MAYO CLINIC

CENTER FOR INNOVATION

2013 COMMUNITY HEALTH TRANSFORMATION

Optimized Care Team

COMMUNITY HEALTH TRANSFORMATION

The Center for Innovation (CFI) is partnering with the Mayo Clinic Health System (MCHS) and Employee and Community Health (ECH) to create, pilot, and implement a population health model that includes:

Optimized Care Team
A colocated, multi-disciplinary group that works together to meet the needs of a shared team patient panel.

Patient-centered Care Plan
A unified tool for patients, caregivers, and clinicians to see, make, and act on care decisions together.

Wellness Navigators
A volunteer-provided, clinic-embedded service that connects patients with resources to address social determinants of health.

Community Engagement A clinic-based coordinator facilitates a self-sustaining, grassroots wellness movement with clinic and community champions.

Triple Aim:
Improve the health of the population, enhance the patient experience and reduce the per capita cost of care.

Guided by the **Triple Aim** and informed by CFI's **human-centered design** approach, these projects are contributing to Mayo Clinic's preparations for the radical shift towards pay for value and accountability for the total cost of care.

OPTIMIZED CARE TEAM

WHY CHANGE, WHY NOW?

With rising costs and inconsistent outcomes, the current model of care delivery is unsustainable. We know that we need to rethink the way we deliver care, moving beyond our current focus on face-to-face clinic visits and individual physicians as the sole business model.

In a population health model, **reimbursement will no longer be tied to providers or appointment types**, opening up possibilities for innovative models of care delivery that may seem counterintuitive because of the long history of current practices. Rather than relying on physical visits to the clinic, patients can expect to receive care in their communities, at home, and at work through their preferred mode of communication. Primary care providers will not be the only source of meaningful advice and follow-up. Multidisciplinary teams will build strong relationships with their patients and share responsibility for the coordination of care for all patients on the team's panel including the growing population of patients with multiple chronic conditions.

We will shift away from individual provider practices, towards a collaborative, team-based care model where each role is leveraged to the top of their licensure. This shift is critical for meeting patient needs with the most appropriate service, offered by the most effective member of the team. Building on Mayo Clinic's rich history and experience, the Optimized Care Team is the next evolution of the integrated practice model. While many parts of the enterprise are working on team-based care and related projects, this model seeks to bring together best practices and create a new model of care that prioritizes the concerns of patients and communities. The Optimized Care Team supports a holistic view of primary care and its role in patient health.

THE RIGHT CARE, AT THE RIGHT PLACE, THE FIRST TIME

Conveyor Belt Care

"I'd rather come in for one very thorough 45min appointment where I see the whole team, than come back 3 times in 3 months."

— Patient interview

Team-based Care

The Optimized Care Team model enables the team to improve wrap-around care for patients and increases the team's ability to address all of a patient's health concerns with a single visit, phone call, or secure message.

WHAT IS THE OPTIMIZED CARE TEAM?

The Optimized Care Team is a colocated group of clinicians, nurses, assistants, and other specialized staff who work together in a way that allows all team members to add value to every patient touch-point and meet the needs of patients. Sharing care responsibilities across the team means increasing nurse-only visits and improving the integration of allied staff members providing specialized services. This creates capacity across the team for new workflows that emphasize non-visit care, proactive patient outreach, and population health management. Daily communication and coordination of patient care through a team-based model ensures that **the entire team is prepared to meet both the anticipated and unanticipated needs of each patient** in the safest, most effective and efficient way possible.

HOW IS THIS DIFFERENT?

This model focuses on establishing how each member of the team can add the most value to direct patient care. This allows care to be delegated across disciplines and increases the capacity of the clinic to serve a greater number of patients.

This is different from other care team models that emphasize physician efficiency and maximizing individual physician productivity. Rather than continuing to drive care delivery through the most expensive, highest trained individual on the team, the Optimized Care Team invests in the potential of previously underutilized clinic roles.

This challenges the current assumptions about the impact of primary care physician shortages.

"The best interest of the patient is the only interest to be considered, and in order that the sick may have the benefit of advancing knowledge, a union of forces is necessary … It has become necessary to develop medicine as a cooperative science; the clinician, the specialist, and the laboratory workers uniting for the good of the patient, each assisting in elucidation of the problem at hand, and each dependent upon the other for support."

—Dr. William J. Mayo

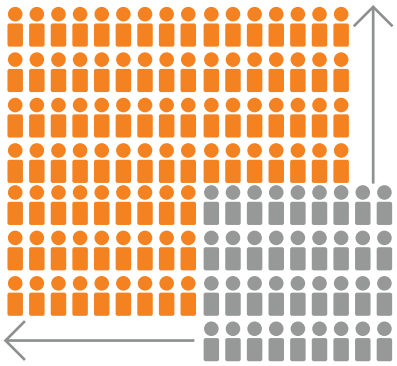
CONTRIBUTING TO POPULATION HEALTH- TRIPLE AIM STRATEGY

"I felt like part of a TEAM rather than an individual working on individual responsibilities."
– Staff member

Experience. Through collaborative teamwork and delegation of care to the most appropriate team member, clinic access is expanded, granting patients more touch points and stronger relationships with their team of providers and staff. Patient visits are coordinated ahead of time to ensure availability of the right team members. As patients express emergent needs or concerns, the team flexes to meet these needs and respond in real-time.

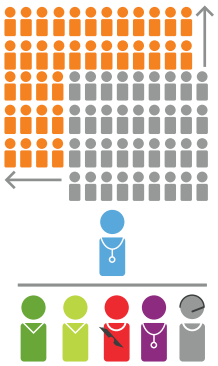
Colocated and working collaboratively, care team members benefit from better relationships with colleagues, increased on-the-job learning, and increased capability to complete work tasks more efficiently. Providers can focus on a smaller group of high-needs, complex patients who benefit the most from their expertise while the rest of the team works together to address the concerns of healthier patients. Improving staff experience can lead to improvements in service and efficiency through empowerment and satisfaction of staff members, a process known as the virtuous cycle.

