TEAMcare at The Polyclinic: Multi-Condition Collaborative Care for Diabetes, Heart Disease and Depression

Elise Ernst, MEd, MSW, MBA
Oren Townsend, MD
Paul Ciechanowski, MD, MPH

Multi-Condition Collaborative Care: An Effective Model for Integrating Behavioral Health in Primary Care and ACO Settings

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Dept. of Psychiatry
Diabetes Care Center
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Seattle, WA

Mr. T.

64 yr. old married, naval shipyard worker

- Uncontrolled type 2 diabetes (A1c = 9.6%)
- Hypertension (BP = 174/94 mmHg)
- Hyperlipidemia (LDL = 141 mg/dL)
- Obesity (Weight = 269 lbs; BMI = 39.7 kg/m^2)
- Hypothyroidism, psoriasis, gout
- History of diverticulitis, kidney stones

Medications: glyburide, lisinopril, atenolol, atorvastatin, levothyroxine

It gets worse…

Mr. T.

Primary complaint: ongoing fatigue

PHQ-9 = 19/27:

meets criteria for major depression

The Challenge of Multiple Comorbidity for the US Health Care System

Anand K. Parekh, MD, MPH
Mary B. Barton, MD, MPP

THE AGING OF THE US POPULATION, COMBINED WITH improvements in modern medicine, has created a new challenge: approximately 75 million people in the United States have multiple (2 or more) concurrent chronic conditions, defined as "conditions that last a year or more and require ongoing medical attention and/or limit activities of daily living."[1,2] Is the 21st-century US health care system prepared to deal with the consequences of successfully treating patients who have conditions, often multiple, that they would not have survived in the early 20th century? Current indications suggest that it is not.

As the number of chronic conditions affecting an individual increases, so do the following outcomes: unnecessary hospitalizations; adverse drug events; duplicative tests; conflicting medical advice; and, most important, poor functional status and death.[1-5] Approximately 65% of total health care spending is directed at the approximately 25% of US population who have multiple chronic conditions.[2] Individuals with multiple chronic conditions also face financial challenges related to the out-of-pocket costs of their care, including higher prescription drug costs and total out-of-pocket health care spending.[2]

future of health care reform is uncertain, Congress has drafted legislation that includes experimental and pilot approaches to realigning such incentives and payments. Even if these necessary reforms were enacted, the effects of the clinician in improving health outcomes would remain dependent on the active participation of the individual patient. It is not clear whether the potential benefits of chronic disease self-care management; personal health records; and other health information exchange platforms, such as secure messaging, are being fully realized to maximize patient participation and health.

The "Multi-Condition" Patient

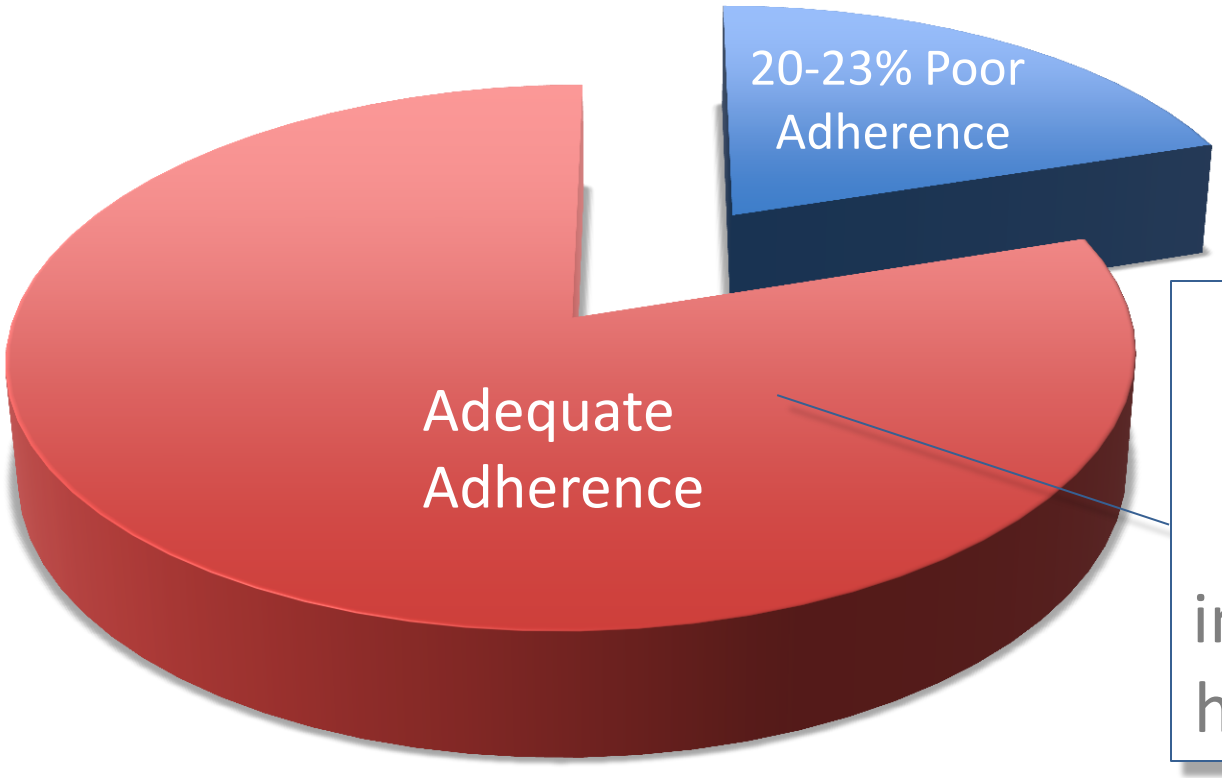
JAMA, April 7, 2010

Study: 161,697 Patients

- $HbA_1c \geq 8.5\%$
- Systolic blood pressure > 140 mmHg
- LDL > 130 mg/dL

Schmittdiel et al., J Gen Intern Med. 2008; 23(5): 588–594.

