Interdisciplinary Teamwork: How Physicians, Nurses and Pharmacists Can Work Together to Provide Accountable Care

Mark Loafman MD, MPH
Assistant Professor Family Medicine, Northwestern Feinberg School of Medicine
National Faculty Co-Chair, HRSA Patient Safety/Clinical Pharmacy Services Collaborative
Chief Clinical Integration Officer, Norwegian American Hospital

No Conflicts of Interest to disclose

Learning Objectives

• Identify the critical emerging role for integrated med mgmnt in achieving the triple aim for patient centered health care services.
• Describe the knowledge and systems barriers adversely affecting providers’ ability to achieve optimal health outcomes in patients with chronic conditions.
• Articulate how integrating clinical pharmacy services into an interprofessional team can address systems barriers to optimal care.
• Explain the Institute for Healthcare Improvement (IHI) Collaborative Model for Breakthrough Improvement in terms of rapid cycle improvement involving clinical pharmacy services.
• Recognize the value in defining a small population of focus as a starting point in the work of systems improvement.
If health care were an Olympic sport, how many medals would the U.S. win?

#1 in “rescue” care

#37 in population health

Allocation of Healthcare Resources and Workforce
...what’s keeping us busy today in healthcare?

- HTN, Diabetes, and Dyslipidemia
- Obesity, Tobacco
- Cancer
- Trauma, Accidents
Allocation of Healthcare Resources and Workforce

...what does it take to get our Gold medal care?

- Uncontrolled HTN, Diabetes and Dyslipidemia,
- Persistent Obesity, Tobacco
- Cancer not Prevented
- Trauma, Accidents not Avoided

Allocation of Healthcare Resources and Workforce

...in comparison to Population w/chronic disease

- Estimated 70% of $$$$

46 million Patients with Chronic Disease

Patients with Advanced Stage Disease

Patients who are dying
Epidemiology/Population Health

• Chronic disease prevalence = 46 million
  Diabetes, HTN, Lipids, etc.
  Rx costs + ADE’s = $ and harm
  but, that’s not all...

• Chronic disease causes harm if uncontrolled
  We have an epidemic of uncontrolled chronic conditions

Allocation of Healthcare Resources and Workforce

...what we are focused on today in healthcare?

Safer + Better = Less $
Life Course Perspective
Trajectory for Chronic Disease

- Diabetes
- HTN, Lipids
- Obesity
- Smoking

w/o Primary Prevention

- Vascularopathy
- CV and Renal damage
- Mild Disability

w/o Secondary Prevention

- ESRD, MI, CVA
- Heart, Kidney Failure
- Severe Disability

End Stage Care - Death
Life Course Perspective
*Trajectory for Chronic Disease*

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w/o Primary Prevention

w/o Secondary Prevention

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End Stage Care - Death

Current Healthcare Delivery System
*We wait for patients to crash before giving them our best?*

The cost of rescue focused care

- Private, commercial
  - Among the highest cost of doing business
- Medicare
  - 50% have ≥ 3 chronic conditions
  - 20% have ≥ 5 conditions, and providers
  - “Dual eligibles” are literally breaking the bank
- Medicaid
  - States can’t afford underfunded rates, let alone...
- Undocumented, uninsurable left out entirely
The cost of rescue focused care

• And the human costs ….. a quick case study

• If Healthcare were a movie for our patients with chronic conditions, what kind of Soundtrack would there be?

Scary Music

Highly Effective Healthcare

• What does “world class” care look like?
• Examples
  – EMS, door to balloon, ICU, Service Lines/bundles
• Opportunity
  – Harvest lessons learned on rescue care
  – Move upstream
  – Not just “pre-hospitalization”
  – From Medical Home to “Neighborhood”
Life Course Perspective – **New** Delivery System  
*Changing the Trajectory for Chronic Disease*

- Diabetes  
- HTN, Lipids  
- Obesity  
- Smoking  

**Primary Prevention**

*Minimal vascular disease*  
*Preserved Heart, Kidney Function*

End Stage Care - Death

- ESRD, MI, CVA  
- Heart, Kidney Failure  
- Severe Disability

End Stage Care - Death

Health Care Resources, Workforce and Population

Many Patients with **Uncontrolled** Chronic Disease

More Patients with Advanced Stage Disease   
Patients dying younger and sicker

Many Patients with **Controlled** Chronic Disease

Less Patients with Advanced Stage Disease   
Patients still die, but later and “better”
Health Care Resources, Workforce and Population
Realizing the Triple Aim

Many Patients with
Uncontrolled Chronic Disease

Safer + Better = Less $

Many Patients with
Controlled Chronic Disease

Moving Systems “Upstream”

Less Patients with Advanced Stage Disease

Patients still die, but older and “better”

Achieving the Triple AIM

Integrated CPS

Health Status

Adverse Drug Events
# How Reliable is our Care?