Outcomes. Patients are able to address multiple needs in a single visit with the team, decreasing the total number of clinic visits while increasing the likelihood that preventive measures are taken. For complex patients, the team invests time in creating realistic care plans that enable effective self-management. Integrated team members, such



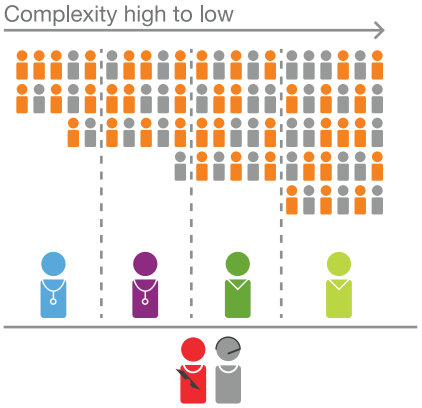
1. INCREASED DEMAND FOR PRIMARY CARE SERVICES

Primary care at Mayo Clinic is facing an influx of patients referred back from the specialty practices as well as patients newly insured though the Exchanges who are seeking to establish care.



2. CURRENT PROVIDER PANELS WILL GROW IN SIZE

Increasing demand will place increasing pressure on empanelled providers to manage and provide quality care.



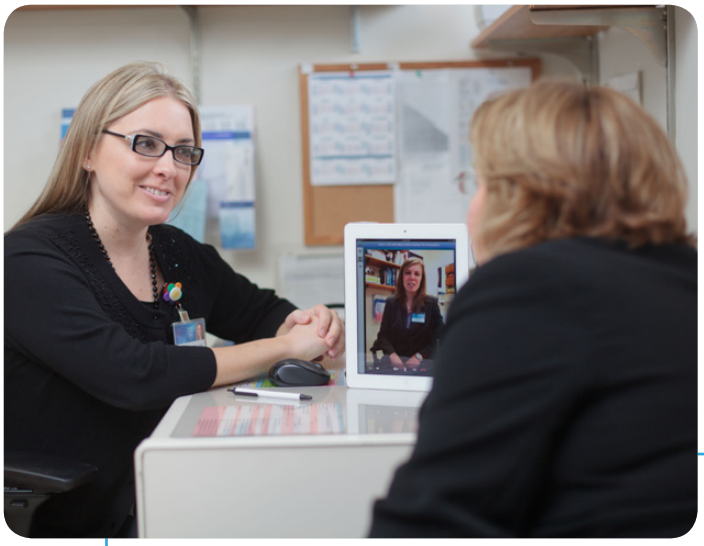
3. OPTIMIZED TEAMS DISTRIBUTE CARE ACROSS THE TEAM

Optimizing each team member to work to the top of their licensure will enable patient care responsibilities to be distributed across the team with plans of care overseen by providers.

*Currently projecting that new demand will double panel sizes and the influx of patients from specialty practices will increase the number of higher tier patients on the Care Team's panel.

as pharmacists, care coordinators, or behavioral health staff who have specialized areas of expertise, are more consistently involved in patient care and are able to provide targeted services. Pre-visit planning and panel management workflows offer ways to proactively care for patients, especially high utilization patients with multiple complex conditions.

Cost. Over time, there is potential to see a decrease in total cost of care due to more effective utilization of primary care and more effective overall management of patient needs. A team seeing patients rather than an individual provider, opens up access and includes services that support a wide range of needs. As a result we expect to see a greater number of patients choosing primary care over emergency departments (ED) or specialty follow-ups and a greater capacity for primary care teams to care for a larger panel of patients.



PATIENT QUOTES FROM OPTIMIZED CARE TEAM EXPERIMENTS

"I kind of already knew about healthy habits, but I felt jump started! It was good to talk about it."

"It seemed continuous even though there were three people coming in. They knew what I said to the others."

"It was nice because the nurse could provide more education. It didn't feel rushed."

"Seeing the pharmacist was great. I pick up the meds for the family and I got to ask questions I otherwise would have forgotten."

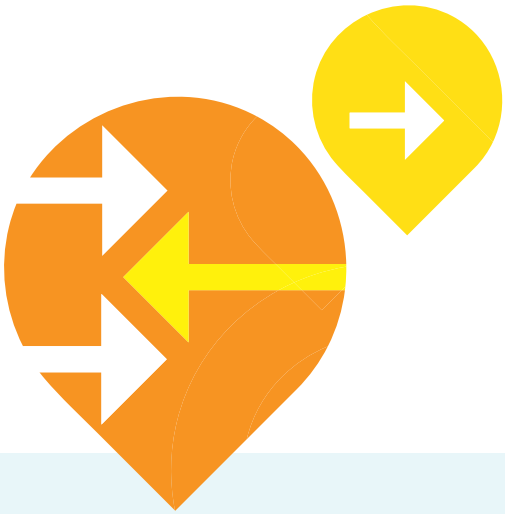
"I liked that everyone seemed to know about me. "

INSIGHTS

REDEFINING THE PRACTICE

The term “care team” is interpreted differently from clinic to clinic and is applied to a variety of staff compositions and role definitions. Often, these care teams are built around clinic facilities- hallways and room numbers- to serve administrative purposes. On these teams, each role operates independently, with little interaction and only a general understanding of the capabilities of other team members.

Optimized care teams bring a collaborative clinic culture and mindset to their work. They make daily choices that continuously reinforce and support team-based care. Isolated clinic roles are replaced by an interdependency that pools resources and enables greater flexibility, resilience, and patient care.



TEAM-BASED CARE IS A BEHAVIOR CHANGE FOR THE STAFF

Despite the benefits that many team members experience in practicing collaboratively, the shift in mindset and practice habits is not immediate. It must be actively managed as a behavior change.

Individuals need to be motivated to change their practice habits, believing that team-based care will benefit them and their patients. Practice leaders and operations must be supportive in activating each team to work differently; providing workflows, guidelines, and feedback that help teams improve and reinforces their motivation to practice differently.

TERMS GLOSSARY

Colocated: Shared team workspace that replaces individual offices and facilitates collegial collaboration, accountability and communication.

Team Calendar: A shared schedule that provides a view of the team’s workload for the day and which team members have been assigned to each patient appointment.

Patient Agenda: A form that patients receive when checking in to the clinic asking: “What would you like to accomplish in your visit today?” and “Is there anything else you would like your care team to know?”

Pre-Visit Planning: Looking ahead at the team calendar a few days in advance to plan for patient visits with the right provider and right team members as well as to plan for non-visit care.

