Promoting Improved Interventions and Clinical Outcomes in Diabetes Care

Care Teams for Diabetic Patient Management and Support Training Session 1A

March 20, 2019

NATIONAL ASSOCIATION OF Community Health Centers

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Hello!

Cheryl Fattibene

Jillian Bird

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Today's Schedule

Time	Module	
15 minutes	Welcome and Introductions	• Orientation to the learning collaborative and goals • Introductions
15-20 minutes	Topic 1: Care Team Models/Design	• Defining your team • Care Team Mapping Diagram
10-15 minutes	Diabetic Care Team Diagram activity	Sketch out your current care team configuration
15-20minutes	Topic 2: Clarifying and Optimizing Team Roles	• Defining team roles and responsibilities - Swim lanes and RACI Matrix • Optimizing team roles - Examples
10-15 minutes	Q+A	
5 minutes	Conclusion/Wrap-Up Practice Transformation Work: Care Team Mapping	

Welcome & Introductions

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Getting to know you…

In the chat box, for each participant, please enter:

1. Your name and email (necessary for CE credit)
2. Your role.
3. Your organization.
4. One thing you would like to learn/contribute today about diabetic care teams.

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National Nurse-Led Care Consortium

The **National Nurse-Led Care Consortium (NNCC)** is a membership organization that supports nurse-led care and nurses at the front lines of care.

NNCC provides expertise to support comprehensive, community-based primary care.

- Policy research and advocacy
- Technical assistance and support
- Direct, nurse-led healthcare services

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Acknowledgements

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This learning collaborative was sponsored by the National Association of Community Health Centers (NACHC) and draws upon tools, resources, and best practices developed by NACHC and the Clinical Advisory Group convened by NACHC to provide subject matter expertise for its *Improve Diabetes Care in Health Centers* project.

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Acknowledgements

NNCC would like to thank **Arizona State University**, **Interprofessional by Design**, and the **National Center for Interprofessional Practice & Education at the University of Minnesota** for its partnership and collaboration in the development of these training materials.

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Arizona State University

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Promoting Improved Interventions and Clinical Outcomes in Diabetes Care

- Thank you for participating and sharing knowledge!
- Overview of training sessions
- Overview of facilitation sessions
- Practice transformation work
- Health center participation

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Promoting Improved Interventions and Clinical Outcomes in Diabetes Care

- 1A: Care Teams Training - TODAY
- 1B: Care Teams Facilitation – Wed., Apr. 3, 1:00-1:30 PM EDT
- 2A: Pre-Visit Planning Training – Wed, Apr. 24, 1:00-2:30 PM EDT
- 2B: Pre-Visit Planning Facilitation – Wed., May 8, 2:00-2:30 PM EDT
- 3A: Patient Engagement Training – Wed., May 29, 1:00-2:30 PM EDT
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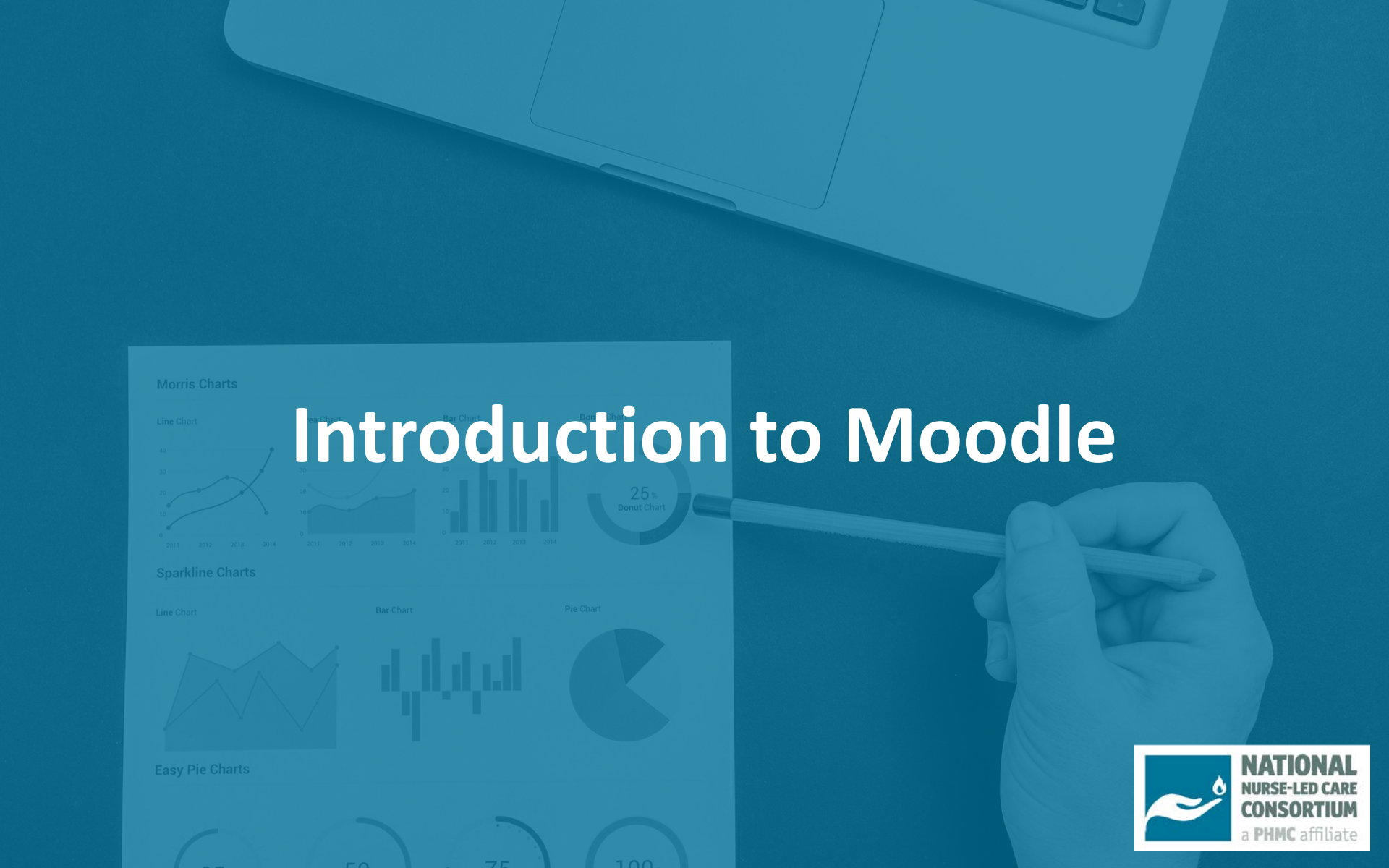