Study: 161,697 Patients

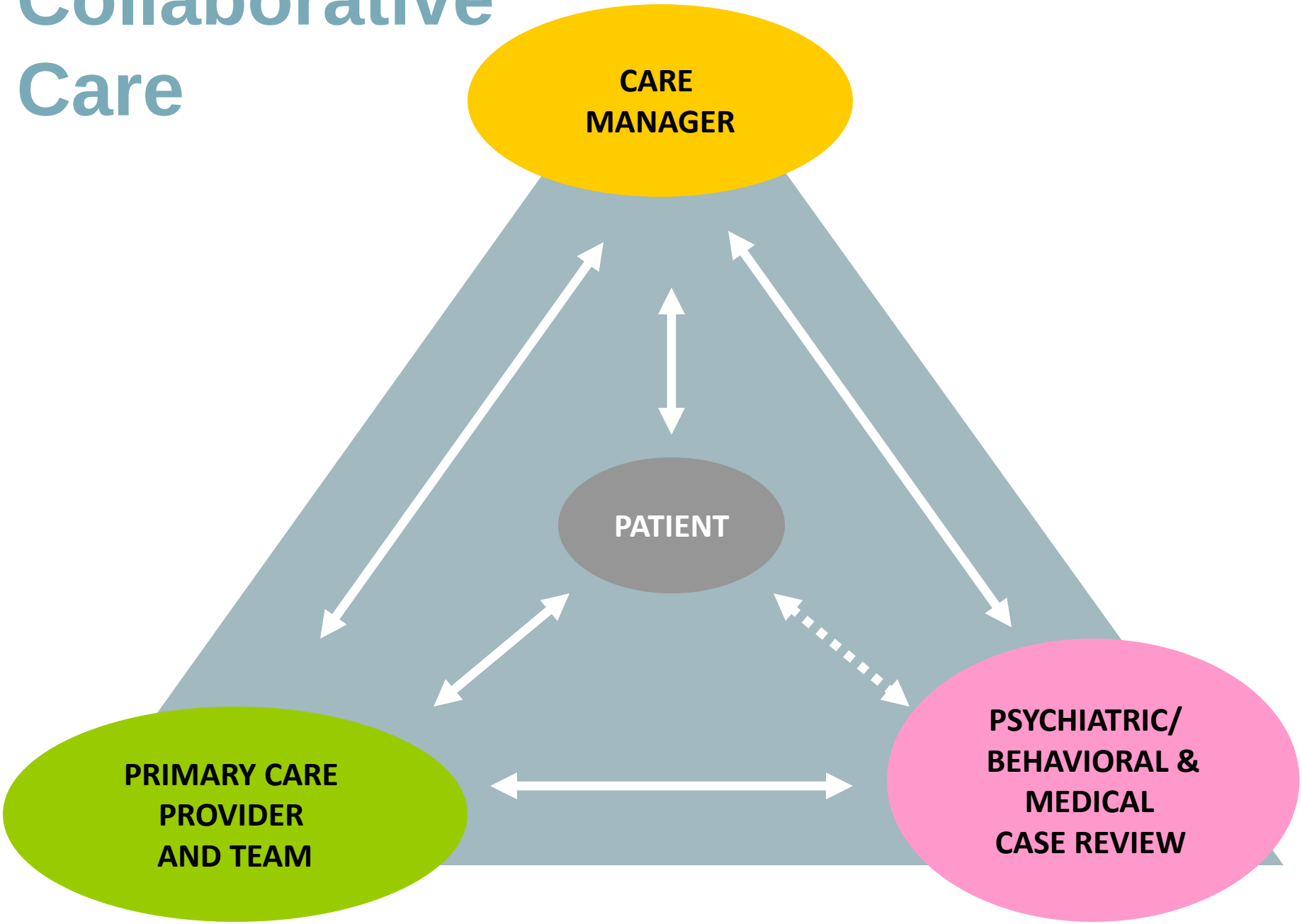


Clinical Inertia:

30-47% lacked treatment intensification by healthcare team.

Schmittdiel et al., J Gen Intern Med. 2008; 23(5): 588–594.

Collaborative Care



TEAMcare

Improving chronic illness outcomes in the medical home

Up to 20% of patients with chronic conditions such as diabetes and heart disease have co-existing depression and are at higher risk of heart attack, stroke and other complications.

- Dr. Wayne Katon

a TEAM behind you committed to care

training | research | resources

in the news

January, 2011 - In a randomized controlled trial, testing an intervention called TEAMcare, nurses worked with patients and their doctors and health teams to manage care for depression and physical disease together, using evidence-based guidelines. more