Care Pathways: How a patient’s plan of care is enacted over time. It varies by the type of touch or care offering, the frequency, and the clinic personnel involved.

High-Tier: Patients with complex or chronic conditions that are at an elevated risk of hospitalization or other adverse medical complications.

OPTIMIZED CARE TEAM CORE ELEMENTS

Based on experimentation and testing with Family Medicine care teams, we have a high degree of confidence that the following elements are key to the model.

Establishing small, cohesive teams optimizes relationships.
The team's internal relationships have a critical impact on performance. Maintaining a consistent team builds trust and familiarity both within the team and with patients. The larger the team, the more difficult it is for patients to form meaningful relationships with the members. Teams of 3-4 providers (MD, NP or PA mix), 1-2 RNs, 3-4 rooming staff and 1 scheduler are small enough to build trusting relationships between staff members while still maintaining the size necessary to support team flexibility. Matching complementary personalities and practice styles is key to the success of these new relationships. Bringing together staff from a variety of backgrounds broadens the expertise of the team.

Colocation enhances communication, awareness, and team flexibility for improved access.
Despite the constraints of clinical spaces not designed for teams, it is essential that clinics colocate as many team members as possible. Working side by side, teams build the necessary rapport to deliver collaborative patient care. This is a fundamental shift from the traditional physician office and "team room" model Mayo Clinic currently uses. The core principle behind colocation of all team members is that there is rarely any conversation that needs to take place outside of a patient's care team. Increasing the effectiveness of communication within the team reveals opportunities for more efficient pre-visit planning, less inbox messaging and smoother hand-offs of care delivery.

Team discussion of patients encourages team-based thinking and improved utilization of team members.
Team huddles, like inpatient rounds, are a valuable practice for discussing patient cases. Twice daily, teams gather to review the Team Calendar and plan for each patient's visit. Involving all team members in the huddles is critical for sharing how different team roles are best suited to meet individual patient needs and for building a shared understanding of the capabilities of each team member. As teams become more familiar with each other and their roles, huddle duration will decrease, multidisciplinary team members will be utilized more frequently in direct patient care, and huddle conversation will shift to focus on complex patients or proactive outreach to at-risk patients.

TEAM SIZE FOR EXPERIMENTS

3-4 Providers
(MD, NP, PA mix)

1 Care Team RN

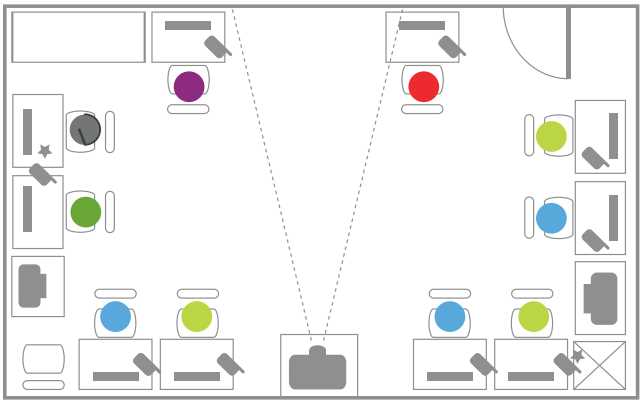
1 Triage RN

3-4 LPN / MA
(Rooming Staff)

1 Patient Appointment Coordinator (Scheduler)

1-2 Clinical Assistants

Observations and feedback collected to date suggest that at this size, patients are able to build trusting team relationships while the team is able to maintain flexibility.



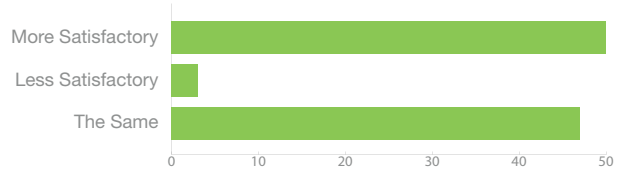
Example team room with colocated care team members, drop-in space for integrated team members, and projector for shared view of team schedule.

Warm hand-offs address concerns patients have about continuity.
Patients need time to build relationships with the team and may have concerns about seeing team members they have not previously met. In order to respect existing relationships while fostering new ones, the Optimized Care Team implements the practice of warm hand-offs to introduce new team members. The primary provider checks in with patients and sets a positive expectation for the new provider. Warm hand-offs boost patient confidence in the team as a whole and help them feel that team members have the permission and oversight of the primary provider.

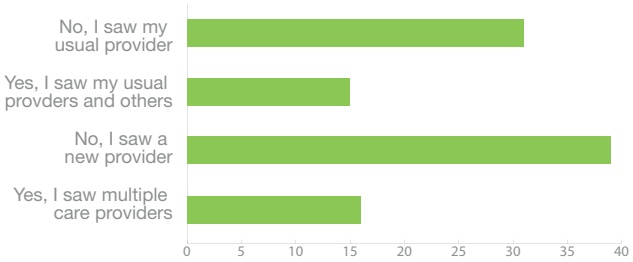
OPTIMIZED CARE TEAM SURVEY: PATIENT SATISFACTION

Many patients saw multiple members of their care team and reported more satisfactory or the same outcomes. Survey conducted during Spring 2013 experiments. (n=125)

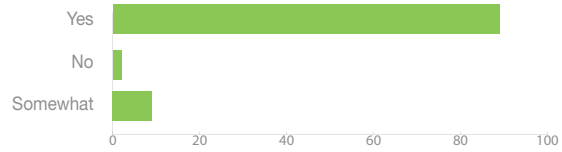
Visit Satisfaction comparison



Did you see more than one care provider?



Did your care providers know your story and the reason for your visit?



"I'm sitting here jealous. I wish it had been my visit!"
— Caregiver accompanying patient to appointment

OPTIMIZED CARE TEAM SUPPORTING ELEMENTS

Pre-visit planning (calling patients ahead) optimizes visits and avoids unnecessary ones.
Planning ahead for patient care improves huddle efficiency and increases the ability for integrated team members to participate in direct patient care. Pre-visit information can facilitate the coordination and discussion of patient care with team providers, ensuring that appropriate continuity is maintained and that specialized expertise is available in advance. The team is able to call patients ahead of time if there are questions about the nature of their visit or if their visit is not necessary, allowing the patient to decide if what they are hoping to accomplish necessitates a trip to the clinic.

