

Teams in Action: Stories from the Field

October 9th, 2008
Thunder Bay

OHQC Attributes of a High Performing System

- Accessibility
- Effectiveness
- Efficiency
- Patient-centredness
- Safety
- Equity
- Population Health Focus
- Appropriately Resourced
- Integrated

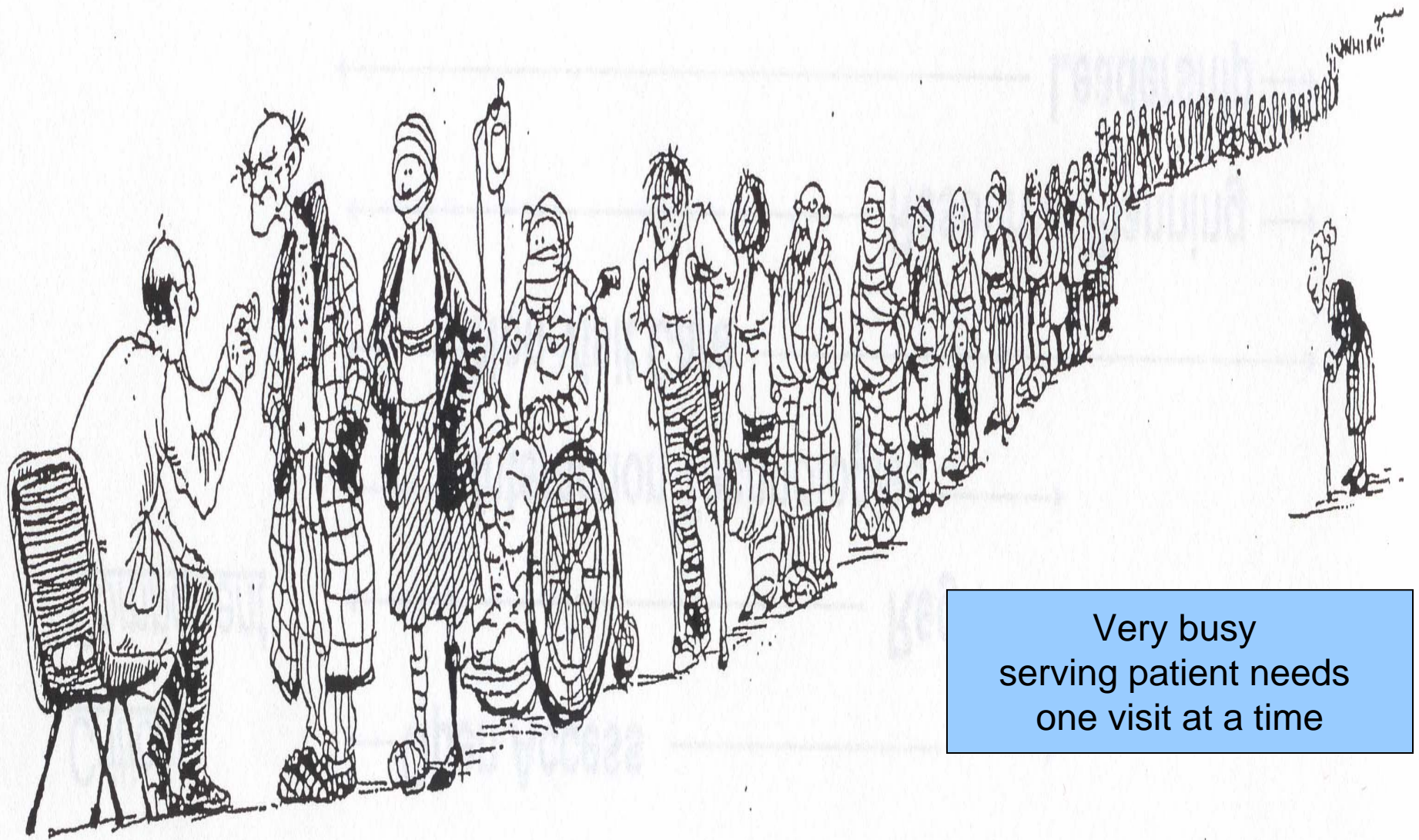
Objective today

1. Why care about an inter-disciplinary approach?
2. How to look at the work?
3. Succeeding at the new inter-disciplinary approach

Silos of Care

Each discipline focuses on their own interaction with the patient/client, leaving each patient/client to manage the

- duplication
- gaps in care
- conflicting messages



Very busy
serving patient needs
one visit at a time

How patients/clients recognize an integrated health system

Leatt, Pink, Guirre 2000

- A. Do they have to repeat their health history for each provider?

- B. Do they have to undergo the same test for multiple providers?