our program
WHO WE ARE

training
GET STARTED

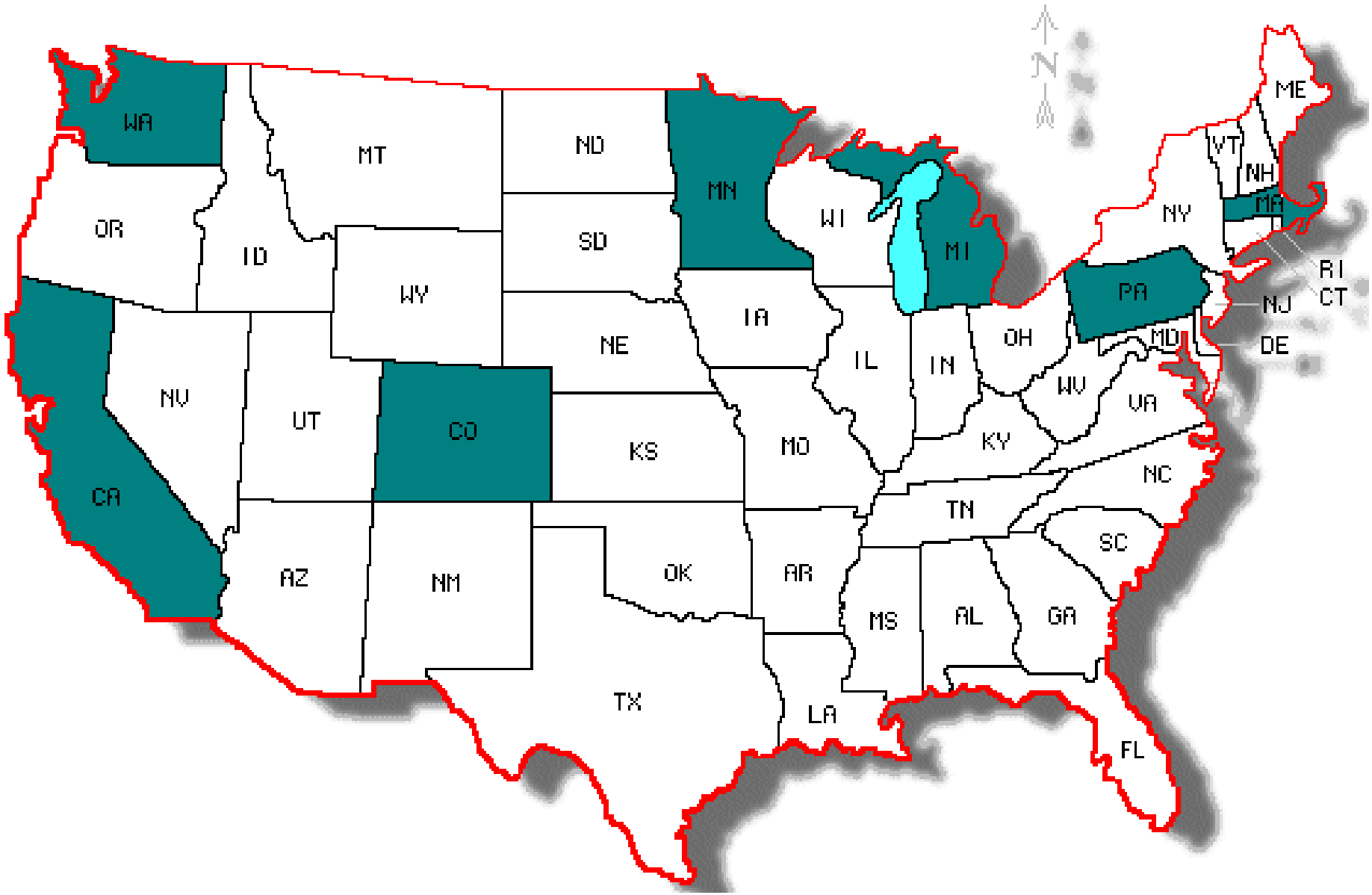
resources
EDUCATIONAL MATERIALS

news
NEWS & EVENTS

publications
GET THE FACTS

contact us
REQUEST MORE INFO

teamcarehealth.org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MA
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NH
ME

THE POLYCLINIC

MEMORIAL HERMANN
Texas Medical Center

COMMUNITY HEALTH PLAN of Washington™

ICSI Institute for Clinical Systems Improvement

KAISER PERMANENTE®
COLORADO

KAISER PERMANENTE
Kaiser Foundation Health Plan, Inc.
Southern California Region

MAYO CLINIC
HEALTH SYSTEM

Mi-CCSI
Center for Clinical
Systems Improvement

Patient Identification

- Automated data (ICD-9) of having:
  - *diabetes and/or coronary artery disease*
- Poor disease control:
  - *HbA1c ≥ 8.5%*
  - *Blood pressure > 140/90 mmHg*
  - *LDL >130 mg/dL*
- PHQ-9 ≥ 10

Program Goals

- Improve depression care
  - Behavioral activation
  - Antidepressants
- Improve medical disease control
  - HbA_{1c}, HTN, LDL
- Improve self-care
  - Diet, Exercise
  - Cessation of Smoking
  - Glucose Monitoring