Pre-Visit Planning Experiment Findings
Many patients saw multiple members of their care team and reported more satisfactory or the same outcomes.

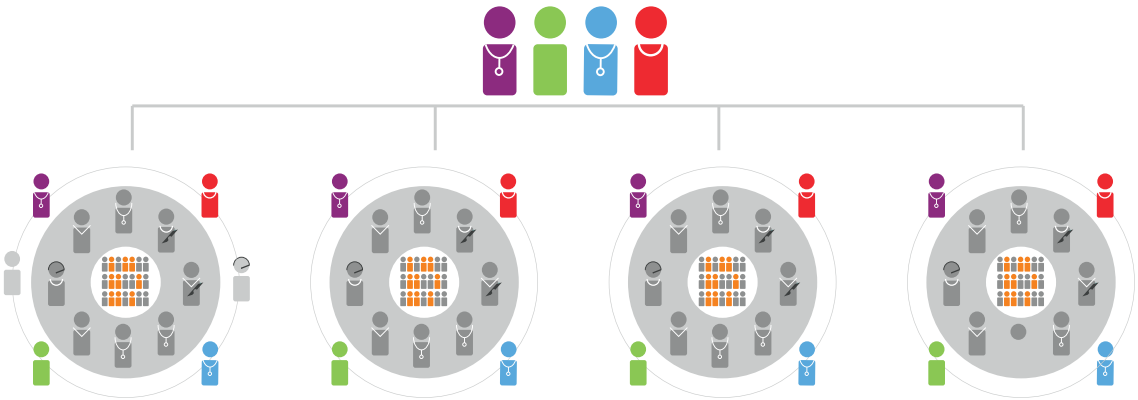
+ Planning too far in advance was unproductive; many patients did not keep their appointments. Same day planning is too late. Experiments suggest a one or two day lead time in planning patient visits is optimal but continued testing is needed.
+ Colocating Patient Appointment Coordinators (PACs) in the room enabled real-time triage of team patient appointments. Initial experiments showed that 1-2 PACs were able to handle the vast majority of calls from the team's patients.

Team calendars facilitate work management and create flexibility for access.
The Team Calendar was created as a means to generate a shared awareness of the team's patients, their needs, and the team's plan for their visit. The Team Calendar provides a bird's-eye view of patient traffic for the day and indicates the workload of each team member. Sharing this view of patient demand and care team capacity drives team flexibility, and allows the team to assess availability and access in real time. This often results in sharing patients with different team members and delegating care to others, improving patient flow.

Integrated disciplines add value to "normal visits" when needed.
Integrated team members include Pharmacy, Care Coordination, Integrated Behavioral Health, Social Work, etc. Just as the core team benefits from colocation, they also need experience with integrated team members. This builds an awareness of the services they offer and a confidence in the care they provide patients. Relationships with integrated teams are further enhanced with well-documented workflows and outcomes achieved by their services.

INTEGRATED TEAM MEMBERS

Integrated team members support patients from multiple care teams and provide services that are shared across a clinic or department. These services can add to the core team's capacity to help patients connect with community resources, manage their medications, or deal with complex medical conditions. During a two-week period of experiments with a Family Medicine Care team, we found that 36% of the patients seen would have benefitted from an integrated team member as part of their visit.



PATIENT QUOTES: INTEGRATED TEAM MEMBERS AS PART OF A NORMAL VISIT

"Being able to talk with the pharmacist let me get a lot of questions answered that nobody else could have."

"Seeing pharmacy in my visit was really helpful. There were questions I was able to ask that I wouldn't want to ask when I'm in the pharmacy picking up my medications."

"The Wellness [Navigator] made me feel better knowing that there is someone I can contact, she connected me with some useful resources… this should be at every visit."

"Before, you had to make an appointment just for one thing, it's nice to have everything taken care of."

THE EXPERIENCE OF THE OPTIMIZED CARE TEAM MODEL: SPRING 2013 EXPERIMENT FEEDBACK

	WHAT WENT WELL	WHAT PRESENTED CHALLENGES OR COULD HAVE BEEN BETTER
CLINICS	+ Improving staff and patient satisfaction + Increasing capacity. + Improving patient outcome measures. + Increasing the accountability of individual team members to use best practice standards in the care they provide and workflows they use.	+ Rethinking their staffing models. + Redistributing their teams. + Leveraging available clinical space not necessarily designed to support care team needs. + Additional burden of managing change.
PROVIDERS	+ Connecting with other team members and leaving their silos. + The sense of shared responsibility. + Leveraging specialized expertise to help patients. + Fewer inboxes and other efficiencies gained through colocation. + Having more time to focus on complex patients.	+ Disruptions to continuity of care. + Handing care off to other team members. + The added responsibility of being the sole source of approval for triage. + Not knowing exactly what skills other disciplines are able to offer.
ALLIED HEALTH STAFF	+ Increased patient interaction and involvement in direct patient care. + Offering resource referrals. + Learning on the job from other members of the team. + Getting to know the providers as people.	+ Iterative process of experimentation and the added complexity and ambiguity it creates. + Group discussions of patient care details without a definition of appropriate confidentiality.
PATIENTS	+ The idea that a team is planning ahead for their visit. + Receiving second opinions from different providers. + Spending time with a pharmacist. + Receiving “specialized education” from care team RNs. + Talking about wellness goals and holistic health at general exams.	+ Not knowing who they are going to see. + Lack of communication around what the care team is, why the clinic is implementing it, and what benefits it provides.

OPPORTUNITIES

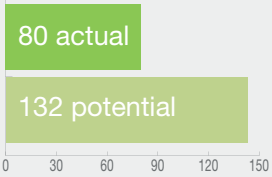
INCREASING THE CLINIC'S CAPACITY TO CARE FOR MORE PATIENTS

How much clinic capacity will be discovered once the team's mindset is fully optimized?
As teams colocate and adopt the necessary mindsets to successfully shift their practices towards collaborative, team-based care, they will gain efficiencies that will result in a greater capacity for new, population health workflows. This capacity is the biggest driver for adopting a collaborative, team-based approach. Fully realizing this capacity happens over time and will vary by team, making it difficult to measure during limited experiments.

