proper administration of oral agents and insulin treatment program, all other current medications, and addition of any new medications to current regimens
   - Instruct and support the patient to make healthy life style modifications (Appendix A)
     - Smoking cessation, weight management, healthy eating, exercise, and limiting alcohol consumption.
   - Self-monitoring of blood glucose (SMBG)
     - Assist the patient in the selection of an appropriate glucose meter (Appendix B), instruct on proper use, care and maintenance of the meter

  - Observe patient perform a test and demonstrate competence in care and maintenance of the meter
  - Review records of self monitored glucose at each visit to help patients identify, understand, and manage impact of food, activity and medications based on the pattern of glucose testing results
- Support the patient to develop effective problem solving and coping skills related to disease process and desired lifestyle changes

B. Maximize the benefits of drug therapy and reduce unwarranted side effects, drug-drug interactions and food-drug interactions.

C. Manage and prevent episodes of hypo / hyperglycemia through review of HbA1c, estimated Average Glucose (eAG) and percentage of SMBG readings that are within goal range with patient at each visit.

D. Sustained follow up to support self-care and provide consistent disease monitoring and management for diabetes and related renal and/or cardiovascular issues, i.e. hypertension, lipid management, nephropathy

E. Monitor effectiveness of patient treatment plan and DSM program by tracking the following clinical indices for DSM program patients: HbA1C, Blood glucose, self monitored blood glucose (SMBG), lipid profile (fasting cholesterol, HDL-C, LDL-C, and TG), urine albumin, electrolytes, weight, blood pressure, eye exam, and depression screen

DMSP REFERRAL CRITERIA

Adult diabetic patients are referred to the program by the patient's primary care physician or through outreach efforts. Program referral criteria include:

- All newly diagnosed diabetic patients
- All patients new to the practice with preexisting diabetes diagnosis
- All diabetic patients who meet the following clinical indices:
  - ✓ BP greater than 140/90
  - ✓ LDL equal to or greater than 100
  - ✓ HbA1c equal to or greater than 8

DMSP OUTREACH CRITERIA

Adult diabetic patients receive outreach efforts by a member of the DMSP team if they meet any of the following criteria:

- Diabetics who meet DMSP referral criteria but who have not yet been enrolled in the program
- Diabetic patients with missed DMSP appointment

DMSP REFERRAL PROCESS

Patients with diabetes may be referred to the Registered Dietitian, Nursing, Pharmacy, Endocrinology, at any stage of therapy. CHA providers complete an electronic Nutrition or Pharmacotherapy referral in EPIC. The nutrition referral is sent to the referral coordinator and Central Referral Office; the pharmacotherapy referral is sent to the Pharmacotherapy DSMP designated order inbox automatically once signed.
For a referral for Nurse Care Management, CHA providers electronically forward the patient's chart in Epic and/or perform a "warm hand-off"/face-to-face introduction of the diabetic patient to the Team RN. The current Nurse DMSP referral process is being re-worked to be more aligned and electronically mimic the Pharmacotherapy and Nutrition referral workflows.

OVERARCHING GOALS OF THE DMSP MULTI-DISCIPLINARY TEAM

Members of this multidisciplinary team retain their individual disciplinary identity, but work interdependently, consult with one another, and have shared patient goals.

- Refer, schedule and introduction (when possible) to appropriate team members as needed for optimal care
- Communicate with team members and ensure outreach and follow-up are adequate
- Monitor health maintenance schedule, vaccinations and referrals needed at each visit or follow up communication as appropriate
- Utilize technology, physical co-location and other tools to make care most efficient and streamlined, including scheduling patient appointments in a patient centered approach
- Collaborate to meet established CHA ambulatory quality goals
- Ensure active standing orders are in place in accordance to Policy C-PFH-0064 (Standing Laboratory Orders for Diabetes Management-Ambulatory); Education and effective communication from the team to the patient regarding laboratory results and implications toward self management goals

Multi-Disciplinary Team Member Roles & Repsonsibilities
Diabetes Care at Primary Care Site

Primary Care Provider (PCP):