Program Goals

- **A**1c
- **B**lood Pressure
- **C**holesterol (LDL)
- **D**epression

Collaborative Depression Care

+

Chronic Care Model

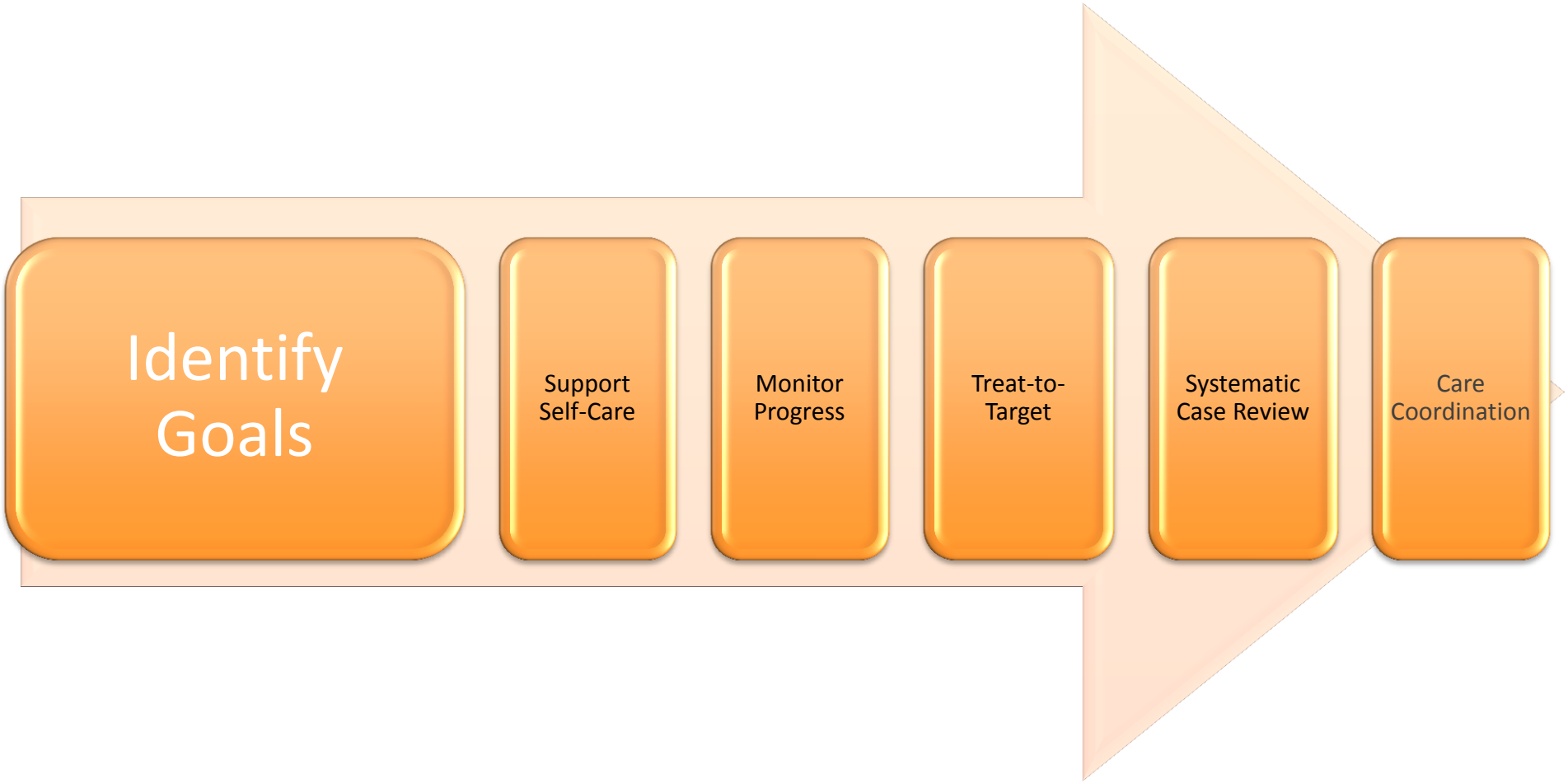
+

Treat-to-Target Approach

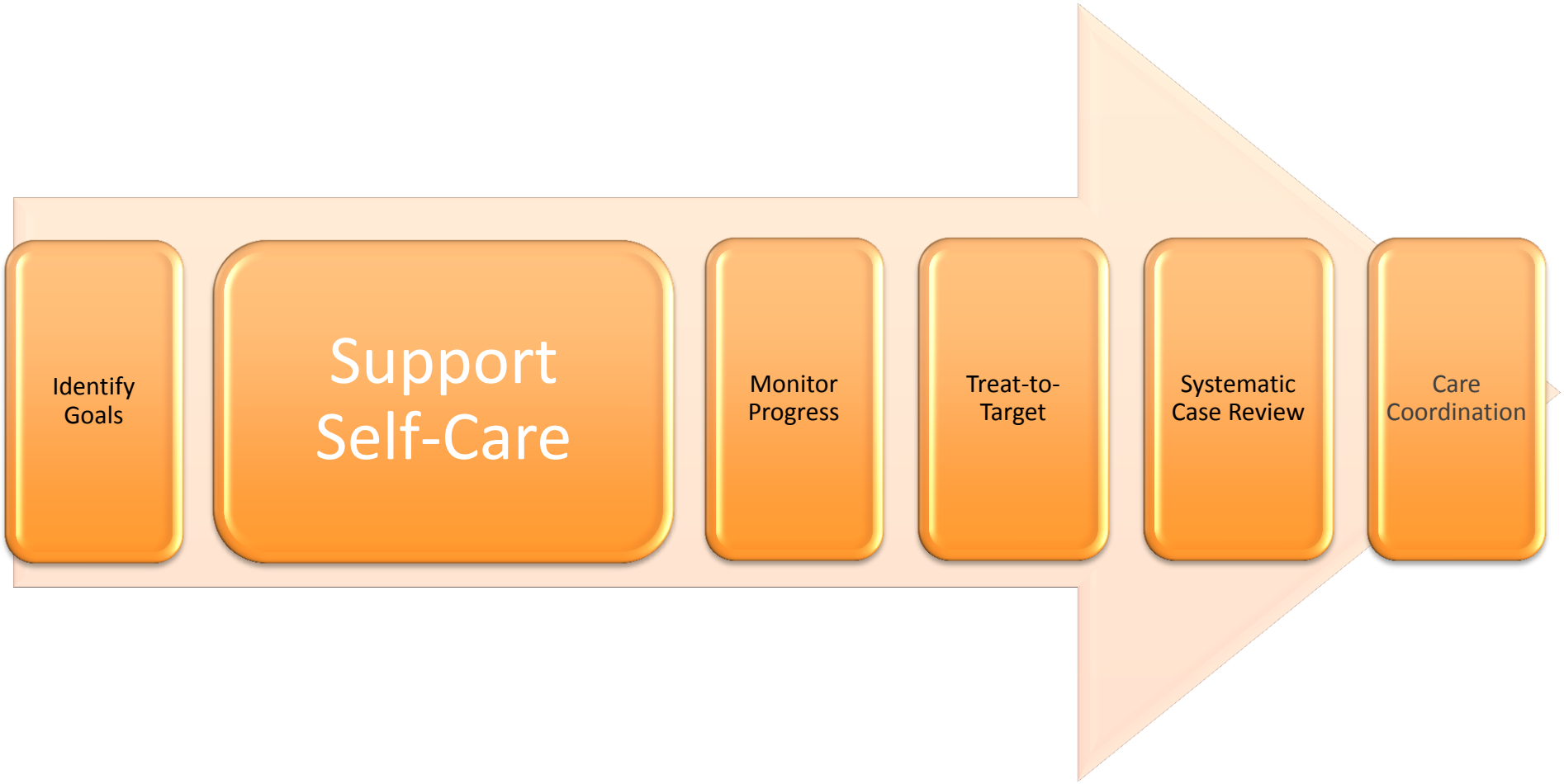
One Approach Across Different Chronic Illnesses

Wagner, 1996; Bodenheimer 2002;
Katon 1995; Unutzer 2002; Riddles 2003

Core Components



Core Components



Improving Adherence

- Patient self-care materials: book and video on depression, patient manual
- Nurse support/education/motivational interviewing
- Medisets
- Simplifying medication regimen
- $4 generics to avoid $10 co-pays

Self-Monitoring Tools

Care Managers

- Motivational interviewing/enhancement
- Problem solving
- Behavioral activation

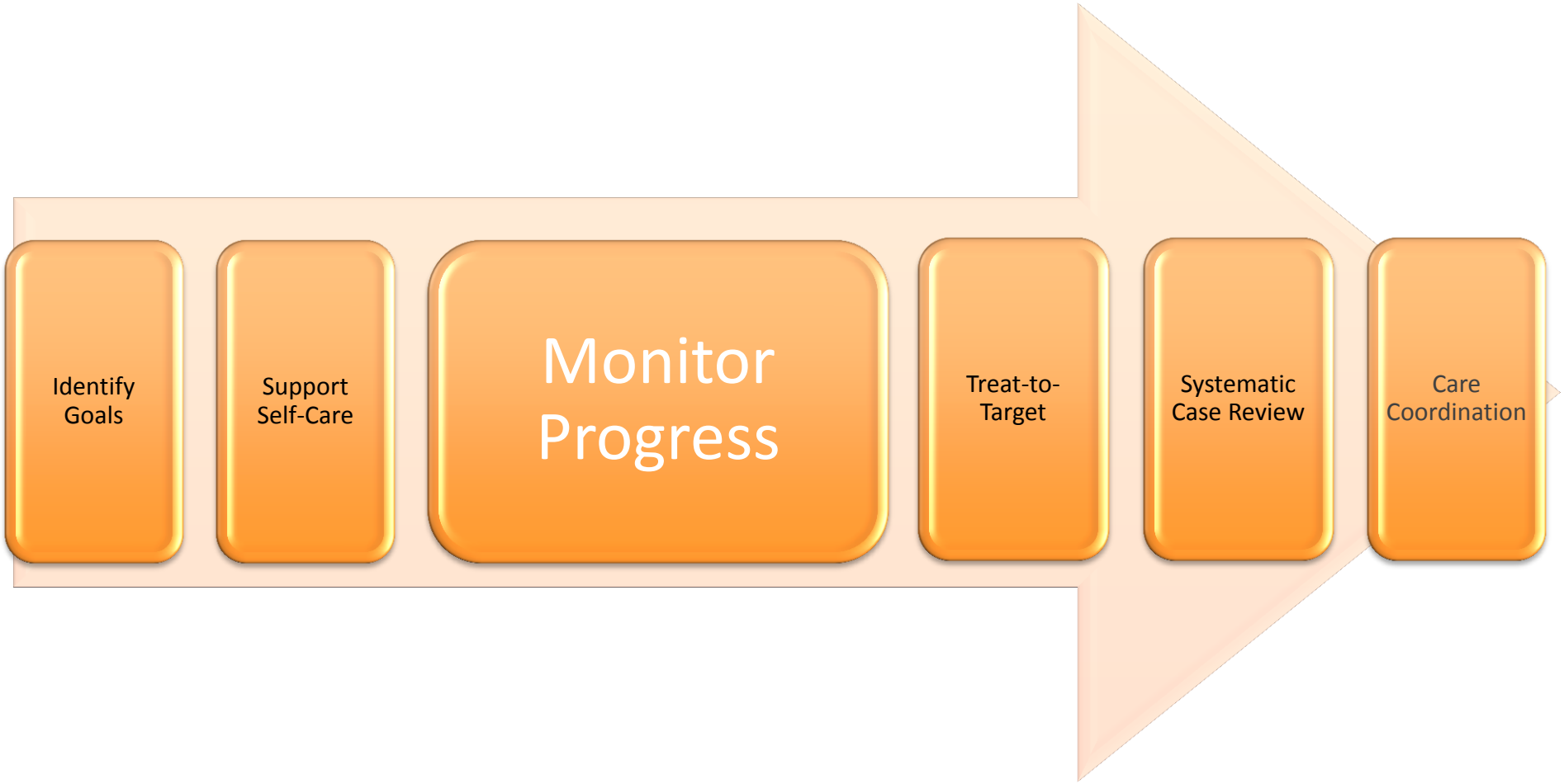
Decisional Balance (e.g. smoking)