*A function of System and Culture*

<table>
<thead>
<tr>
<th>Chaos Theory</th>
<th>Teamwork</th>
<th>Highly Reliable Organizations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Custom-crafted processes</td>
<td>Standard process, habits and patterns</td>
<td>Deference to expertise, “safety culture”</td>
</tr>
<tr>
<td>Each Doctor writes individual orders</td>
<td>Each staff member has his/her own way</td>
<td>Multi-disciplinary rounds</td>
</tr>
</tbody>
</table>

**Autonomy**
- **Chaos Theory**
  - 1:10

**Teamwork**
- **1:100**
- **1:10,000**

**Highly Reliable Organizations**
- **6 sigma error rate**

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**Inter-Professional Care Teams**

Engaging Physicians in Performance Improvement
Engaging Physicians? ... it’s like herding cats

<table>
<thead>
<tr>
<th>What we say</th>
<th>What doctors hear</th>
</tr>
</thead>
<tbody>
<tr>
<td>Performance improvement</td>
<td>You question my judgment?</td>
</tr>
<tr>
<td>Accountability</td>
<td>Insult my integrity</td>
</tr>
<tr>
<td>Collaborative practice</td>
<td>Losing control</td>
</tr>
<tr>
<td>Guidelines</td>
<td>Cookbooks</td>
</tr>
<tr>
<td>Electronic Records</td>
<td>OMG!</td>
</tr>
</tbody>
</table>

Understanding the frustration

- Satisfaction with practice has decreased for many physicians.
- The “psychological contract” has been changed, without informed consent.
- Professional ethos that got them here is no longer working.
Understanding the frustration

• Satisfaction with practice has decreased for many physicians.
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but, CHANGE IS NECESSARY and INEVITABLE

so arm yourself with data and join the cause

Performance Improvement as Translational Research

IHI Breakthrough Model for Improvement
Breakthrough Improvement Model: **Key Attributes**

- Patient-Centered
- Inter-professional care teams, best practices *(HP teams)*
- Cross-organizational w/medical homes at the center
- Systematically addresses safety, risk, gaps and costs
- PDSA cycles for rapid improvement
- Ripe for spread to many other conditions
- Is not new work to do, but a powerful new way to do the work we already have
Change Package
A Road Map to Improvement

- Details the leading practices that together address the Aim and Goals of the improvement process.
- Developed by harvesting lessons from high performing organizations that have achieved outstanding results.
- Reviewed and vetted by a panel of national experts.
- Serves as the catalogue of leading practices that teams adapt and use to accelerate the improvement process.

Change Package for Performance Improvement in Medication Use

- Leadership Commitment
  Develop organizational relationships that promote safe medication-use systems and optimal health outcomes.
- Measurable Improvement
  Achieving change using the value and power of data-driven improvements.
- Safe Medication Use Systems
  Develop and then operate safety medication-use practices.
- Patient-Centered Care
  Build a patient-centered medication-use system.
- Integrated Care Delivery
  Build an integrated health care system across providers and settings that produces safety and optimal health outcomes.

http://www.healthcarecommunities.org
The Breakthrough Model for Improvement

- What if we unleash the Model for Improvement, using CPS and IMM, on our “to-do” list?
- Do we have “permission” to do this work?
- Are we ready to help drive a bold PI approach?
- The most important next step I can take is...?
  Start small, think and act big
Inter-Professional Teams -
*Changing the Soundtrack*

• Patient Care Medical Home? It's all good
  – But PCMH alone won’t get it done
  – Patients with chronic conditions and their primary care providers are alone and underpowered

• Clinically Integrated Network
  – Interdisciplinary teams armed with EBM are how we address complex issues
  – With so much to do, each team member must function at the highest level of their skill/training

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Inter-Professional Teams - Approach to Clinical Integration

• Process focus
  – Case and Disease management
  – Doing things right
  – Get patient to the right place at the right time
  – Push against “non-Compliance”

• Outcomes focus
  – Patient centered care coordination
  – Doing the right things
  – Achieving optimal health measures
  – Safe and Effective Medication Use
Inter-Professional Teams - Approach to Clinical Integration

- **Process focus** (*putzing around*)
  - Case and Disease management
  - Doing things right
  - Get patient to the right place at the right time
  - Push against “non-Compliance”

- **Outcomes focus** (*getting it done*)
  - Patient centered care coordination
  - Doing the right things
  - Achieving optimal health measures
  - Safe and Effective Medication Use

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Inter-Professional Teams

*Models for Clinical Integration*

- **Levels of Integration**
  - Referral
  - Colocation
  - **Fully integrated**

- **Consider Implications**
  - Integrated Medication Management
  - Safe and Effective Systems for Medication Use
Achieving Clinical Integration
Augmenting your “Permission”

▶ Create time for physicians
  ◦ Documentation tools, protocols, care maps
  ◦ Standardize/enhance Allied Health staff
  ◦ Reduce “non-productive” time

▶ Generate value for physicians
  ◦ Help achieve quality/satisfaction goals
  ◦ Financial incentives and support
  ◦ Share technology, resources and even staff

Putting it all together: Breakthrough Model to Drive Change:
Improvement Model, CPS, Clinical Integration

• Patient centered, outcome focused
  – Bigger than processes and surrogate markers
• Consistent use of EBM practice guidelines, documentation tools, order sets, etc.
• Team, with each profession working at highest level possible
• Changing and refining practices in response to performance data
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“Answering the Call to Action”

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