- Diagnosis & treatment of diabetes patients per clinic guidelines
- Determine risk stratification level of diabetic patient for team management
- Create shared visit agenda with patient to help meet patient's DSM goals
- Selects patients to refer to other team members based on needs; Communicates with patient and refers accordingly, warm-hand off introduction if possible and plan for follow-up with each team member
- Collaborate and attend planned care meetings, provide clinical input
- Reviews daily schedule for diabetes-related activities and notes needs on the appt notes

Registered Nurse (RN) :

- Diabetes Self-Management goal setting via direct patient education , telephone follow-up and coordination with other team members to meet those needs; Utilization of motivational interviewing
- Outreach to Diabetes patients for planned care needs, referrals and sick day/post- discharge follow-up and between PCP visit continuity of care
- Assesses progress toward goals and develops an individualized care plan, documented in the EPIC record
- Communicate changes to the risk stratification category
- Medication titration per protocol (e.g. insulin titration)
- Monitor laboratory values and progress toward goals in collaboration with team
- Vaccinations as appropriate
- Reviews daily schedule for diabetes-related activities and notes needs on the appt notes

Medical Assistant/Medical Receptionist/Licensed practice nurse (MA/LPN):

- Appointment scheduling, ensure referral processing and coordination, reminders, outreach
- Insurance verification
- Vaccinations as appropriate (LPN)
- Laboratory and health maintenance reminders and outreach
- Communicate to team members progress on responsibilities
- Route incoming calls for health care requests and coordination of care
- Reviews daily schedule for diabetes-related activities and notes needs on the appt notes

Planned Care Coordinator (PCC):

- Identify clinical needs proactively by review/scrubbing of monthly quality reports and communicating what is needed in a timely fashion
- Reviews daily schedule for diabetes-related activities and notes needs on the appt notes
- Schedules and manages all team meetings and delegates tasks to appropriate team members

Clinical Pharmacist (RPh) :

- Diabetes Self-Management goal setting via direct patient education , telephone follow-up and coordination with other team members to meet those needs; Utilization of motivational interviewing
- Outreach to Diabetes patients for planned care needs, referrals and sick day/post- discharge follow-up and between PCP visit continuity of care
- Assesses progress toward goals and develops an individualized care plan, documented in the EPIC record
- Manages medications prescribed to meet DSM goals and clinical goals, including dosage titration, initiation and discontinuation of medications, monitor laboratory values and progress toward goals in collaborative practice with PCP.
- Vaccinations as appropriate
- Reviews daily schedule for diabetes-related activities and notes needs on the appt notes

Registered Dietician (RD):

- Assesses patient recommended dietary needs, creates a patient-centered plan to meet appropriate dietary goals
- Responsible to collaborate with care teams regarding diabetes nutrition needs in the absence of attending regular team meetings; Outreach to appropriate patients and follow-up with previously seen patients

Social Worker:

- Collaboration in complex care management
- Assistance with social, financial and insurance related concerns
- Coordinate family and caregiver support

Multi-Disciplinary Team Goals

- Refer, schedule and introduce (when possible) to appropriate team members as needed for optimal care
- Communicate with team members and ensure outreach and follow-up are adequate
- Monitor health maintenance schedule, vaccinations and referrals needed at each visit or follow up communication as appropriate
- Utilize technology, physical co-location and other tools to make care most efficient and streamlined, including scheduling patient appointments in a patient centered approach
- Collaborate to meet established CHA ambulatory quality goals
- Ensure active standing orders are in place in accordance to Policy C-PFH-0064 (Standing Laboratory Orders for Diabetes Management-Ambulatory); Education and effective communication from the team to the patient regarding laboratory results and implications toward self management goals

Extended PCMH Diabetes Management Resources

- If patient meets risk criteria for Complex Care Management (CCM), referral to Complex Care manager
- Registered Dietician at alternate CHA site, if schedule on-site is not adequate for patient.