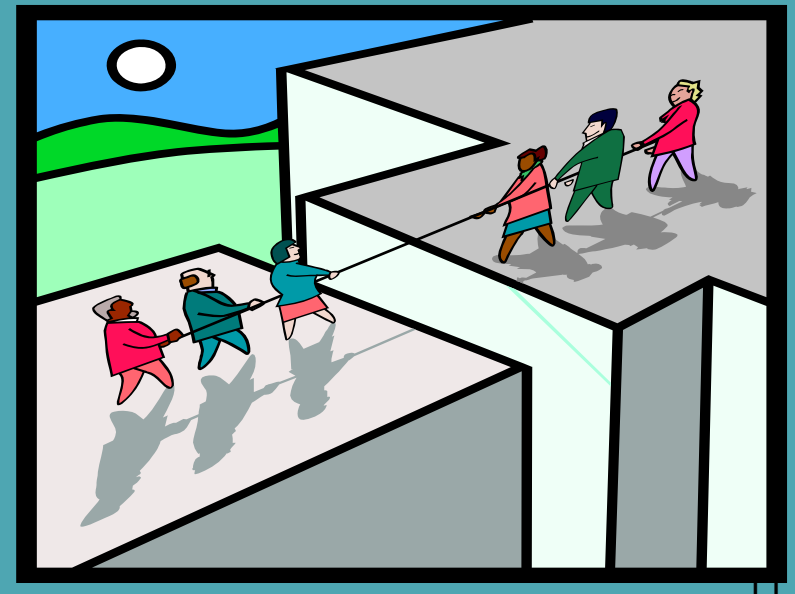
- C. Are they the ones informing their physician that they have been hospitalized or undergone diagnostic/treatment procedures; been prescribed drugs by another physician; not filled a previous prescription; or been referred to a health agency for follow up care?

- D. Do patients have to wait at one level of care because of incapacity at another level of care?

- I. With chronic diseases, are patients/clients routinely contacted to have tests that identify problems before they occur, provided with education about the disease process and provided with in home assistance and training in self care to maximize their autonomy?

Inter-disciplinary teams

- A. Build on strengths
- B. Patient/Client mapping
- C. Communication Routines
- D. Understand current flow of care across team
- E. EMR/Information flow



2 dimensions of your team ...

Care Team

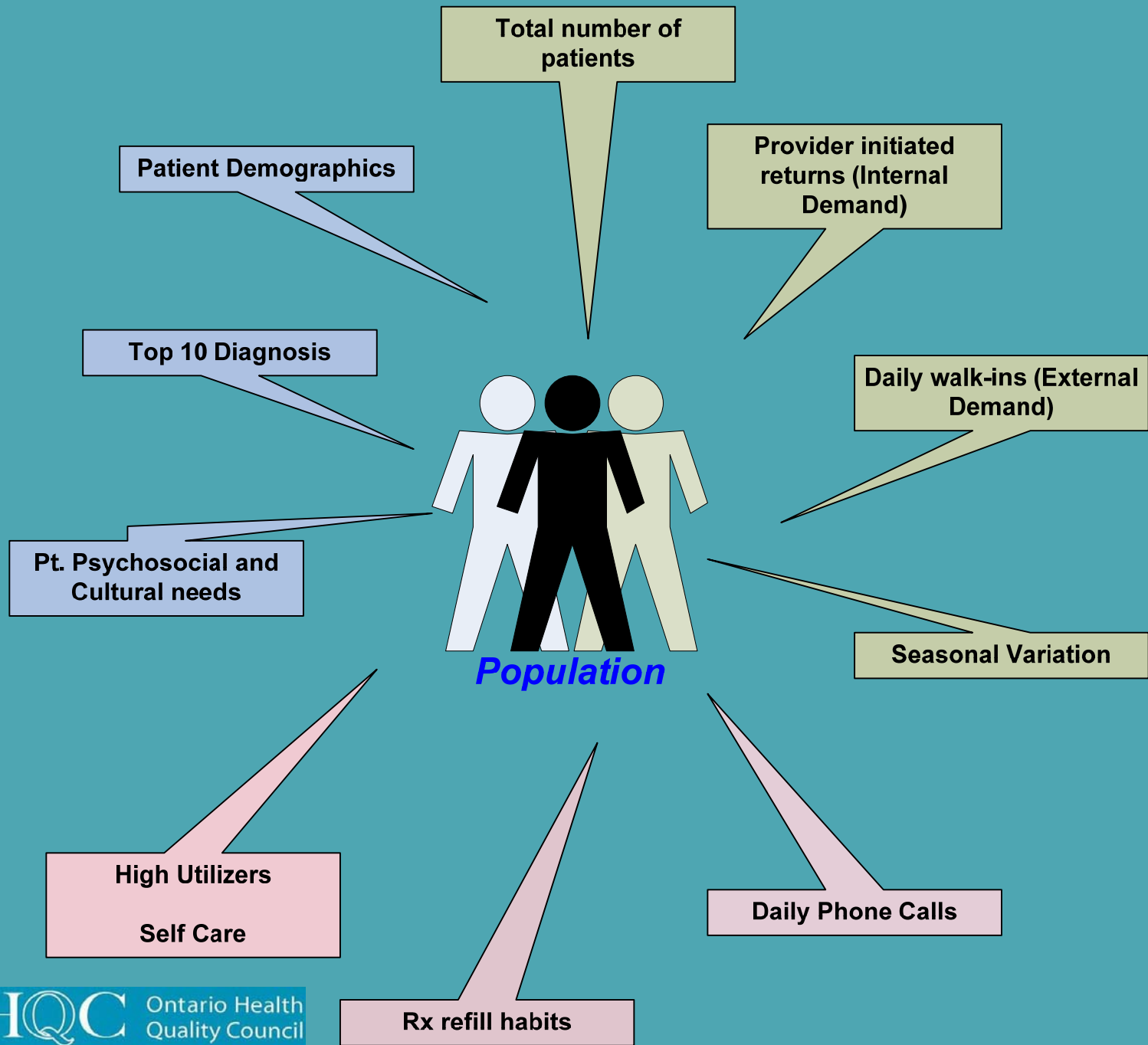
An integrated group of professional and clerical staff whose processes and skills enable them to care for the needs of a patient population over time.