Introduction to Moodle

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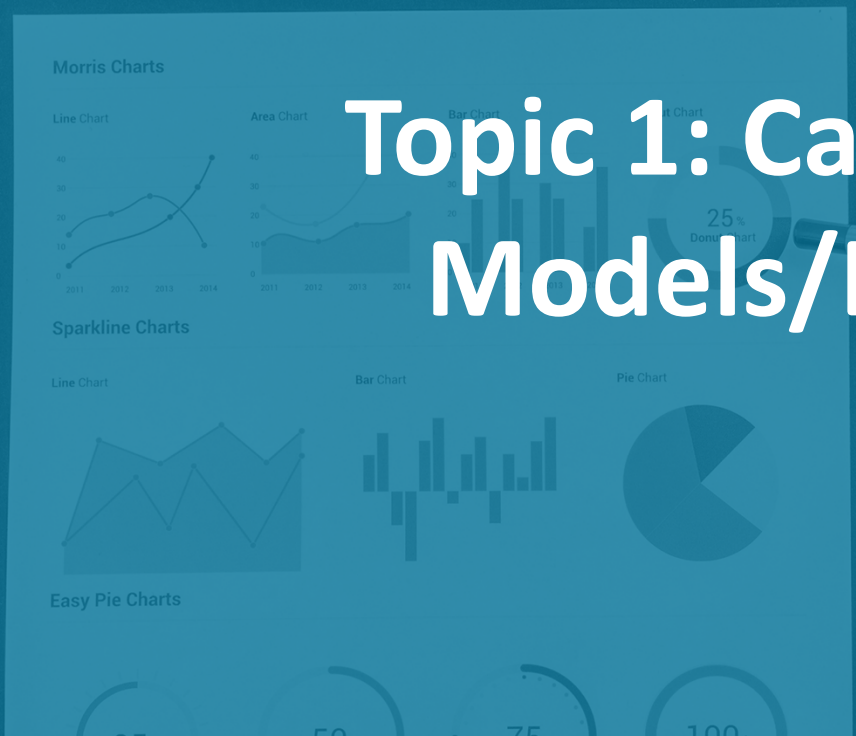
Topic 1: Care Team Models/Design



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Learning Objectives

1. Attendees will be able to define current care team member roles, functions, and responsibilities in their practice facility that support the care of diabetic patients.
2. Identify at least 1 teaching-learning strategy to improve role clarity and optimization to support diabetic patients in your setting.
3. Attendees will be able to identify opportunities for role redesign and optimization in their practice setting.

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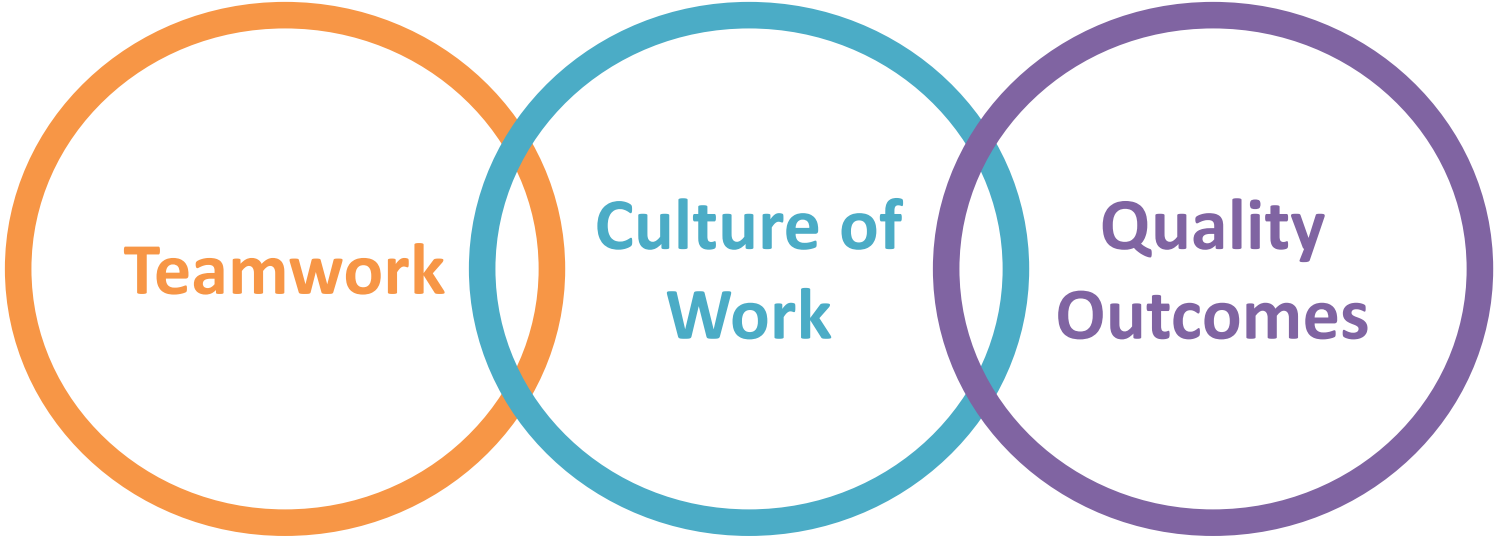

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Core Competencies for Interprofessional Collaborative Practice (2016 Update)

Interprofessional Education Collaborative (2016)

Values/Ethics for Interprofessional Practice

Work with individuals of other professions to maintain a climate of mutual respect and shared values.

