



cahps[®] transcript

Teamwork in Quality Improvement

February 2012 • Podcast

Speaker

Marjie Harbrecht, CEO, HealthTeamWorks

Moderator

Carla Zema, Consultant, CAHPS User Network; Assistant Professor of Economics and Health Policy, Saint Vincent College

Presentation Available

<https://www.cahps.ahrq.gov/News-and-Events/Podcasts.aspx>

Carla Zema

The Agency for Healthcare Research and Quality's CAHPS User Network welcomes you to the CAHPS podcast series on improving patients' experiences with care. I'm Carla Zema from St. Vincent College and consultant to the CAHPS User Network. I'm here today with Marjie Harbrecht, CEO of HealthTeamWorks. Marjie is here today to share her expertise on one of her favorite topics; teamwork. In our earlier podcasts in this series, we talked about why improving patient experience is so important and began discussing some of the factors that are important to any quality improvement effort, such as leadership and personnel.

Today we're going to highlight another one of those factors - teamwork. Marjie thanks so much for joining us today.

Marjie Harbrecht

Thank you for having me.

Carla Zema

So tell us, why is teamwork so important to any quality improvement effort?

Marjie Harbrecht

Well, our system has become incredibly fragmented with everyone practicing in silos, and this can become very confusing for patients who see multiple providers, often get conflicting information which can lead to higher cost in the system, such as when we need to repeat tests because we don't have access to those results or lower quality of care with potential safety issues, such as we see with adverse medication interactions. And it really leads to lower satisfaction for patients and the health care teams that feel that everyone's on a treadmill and that care is very disjointed.



Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov

As we start to really reorganize how primary care is delivered through medical homes, at the same time we also need to determine ways to bring multiple stakeholders together including payers, providers, employers, patient groups and others from a community to determine what are the best ways to share important information and coordinate care across the entire health care system -- particularly in that health care community. So there are many great efforts that we see across the country and this is to help redesign care and to help redesign payment systems, but often we see that they're not coordinated to achieve the goals that we want. They really all become one off.

Carla Zema

Great. It's certainly hard to have patient-centered care without having teamwork. Many people think of teamwork as terms of the provider team, but I know you define teamwork more broadly. What are the three components of teamwork?

Marjie Harbrecht

So really as I was saying before, this has to happen at every level. So it has to happen in the practice level where the team within the practices are really working well together. They're communicating, and they're starting to develop a care team approach. It also has to happen with patients and their families. So how do we bring them into that team where they become a key partner and it's not that we're doing care to them, but they're really a part of helping to develop that care plan and much more engaged in that to implement the care plan.

And then the third part is really starting to go outside of the practices into the entire medical neighborhood to coordinate care, so that includes specialists, hospitals, mental health and behavioral health professionals, long term care facilities. Even we've seen it with volunteers such as promotoras in certain communities that are helping to work with certain populations to avoid disparities, local churches, even the YMCA and local health clubs that can really become involved in making sure that patients can reach the highest level of health. So really those three levels are key to a successful outcome.

Carla Zema

Great. So let's break those three levels apart. First tell us what teamwork means from a provider practice perspective.

Marjie Harbrecht

This is a bit different than we have been organized in the past. Many practices are organized where we have a provider, we have a physician, we have maybe a nurse practitioner and we also have nurses or MAs, we have a front desk folk, back desk folks that do some of the billing, and administrators. And it's not that they don't work together or talk, but there is a different approach to really starting to bring every person that is in the practice to the table and recognize that individual for the skills that they bring to be able to actually engage and elevate that care team to the highest skill level that they can.

So this really starts to engage clarifying and assigning roles and responsibilities, using job descriptions, which are very important to really outline "what is my role in this practice in making sure that patients get the care that they need", even if I'm the person that answers the phone at the front desk. How can I be a greater part of the team to ensure very smooth communication, seamless communication between the team members, so everyone functions at the highest level of their licensure?

We start to put some very specific strategic plans into place that have what we call aim statements that say what do we want to accomplish in our practice, what are our, kind of a mission statement for our practice, start to set up improvement or redesign teams that include representatives from each level of the practice. And start to look at what things are working well in the practice, what things are not working well and start to develop some plans of how we want to improve those things.