- Certified Diabetes Educator (CDE): referral to CDE provider for more intensive DSM education and planning as needed.
- Referral to specialty services: Ophthalmology, Endocrinology, Podiatry, Neurology, Cardiology, Vascular, Wound Care , Dental
- **Group Education and support groups:** My Life, My Health, Diabetes group visits (some sites), other external groups

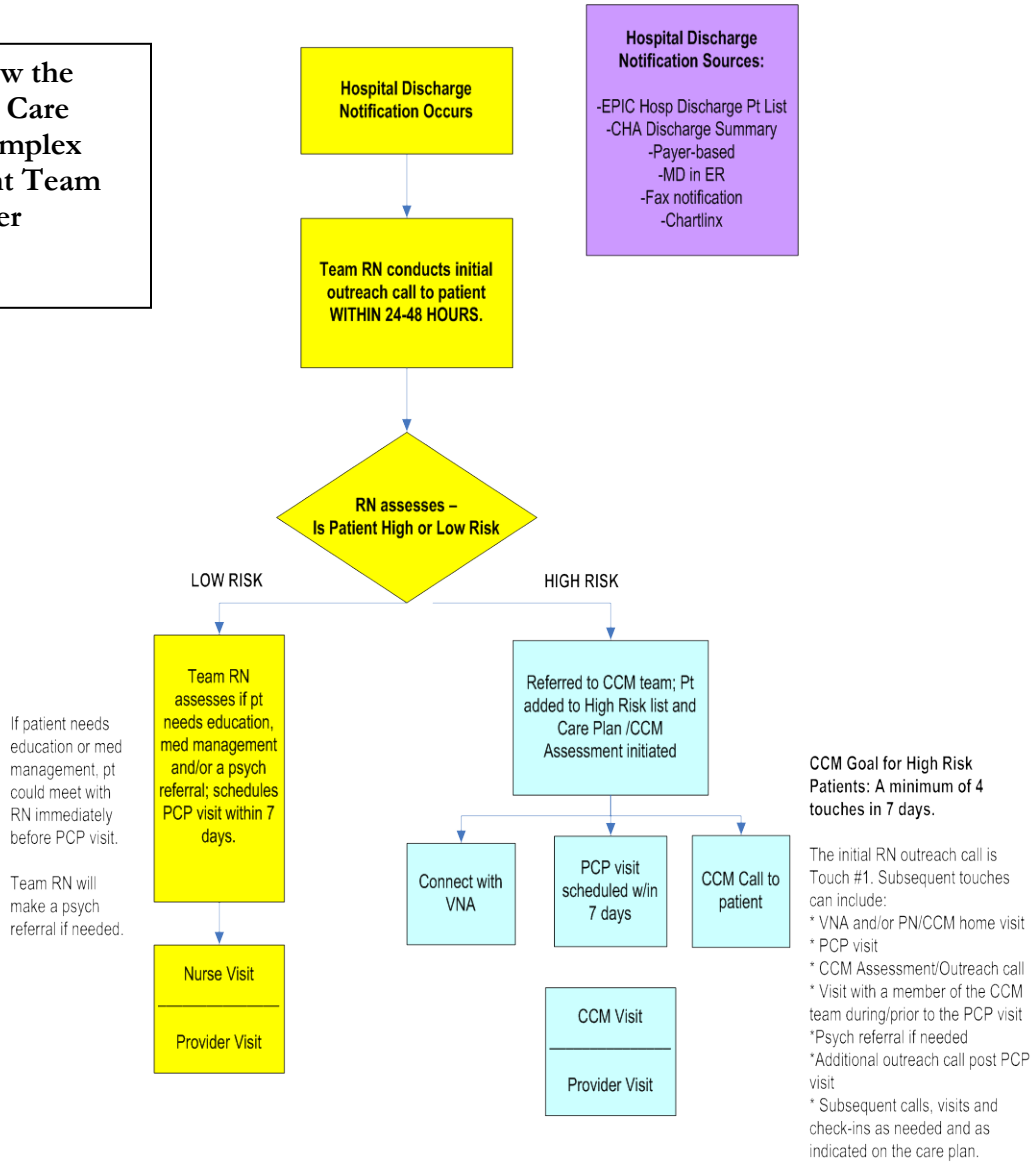
Referral Criteria

- All newly diagnosed diabetes patients
- All patients new to the practice with existing diabetes
- **All patients who do not meet ambulatory quality goals*:**
  - HgbA1c < 8
  - BP < 140/90 (or < 130/80 with microvascular disease)
  - LDL < 100
- **Prioritization of referrals for:**
  - Diabetic patients not at BP goals despite appropriate medication
  - Patients with BMI > 35 to see registered dietician