***Roles/Responsibilities**

Use the knowledge of one's own role and those of other professions to appropriately assess and address the health care needs of patients and to promote and advance the health of populations.

Interprofessional Communication

Communicate with patients, families, communities, and professionals in health and other fields in a responsive and responsible manner that supports a team approach to the promotion and maintenance of health and the prevention and treatment of disease.

***Teams and Teamwork**

Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan, delivery, and evaluate patient/population-centered care and population health programs and policies that are safe, timely, efficient, effective, and equitable.

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Patient & Family Outcomes	Team Outcomes
Satisfaction	Self-efficacy
Increased Engagement	Improved BMI assessment
Increased Adherence	Accurate problem identification
Self-care	Fewer errors
Fewer missed visits	Less turnover
Improved clinical outcomes	Increased job satisfaction

Recognizing High-performing Teams

What are characteristics of high-performing teams?

What differentiates teams that meet their goals from those that do not?

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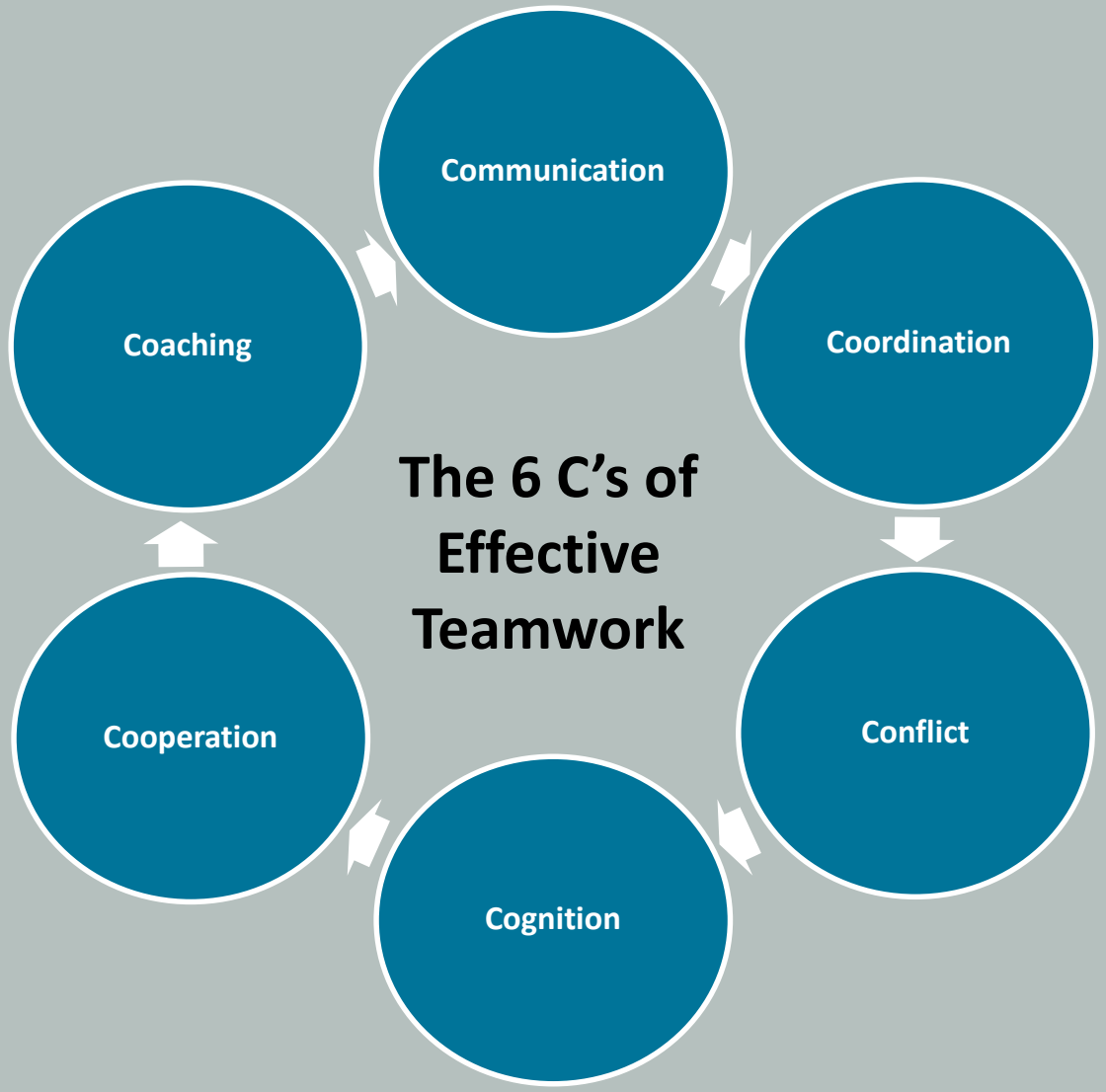

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Core “Team” Principles from the IOM (NAM) Roundtable

- Shared goals
- Clear roles
- Mutual trust
- Effective communication
- Measureable processes and outcomes

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Effective Team Communication

CLEAR CONSISTENT COMMUNICATION

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Ineffective Team Communication