	Changing	Not changing
Benefits (Pros)	•Less coughing •Wife will be happy •Socially acceptable •Faster healing	
Costs (Cons)		•Higher risk of cancer •Poorer health •Wound will not heal

Decisional Balance (e.g. smoking)

	Changing	Not changing
Benefits (Pros)	•Less coughing •Wife will be happy •Socially acceptable •Faster healing	•Helps me deal with stress •Helps me think clearly •Keeps the weight off
Costs (Cons)	•Lose friends who smoke •Gain weight	•Higher risk of cancer •Poorer health •Wound will not heal

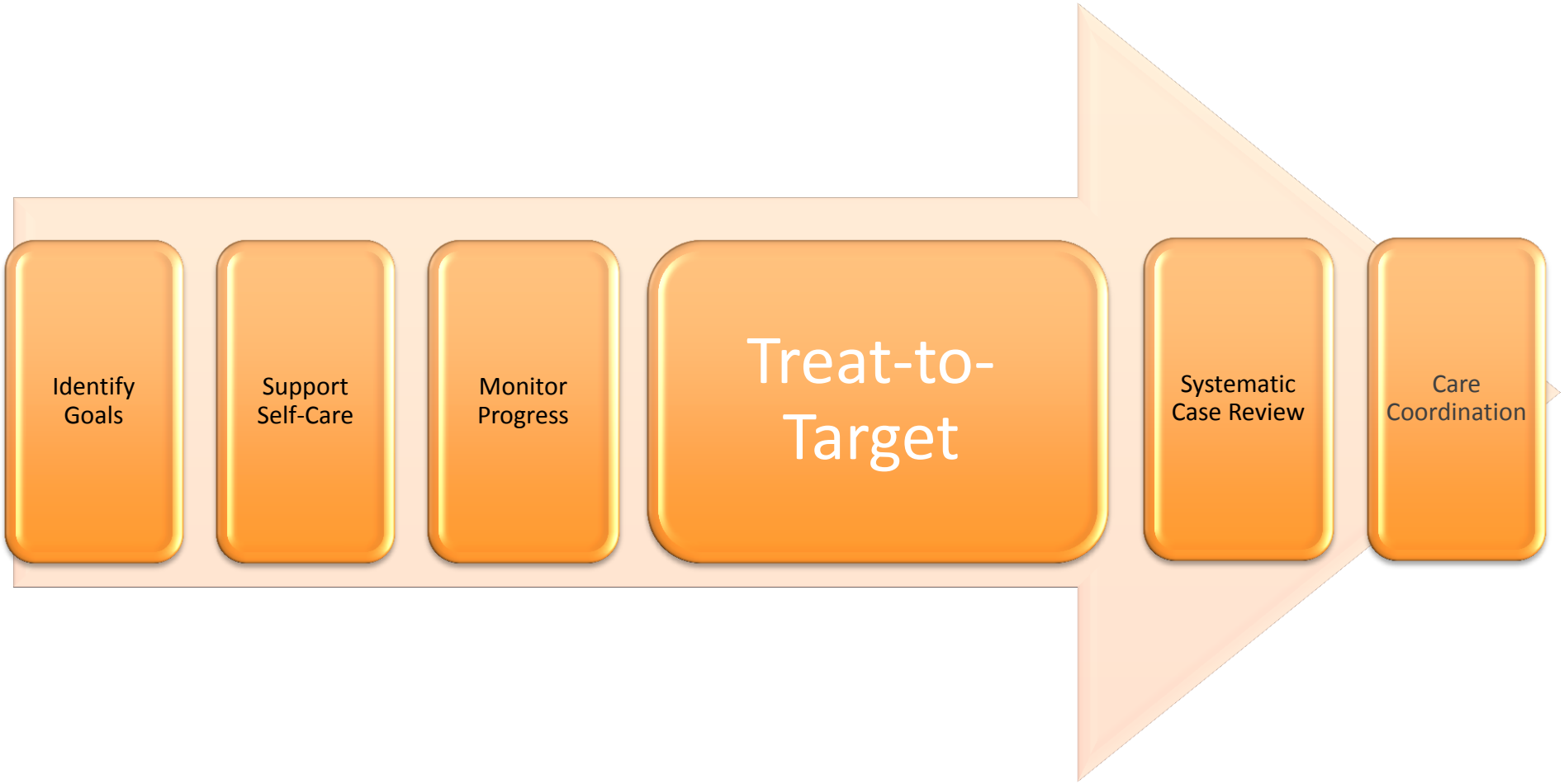
Core Components



Initial	Clinic	Enroll Date	PHQ		BP		HbA_{1c}		LDL	
			BL	Now	BL	Now	BL	Now	BL	Now
	BRN	8/11/2008	19	14*	152/86	140/100*	10.1	6.91	135	106*
	OLY	5/19/08	19	19*	141/69	127/77	7.3	6.8	181	138*
	EVM	11/12/07	14	9*	160/98	150/85*	6.4	6.8	108	67
	NGT	10/30/07	13	2	209/119	126/76	9.2	8.3*	119	99
	LYN	8/23/07	14	3	149/71	111/58	8.1	7.7*	85	82

