Reflections on the Day: Team-Based Care for a Healthier North Carolina

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Today's meeting in 2 slides. Slide 1

- Recurrent themes of integration: *within* health care, *between* health and community settings, *along* patient care pathways
- Team-based models require broadening our definition of who is on the care team
- Implementing team-based care requires (at practice-level):
  - strategic redistribution of work
  - role clarity among team members
  - redesigning workflows
  - recognition that team composition is dynamic

Today's meeting in 2 slides. Slide 2

- Implementing team-based care requires (at structural-level):
  - Shifting focus from predominantly educating students in pipeline to retooling existing workforce
  - Redesigning health professions regulation
  - Undertaking culture shift
- Today highlighted ***potential*** benefits of satisfied patients, healthier populations, and happier professionals
- Throughout the day, some of you were probably wondering, haven't we been down this road before?

Everything old is new again

In 1964….

Canad. Med. Ass. J.
May 23, 1964, vol. 90

SPECIAL ARTICLE

The Education of Physicians in Canada

JOHN F. McCREARY, M.D., F.R.C.P.[C],* *Vancouver, B.C.*

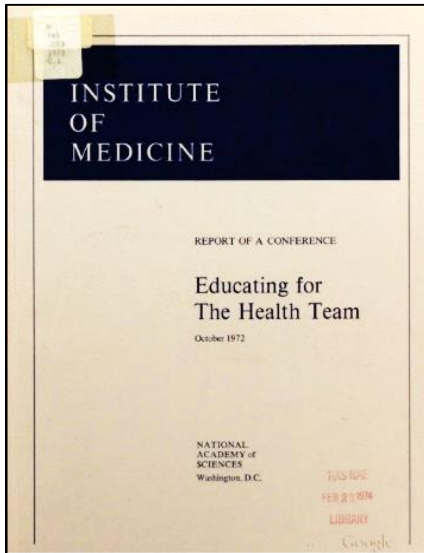
THE provision of health services to Canadians is a subject which has been of considerable interest to legislators in recent years. Although much has been written concerning the extent of such services, how they are to be instituted and what their effect will be on the overall Canadian economy, little attention has been directed towards ensuring a sufficient supply of competent physicians

expect this source of supply to continue. Many of these immigrant physicians were unhappy under some form of health insurance that existed in their own country. As the years go by, the number of such malcontents will become less, in part because physicians have adapted to the new system and in part because types of prepaid health insurance in other countries have improved as the difficulties

It has long been accepted that no physician, however able and however highly motivated, possesses all of the skills required to provide complete health services for a population group. Such services can only be provided by a team: the physician, dentist, pharmacist, nurse, physiotherapist, occupational therapist, social worker, clinical psychologist and others. Although lip service has been paid to the team approach to health care, little has been done to form the above-mentioned group into a team. They have been educated in isolated parts of the campuses of universities, using different teachers, teaching different vocabularies and building up artificial barriers between the various disciplines. All of these diverse members of the health team should be brought together during their undergraduate training years, taught by the same teachers, in the same classrooms and on the same patients. Under these circumstances, with students studying together, working together, reading together, eating together, it should be possible for the various disciplines to be welded into a true health team such that each can contribute, with full respect for what the other has to offer, his share of the health services. So, according to this concept, the small university
… a Health Sciences Centre for
… lth team.

Source: Barbara Brandt, National Center for Interprofessional Practice and Education, The Nexus Summit, Creating Results: Interprofessional Vision to Action, August 2018

And from the Institute of Medicine in 1972



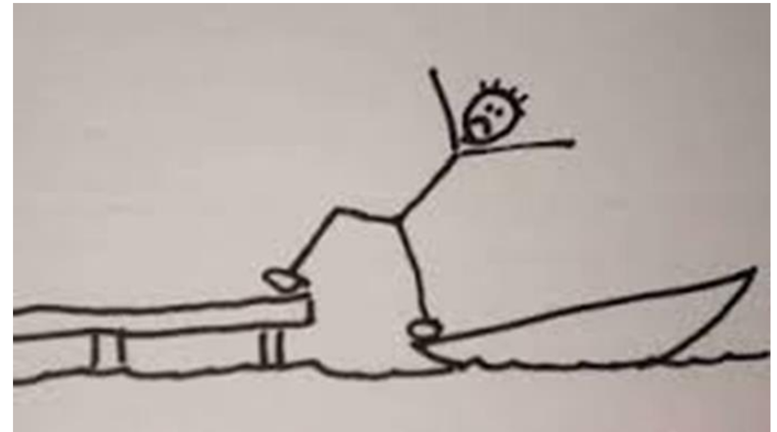
The purpose of a group or team approach is to optimize the special contribution in skills and knowledge of the team members so that the needs of the persons served can be met more efficiently effectively, competently, and more considerately than would be possible by independent and individual action. Without question, the patient himself is a member of the team and, in a democratic society, can be expected increasingly to exert his prerogatives to participate in decisions that affect his well-being.