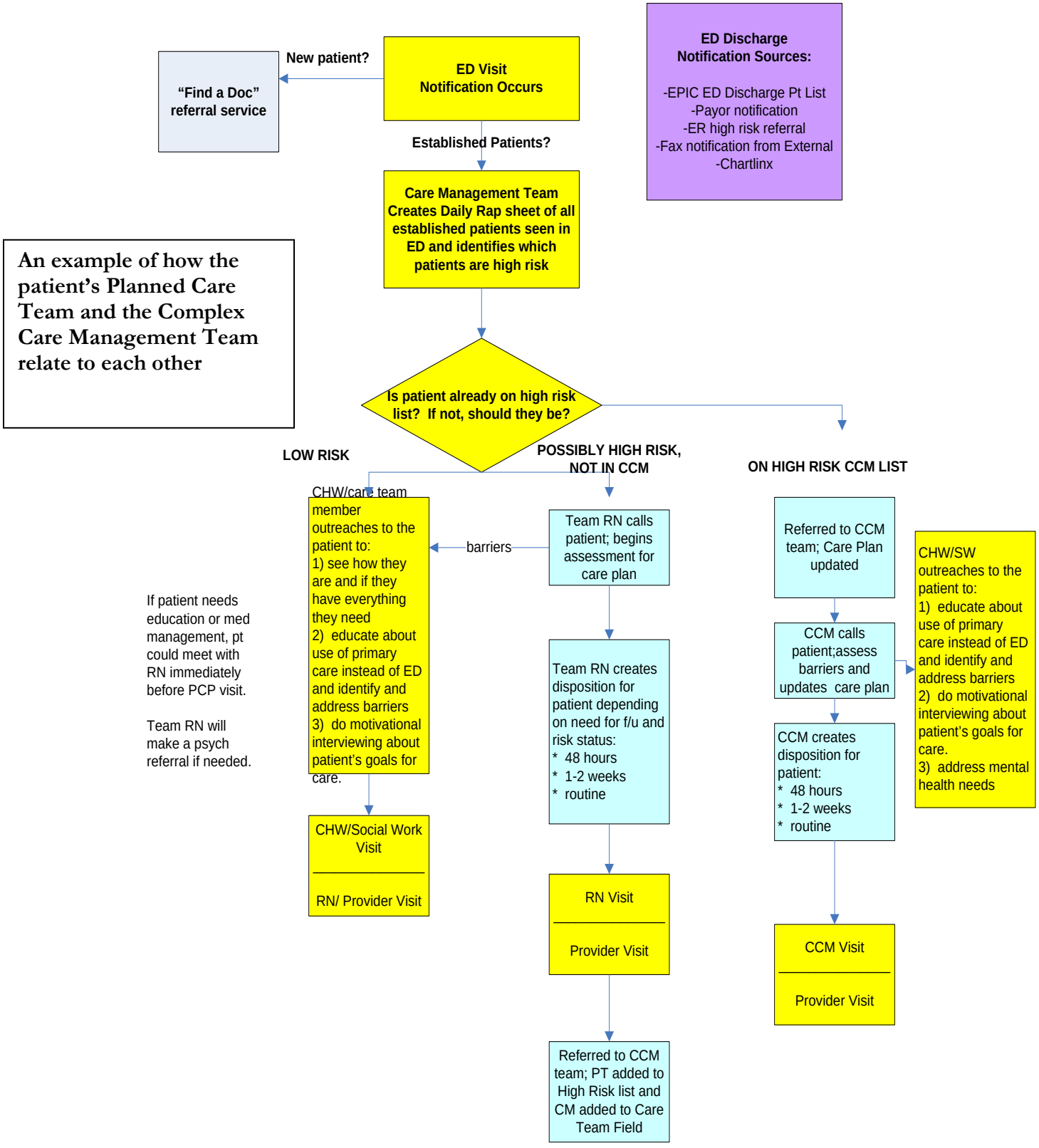
Diabetes Type 2 Standard of Care	Routine Care (Level 1)	Care Management (Level 2)	Complex Care (Level 3)
Diagnosis			
Review lab tests related to the diagnosis of Type 2 Diabetes		PCP	
Confirm diabetes diagnosis		PCP	
History			
Medical & Family	PCP		
Assessment of life style habits and activity level	PCP	RN, Clin Pharm, RD	CCM
Determine CVD co-morbidities: HTN, dyslipidemia, other CVD risk factors	PCP	RN, Clin Pharm, RD	CCM
Assess cultural & psycho social issues	PCP	RN, Clin Pharm, RD	CCM
Assess social & economic resources	SW or CRS	RN, Clin Pharm, RD	CCM
Screening and assessments			
Depression Screening	MA	RN	CCM
Tobacco use Screening	MA	RN, Clin Pharm	
Care Team Huddle for daily schedule	PCP, RN, MA, receptionist	PCP, RN, MA, Clin Pharm, RD, CCM	
Vital Signs			
Blood pressure & pulse	MA	RN, Clin Pharm, RD	
Height, weight (to generate BMI)	MA		
Comprehensive physical exam			
Comprehensive physical exam	PCP		
Shoe and sock removal for visual evaluation	MA		
Foot check with monofilament	PCP	RN	
Labs, Vaccines, Tests (Provider ordered or by Standing Order)			
HbA1c	MA		
Fasting Lipid profile or direct LDL	MA		
Urine microalbumin, serum creatinine/CMP	MA		