Weekly Clinical Summaries

Core Components



Treat-to-Target (TTT)

Treatment titration

- Frequent and consistent
- Relentless, incremental increases/changes

Always:

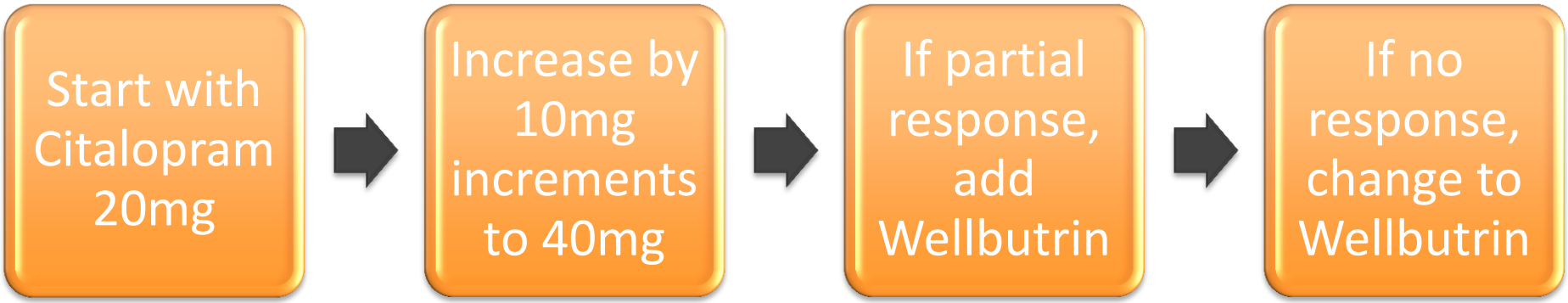
- *Increase/change to next step*
- *If not, document why not!*

TTT Algorithm

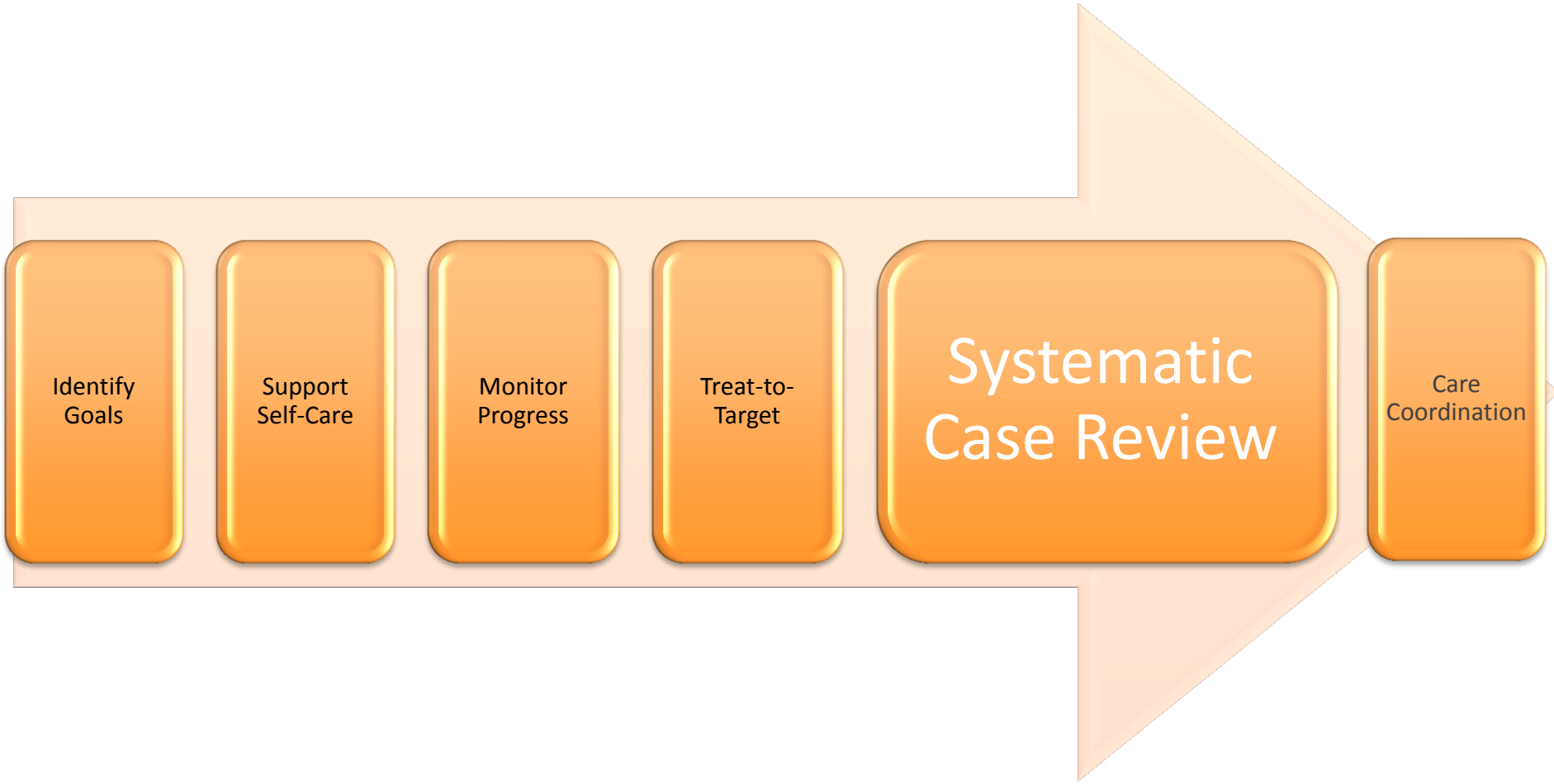
- Simplified and uniform approaches across conditions to achieve targets
  - Riddles et al., Diabetes Care, 2003
  - Kaiser Permanente, Care Management Institute