A major deterrent to our efforts to fashion health care that is efficient, effective, comprehensive, and personalized is our lack of a design for the synergistic interrelationship of all who can contribute to the patient's well-being. We face, in the next decade, a national challenge to redeploy the functions of health professions in new ways, extending the roles of some, perhaps eliminating others, but more closely meshing the functions of each than ever before.

Source: Barbara Brandt, National Center for Interprofessional Practice and Education, The Nexus Summit, Creating Results: Interprofessional Vision to Action, August 2018

Why now?
New payment models will drive change

- Most health care systems currently operating in predominantly fee-for-service model, but actively planning for value-based payment



- Medicare, Medicaid and private payers increasingly focused on value
- Medicaid transformation in NC will incentivize new workforce configurations, especially around the SDOH

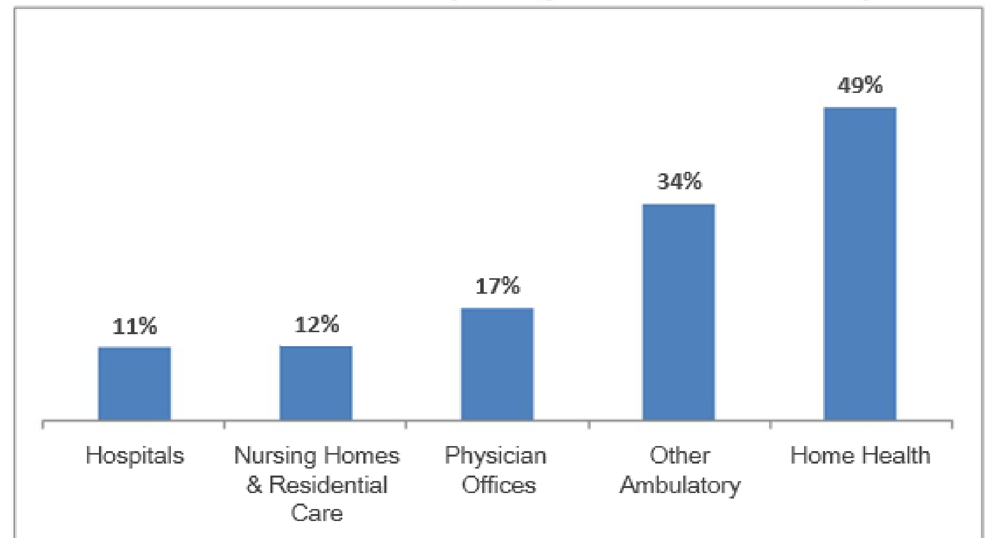
Hospitals, health systems and practices actively experimenting with new care delivery models

- Ongoing experimentation underway to transform the way health care is paid for, organized, and delivered
- Increasing attention being paid to aligning workforce to meet needs of evolving system
- But historic lack of true team-based models of care may be one reason that new care delivery and payment models are not showing expected outcomes*

*McWilliams JM. (2016). Savings from ACOs-building on early success. *Annals of Internal Medicine, 165*(12), 873-875.
Sinaiko AD, Landrum MB, Meyers DJ, Alidina S, Maeng DD, Friedberg MW, Rosenthal MB. (2017). Synthesis of research on patient-centered medical homes brings systematic differences into relief. *Health Affairs (Millwood),* 36(3), 500-508.

Focus on SDOH is shifting care upstream, outpatient and to community

- Shift underway from visit-based to population-based strategies
- Growth of “boundary spanning” roles
- Team broadened to include social workers, navigators, panel managers, community health workers, lawyers, the church, and range other health and community-based workers



Source: Authors’ analysis of BLS Current Employment Statistics data.

Turner A, Roehrig C, Hempstead K. What’s Behind 2.5 Million New Health Jobs? *Health Affairs* Blog. March 17, 2017.
http://healthaffairs.org/blog/2017/03/17/whats-behind-2-5-million-new-health-jobs/

“Relative to the patient’s life overall, we’re just not that important”
-- Jan Freeman

Increasing recognition that workforce already employed in the system will be the ones who transform care

- Most interprofessional education focused on redesigning curriculum for students in pipeline
- But health care workforce ***already employed in system*** will transform care
- Need more collaborative practice environments that benefit patients, family and communities as well as learners

Number of Health Professionals in the Workforce Versus New Entrants to the Workforce, Select Professions, 2012

Profession	Total workforce	New entrants	New entrants as a percentage of total workforce
Physicians	835,723	21,294[a]	2.5%
Physician assistants	106,419	6,207	5.8%
Registered nurses	2,682,262	146,572	5.5%
Licensed practical nurses and licensed vocational nurses	630,395	60,519	9.6%
Dentists	157,395	5,084	3.2%
Chiropractors	54,444	2,496	4.6%
Optometrists	33,202	1,404	4.2%
Social workers	724,618	41,769	5.8%
Physical therapists	198,400	10,102	5.1%
Occupational therapists	90,483	6,227	6.9%

Fraher E, Ricketts TC. Building a Value-Based Workforce in North Carolina. *North Carolina Medical Journal*. 2016; 77(2): 94-8.