Early experiments suggest that efficiencies in communication and teamwork are gained through colocation of all team members and group discussion of patient care. In particular, we saw a reduction of inbox messages, an increase in the awareness and utilization of integrated team members, and avoidance of unnecessary patient visits through proactive patient outreach or provider triage. There was a concerted effort to better document plans for patient care in the medical record (the Impression/Report/Plan of the visit note) so that other team members could appropriately care for patients, leading to an increase in nurse and integrated team member visits. Future experiments will seek to streamline the workflows, processes, and tools to increase the team's clinical capacity.

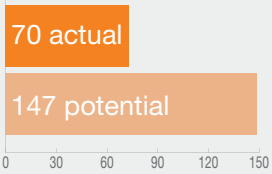
839 Patients were seen by the Optimized Care Team in Baldwin Family Medicine experiments.

NURSE ONLY VISITS



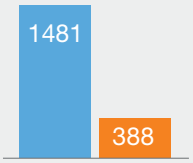
80 Visits were delegated to RN team members. 132 additional visits could have been delegated to RNs with additional protocols.

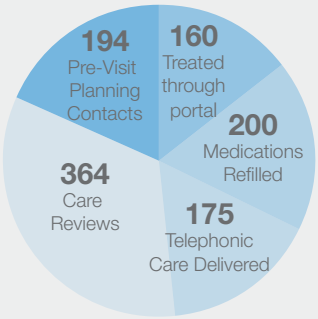
NON-VISIT CARE VISITS



70 patients received care over the phone in place of an office visit. 147 additional visits could have been phone calls.

TOUCHES VS. VISITS
Out of 1481 Patient touch-points over two weeks, only 388 were office visits.

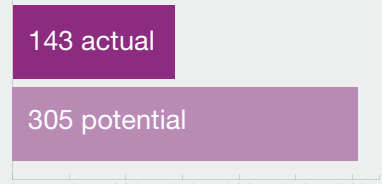




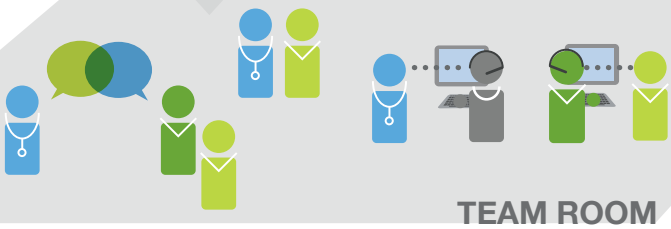
The breakdown of the 1093 non-visit care patient touch-points is documented at left.

WE SAW AN IMMEDIATE 6% reduction in inbox messages related to appointments and telephone messages.

Utilization of Integrated Team Members
143 office visits leveraged integrated team members in direct patient care. 305 additional visits could have delegated patient care to integrated team members.



INTEGRATED TEAM



TEAM ROOM

EXAM ROOM

DEFINING THE OPTIMIZED CARE TEAM FOR BROAD DIFFUSION

How will care teams be defined at clinics of varying sizes and staffing ratios?

We have experimented and defined a recommended team size while acknowledging financial constraints and clinic differences may prevent adoption of this recommended model.

Clinics will need to modify the Optimized Care Team staffing model based on their patient populations, staff ratios, and FTEs.

EXAMPLE TEAM SIZES INCLUDE:

MAXIMUM CORE TEAM

- 4 Providers (2MD + 2NP/PA)
- 2 Registered Nurses
- 4 Licensed Practical Nurses or Medical Assistants
- 1 Scheduler

RECOMMENDED CORE TEAM

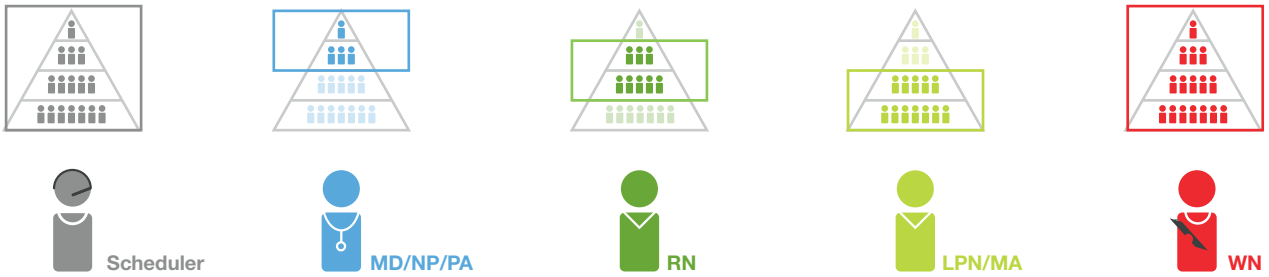
- 3 Providers (MD and NP/PA mix)
- 1 Registered Nurse
- 3 Licensed Practical Nurses or Medical Assistants
- 1 Scheduler

MINIMUM CORE TEAM

- 2 Providers (MD or NP/PA)
- 1 Registered Nurse
- 2 Licensed Practical Nurses or Medical Assistants
- 1 Scheduler

In an environment where physicians are the most expensive or scarce resource on the team, we have to consider how to best leverage their services to care for the most complex patients, and how to best leverage NP/PAs and other roles to fill the gaps in patient care. The focus should be on workflows and how to best meet patient and team needs rather than titles or licensure.

Continued refinement of team roles and responsibilities will be an important part of testing different staffing structures. Through our experiments, we have identified new workflows and roles for different team members that meet the needs of a collaborative, colocated team and optimize for flexibility. As more clinics adopt the care team model, these team roles and workflows will iterate and evolve.



Scheduler Role:

Elicit patient needs and match with the right provider. Communicate the services and benefits offered by the team.

Provider Role:

Ongoing treatment, management and coordination of care for complex patients. Efficiently manage acute patient needs.

RN Role:

Ongoing management, support, and education of chronic disease patients and mid-tier patients. Triage and pre-visit planning workflow.

LPN/MA Role:

Preventive services and screening/triage support. Panel management and pre-visit planning in partnership with providers.