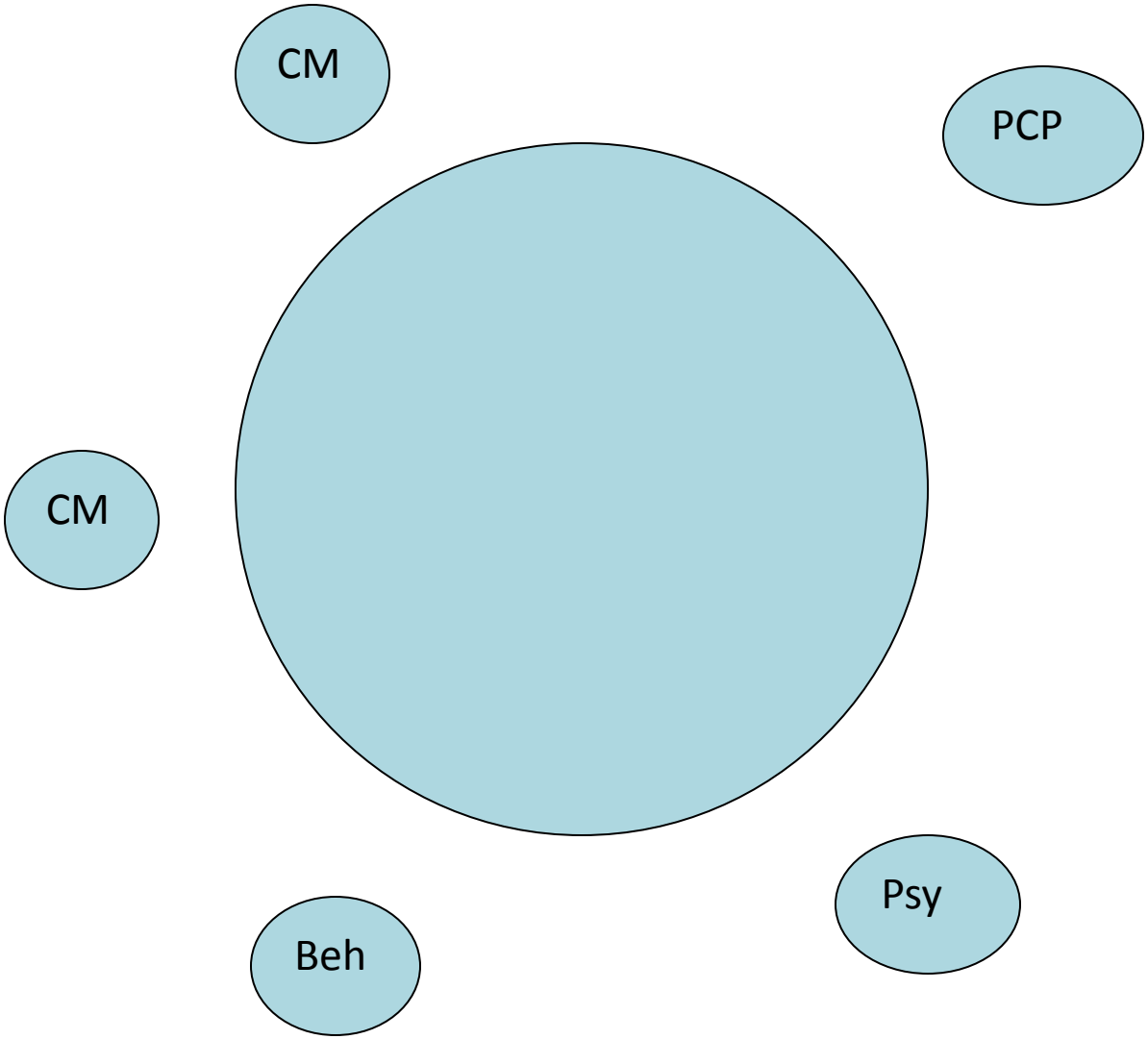
Treat-to-Target (TTT)