That will start to really bring in regular team meetings and even huddles, like short huddles in the morning where we're starting to see in a variety of practices that are becoming very successful with this. That if they start meeting on a regular basis and really following a plan for the practice, just like you would a care plan for a patient, you start to get a much more organized and a team-based approach that can get you much better outcomes.

So for instance, an example of how team approach work in the new way would be that a patient would call in, we would identify them right there as having diabetes or needing certain tests, allow them or ask them to have those tests done even ahead of time so the results could be tracked and come back to the practice and they'd be ready for the patient visit, once the patient came in. As the patient was checking in, the nurse or MA would have a tracking sheet that would show what the patient was due for -- for their preventive conditions, their chronic disease and any acute issues they've had.

Carla Zema

Great. Sounds like without teamwork we really don't get the best out of everyone then. So what does it mean to have teamwork with the patient?

Marjie Harbrecht

So as we start to talk about patient-centered care, it really is a different thought process. In many of the care organizations that we have developed, and it's reasonable to see why this has happened, we're in very busy practices, everybody is running as fast as they can to get through their day, but unfortunately we've really designed care around the needs of the practices and our schedules. And this is really an opportunity for us to relook at how we can deliver that care in a much more efficient and effective way and bring the patients right to the center of care.

It really starts with a customized care plan that starts with shared decision-making between a physician and their provider and the patient to really determine what do they need for their care because of their age and their gender, what do they need for their preventive services, what do they need for their chronic conditions and what do they have that are acute concerns for them.

Once this customized care plan is developed, it's no longer the idea that well I'm only going to take care of you for this visit and then I'll wait until you come in for the next visit with your choosing to come in. It actually is a discussion with the patient of we know certain things that need to be done for diabetic patients, how do we make sure that we talk about you're going to have four visits this year for your diabetes, here's what we're going to do for prevention, if you have any acute issues in between, please make sure that we communicate about that. And it really becomes a shared tool for both the practices and the patients to monitor and manage together.

So just a quick example. We had a patient in one of our practices that was really struggling, had gained a lot of weight, was a diabetic, a smoker, really what we used to call a “non-compliant” patient.

And what we really start to think about now is someone that’s just not yet engaged. And so the physician really started to work with them, they got their care coordinator who is an MA and also brought their nurse in and started to work with the patient using motivational interviewing, self management support goals to actually find out what the patient felt that they could do. And one of the key things for this particular patient was they brought him into a group visit.

And initially he was very reticent, the patient ended up actually loving being able to relate to other patients with the same condition, start to understand how the support group could help him, he was able to lose weight, quit smoking and has really gotten his diabetes under control. So it’s really an amazing opportunity to engage the patient, and even their families, into the care plan to make sure that they have the support that they need.

Carla Zema

What a powerful example of a patient and provider team. So your third component was a medical neighborhood. Can you talk to us a little bit more about what that is and why it’s so important to include this in teamwork?

Marjie Harbrecht

So you could have the best medical home in the world and everybody’s working very collaboratively, we have really good communication, things are working very smoothly, patients are getting most of the care they need. But ultimately primary care and medical homes are not the only piece of the system. And so part of our job as primary care and medical homes is to help coordinate a patient’s care as they move across the entire health care system.

So that’s going to really need to engage others: specialists, hospitals, as we were talking about before, mental health and behavioral health experts, long term care facilities, nursing homes, others that are in the community that really have a lot of resources that we don’t actually connect with or use right now, because we don’t know about them. And so really starting to think about how do we use a lot more of the resources and start to communicate with others that are touching this patient that normally in today’s health care may end up just happening in silos again and fragmentation and not really coming together.

This is an opportunity to really start to utilize some care coordination functions to identify and connect to others that we need to for our patients. So, for instance, this is an example where we -- one of our practices found some community resources that they didn’t know about. This was a senior resource center that actually was able to go to a patient, it was a senior patient that had been hospitalized that had a fair amount of complications and was coming out and there was a lot of question about what were they going to be able to do, could they stay in the home or not.

