A Day in the Life: Huddles, Work flows
Creating Patient Centered Access

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A Day in the Life Team

- Provider: Dr. Cynthia Sammis
- Medical Assistant: Beth Cosman
- Office Manager: Diane Bell
- Behavioral Health representative: Holly Gartmayer DeYoung
- Also thank: Donna Beverly, Robin Bickart, Mary Stubbs and their PMH-NP
Today’s Plan: 101/201

• Collect expectations
• Frame the facts
• Get buy in
• Expand what might be acceptable/expected
• Identify a range of tools
• Role Play a real practice team’s process
• Brainstorm solutions together
Who’s in the Room?

Medical Directors, Nurses, MA’s, lead PSR, Practice Manager, CEO, Office Manager, Care Coordinator, RMA, LPN, MD, NP
Patient Centered Care

- First step (and at every step): *Ask the patient. What is important to them?*
  - This is shared decision making.

- Second step: The *relationship with the provider* must be given time and space. It is a *patient priority*.
  - This is *why we need team support*. 
Anything less just won’t do

- Empathy
- Compassion
- Flexibility
- Communication
- Education
- Quality
- Relationship
- Partnership
- Access

- Poor outcomes
- Cost
- Utilization
- Medication errors
- Silos
- Poor transitions
- Misunderstanding
- Malpractice risk
Patient – Centered Care

Access

To the provider

To a visit
“I’m not telling you it’s going to be easy – I’m telling you it’s going to be worth it.” – Art Williams
Primary Care: Is There Enough Time for Prevention?

| Kimberly S. H. Yarnall, MD, Kathryn I. Pollak, PhD, Truls Østbye, MD, PhD, Katrina M. Krause, MA, and J. Lloyd Michener, MD

Objectives. We sought to determine the amount of time required for a primary care physician to provide recommended preventive services to an average patient panel.

Results. To fully satisfy the USPSTF recommendations, 1773 hours of a physician’s annual time, or 7.4 hours per working day, is needed for the provision of preventive services.

Conclusions. Time constraints limit the ability of physicians to comply with preventive services recommendations. (Am J Public Health. 2003;93:635–641)
Development of a primary care physician task list to evaluate clinic visit


Task list has 12 major tasks, 189 subtasks, and 191 total tasks.
The Myth of Standardized Workflow in Primary Care

Discussion: PCP workflows were unpredictable during face-to-face patient visits. *Workflow emerges as the result of a “dance” between physician and patient as their separate agendas are addressed, a side effect of patient-centered practice.*

Conclusions: Future *healthcare redesigns should support a wide variety of task sequences* to deliver high-quality primary care. The development of tools such as electronic health records must be based on the realities of primary care visits if they are to successfully support a PCP’s mental and physical work, resulting in effective, safe, and efficient primary care.

Provider Access

- Patient story
- Good listening
- Education
- Charting
- Orders
- Complex medication review
- Care planning
- Medical decision making
- Screening
- Coordinating care
- Reviewing records
- Risk stratification
- Shared decision making
- Social needs
- Mental health needs
- Expectations
- Alternatives
- Relationship building
- Health coaching

Depends on the team
What is Patient-Centered Access?
Patient-Centered Visit Access is Not

• A patient is advised to call at eight o’clock for an appointment that day and calls and calls and calls

• A patient can’t get an appointment on her day off, she takes time off, the traffic is heavy she arrives at 10am, her card says 9:45 the front desk advises her appointment was at 9:30 and is unable to see her today

• A patient has an appointment at 2pm for COPD treatment review. The cab is late, the walk in is long, the patient arrives at 2:20 and is asked to reschedule for another day.

• A patient has a sore throat and is advised to go to the ER

• A patient calls the PCP office, no one answers

• A patient cannot find a PCP
Access is a Continuum

• Your team must ask where are we now?
• Where do we want to be?
Ways to Expand Access

• Panel management
• Extended schedules
• Group visits, telehealth
• Add capacity with RN or Care Management built into a visit
• Team pods: provider, MA 1:1 or 1:2 with BH, RN, Healthcoach, front desk support supporting more than one provider teamlet
Start from: How you can best serve the patient?

• Patients want whole person integrated care
• Providers want to provide this comprehensive care and their ability to do so will reduce burnout
• Population health is a team sport
• Roles must evolve, providers must let go of tasks that can be met with protocols
• Volume to value must be understood as an every time event
Communication

• “must be meticulous between the team and the patient and the provider and the team”
• Must be a flexible fluid process
• Must take into consideration the needs of the team members and the provider too
• We cant do everything for everyone, at least not all at the same visit
There are Solutions!