Operational Team

Focuses on efficiency, reliability, safety and appropriateness of the way work is done.

Operational and Clinical Teams





How are others approaching this?




Taber 1999

- Patients in this rural community would travel to 3 different sites for care; lab/hospital, physician clinic, health centre.
- Health providers were spending way too much time playing phone tag with each other, with nobody winning.
- Eight physicians; working faster and longer, no relief in site and burnout was a real issue.

Build on strength; Quality CD program

- Weakness, referral system packaging
 - Single referral for any chronic disease service
 - Vascular Protection
 - Diabetes
 - Hypertension
 - Cardiac Rehab
 - Asthma
 - COPD



**BUILDING HEALTHY LIFESTYLES
PROGRAM REFERRAL**

REFERRAL INFORMATION	
Client Name: _____ D.O.B.: _____	
Age: _____ Gender: _____ PHN: _____	
Home Phone: _____ Work Phone: _____	
Mailing Address: _____	
Alternate Contact: _____ Alternate Contact Phone: _____	
Family Physician: _____ Specialist(s): _____	
REASON FOR REFERRAL:	INDICATE PROGRAM:
<p>Please select all that apply</p> <p><input type="checkbox"/> New Diagnosis</p> <p><input type="checkbox"/> Management Issues:</p> <p style="padding-left: 20px;"><input type="checkbox"/> Disease Management</p> <p style="padding-left: 20px;"><input type="checkbox"/> Risk Factor Management</p> <p><input type="checkbox"/> Complication</p> <p><input type="checkbox"/> Other: _____</p>	<p>Chronic Respiratory</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> COPD</p> <p>Vascular Protection</p> <p><input type="checkbox"/> Cardiac Rehab</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Dyslipidemia</p> <p><input type="checkbox"/> Hypertension</p> <p><input type="checkbox"/> Heart Function</p> <p><input type="checkbox"/> Obesity</p>
COMMENTS / HISTORY:	<p>Clinical Nutrition</p> <p><input type="checkbox"/> Specify: _____</p> <p>Healthy Lifestyle Classes</p> <p><input type="checkbox"/> Healthy Eating</p> <p><input type="checkbox"/> Healthy Activity</p> <p><input type="checkbox"/> Self-Management</p> <p><input type="checkbox"/> Smoking Cessation</p> <p><input type="checkbox"/> Stress Management</p> <p><input type="checkbox"/> Weight Management</p>
<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Other</p> <p><input type="checkbox"/> Specify: _____</p>
SITE PREFERENCE:	<p>(Please indicate all sites where you would attend an appointment)</p> <p><input type="checkbox"/> Blood Reserve <input type="checkbox"/> Lethbridge <input type="checkbox"/> Pincher Creek</p> <p><input type="checkbox"/> Cardston <input type="checkbox"/> Magrath <input type="checkbox"/> Raymond</p> <p><input type="checkbox"/> Crowsnest Pass <input type="checkbox"/> Milk River <input type="checkbox"/> Taber</p> <p><input type="checkbox"/> Fort Macleod <input type="checkbox"/> Picture Butte <input type="checkbox"/> No Preference</p>
Name of person completing referral: _____ Date: _____	
Signature: _____ Phone: _____	
<p><i>Fax or mail completed referral forms to BHL Home Base:</i> 801-1st Ave. South • Lethbridge, AB • T1J 4L5 Toll Free 1-866-506-6654 • Phone: 388-6654 Fax: 317-0435</p>	

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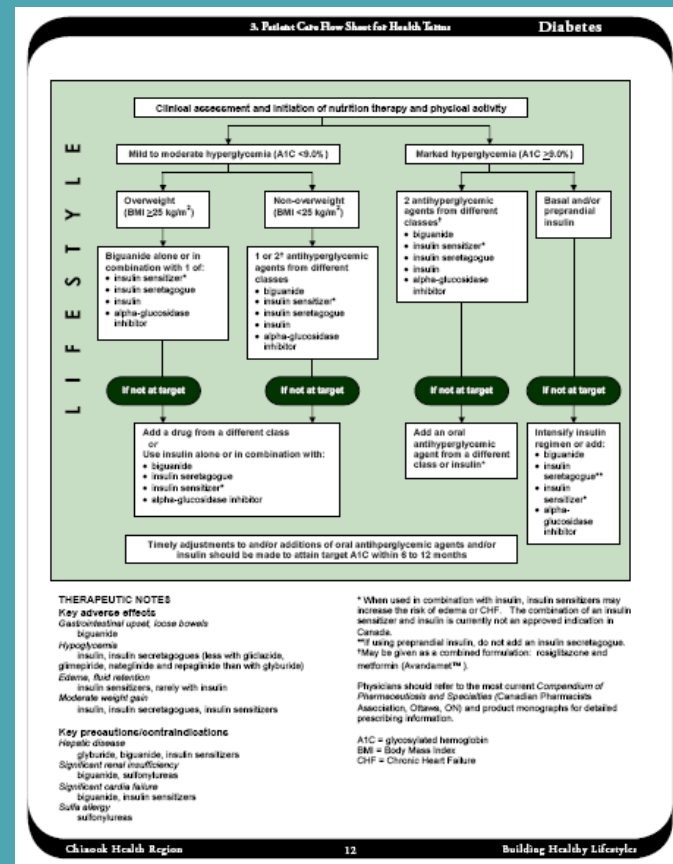
Team Care