Hospital Discharge WorkFlow

An example of how the patient's Planned Care Team and the Complex Care Management Team relate to each other



ED to Outpatient Transition



Levels of Team-Based Care

Level	Who is on the team as a caregiver?	What supportive team structures are in place?	What kind of work is done as a team?	Team-Based Access	Who leads/is responsible for the team?	How does the team improve its work?
1	Provider alone	Meets less than monthly as a team to discuss panel of patients.	Little or none	Patients identify with their provider alone; messages come to provider triaged by RN, who are not empowered to resolve. Providers have access/training to use quality reports,	Provider; Planned Care Coordinators help to lead the quality work but primarily serve as outreach workers.	No structured process for team member suggestions to come through – general "if you have an idea" send it your way.
2	Provider and MA	Pre-session huddles routine between at least the provider and MA meet at least monthly to proactively discuss Planned Care.	Quality/population health work; flow work	Patients begin to identify both their provider and their MA. MAs and medical receptionists receive access to registries/tools to manage patients.	MAs become the captains of flow and lead achievement of Planned Care goals during the visit before the doctor has seen the patient.	Formal process for team members to make suggestions to improve the practice based on what they've learned (suggestion box, suggestion sheet).
3	Provider, MA and RN **or** receptionist	Presession huddles routine with RN or receptionist; meets weekly as a team to do Planned Care.	Daily work and population health work; some outreach by team RN to high risk patients	Team-based scheduling to assure continuity of care	MA emerges as the leader for the routine Planned Care work. Receptionist emerges as leader for referral work.	Practice improvement team (PIT) formed that includes frontline staff, patients, and a leadership supporter.
4	Provider, MA, RN **and** receptionist	Presession huddles routine with RN and receptionist; coscheduling or colocation of part of the team (at least provider-MA during session).	All core work is done as a team; RN plays an increasingly important role as a chronic disease manager; may be supported by LPN	Calls routed to the care team; improved first call resolution. Team-based scheduling to assure continuity of care through visits, portal, etc	RN emerges as the leader for chronic disease management work.	Seamless process of care teams communicating improvement suggestions to leadership and PIT.

5	Provider, MA, RN, receptionist, complex care manager	Presession huddles for the whole team. CCM part of weekly team meetings to discuss high risk patients. Coscheduling and colocation of the clinical care team	Team works with complex care management team to connect usual care to complex care	Team accesses patient at home and throughout the continuum of care; telephone and portal f/u common	CCM emerges as the leader for the highest risk work.	Culture of continuous quality improvement, measurement, and rigorous process of spread that permeates how the practice does its work (beyond care teams).
6	Provider, MA, RN, receptionist, CCM, integrated mental health specialist	Presession huddles for the whole team including a mental health clinician; CCM part of weekly team meetings to discuss high risk patients. Mental health clinician joins team meetings to discuss patients with MH issues. Coscheduling and colocation of the core clinical care team.	Patients move seamlessly between usual care, chronic disease management, and complex care management, with support of a whole person orientation that integrates physical and mental health	Telemedicine, evisits, phone visits routine with between patient and their care team	Every team member knows what part of the work they lead and feels competent, empowered and accountable for achieving the needed outcomes, with others on their team.	