• Scheduling tools
  – The No-Show Reduction Playbook
  – Finding hidden capacity
• Chart preparation and pre-work
  -EHR templates
  -off load EHR data entry from provider where possible
• Work flows optimize every team member with prework
• New definition of a visit: telehealth, groups, shared
Solutions!

• The Daily Huddle: Shared care mode, MA leads
  – Patient Care Team Huddle 1,2,3
  – Huddles Increased Efficiency
  – Huddle Protocols: West County Health Centers
  – Huddle Coaching and evaluation/support
• Learn Work Flow Mapping
• Build support that nurtures each unique provider
  -scribes, clinical assistants, access to resources, EHR support, training
Tools and Resources

- Team Role Development
  - LEAP Share the Care Tool
  - Cambridge Health Alliance Model Guide & Toolkit
  - UCSF Team Documentation & Scribing Toolkit
  - SETMA MA/LVN role
  - Teamlet Model
  - Add Health Coaches to your Team
- Standing order protocols EMPOWER
  - US Preventive Services Task Force Guidelines
  - West County DM
  - Miramont Family
  - High Plains Health Center
  - Center for Excellence in Primary Care UCSF.edu
The greatest of all mistakes is to do nothing because you think you can only do a little.

*Zig Ziglar*
Stuck?

• “Start Where You Are, But Don’t Stay There”
  H Richard Milner

• Building Blocks of Primary Care Assessment
  www.safetynetmedicalhome.org

• Call your Quality Improvement Specialist

• Healthy Huddles Happen assessment tool
let’s look at a living practice innovating, adapting, breathing as they grow......
Contact Info/Questions for PCMH/Health Home Practices

- PCMH/HH Quality Improvement (QI) Specialist
- Maine Quality Counts website
  – www.mainequalitycounts.org
  
- Maine PCMH/HH webpage
  (See “Programs” → Maine PCMH/HH → Learning Collaborative)
  (can also go to “What We Do” → “Helping Practices Improve Quality” → Maine PCMH/HH)
References

Enhancing Access
http://www.improvingprimarycare.org/work/enhancing-access

The No-Show Reduction PlayBook: A tool for PCS Teams:
http://www.patientvisitredesign.com/docs/No_Show_Reduction_Playbook_revised_1.29.pdf

Coleman Associates: Finding Hidden Capacity

Coleman Associates: Rapid DPI Toolkit

The Patient Care Team Huddle 1, 2, 3 Hut, Hut!

TransforMED
Huddles: Increased Efficiency in Mere Minutes a Day

Cambridge Health Alliance Model of Team-Based Care Implementation Guide and Toolkit
http://www.integration.samhsa.gov/workforce/team-members/Cambridge_Health_Alliance_Team-Based_Care_Toolkit.pdf

USPSTF Recommendations That Were New or Updated in 2014
http://www.aafp.org/afp/2015/0515/p686.html
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Time and the Patient–Physician Relationship
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1496869/

UCSF: Healthy Huddles
http://cepc.ucsf.edu/healthy-huddles

Huddle Protocol – West County Health Centers, Inc.
http://www.improvingprimarycare.org/sites/default/files/topics/PlannedCare-Step4-Sebastopol-Care%20Team%20huddle%20roles%20and%20responsibilities.pdf

Team Documentation & Scribing Evaluation Toolkit
https://cepc.ucsf.edu/sites/cepc.ucsf.edu/files/Scribing%20Evaluation%20Toolkit%202014-0701.pdf
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UCSF Health Coaching
http://cepc.ucsf.edu/health-coaching

UCSF Workflow Mapping
http://cepc.ucsf.edu/workflow-mapping

Huddle-Coaching: A Dynamic Intervention for Trainees and Staff to Support Team-Based Care
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http://healthaffairs.org/blog/2012/01/24/patient-centered-care-what-it-means-and-how-to-get-there/

West County Health Centers Care Team Diabetes Protocol

Miramont Family Medicine Standing Orders
http://www.improvingprimarycare.org/sites/default/files/topics/MA-Step5-Miramont-MA%20Standing%20Orders_0.pdf

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http://www.annfammed.org/content/11/3/272.full
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http://www.annfammed.org/content/12/6/573.full

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