- Strength; Evidence based care
- Weakness; Role clarification across disciplines

– Team Clinical Guidelines

- Diagnosis
- Classifications
- Patient Care Flow Sheet for Teams
- Mngt Strategies for Teams
- Mngt Strategies for Patients
- Referral processes
- References

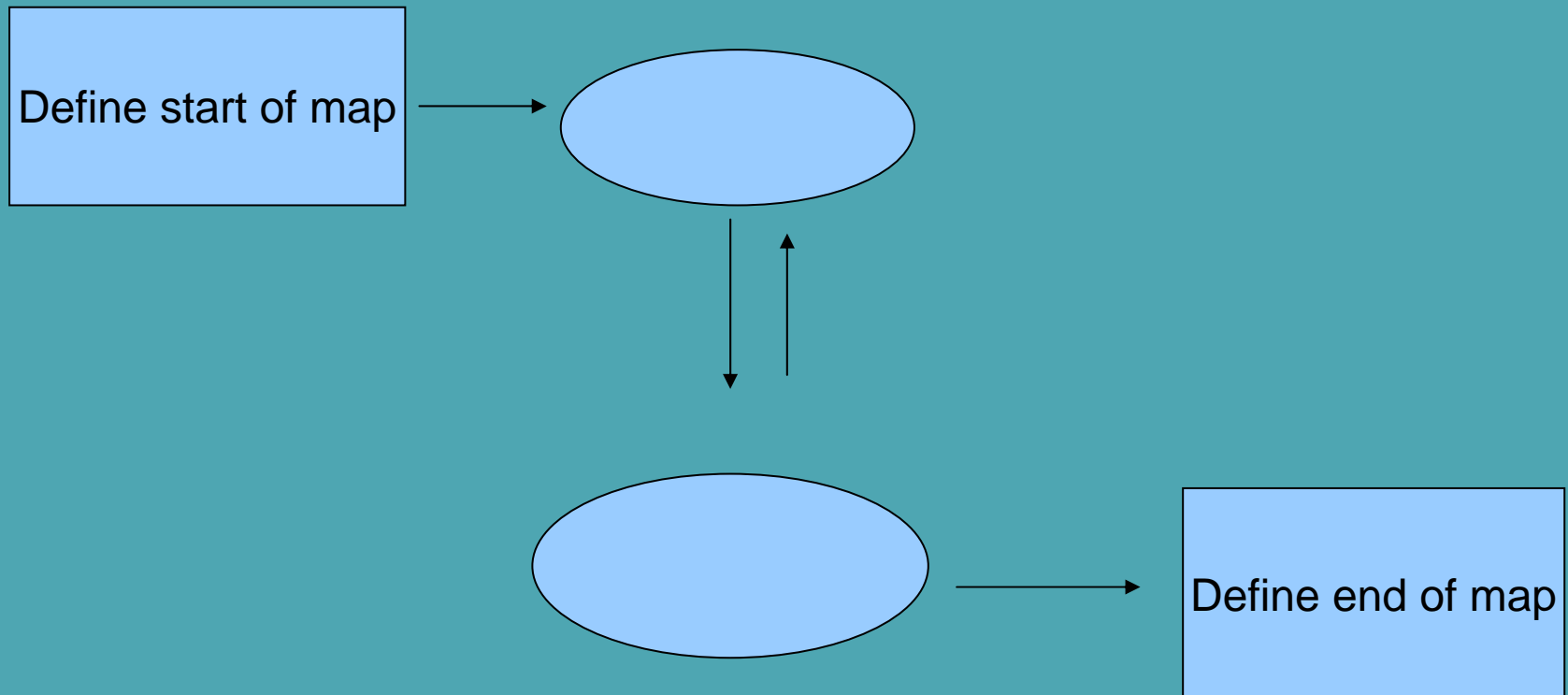
<http://www.toolkit.cfpc.ca/>



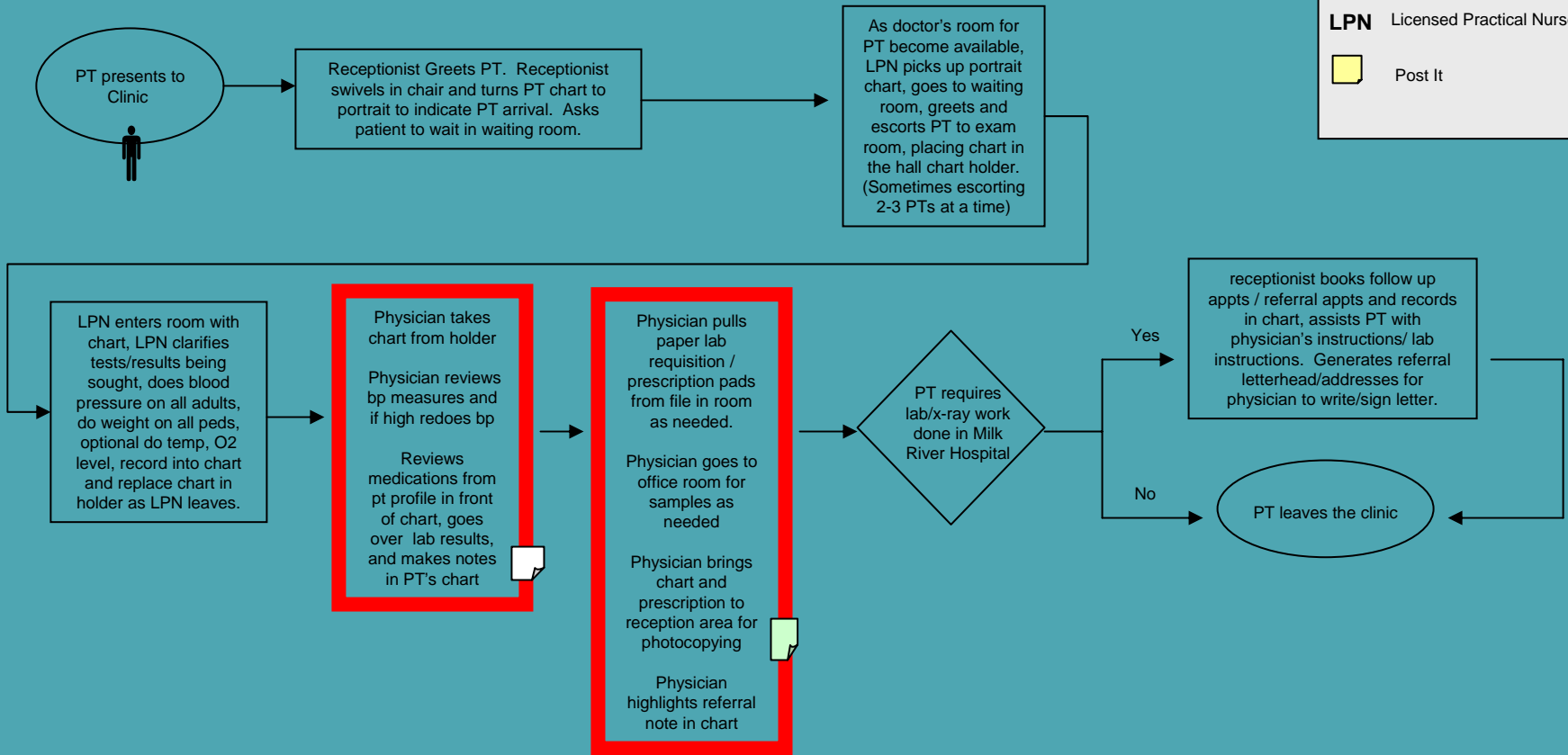
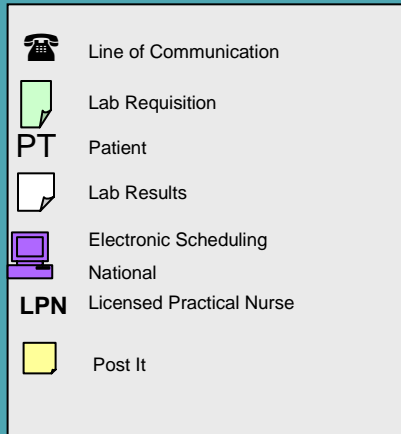
Patient/Client Mapping

- Purpose is to
 - understand current state
 - look for opportunities for improvement
 - then solidify the improved process in terms of role clarification, and hand-overs

Give as many details as possible to describe what happens, how often, between each step.



Generalist Team Approach



Comments/Suggestions: 'runner' could copy prescription, escort PT out OR could get duplicate prescription pad

Physicians all handle charts differently post appointment:

- Take chart to desk in order to free up room:

- Complete chart in room and leave on desk

- Keeps charts, hands over pile to LPN as appropriate

Flow between systems or across inter-disciplinary teams

- What ...
 - do we know about work being sent? Amount and type.
- Dialogue ...
 - to clarify parameters of work that should be sent in the future, consider it a draft that can be revisited. This must be a collaborative decision, not one sided.
- Establish ...
 - expected communication process for this, if there are questions should they be handled via e-mail or phone? What is expected response time?