COMMUNICATION ERRORS

Dissatisfied Patients and Staff	Project failures and failed change management	80% of serious medical errors during transfer
35-40% malpractice claims (1.7 billion healthcare malpractice costs)	3rd leading cause of death in U.S.	Overutilization & overtreatment

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Effective Communication for all Team Based Care

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Diabetic Care Team Diagram Activity (10-15 mins)

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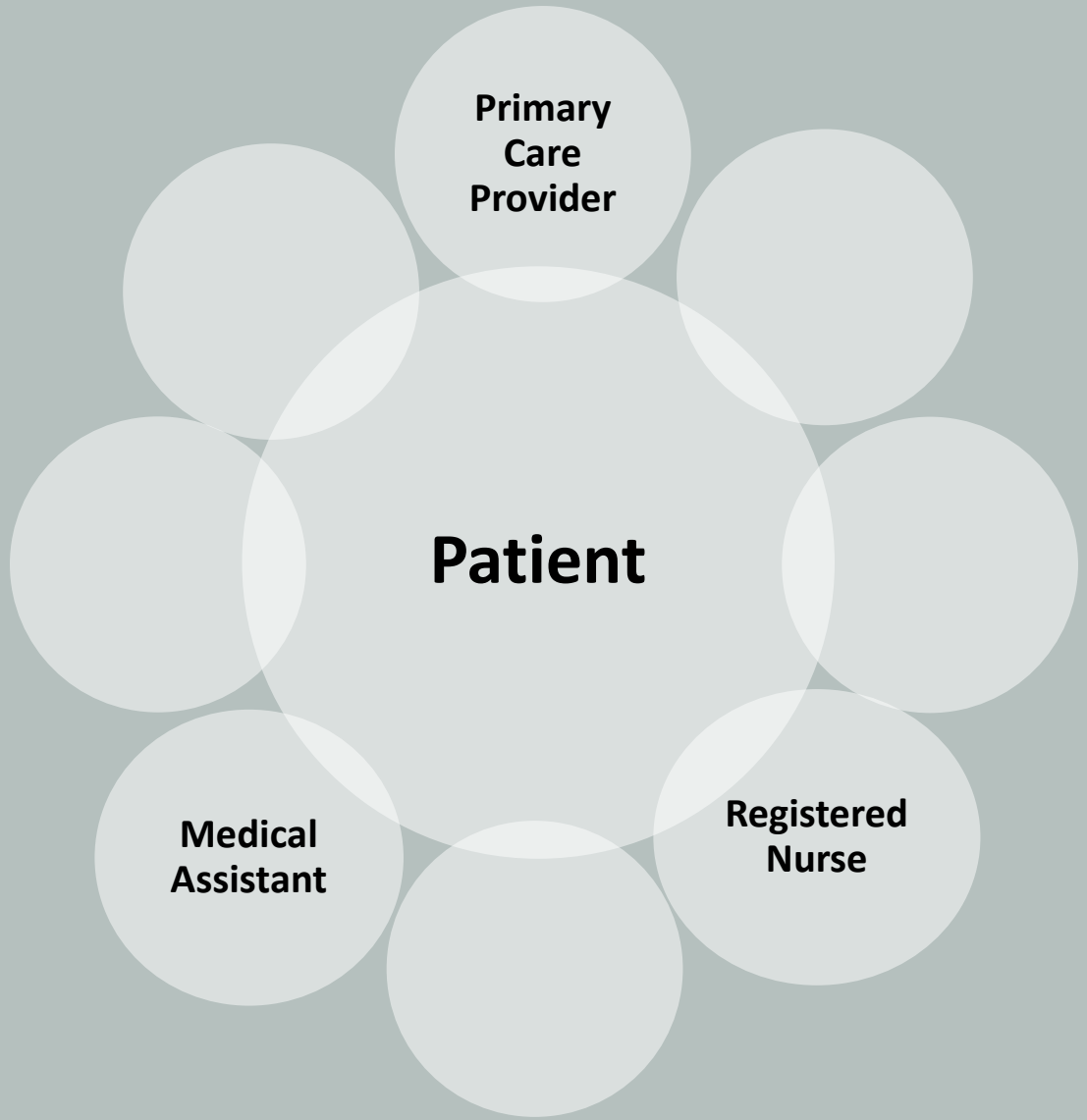