Implementing team-based care in practice requires strategic redistribution of work

- Instead of retrofitting care delivery models to meet existing competencies of the existing workforce, need to ask:
  - what and *where* are patients' needs for services?
  - how can health roles be redesigned around those needs?
- Existing workforce is flexible and can adjust their scopes of services to meet patients needs
- "Plasticity" of workforce depends on numerous individual-, practice- and system-level factors

Factors affecting plasticity of workforce to adapt to new roles and responsibilities

- Density/availability of other providers with similar/competing scopes of practice
- Local geography
- Patient population
- Funding model
- Model of care and referral patterns
- Professional's education and training (initial and ongoing)
- Personal preferences
- Regulation
- Hospital executives, practice managers and HR decisions about deployment and payment

So how do we redesign practice to support team-based care?

- Need to minimize role confusion by clearly defining competencies and contributions to team
- Existing staff won't delegate or share roles if they don't trust that other staff members are competent
- Job descriptions have to be rewritten or created
- Work flows have to be redesigned
- Lack of standardized training and funds to support training is big obstacle to team-based care
- Time spent on training is not spent on billable services

Do teams prevent burnout and increase resiliency? Mixed evidence

- Potentially yes, but…
- VA studied burnout among 777 dyads of PCPs and nurses in VA primary care clinics
- Task shifting resulted in lower burnout for PCPs but higher burnout for nurses

ORIGINAL RESEARCH

Task Delegation and Burnout Trade-offs Among Primary Care Providers and Nurses in Veterans Affairs Patient Aligned Care Teams (VA PACTs)

Samuel T. Edwards, MD, MPH, Christian D. Helfrich, MPH, PhD, David Grembowski, PhD, Elizabeth Hulen, MA, Walter L. Clinton, PhD, Gordon B. Wood, MS, Linda Kim, PhD, MSN, RN, PHN, Danielle E. Rose, PhD, and Greg Stewart, PhD

Purpose: Appropriate delegation of clinical tasks from primary care providers (PCPs) to other team members may reduce employee burnout in primary care. However, (1) the extent to which delegation occurs within multidisciplinary teams, (2) factors associated with greater delegation, and (3) whether delegation is associated with burnout are all unknown.

Methods: We performed a national cross-sectional survey of Veterans Affairs (VA) PCP-nurse dyads i Department of VA primary care clinics, 4 years into the VA's patient-centered medical home initiative. PCPs reported the extent to which they relied on other team members to complete 15 common primary care tasks; paired nurses reported how much they were relied on to complete the same tasks. A composite score of task delegation/reliance was developed by taking the average of the responses to the 15 questions. We performed multivariable regression to explore predictors of task delegation and burnout.

Results: Among 777 PCP-nurse dyads, PCPs reported delegating tasks less than nurses reported being relied on (PCP mean ± standard deviation composite delegation score, 2.97± 0.64 [range, 1–4]; nurse composite reliance score, 3.26 ± 0.50 [range, 1–4]). Approximately 48% of PCPs and 35% of nurses reported burnout. PCPs who reported more task delegation reported less burnout (odds ratio [OR], 0.62 per unit of delegation; 95% confidence interval [CI], 0.49–0.78), whereas nurses who reported being relied on more reported more burnout (OR, 1.83 per unit of reliance; 95% CI, 1.33–2.5).

Conclusions: Task delegation was associated with less burnout for PCPs, whereas task reliance was associated with greater burnout for nurses. Strategies to improve work life in primary care by increasing PCP task delegation must consider the impact on nurses. (J Am Board Fam Med 2018;31:83–93.)

How do we redesign regulation to support team-based care?

- Scope of practice battles emerging with increased frequency due to concerns about shortages, rising health care costs and access to care issues
- Entrenched stakeholders involved in SOP battles, often focused on professional self-interest, not patients' interests
- Lack of evidence about SOP changes makes evaluation difficult
- Regulation not keeping pace with change
- The way forward for North Carolina is evidence-based SOP and regulation. Good models in MN and CA.

How do we change culture to support team-based care?

With apologies to the economists in the room, it's not just about the money:

- Need to design teams around patients, not professions
- "Professional humility is in short supply"
- Meg talked about "letting go" and sharing care
- Valuing diverse skill sets, roles and peer consultation
- Spreading and scaling culture change
- Physician leadership needed to Untie the Gordian Knot (Brandt, Kitto and Cervero 2018 Academic Medicine)

Engaging patients, families and communities

- Shared decision-making with patient
- From telling to educating
- More asking and listening
- Focus on health literacy, coaching, goal setting, teach back, connection to community resources
- Honoring and validating work of caregivers
- Whole person patient care delivered where and when it is needed

Sustainability?

- More visits, satisfied patients, better care, but expenses>revenue?
- Billing—who is reimbursed and who isn't?
- Sustainability is struggle
- But IS feasible under FFS
- Need to build more evidence about value to practices ***and overall health care system***
- Disseminate lessons learned and challenges to payers, policy makers, accreditors, health systems etc.

Things I didn't have time to cover…

- Technology and scientific advancements will create new roles
- Redesigning physical workspace to encourage team work, co-location vs multiple locations
- Role of North Carolina Community College System
- Career laddering
- The shortage narrative diverts attention from team-based care

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