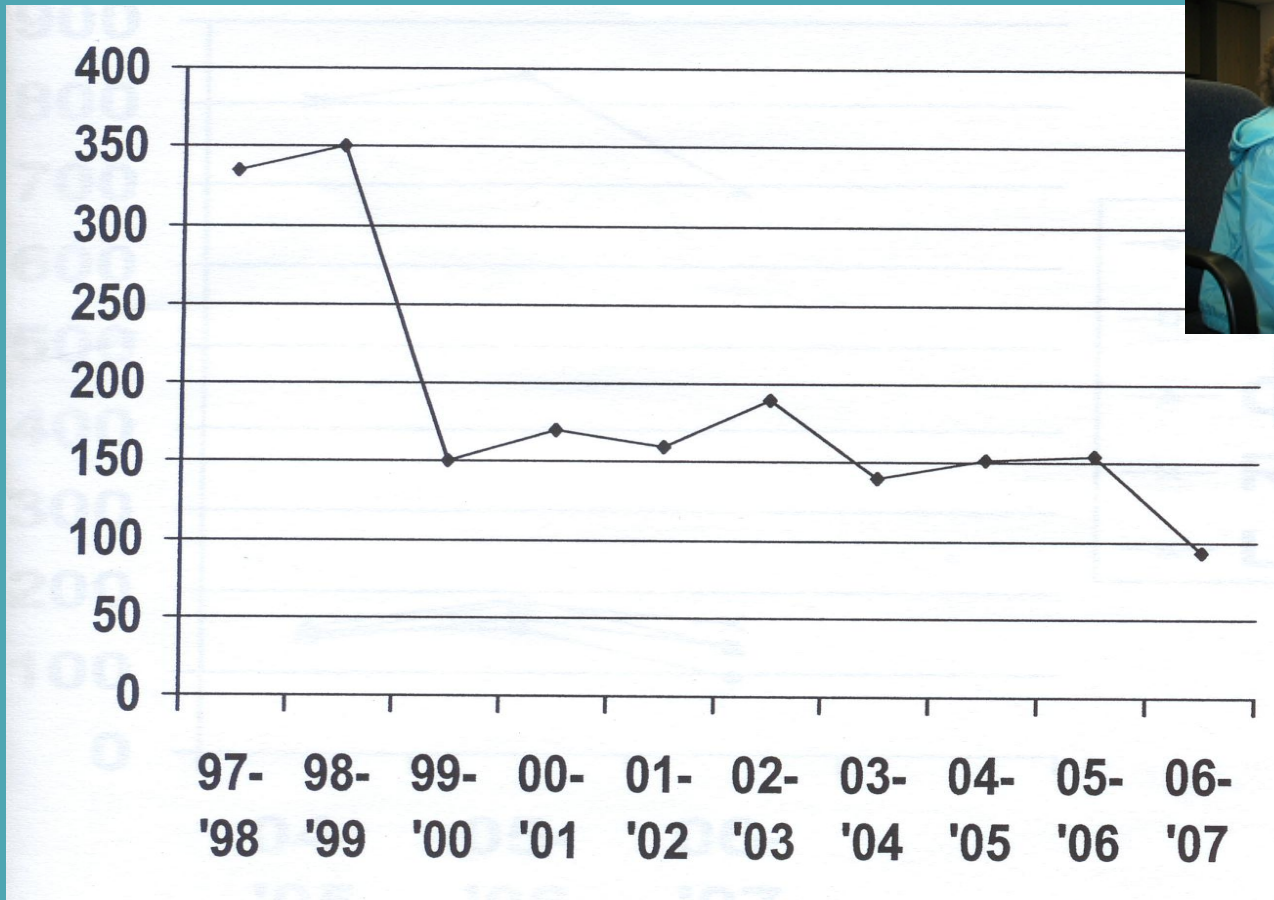
Communication Routines

- Improvement
 - Shared planning opportunities
 - Weekly improvement meetings
 - Daily Huddles
- Clinical
 - Choose daily communication mechanism
 - Case conferencing
 - Shared clinical training

Electronic Information Support

- Taber EMR used to manage patient registers for high risk patient populations and for high prevalence chronic conditions.
 - more proactive diabetes management
 - supports the clinic's capacity to monitor / provide guideline-directed care.
- All clinical staff (MDs, RNs, NPs, RD, RRT) have access to the EMR both on-site and off-site.