Team-Based Behaviors Assessment (please check who is involved)

	Provider	MA	Receptionist	RN	CCM	MH provider	Opportunities for improvement	Action Plan
Pre-session huddles to integrated planned care into every visit								
Planned care meetings □ weekly □ biweekly □ monthly								
Team discussions about high risk patients □ weekly □ biweekly □ monthly								
Colocation								
Coscheduling								
Patients can identify the following members of their team								

Huddle Evaluation Tool for Leadership Team
(Tool for evaluation of Leadership Team huddles and Daily Care Team Huddles)

	Yes	No	Comment
1. Communication Clear?			
2. Roles and Responsibilities understood?			
3. Situation awareness * maintained?			
4. Workload Distribution?			
5. Did anyone ask for or offer assistance?			
6. Were errors made or avoided?			
7. What went well, what should change, what can improve?			

Definition of Situation Awareness: The state of knowing the current conditions affecting the team's work:

- Knowing the status of a particular event
- Knowing the status of the team's patients
- Understanding the operational issues affecting the team

Maintaining mindfulness

\ Appendix A:

DEALING WITH THE DIFFERENT TYPES OF PEOPLE/SITUATIONS IN TEAM MEETING

The following descriptions of different types of people and potentially difficult situations are presented here to stimulate your thinking about how **you** might handle these effectively during a care team meeting that you are leading. Preparing ahead of time may even help you prevent such problems. Each situation is different; therefore use your best judgment to determine what suggestions might be effective in real situations.

If a difficult situation persists, discuss it with your co-workers. Together, you will get the support you need and can decide how best to handle the problem.

The Too-Talkative Person

This is a person who talks all the time and tends to monopolize the discussion.

The following suggestions may help:

- Remind the person that we want to provide an opportunity for everyone to participate equally.
- Refocus the discussion by summarizing the relevant point, then move on.
- Spend time listening to the person outside the group.
- Assign a buddy. Give the person someone else to talk to.
- Use body language. Don't look toward the person when you ask a question. You may even consider having your back toward the person.
- Talk with the person privately and praise him/her for contributions, and ask for help in getting others more involved.
- Thank the person for the good comment, and tell him/her that you want everyone to have a turn at answering the question.
- Say that you won't call on someone twice until everyone has had a chance to speak once first.

The Silent Person

This is a person who does not speak in discussions or does not become involved in activities.

The following suggestions may help:

- Watch carefully for any signs (e.g., body language) that the person wants to participate, especially during care team meetings like brainstorming and problem solving. Call on this person first, but only if he/she volunteers by raising a hand, nodding, etc.
- Talk to them at the end of the care team meeting and find out how they feel about the team meetings.
- Respect the wishes of the person who really doesn't want to talk; this doesn't mean that they are not getting something from the team meeting.

The "Yes, but . . . " Person

This is the person who agrees with ideas in principle but goes on to point out, repeatedly, how it will not work for him/her.

The following suggestions may help:

- Acknowledge team members concerns or situation.
- Open up to the rest of the care team.

- After three "Yes, but's" from the person, state the need to move on and offer to talk to the person later.
- It may be that the person's problem is too complicated to deal with in the team meeting or the real problem has not been identified. Therefore, offer to talk to the person after the meeting and move on with the agenda for the team meeting.
- If the person is interrupting the discussion or problem-solving with "Yes, but's," remind the person that right now we are only trying to generate ideas, not critique them. Ask him/her to please listen and later we can discuss the ideas if there is time. If there is no time, again offer to talk to the person during the break or after the team meeting.

The Non-participant

This is the person who does not participate in any way.

The following suggestions may help:

- Recognize that the people in the teams are variable. Some may not be ready to do more than just listen. Others may already be doing a lot, or are overwhelmed. Some may be frightened to get "too involved." Still others may be learning from the team meetings, but do not want to talk about it in the group. Whatever the reason, do not assume the person is not benefiting from the group in some way, especially if he/she is attending each session.
- Do not spend extra time trying to get this person to participate.
- Congratulate those team members who do participate.
- Realize that not everything will appeal to everyone in the same way or at the same time.
- Do not evaluate yourself as a leader based on one person who chooses not to participate.

