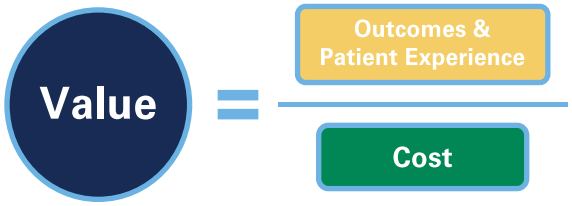
Measuring the Value of Team-based Care: A Dashboard for Health Care Organizations

Introduction

Interdisciplinary team-based care – where health professionals from various disciplines collaborate to care for patients – is an effective lever to improve value by affecting all three components of AHA's value equation.

AHA's Value Equation



For many hospitals and health systems, implementing or expanding their team-based care strategies requires reimagining how to organize care, deciding how health professionals should interact – both with each other and with patients – and reconsidering how to train health care providers. To invest the time, resources and staff needed to implement team-based care, hospitals need champions who can articulate how such investment improves outcomes, enhances the patient experience and reduces cost.

This issue brief from AHA's The Value Initiative shares real-life examples of hospitals that have utilized team-based care to improve value. This dashboard deeper provides health care leaders with metrics that their organizations can use to make the case for team-based care. It demonstrates the value of team-based care in four domains:

1. Process and culture;
2. Quality and outcomes;
3. Patient experience; and
4. Costs.

How to Use this Document

- Health care leaders – including providers such as physicians, nurses, social workers and other clinicians, and quality and patient safety leaders and administrators – can articulate the value of team-based care for their organization by aligning the metrics in this dashboard with existing strategic goals.
- The domains in this dashboard align with the elements of the value equation: quality outcomes, patient experience and cost. Health care leaders can apply the metrics in each domain to make the value-case for team-based care, identify relevant strategies to implement, measure progress and evaluate future strategic directions.
- Health care leaders are encouraged to adapt the metrics to match their organizations' specific needs and goals.
- The AHA offers tools and resources, included at the end of this document, to support leaders as they implement teams-based care in their organizations.

Definitions to Know

Team-based Care

The provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers – to the extent preferred by each patient – to accomplish shared goals within and across care settings to achieve coordinated high-quality care.

Interdisciplinary Care Teams

A team of professionals from various disciplines are involved in reaching a common goal, with each team member bringing his or her discipline's expertise to the team. Team members work formally and informally, and information is shared in a systemic way among team members. An interdisciplinary team is collaborative and integrates each profession's knowledge into the care plan.

American Hospital Association™
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Domain 1: Process and Culture

Hospitals and health systems will need to build a culture that supports team-based care. The skills needed to work as an interdisciplinary care team are not innate; they must be learned and may require an organization-wide mindset shift. Such a culture transpose require that health professionals change existing processes and procedures around how they collaborate. This will enable them to work as teams while providing patient care.

Hospitals and other health care providers should assess in the following inputs, as they create the culture and processes that enables the adoption and sustainability of team-based care:

Training and Coaching	• Percentage of staff trained in teaming with providers from diverse disciplines and professions; and • Percentage of employees that are team-trained as part of onboarding; and • Availability of coaching and education for providers to sustain changes and address challenges.
Care Design	• Processes for patient care design include team-based care and foster inter-professional collaboration; and • Implementation of interdisciplinary, team-based rounds; and • Design and implement virtual systems for seamless communication among team members.
Uptake of Team-based Care	• Percentage of patients treated by interdisciplinary care teams; and • Number of departments, units and/or clinics that adopt team-based care; and • Provider satisfaction with team-based care; and • Staff retention under team-based care.

CHI Health Creighton University Medical Center in Omaha, Neb. has been intentional about building a culture of interdisciplinary collaboration. Through its initial team-based care training in 2017, leaders focused on creating a sense of psychological safety and comradery among all staff members – from the front desk and room cleaning staff to the service providers. Annual culture workshops and the introduction of new medical students or residents enable leaders to refresh and reinforce a culture of collaboration. Amy McGaha, M.D., chair of the Department of Family and Community Medicine, said that while it may be tempting to prioritize quality metrics or readmissions rates, "if you don't have that culture right, it is all going to fall apart." For example, CHI Creighton's team-based culture enabled leaders to quickly respond to COVID-19. By working collaboratively, they were able get telehealth up and running a matter of days.