Wellness Navigator Role:

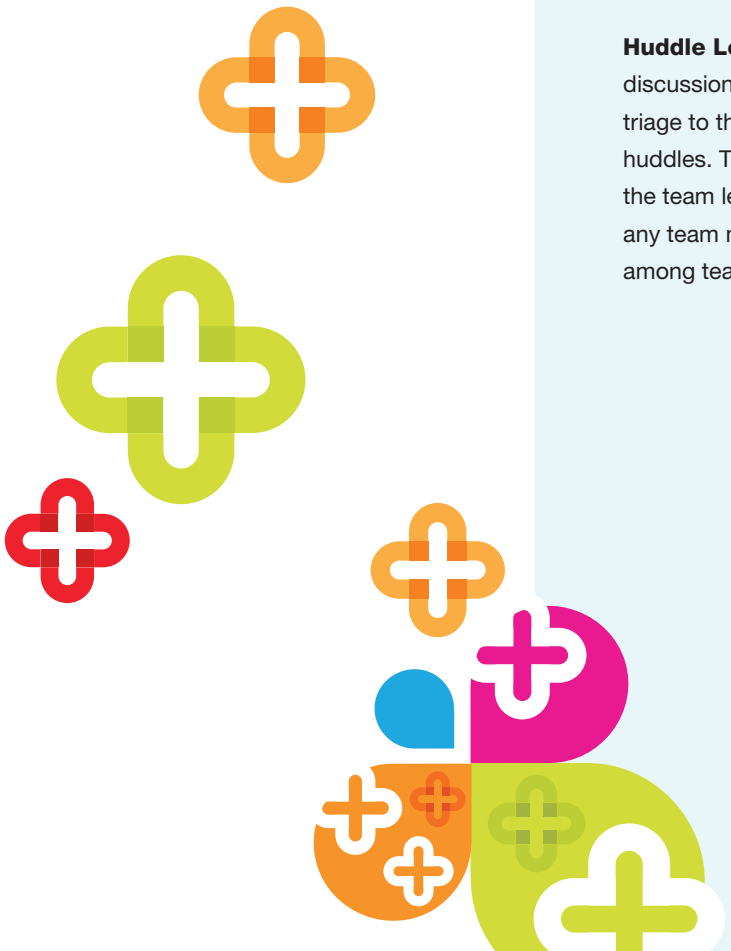
Provides health coaching and resource referral support to patients at all tiers.

OPTIMIZING NURSING

Fully leveraging nurses to the top of their licensure increases the number of nurse-only visits and nurse portions of regular visit workflows.

Nurses provide valuable protocolized care, education, and reinforcement for patients. There are opportunities to better utilize nursing by maximizing use of existing protocols and guidelines along with establishing new ones. Provider documentation that includes anticipatory guidance for other disciplines can further leverage nursing's role in direct patient care as well as the larger team.

At Mayo Clinic, nurses are expected to provide relationship-based care that is compassionate, holistic, and places the patient and family at its center. This philosophy makes nursing especially well suited to play a new role in offering wellness and behavior change support to motivated patients, providing new pathways to support the growing number of patients the clinic must serve.



ROLES GLOSSARY

Core Care Team: All the staff members who are assigned to a single team and support that team on a regular basis- scheduling, nursing, providers and any other dedicated support staff.

Integrated Care Team: Specialized staff members who support multiple teams within a clinic such as pharmacists, integrated behavioral health, social work, etc.

Team Leader: Any member of the care team who supports and leads team-based, decision-making and encourages full utilization of each member's skills. Team leaders must be willing to challenge themselves to think differently about patient care and push others to do the same.

Huddle Lead: Facilitates the discussion of patient care and triage to the right provider during huddles. This role is not limited to the team leader but may also be any team member or rotate among team members.

Air traffic control: Serves as eyes and ears for the team. They are aware of clinic flow and the workload vs. capacity of the team at any given moment. Tasked with ensuring even distribution of work and ultimate communication across the team, their role is critical for supporting delegation and enabling real time flexibility to meet the patient's needs.

Wellness Navigator: A volunteer, or full-time non-licensed staff member, who works with the care team to support patients with reasonable goal setting around healthier choices, or to connect patients with community and social service resources, which address social determinants of health not feasibly addressed directly by the clinic.

Care Coordinator/Care Manager: Registered Nursing staff who have specialized training in complex, chronic condition management and who work closely with patients and providers to proactively support patient self-management, goal setting and achievement.

ENHANCING INTEGRATED CARE DELIVERY

Closer collaboration with integrated care team members increases the capacity to meet patients' needs with appropriate skills and level of training.

Tapping into specialized skill sets in the primary care setting is an important component in driving down total cost of care. Continued experimentation to optimize processes for incorporating integrated team members into daily patient care will also inform similar partnerships with community specialists. Leveraging their expertise to co-manage patients with complex chronic conditions is a critical part of a future population health model and reducing total cost of care.

TEAM PATIENT CARE: COMPLEX PATIENTS

Panel management activities help the team identify and proactively care for high risk patients.

Community specialists support complex patient care in primary care through eConsults and micro-consults (patients and providers connecting in real-time with specialists).

Flexible appointment times allow for longer appointments and specialized service offerings for complex patients.

Time for non-visit care activities is allocated to increase access and for proactive outreach to complex patients.

Care coordination supports complex team patients.

TEAM PATIENT CARE: MIDDLE-TIER PATIENTS

Plans of Care that include anticipatory guidance are established for all team patients.

An increase in nurse-only patient visits is made possible through proactive plans of care for lower-complexity patients.

Phone and patient portal follow-ups are scheduled on team calendars and create greater access for patients.

Better panel management leads to more proactive service offerings such as group visits, education outreach, "diabetes days," etc.

TEAM PATIENT CARE: HEALTHY PATIENTS

Acute patients are handled by the first available team member. Access and timeliness are the priority for acute visits.

Patients are encouraged to ask questions and connect with their team via portal messages, eVisits, and phone calls.

Nursing helps keep the team's patients up to date on their preventive services and healthy living knowledge.

CREATING A SEAMLESS, UNPARALLELED PATIENT EXPERIENCE

What defines continuity for patients and what is appropriate continuity from the practice perspective?

Throughout our experiments, team providers were focused on meeting the needs of the patients that were most appropriate for them to see. This often meant that they shared patient care with other providers who weren't available and other team members who were better suited to meet the patient's particular needs.