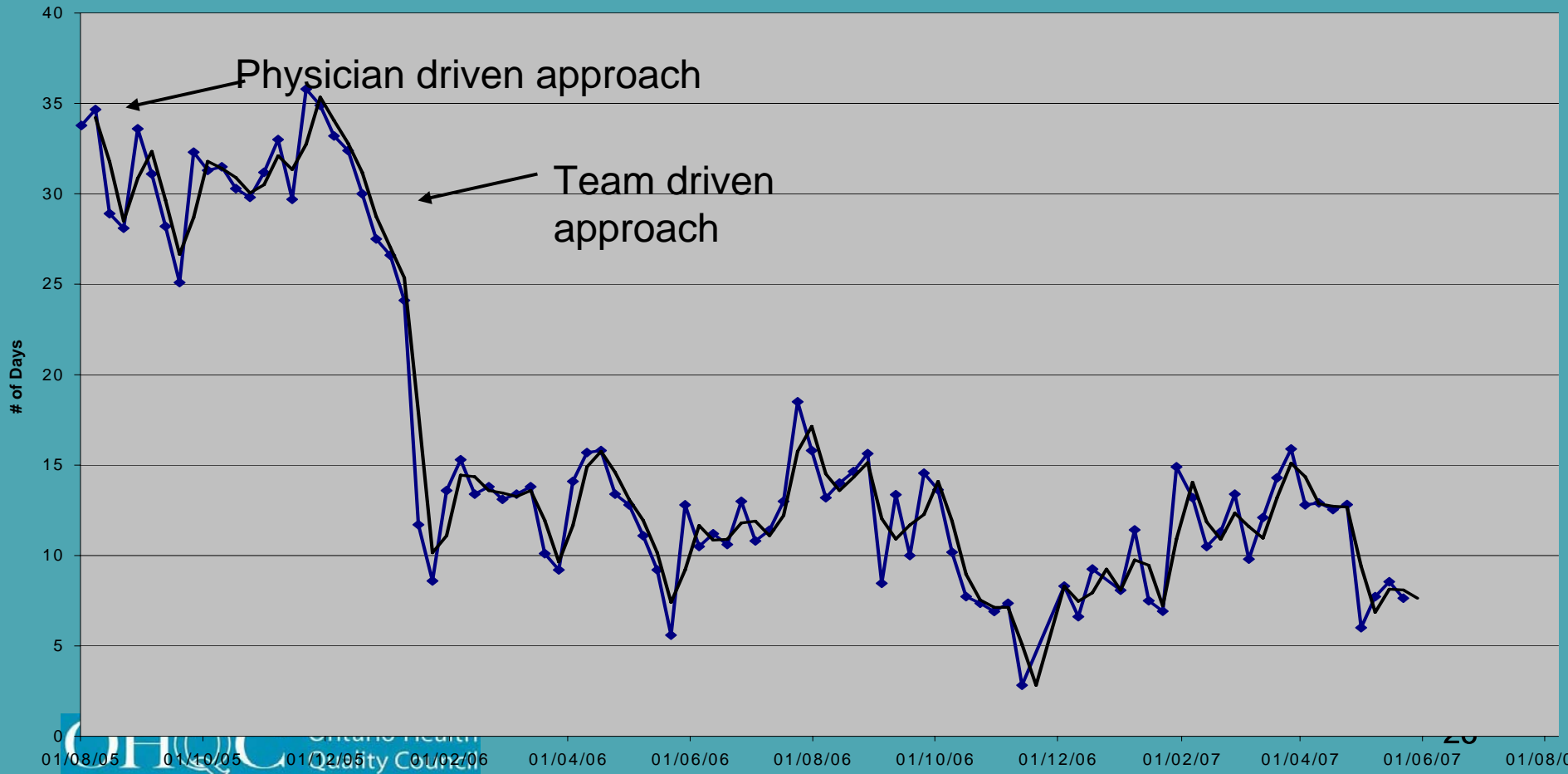
ER visits for Asthma: Taber team story



Collaborative and continued reduction in asthma ER visits

Taber Clinic Delay Data

Average Clinic Delay



Taber 2003

- Patient travel has been significantly reduced due to integrated visits and new health education options available in the physician's clinic.
- Diabetes educators moved to family practice office
- RD / RRT have shifted some time from hospital to family practice office
- Public health offer well baby visits in family practice office
- Home care offices moved to hospital; participate in 'Friday rounds mtgs'



Taber work has changed

- *Where did we start?*
 - *Sense of frustration*
 - *Looking for evidence to help find a better way*
 - *Fragmented care*
 - *Duplication of service*
 - *On a treadmill, going faster and faster, doing the same things*
- *Where has it taken us?*
 - *Sense of purpose*
 - *Applying evidence*
 - *Integrated care for continuity*
 - *Mapping our improving service flow*
 - *Still working hard, and achieving more*

Overcoming Fears

- Initial Fears
 - loss of patient-relationship
 - loss of autonomy
 - clinical
 - business
 - loss of income
 - lack of trust in teams (ie. NP role)
- Reality
 - In the ‘doing’, these fears were not substantiated

Physician-Patient Relationship since introduction of teams

- More pro-active communication
 - fever pamphlets
 - self-care resources
- More knowledge of care provided by others
- Ability to offer more options to patients
- Improved chronic disease management
- Training to support physician - patient communication

Taber influenced region: Chinook 2006

- New integrated resources, education, and shared planning is the norm
- Each of the 17 family practice clinics has added internal allied professionals
- Each family practice clinic has been directly linked to regional CDM leads for vascular protection, diabetes, and in most cases respiratory care delivery (virtual or co-located).

Teams in Action:

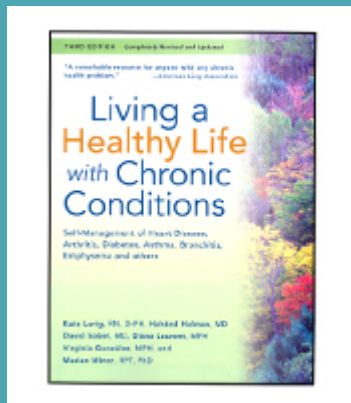
- Case Conferencing
 - physicians, pharmacist and home care
 - Pick 3 priority patients/clients, find the process that is most do-able for team
- Tests of Change:
 - New chart prep system prior to mtg (added work; frustrating)
 - Have dialogue based on existing charts (worked well)

Teams in Action

- Chronic Disease
 - Asthma and diabetes well developed by end of pilot
 - Hypertension and chronic pain in progress
 - Improved access to education
 - Improved CPG compliance
- Tests of change
 - Physician to refer appropriate patient (missed opportunities)
 - At huddles, identify likely referral candidates, and include referral form with chart (successful, led to ‘case finding’)
 - Program team supported generalist activity

Teams in Action

- New resources and group education
 - Self Management program



- Test of change:
 - Refer patients who are on waiting list for rehab to Self Management instead of referring from Rehab (very successful, led to high satisfaction and some patients were able to remove themselves from waiting list post-Self Care)

Program Team Example A

Pincher Creek has “Good Health Team” – internal program team

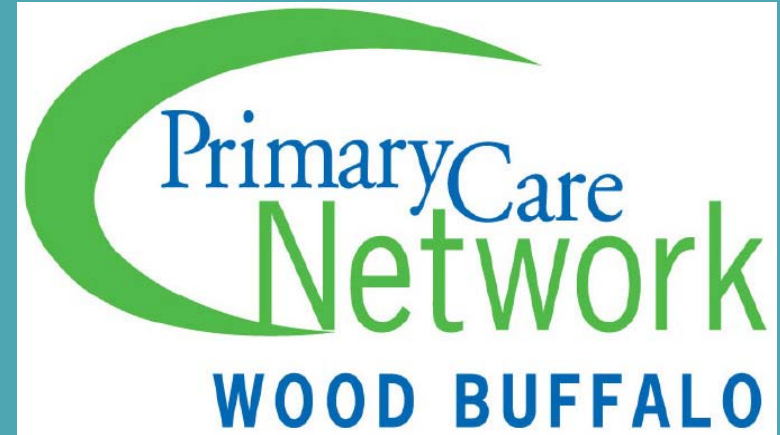
- 8 physicians serving rural community, including satellite clinic with Blood Tribe
- Inter-disciplinary team 2003; RN, RD, Social Worker, Pharmacist
- Patient leads team
- Team supports case management