The Argumentative Person

This is the person who disagrees, is constantly negative and undermines the team. He/she may be normally good natured but upset about something.

The following suggestions may help:

- Keep your own temper firmly in check. Do not let the group get excited.
- If in doubt, clarify your intent.
- Call on someone else to contribute.
- Have a private conversation with the person; ask his/her opinion about how the group is going and whether or not he/she has any suggestions or comments.
- Ask for the source of information, or for the person to share a reference with the group.
- Tell the person that you'll discuss it further after the session if he/she is interested.

The Angry or Hostile Person

You will know one when you see one. The anger most likely has nothing to do with the leader, care team or anyone on the team. However, the leader and team members are usually adversely affected by this person and can become the target for hostility.

The following suggestions may help:

- Do not get angry yourself. Fighting fire with fire will only escalate the situation.
- Get on the same physical level as the person, preferably sitting down.
- Use a low, quiet voice.

- Validate the participant's perceptions, interpretations and/or emotions where you can.
- Encourage some ventilation to make sure you understand the person's position. Try to listen attentively and paraphrase the person's comments in these instances.
- If the angry person attacks another participant, stop the behavior immediately by saying something like: "There is no place for that kind of behavior in this group. We want to respect each other and provide mutual support in this group."
- When no solution seems acceptable ask, "At this time, what would you like us to do?" or "What would make you happy?" If this does not disarm the person, suggest that this issue will need to be addressed outside of the team meeting and ask them to excuse themselves from the team meeting.

The Questioner

This is the person who asks a lot of questions, some of which may be irrelevant and designed to stump the leader.

The following suggestions may help:

- Don't bluff if you don't know the answer. Say, "I don't know, but I'll find out."
- Redirect to the team: "That's an interesting question. Who in the group would like to respond?"
- Touch/move physically close and offer to discuss further later.
- When you have repeated questions, say, "You have lots of good questions that we don't have time to address during this session. Why don't you look up the answer and report back to us next week."
- Deflect back to topic.

The Know-It-All Person

This is the person who constantly interrupts to add an answer, comment, or opinion. Sometimes this person actually knows a lot about the topic and has useful things to contribute. Others, however, like to share their pet theories, irrelevant personal experiences and alternative treatments, eating up team meeting time.

The following suggestions may help:

- Restate the problem.
- Limit contributions by not calling on the person.
- Establish the guidelines at the start of the session and remind participants of the guidelines.
- Thank the person for positive comments.
- If the problem persists, invoke the rule of debate: Each member has a right to speak twice on an issue but cannot make the second comment as long as any other member of the group has not spoken and desires to speak.

The Chatterbox

This is a person who carries on side conversations, argues points with the person next to him/her or just talks all the time about personal topics. This type of person can be annoying and distracting.

The following suggestions may help:

- Stop all proceedings silently waiting for the team to come to order.
- Stand beside the person while you go on with workshop activities.
- Arrange the seating so a leader is sitting on either side of the person.
- Restate the activity to bring the person back to the task at hand or say, "Let me repeat the question."

- Ask the person to please be quiet.

The Abusive Person
This is someone who verbally attacks or judges another group member.

The following suggestions may help:

- Remind the team that all are here to support one another.
- Establish a team rule and remind everyone that each person is entitled to an opinion. One may disagree with an idea someone has but under no circumstances will personal attacks be appropriate. If the abuse continues, ask the person to leave.

The Superior Observer

This is a person with a superior attitude and that he/she already knows everything about the topics on the agenda and is performing their job well.

The following suggestions may help:

- If the person knows a lot and is doing well, you may want to have them provide examples of what they do at selected times for the team.
- A person may also act superior if he/she feels uncomfortable and not a part of the group. If so, include him/her in some way.
- If the person wants to be ignored, then ignore them. They will get bored and leave or start to participate.