> "Today we saw [the new provider] instead because she has a background in cardiology. Is that because you guys are back there looking ahead and discussing my husband's visit? I love that!"
>
> — **Patient Interview**

Patient Perspective

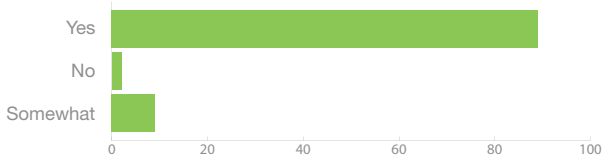
While some patients reported dissatisfaction in not seeing their primary provider or in being offered additional clinic services, the vast majority of patients gave overwhelmingly positive responses to the care they received from the team. These findings suggest future work is needed to determine when continuity with a provider is most appropriate.

For patients with high needs or complex problems, continuity with a familiar provider is best with warm hand-offs to team members for targeted education and coaching. For patients with acute issues, urgency and convenience may be more important, and seeing other team members may be most appropriate.

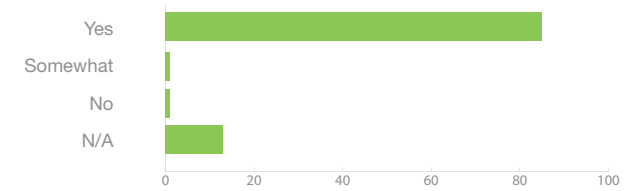
OPTIMIZED CARE TEAM SURVEY: PATIENT SATISFACTION

Survey conducted during Spring 2013 experiments. (n=125)

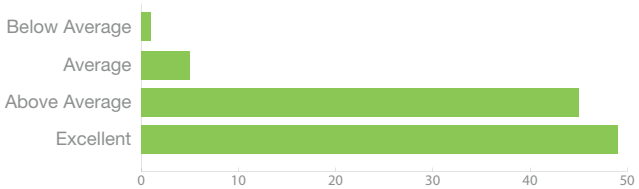
Did your care providers know your story and the reason for your visit?



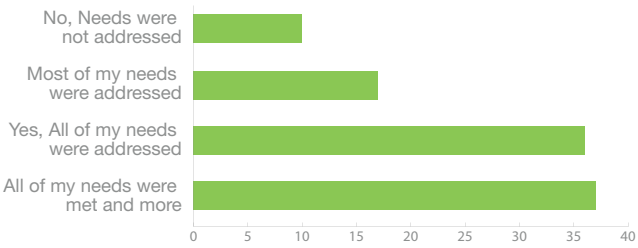
If you did not see your usual provider, did you feel confident in the quality of care provided by your team?



How would you rate the timeliness and efficiency of your team today?



Did you accomplish everything you were hoping to accomplish in your visit today?



Care Team Perspectives

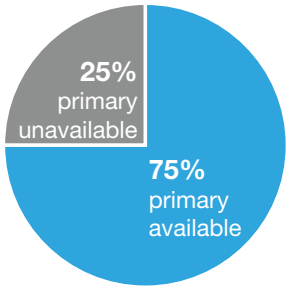
Some providers had concerns about losing relationships with existing patients and being unable to develop relationships with new team patients. Recognizing that relationships are the foundation of Family Medicine, the team-based care model aims to create new care pathways that allow patients to stay connected to their teams beyond the face-to-face visit. This highlights opportunities for new tools and new ways of practicing that both diversify and enrich the relationships teams have with their patients.

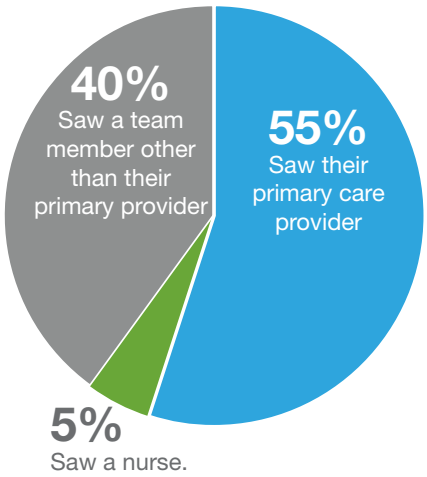
The Optimized Care Team can help support continuity between a patient and provider when appropriate, while also promoting continuity with the greater team for all patients.

DEVELOPING RELATIONSHIPS ACROSS A CARE TEAM

How often is the primary provider available?

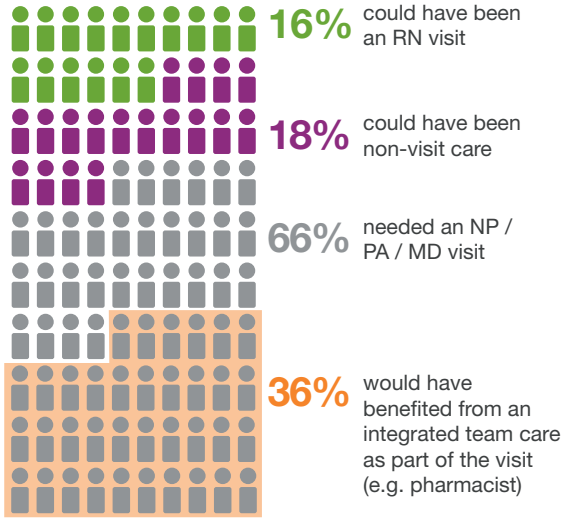
During the experiments, roughly 25% of patients were scheduled when their primary care providers were unavailable. 40% of patients saw a team member other than their primary provider. The majority of patients felt these visits were the same or more satisfactory as compared to other visits (survey results p.8).





How can we best meet patients' needs?

Analysis from the Q1 2013 Optimized Care Team experiments showed potential for improved utlization of the broader team, particularly RNs.



PATIENT INTERVIEWS

"I noticed that you have this team thing going on because I was able to get a second opinion right away… having two physician opinions made me a lot more comfortable with the decision we arrived at today."

"It's a good thing I wasn't sick enough to see the doctor today! I trust that my doctor wouldn't have sent anyone else to see me if they weren't the right person to address my concerns today."

DESIGNING COLLABORATIVE TOOLS FOR POPULATION HEALTH DRIVEN BY PATIENT AND CARE TEAM NEEDS

What tools are needed to effectively deliver population health?

To take full advantage of the capacity gained from the optimized team model, new tools and workflows targeted at better understanding and meeting patient needs, proactive patient outreach, and team flexibility and coordination will need to be created and tested.