Program Team Example B

Fort McMurray

- Central Team
 - Chronic disease
 - Well Woman
 - Palliative
 - Cardiac Rehab
- Serves 20 solo practices
- Referral processes and building trust via virtual team is crucial





Generalist Team Example C

New Vision Team – Kitchener

- Weekly schedule review with physician to identify:
 - unnecessary appointment bookings
 - appointments better served by the allied health team
 - testing that should be ordered prior to visit
 - results which should be obtained prior to visit





Average Time to Next 3rd Available Appointment

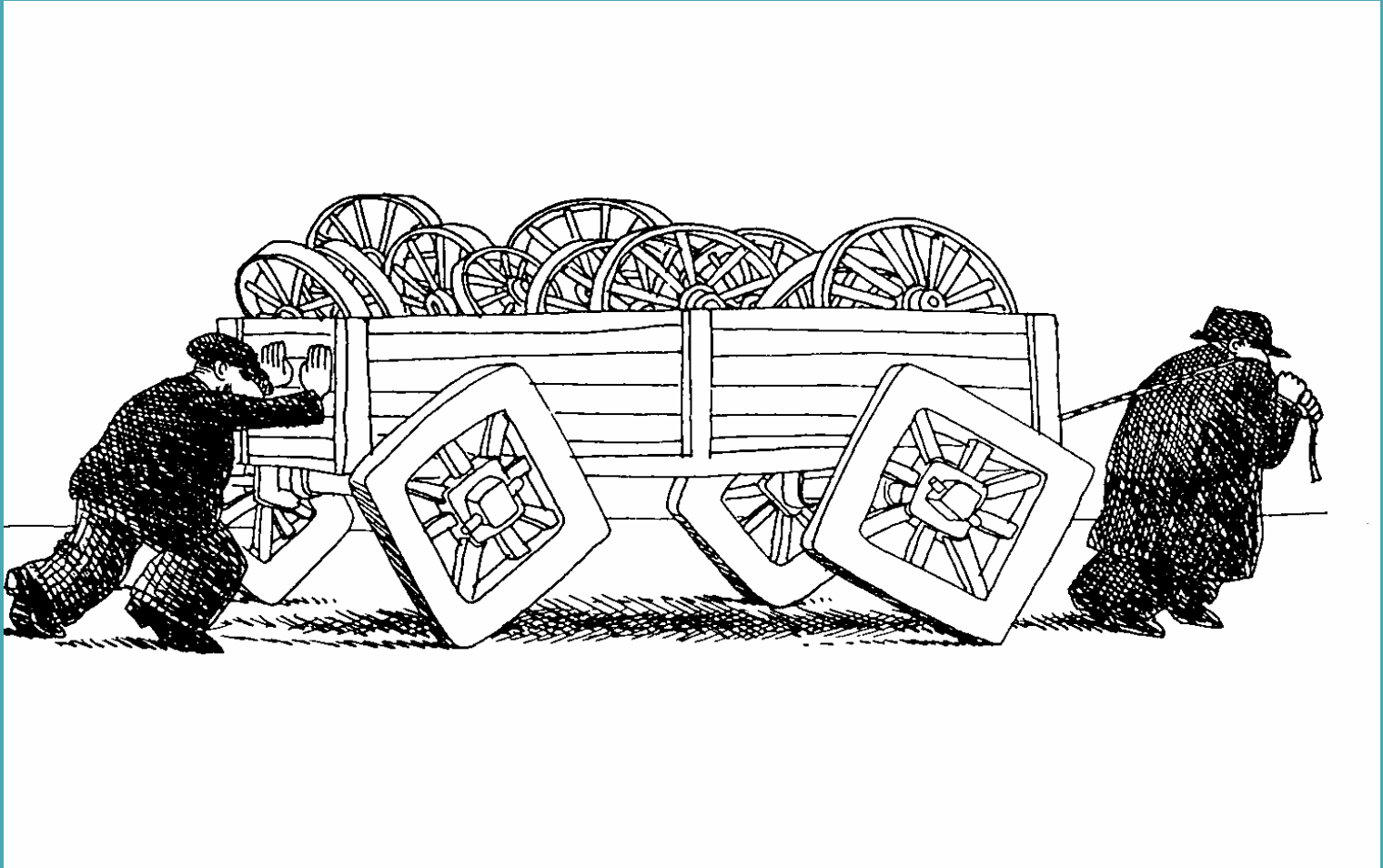
June	13.5 days
July	9.8 days
August	5.8 days

Dr. C. has significantly improved Access, so far has reduced his next 3rd available appointment by 57%.

Lessons Learned

- Follow the basics of Improvement science
 - Get leadership buy-in & align with organizational strategies & goals
 - Focus on all the work coming in, and supporting care across the clinic experience
 - Develop clear objectives
 - Real-time measurement only important data
 - Break down changes into bite-sized chunks, test and learn together

This is your chance to look up!



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