Appendix B: Team Meeting Information Sheet (Template)

Practice Site: _____
Planned Care Coordinator (PCC) Name: _____
Days of the Week PCC Present at Clinic: _____
Date/Time of Monthly ALL STAFF meeting: _____

Team Name (If applicable)	Date/Time of Team Meetings (i.e. 1st Monday of the month from 9-10am) **If meeting times vary, please indicate frequency of team meetings	Meeting Location	Provider(s)	RN(s)	MA(s)	Front Desk Staff	Other Team Members (SW, nutritionist, etc.)	Other Comments (i.e. group visits scheduled, planned vacation schedules for team members)

Appendix C: Team Meeting Agenda (Template)

TEAM NAME:	**Date/Time/Location of today's meeting**
Attendee Names:	
Agenda	

1. Warm up Exercise: Share one patient story that demonstrates the success of teamwork from last week's meeting (3 minutes)

2. Review EPIC Patient List or registry dashboards (panels): Is "scrubbing" required? -> if so, provider will forward patient names to Planned Care Coordinator to "clean" the patient panels.

3. Focus on a segment of the entire population for discussion. What is the work to be done this week? this month? for this segment

4. Follow up from last meeting (Population Focus:)

PATIENT NAME AND MR #
- BRIEF UPDATE ON PATIENT STATUS
- IDENTIFY NEXT STEPS FOR PATIENT AND CARE TEAM MEMBERS

PATIENT NAME AND MR #
- BRIEF UPDATE ON PATIENT STATUS
- IDENTIFY NEXT STEPS FOR PATIENT AND CARE TEAM MEMBERS

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PATIENT NAME AND MR #
- BRIEF UPDATE ON PATIENT STATUS
- IDENTIFY NEXT STEPS FOR PATIENT AND CARE TEAM MEMBERS

Summary of Tasks due - by whom? by when? (Action Items and Timeline):

Dr. XXXX

- ☐ **Task #1 Task #2**

Nurse Practitioner:

- ☐ **Task #1 Task #2**

Registered Nurse:

- ☐ **Task #1 Task #2**

Planned Care Coordinator:

- ☐ **Task #1 Task #2**

Medical Assistant:

- ☐ **Task #1 Task #2**

Front Desk:

- ☐ **Task #1 Task #2**

Appendix D: Medical Assistant (MA Checklist)

	WCC (0-18)	Adult Well Visit	Diabetic visit	OB visit	UTI symptoms	Possible pregnancy AND/OR Birth Control	Sore throat with fever	Pedi with fever	Asthma or Pulmonary issues	Postpartum	Lower extremity pain or injury	Dizzy Lightheaded	Blurred or changed vision/eye injury / Headache
See Childhood Screening Schedule	X												
PEDS/PSC/*MCHAT*	X												
Pharmacy preferred updated	X	X	X	X	X	X	X	X	X	X	X	X	X
Weight		X	X	X	X	X	X	X	X	X	X	X	X
Height		X	▲	▲	▲	▲	▲	▲	X	▲	▲	▲	▲
Blood Pressure		X	X	X	X	X	X		X	X	X	Postural BP	X
Pulse		X	X	X	X		X	X	X	X	X	Postural P	X
Temp		X			X		X	X	X	X	X		
Tobacco Verification/review	X	X	X	X	X	X	X	X	X	X	X	X	X
Pain/*Safety at home (in Soc hx)*	X	X	X	X	X	X	X	X	X	X	X	X	X
PHQ 9		X	▲							X			
O2 Sat								X	X			X	X
ACT (Asthma Control Test)									X				
Visual Acuity	X	>65										X	X
Fall Risk assessment		>65										X	
Fingerstick Glucose			X										
Urine Dip					X								
Ensure Doppler in room				X									
Measuring Tape in counter	X (0-2yr)			X									
Vibrator Fork & monofilament in room/shoes off			X										
Rapid Strep							X						
Urine HCG						X							
Check Health Maintenance	X	X	X	X	X	X	X	X	X	X	X	X	X

X	To be completed at visit
▲	Perform if not completed in the past year
Italics	*New tool coming soon*

	OB related
	Respiratory
	Well/Health Maintenance
	Diabetes

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ACKNOWLEDGEMENT

Information to prepare this toolkit was received from Collene Hawes of Group Health Cooperative, Kate Lorig of the Stanford Patient Education Research Center and John Scott of Kaiser-Colorado. Portions of this toolkit first appeared in or are derived or adapted from the Chronic Disease Self-Management Program (1999) at Stanford University.

We have benefitted greatly from what we have learned from other teams in the Safety Net Medical Home Initiative, the Massachusetts Patient-Centered Medical Home Initiative.