Tools for Understanding and Engaging Patients:

+ A Patient-centered Care Plan that provides an interactive experience that blends EMR data with patient priority concerns to engage patients and their care teams as active partners in improving patient health.
+ Registries, dashboards, and "hot lists" that generate an awareness of the team's patient population, support the team's care delivery workflow, and provide feedback for continued population health improvement.
+ Active identification and planning for patients with complex needs.
+ Active behavior change coaching for patients who are newly diagnosed or otherwise motivated to make lifestyle changes that benefit their health.

Tools for Engaging Specialty:

+ Focused identification and coordination of care for high-utilizer patients.
+ Plans of care that clearly indicate when to connect back to specialty.
+ Micro-consults where specialty opinions for specific problem sets become directly available to patients during visits to primary care through live, secure, video consults.
+ E-Consults where specialty opinions and advice are offered directly to primary care providers through secure messaging.

Tools for Managing Access:

+ Situational awareness tools that support a team's ability to flexibly respond to patient needs in real time, both inside and out of the clinic.
+ Scheduling guidelines and appointment types that reflect team-based care, care planning, non-visit care, and new clinic services.
+ Patient attribution models that reflect care team assignments as well as primary care provider assignments.
+ Team calendars that support team workflows.
+ New order types that are consistent with updated guidelines on appointment types and team roles delivering care.
+ Proactive triage built into the scheduling system so that patient needs are effectively communicated and trigger the right appointment with the right provider the first time.

Diffusion

MOTIVATE  ACTIVATE 

Prepare for Change

Clinic leaders and staff members familiar with the Optimized Care Team work see this model as a way to solve many of their current challenges. Along with this model, we recommend a communication strategy that explains how the shift to an Optimized Care Team model can relieve day-to-day frustrations. By tapping into clinic staff's key motivators for change, clinic leadership can gain positive momentum for buy-in and adoption. Insights into these motivators can be gained by eliciting ideas from staff members for what they would like to see a collaborative team-based model accomplish.

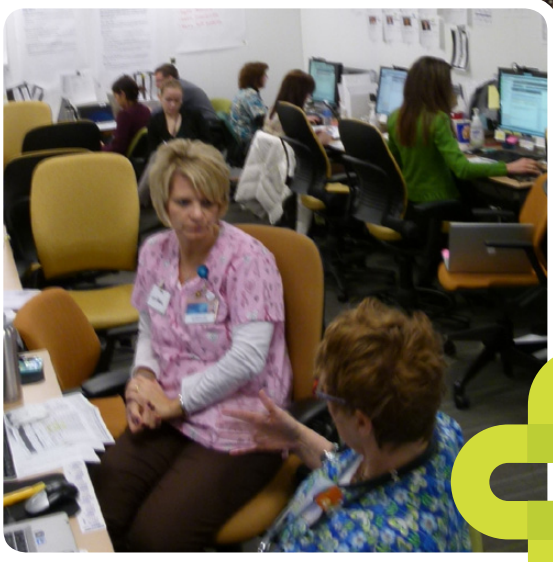
- Identify a physician champion and operational champion: They serve as a positive role model and peer point of view for the staff.
- Assign a role responsible for clinic communication: Proactive communication and messaging to the clinic around goals and expectations will help to build motivation and buy-in.
- Assign a role responsible for patient communications: Communicate to clinic patients that these changes are something that the clinic is testing out and committed to seeing through.
- Create slack for change: Identifying redundancies and eliminating waste are key first steps towards building capacity for change and adoption of new workflows.
- Purposefully assemble your care team: Set care teams up to succeed by deliberately matching personality and practice styles as often as possible.

Begin and Practice the Change

Activate the assembled teams with clearly defined goals. Provide workflows, guidelines, and role descriptions that help them accomplish those goals. Encourage teams to take ownership of their own change process. Empowering them to problem-solve, test ideas, and learn from their failures is critical to maintaining productive enthusiasm. Support the team as much as possible with operations, technology, and practice tools so that they can focus on shifting their mindsets to collaborative team-based care.

- Start small and iterate. Leverage resources like the Team-Based Engagement Methodology (TEM). Select a short list of goals to focus on. Identify 2 to 3 week periods of time to experiment. Plan ahead and protect time to reflect on what worked well and what didn't. Build on the positives.
- Colocate as many team members as possible. Huddle twice daily to discuss plans for patient visits and what each team member might offer in terms of care for each patient.
- Familiarize every team with the members of the integrated teams and the services they provide through defined periods of colocation, participation in huddles, and clearly defined workflows.
- Plan ahead to effectively collaborate on visits. Look ahead at calendars to predict patient needs and introduce team members with warm hand-offs during face to face visits.
- Ask patients what they would like to accomplish during their visits and explore how your teams can flex to meet these goals at the point of care.
- Create collaborative practice agreements that enable other team members such as pharmacy, to share the team's patients.

FEEDBACK



Support and Affirm the Change: Build a practice to meet the patient's needs, not the physician's.
Collecting real-time feedback on the impact of practice changes helps to support and encourage the team and drive iterative changes the team may want to try. Feedback from patients, staff members, and workflows should be combined to create a real-time representation of the progress of the team. As the team evolves, this "progress feedback" may become a part of their workflow and continous quality improvement.

CONTINUED DEVELOPMENT OF THE OPTIMIZED CARE TEAM MODEL

Refinement of the Optimized Care Team model will continue in partnership with Baldwin Family Medicine, Mayo Family Clinic Kasson, and ECH. The learning and insights gained from further testing will be used to inform recommendations to the Office of Population Health Management's (OPHM) Team-Based Care Program.

OPHM welcomes clinics that are interested in experimenting with this model in its unfinished state to contribute to the collective knowledge that will inform refinements. These refinements will be integrated into the OPHM's ACT Initiative – a coordinated system-wide approach to Accelerating Care Transformation in preparation for a total cost of care environment.

Tools are available to Mayo Clinic employees on the CFI's internal website or can be requested by contacting innovation@mayo.edu

MAYO CLINIC
mayoclinic.org

4500 San Pablo Road
Jacksonville, FL 32224

200 First Street SW
Rochester, MN 55905

13400 East Shea Boulevard
Scottsdale, AZ 85259

MC6295-134