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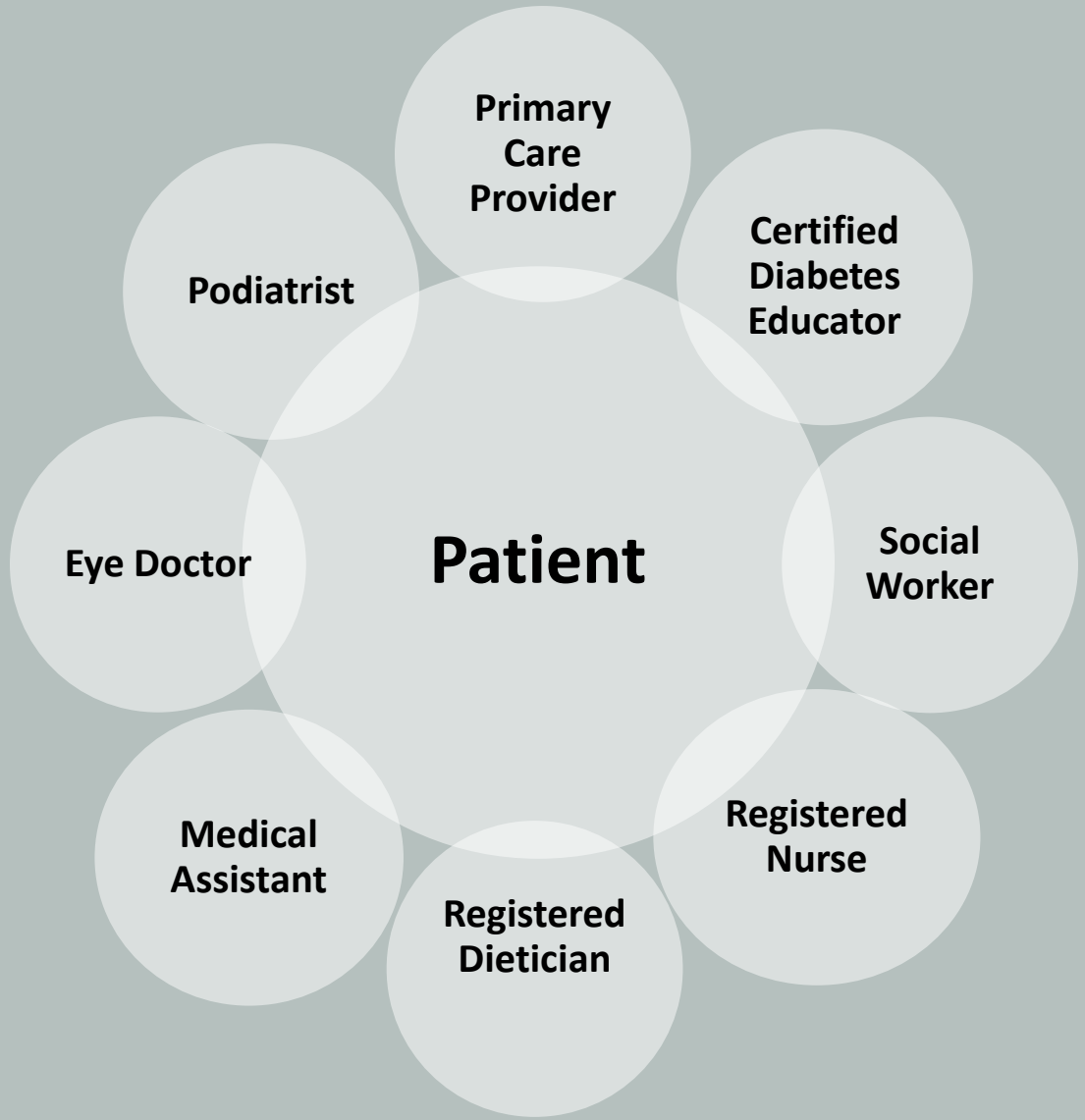

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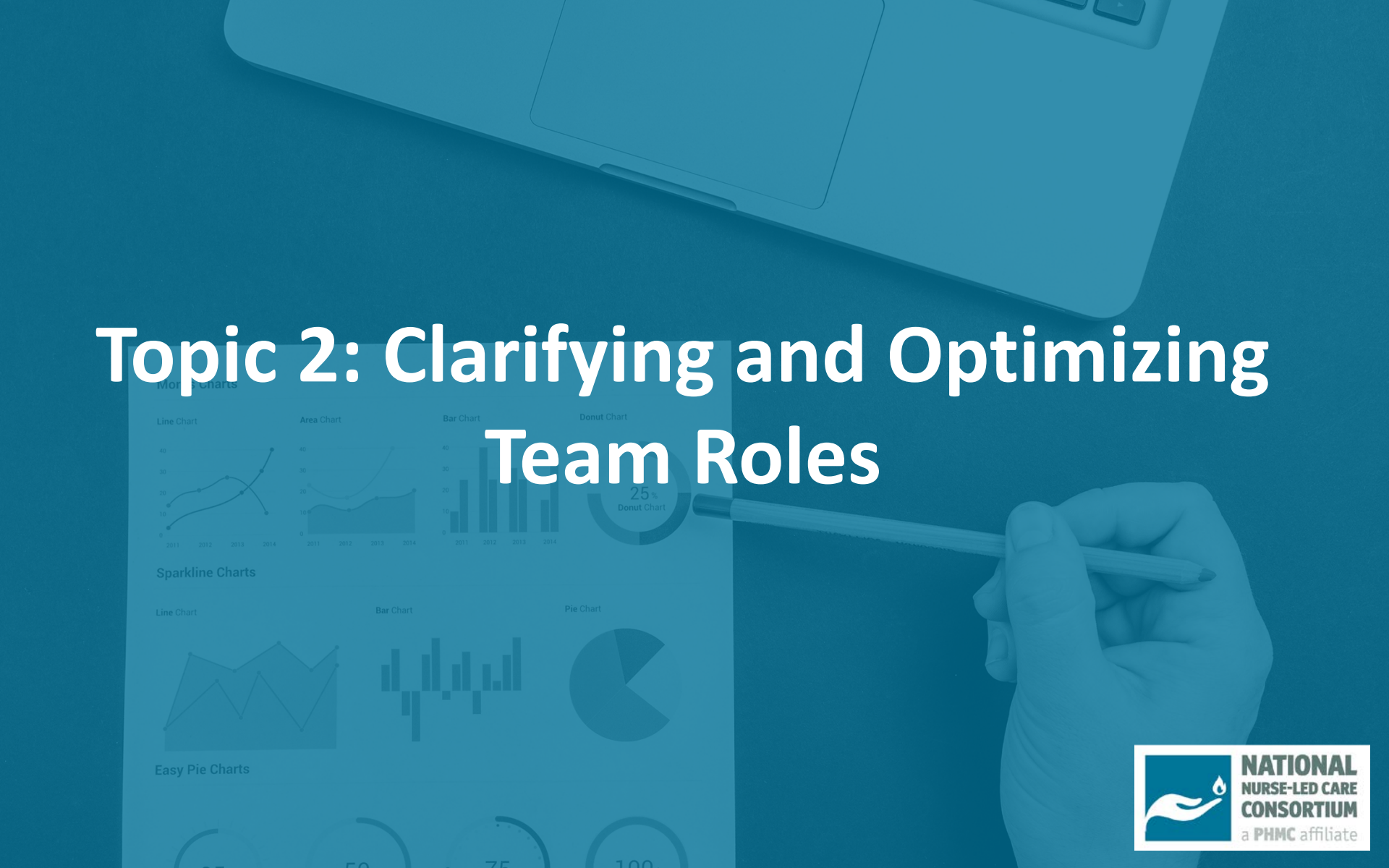
Topic 2: Clarifying and Optimizing Team Roles