Domain 2: Quality & Outcomes

Team-based care is a tool to improve the quality of care and patient outcomes. While team-based care is only one driver of quality and outcomes, prospective monitoring these measures may help identify team-based care's impact. Hospitals can consider measuring both process and outcomes-metrics. These metrics include, but are not limited to:

Process	
Care Coordination	• Timeliness of intra-hospital transfer (such as emergency department (ED) to inpatient floor; intensive care unit (ICU) status changes); • Percent of patients receiving follow-up visits within the health care system; • Time taken to receive a service; • Completion of preventive screenings; • Closed loop referrals made (within health system and with community partners); and • Time to completion of medication reconciliation.
Standardized Care Procedures	• Adherence to evidence-based guidelines (e.g., for stroke and cardiac care); and • Utilization of handoff checklists.
Communication	• Frequency of structured handoffs; • Frequency of briefs or debriefs among the care team; • Communication and collaboration among care providers for each patient (such as Hospital Survey on Patient Safety Culture); and • Assessment of patient health literacy and utilization of teach-back.
Outcomes	
Chronic Disease Management	• Biometrics (such as blood pressure or A1C levels).
Patient Safety	• Patient safety events (such as infection rates or medication errors and misdiagnoses); • Low-value tests or procedures; • Complication rates; and • Trends in patient safety events;
Health Care Utilization	• Avoidable readmission rates; • ICU readmission rates; • Use of appropriate care levels, including across primary care, preventive care, and other levels; and • Appropriate ED use.

San Antonio-based University Health System's palliative care program utilizes an inpatient and outpatient settings interdisciplinary team care for patients with serious illnesses. The care team consists of physicians, nurse practitioners, chaplains and social workers, as well as nurses, therapists, volunteers, operations managers and a nurse director. The program makes a particular effort to reach underserved, rural and immigrant patients and partners with promotores, or community health workers who serve migrant patients. The program has reduced mortality rates in the ICU and lowered lengths of stay.

Domain 3: Patient Experience

Interdisciplinary teams that can respond to patients' medical, behavioral and social needs can enable hospital leaders to design care that reflects what matters most to patients, thereby improving the patient experience. Hospitals can conduct surveys and interviews to identify what aspects of care matter most and the extent to which those needs are being met. Providers can measure improvements in the patient experience through:

Communication	• HCAHPS scores on satisfaction with communication from physicians and nurses; • Admission pre-briefs about care goals and preferences; • Post-discharge follow-up; • Implementation of shared decision-making process for relevant conditions; • Inclusion of patients in the debrief about their experience; and • Patient self-efficacy/activation.
Overall Satisfaction	• HCAHPS scores for global items; • Unit-level surveys; and • Patient-Family Advisory Council feedback on care experience.

New York City-based Mount Sinai's Mount Sinai at Home program uses team-based care to provide hospital-level services to acutely ill patients in their homes. A team of nurses, doctors and social workers provide patients with a suite of integrated services. Not only do patients who receive hospital-at-home care show improved outcomes, but Mount Sinai also reported increased patient satisfaction. Individuals in the program also reported superior patient experiences compared to traditional inpatient care (67.8% versus 45.6%).

Domain 4: Costs

When implemented correctly, team-based care can drive cost savings for hospitals and patients. Metrics to articulate this improvement include:

Hospital Costs	
Care Utilization	• Avoidable readmissions; • Utilization of ED or urgent care services; • Safety and hospital-acquired infection issues (e.g., CLABSI, CAUTI, falls); • Hospital length of stay; and • Chronic disease exacerbation (e.g., readmissions for diabetes, COPD, heart failure).
Patient Costs	
Costs Avoided	• Admissions or readmissions to the hospital; • Low-value tests, procedures or medications; • Utilization of high-cost medications; and • ICU length of stay.

Salt Lake City, Utah-based Intermountain Healthcare's Mental Health Integration model applies a team-based approach to integrate behavioral health into every patient visit. In addition to primary care clinicians, the customized care team may include social workers, therapists, psychiatrists, care guides, care advocates, care managers, physical therapists, nutritionists, pharmacists and peer mentors. Through team-based care, Intermountain has saved $13 million per year, primarily by reducing hospital visits and unnecessary ED utilization.

Supporting Tools and Resources

The AHA will continue to develop tools to assist hospitals and health systems as they transition toward team-based care. Explore the following resources on team-based care and value:

AHA Team Training

TeamSTEPPS offered through AHA Team Training is an evidence-based approach that teaches clinical and non-clinical providers to communicate more effectively, empowering them to create and sustain a culture of quality and safety.

Team-based Care Creates Value

To better support patients and their families through an acute or chronic illness, hospitals are adopting team-based models of care that encompass patients' medical and social needs across the care continuum. This issue brief from The Value Initiative also highlights AHA Team Training and discusses how hospitals have utilized care teams before and during the COVID-19 pandemic.

Webinar: How Team-based Approaches Improve Value

This webinar provides a framework for articulating the value of team-based care and shares lessons learned from hospitals and health systems around the country that have engaged teams to lower cost, improve outcomes and enhance the patient experience.

Integrated Behavioral Health is High-value Care

Integrating physical and behavioral health care services can help hospitals and health systems overcome patient barriers to accessing behavioral health services while improving outcomes and value. This issue brief examines how integration can take various forms based on provider, patient and community needs and how telebehavioral health can help in areas with shortages of behavioral health professionals.

Improving Value for Patients with a Serious Illness

Palliative care – a specialized care model for individuals living with serious illness - is an effective approach to address patients' medical and psychosocial needs while reducing cost. This issue brief examines how palliative care promotes value for patients, hospitals and communities, and includes case examples and resources.