By utilizing one of the community resources, they were able to put people into the home to actually do some of the immediate follow up care with nurse training, then also be able to actually help this patient with house cleaning, with staying with them when the daughter and the son couldn’t be with them. So really starting to use your community resources to support the patient and their families, as well as the practice, in helping this patient get to the best care that they could.

Carla Zema

Great. So if all of these components are working together the way they should be, what does the ideal vision of teamwork look like?

Marjie Harbrecht

So I would think just to summarize all these different components and pieces, it would be really bringing multiple stakeholders in the community together with a shared vision and leadership to determine what is the most effective and efficient way to deliver high quality, safe, affordable care to our community members. That will start both from the practice level moving upward, it will start at the community level, and it will start at the higher systems level with payment issues.

And so it would, again, look like from the ground up, patients would have a personal care team that knows who they are, what their history is, and how they can navigate the system when they're sick, but more importantly work with them to stay healthy and prevent a lot of the things that we see now that really are avoidable and don't need to happen if we can really start to get on top of it ahead of time.

That care team then will include several people working together both at the practice level, a primary care practice to bring varied skills to the table, to ensure patients get the care that they need. But then expanding that team to include either community resources or specialists, hospitals, where everybody is working together as a care team or expanded care team, sharing a customized care plan that is developed with the patients and providers and then being able to share that among all those that are touching the patient to ensure that there's a consistent message, that everybody is on the same page and that patients are not getting conflicting information.

And then really communicating with patients even in a secured patient portal or communication method where we can start to redefine visits, where it's not just patients that are sitting in front of us, but it's any way that we can manage our patient panel to get the best care that we can and not make patients have to come in to get that care. To do that, we need to redesign our payment system to incent outcomes for these populations rather than volume and make sure that providers get off the treadmill and we can promote coordinated care among all those that touch the patient so that we can restore a strong primary care base that is able to work seamlessly with the medical neighborhood to ensure more integrated and virtually integrated community care.

Carla Zema

That sounds fabulous. But I know it can also sound a little bit daunting. Can you give us some examples of what listeners can do right now today to help them work towards this vision?

Marjie Harbrecht

So it's important, although this seems very overwhelming, just start somewhere, even if you have to start small, start somewhere. It is a journey and you'll be able to get there eventually. But one of the things that we've worked with practices on is starting to build an improvement team where they bring various members to the table including a front desk person, a nurse or an MA, a physician lead, an office administrator and really start to form an team that starts to look at what's working in the practice well, what's not working and start just putting systems into place to decide.

And one of the most important things to do is actually getting a registry -- a registry functionality that might be part of your electronic medical record that can actually help you determine what patients -- let's say I'm going to look at all of my diabetic patients and determine what percent of them have gotten what they need according to the guidelines: have gotten a flu shot, have gotten their blood pressure under control, have gotten an eye exam or a foot exam. And once you start to track that, you can then start to determine how do you outreach to those patients who are not coming in and then start to manage that population.

So it's important to start small with one condition and really learn the techniques of how do you use a team appropriately and effectively and then you can start to spread to other conditions as you get more and more advanced. So that's something that many practices can do even in the current payment system and just start to track a specific population and work with that population to get them the highest care that they can according to evidenced-based guidelines.

Carla Zema

Well that is really great advice for our listeners, Marjie and thank you so much for sharing your expertise with us. In our next podcast, Donna Farley of the CAHPS Grantee Team for RAND, will be giving us an overview of how to decide exactly where to start with improving patient experience. You can download all the podcasts in this series at the CAHPS User Network Web site at www.cahps.ahrq.gov. That's www.c-a-h-p-s.a-h-r-q.gov [www.cahps.ahrq.gov]. For more information on teamwork, check out the CAHPS Improvement Guide on the Web site. This guide has a lot of useful information from planning a QI initiative through specific strategies that you can use.

You can also access other quality improvement resources, such as case studies detailing the use of CAHP survey results for QI. The CAHPS User Network also offers free technical assistance and can be reached by calling the CAHPS Help Line at 1-800-492-9261 or via email at cahps1@ahrq.gov. That's cahps, the number one, at a-h-r-q.gov [cahps1@ahrq.gov].

We thank you for joining us today and we look forward to bringing you more stories and experiences from users of CAHP surveys.

(END OF TRANSCRIPTION)