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Roles and Responsibilities for Effective Teamwork

- All roles are understood and respected
- Scope and responsibilities of each role are explicit
- Each team member understands how his/her role fits in the work of the team
- Create minimal competencies for all on diabetes care team
  - a basis for education, training, development, and performance appraisal

Steps to Care Team Optimization and Redesign

1. Identify current staffing, functions and responsibilities.
2. Identify the role of patients and families on the care team.
3. Use care mapping tools to assist in assessing and improving role clarity and efficiency.
4. Assess current team role functions and opportunity for role redesign and optimization.
5. Select measures to evaluate role clarity and optimization in your setting.

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Care Team Roles Driven By…

- Competencies
- Scope of practice
- Licensure
- Values and ethics
- Education / accreditation standards

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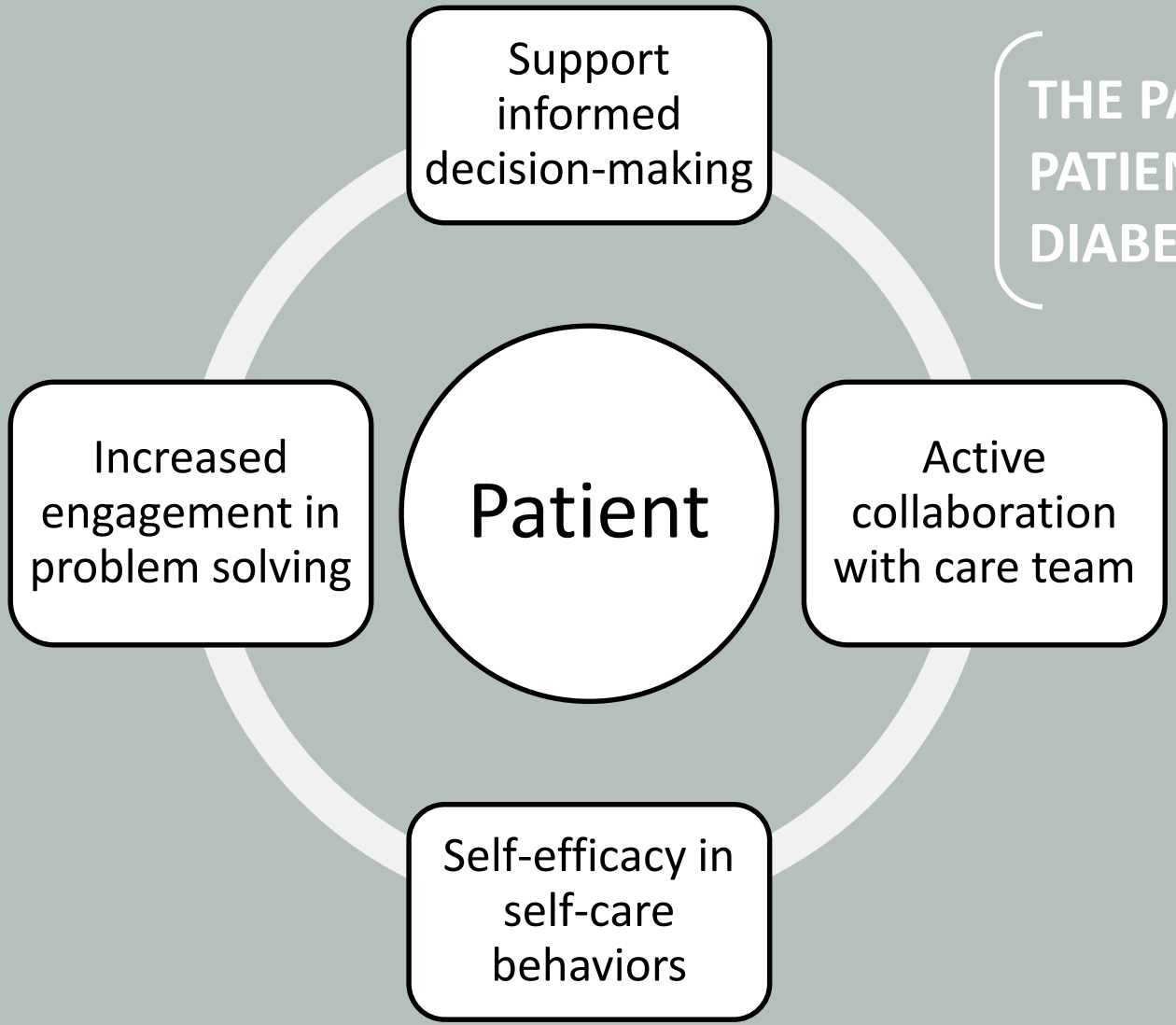
THE PATIENT'S ROLE ON PATIENT-CENTERED DIABETES CARE TEAMS



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Care Mapping Tools

Care mapping tools assist with role clarification and efficiency.

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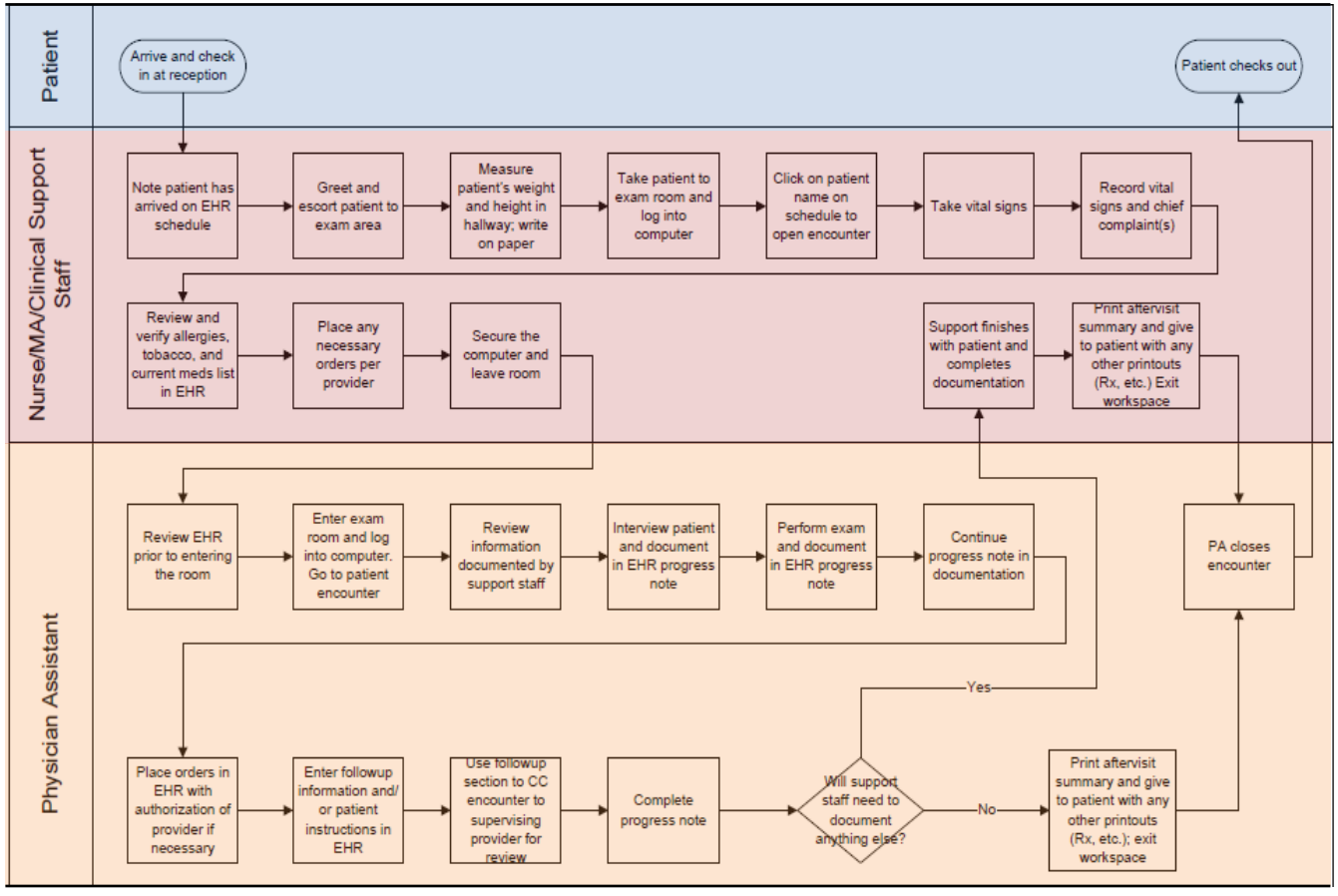
Example: Swim Lane Diagram for a Physician Assistant Office Visit



Adapted from "Physician Assistant (PA) Office Visit" available at:
http://www.hrsa.gov/publichealth/business/healthit/toolbox/HealthITAdoptiontoolbox/index.html

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RACI Matrix

- Responsible, Accountable, Consulted, Informed
- Defining these roles for a task improves clarity, ownership and communication
- Identify functional roles (e.g., front desk, RN, etc.)
- Identify activities or decisions
- Good for QI projects or introducing new EBIs

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RACI Matrix Example

	Medical Director	RN Manager	MA	Clinic Director	Student Intern
Research colorectal cancer screening tool	R	I		A	
Arrange for training for iFOBT screening work flows	R			C	
Create new screening protocols	R	C			
Identify patients in need of screening in the EHR	I	R	I		
Educate patients and provide iFOBT screening kits		C	R		
Run weekly reports to see how many returned kits				I	R
Call patients to remind them to return cards or discuss follow-up		I	R		

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Tips on Care Mapping

An important rule of thumb when mapping a process is “the person who controls the process controls the pen.” This means the person who actually carries out a particular process is the one who maps that step of the process.

Tips on Care Mapping

- Be sure to map current process
- Get key players involved and their input
- Recognize that any care team mapping will take multiple revisions before the final
- Leverage existing experts and experiences
- Remember this is about distribution of duties to be more efficient and remove bottle-necking, ineffective processes

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Simple steps on Care Mapping

Step 0: Assemble your team!

Step 1: Select a process to map out

Step 2: Determine the beginning and ending points

Step 3: Identify each step in the process

Step 4: Put the steps in order, identify who is doing what

Step 5: Review and edit the first draft

Step 6: After a day or two review the diagram with the team for input, missing steps, staff to be consulted

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Now what to do with your completed care map?

Look at the workflow and examine it

- beginning and ending points
- assess wait points
- assess decision points
- hand-offs

Ask questions about the workflow

- does that step need to be there? omit, move, modify

Map out improved workflow map

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What NOT to do with your completed care map?

- Map out the process you wish you had
- Speaking to only a few staff to get an understanding of the process instead of shadowing all involved in the process.
- Ignore the opinion of the people who are most familiar with the process
- Put the work flow map on a shelf and never look at it again.

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Processes to be Included in your Care Team Workflow Map Generally

- Answering phones
- Making appointments
- Scheduling procedures
- Making referrals
- Providing health advice by phone or e-mail
- Assigning patients to panels
- Completing new patient workups
- Educating patients and family
- Managing patient panels
- Planning patient visits
- Coordinating referrals
- Conducting patient outreach
- Checking formularies
- Entering lab results into the information systems
- Making referrals for specialty care and community services
- Consulting with specialists

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Processes to be Included in your Diabetic Care Team Workflow Map - Nursing

- Assess feet for temperature, pulses, color, and sensation
- Assess the patient's skin integrity
- Consult with the dietitian to educate the patient on diet regime for diabetics
- Assess the patient's current knowledge and understanding about the prescribed diet
- Assess the pattern of physical activity
- Teach patient how to perform home glucose monitoring
- Instruct patient to take oral hypoglycemic medications as directed
- Instruct the patient on the proper preparation and administration of insulin
- Teach patient that anxiety, tremors, and slurred speech are signs of hypoglycemia
- Evaluate the patient's self-management skills, including the ability to perform procedures for blood glucose monitoring
- Supply the patient with a free 30 day supply of testing strips, lancets, one free glucometer, and insulin syringes

Roles and Responsibilities: It Takes a Team!

http://links.asu.edu/fm3

Enter

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Optimizing Team Roles

Team Composition

Who do we have on staff, who can we afford, who is available to hire, etc.

Practice Workflow

Physical space of the clinic, room types, equipment, etc.

Visit Scheduling

What are our visit types, what are their lengths, flexibility in scheduling, etc.

Staff Licensure/Expertise

What are team members legally allowed to do, approved scope, training, etc.

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Team Redesign for Enhanced Diabetic Care

Primary care team members	Redesign examples
Registered nurse	• Expanded role as diabetic care coordinator • Health promotion, chronic illness management for diabetic patients • Identify priority patient populations (lost to care, high risk, comorbidities, etc.)
Medical assistant	• Expanded responsibility for tracking and updating diabetic metrics • EHR superuser and governance of data • Provide patients basic overview of expectations for DM self-care
Certified Diabetic Educator	• Focus on most difficult cases • Train MAs/RNs in diabetic patient self-management

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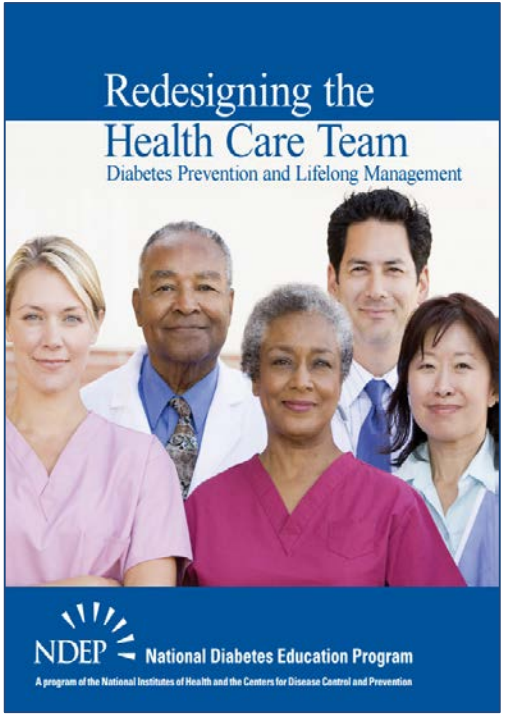
For additional reference on role re-design



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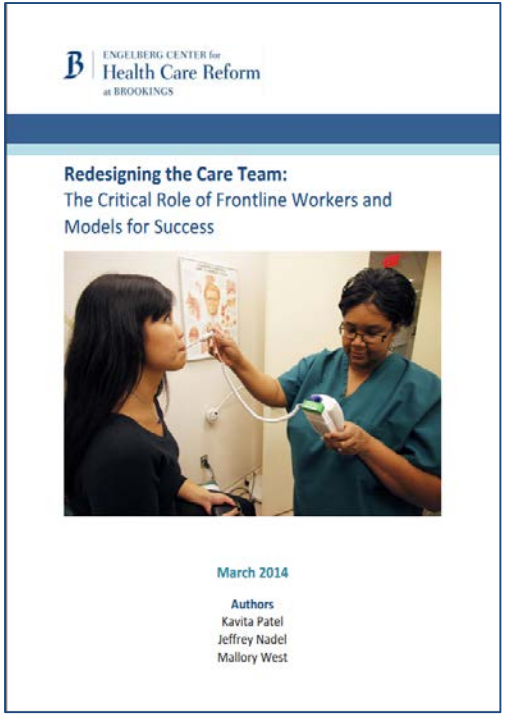

https://www.brookings.edu

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Outcomes of Role Clarity and Optimization

Practice Outcomes	How to Measure
• Realistic expectations of team members	• Enhanced job description with defined roles.
• Efficient workflow	• Wait times, time spent rooming, etc.
• Improved decision-making	• Use of standing orders
• Team member satisfaction, perception of being valued	• Satisfaction surveys, assessment
• Less conflict	

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Final Questions

Final Reminder!

Practice Transformation Work

1. Identify members on care team- bubble diagram
2. Identify a mapping tool to use with your diabetes care team RACI, Swim Lane
3. Conduct a care mapping exercise with your diabetes care team members to clarify roles
4. If care mapping has been done, engage the team on optimization work
5. Resources available in session 1B on Moodle
    a. Chat function for sharing ideas- in Moodle
6. Session 1B: check in to share progress & feedback

THANK YOU!

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