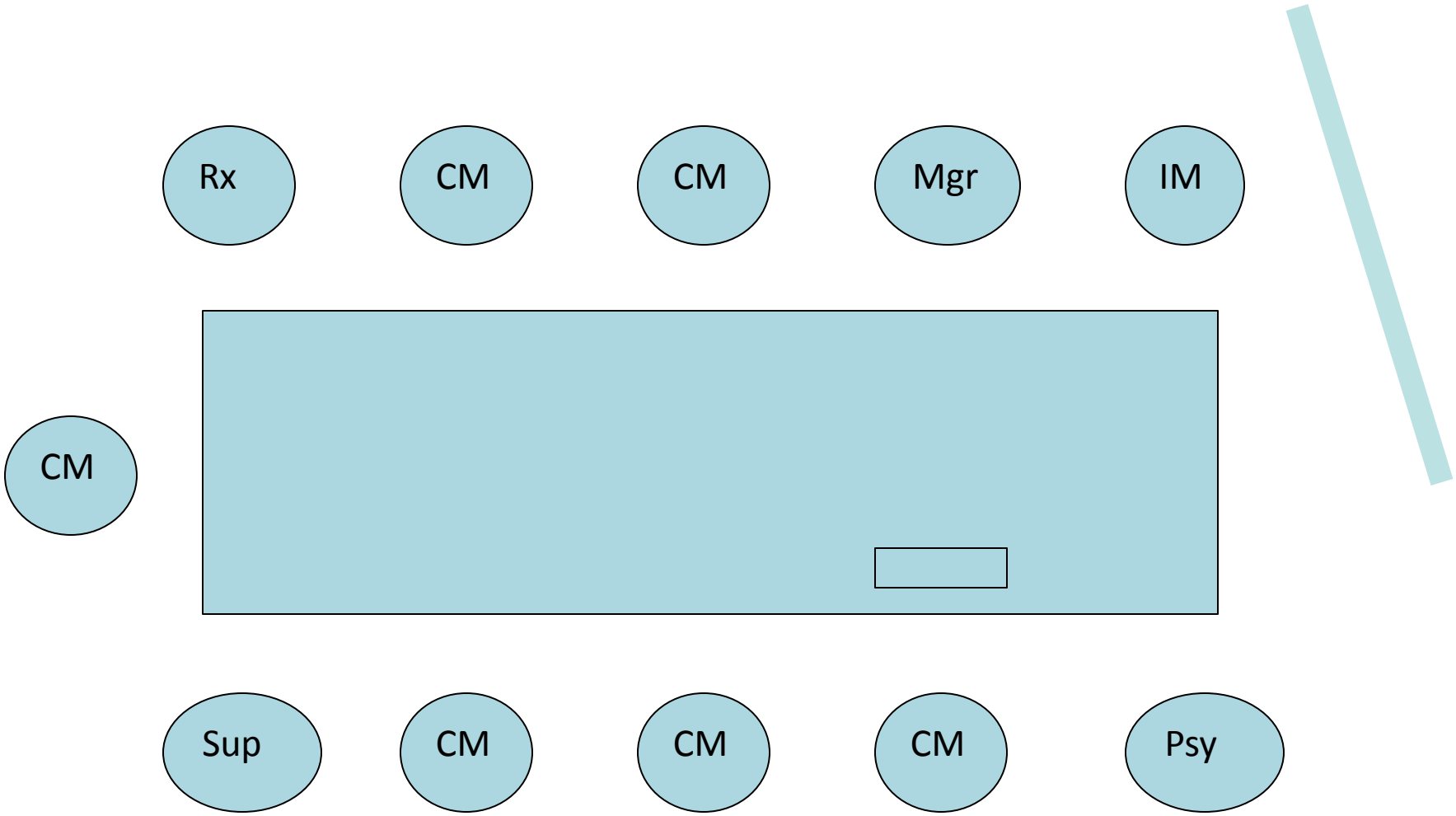
Depression



Core Components




CM
PCP
CM
Psy
Beh


Rx
CM
CM
Mgr
IM
CM
Sup
CM
CM
CM
Psy

Case manager:	Date:	Suggested actions
Patient ID: Next contact:		Medication changes: • Simplify, consolidate • Check formulary • Check lowest prices • Assess adherence • Assess side effects Behavioral activation: • Physical activation • Social activation • Pleasant events Motivational issues: • Stages of change • Decisional balance Disease self-management: • BP cuff, BP record • Pedometer • Glucometer (new or 2nd) • Sleep hygeine • Nutritionist/Dietician • Mediset Strategies for hard-to-reach: • Contact PCP • Voicemail • Letter
Patient ID: Next contact:		
Patient ID: Next contact:		
Patient ID: Next contact:		
Patient ID: Next contact:		

Patient ID: 870 [redacted]
Case Manager [redacted]

① 200mg Zoloft - start ↑ 150mg (for 150mg dose) 2-3 weeks then go up to 200mg

② diabetes education → already has referral, f/u ↑ this

③ give option ↑ interns, is she willing?

Next contact:

Patient ID: 744 [redacted]
Case Manager: [redacted]

① diabetes education → check BS BID either QAM and QHS or QAM and 2° p meal

② citalopram ↑ 30 40mg (ask Dr [redacted] about 30mg for 1 month then 40mg)

Next contact:

Patient ID: 817 [redacted]
Case Manager: [redacted]

raise her to report to you
get a edometer

① make plan in the next week to do 1 thing to get her active

② how much metformin is she taking?? (1500 or 750??)

Next contact:

Updating
- Chart
- Supervision sheet
- Labs
- PHQ-9 score
- EPIC, Access

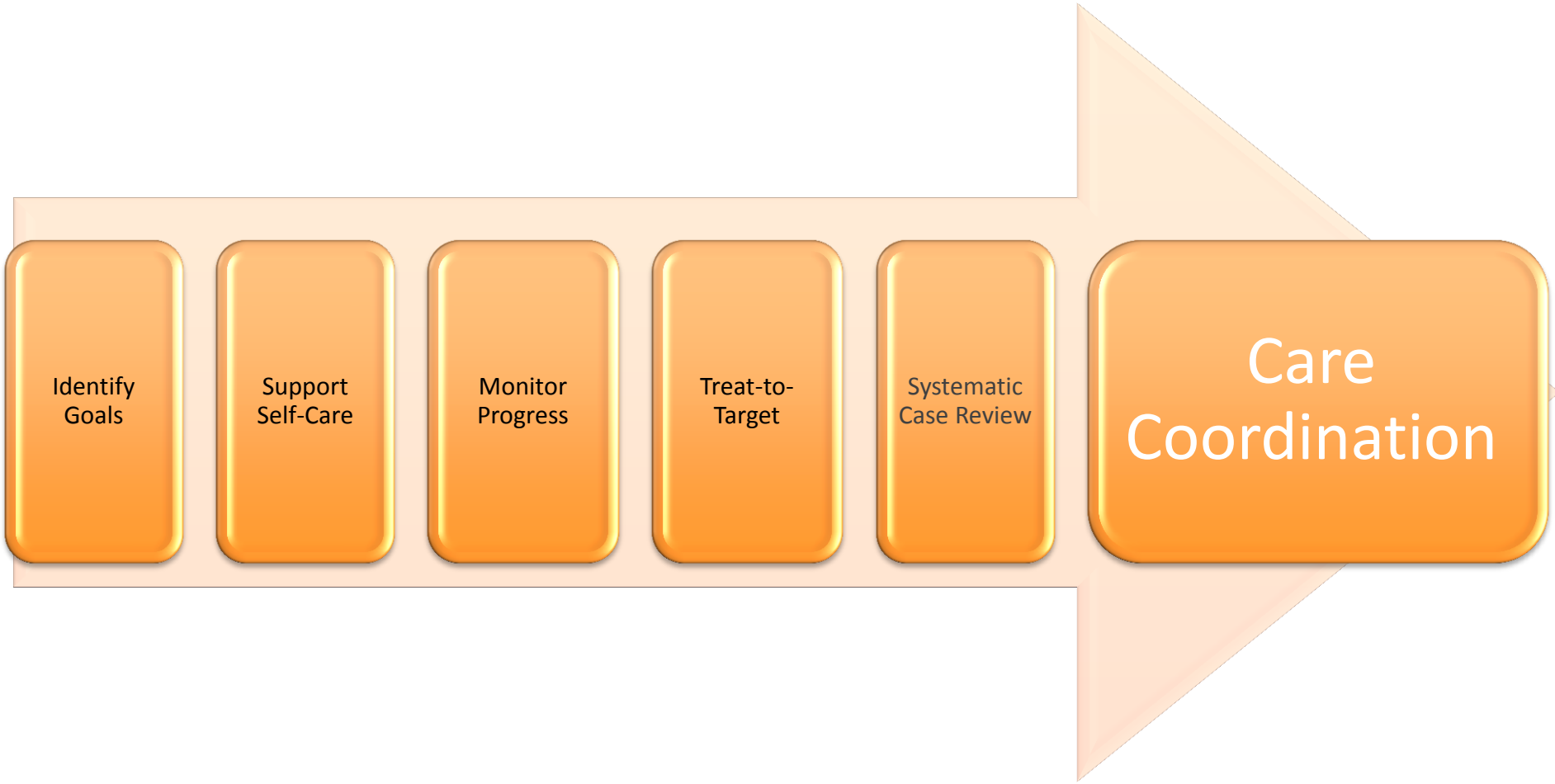
Checking
- Patient chart- ? updates
- Labs

Strategies for hard-to-reach
- Contact PCP
- Voicemail
- Letter
- Opt-out visit by voicemail

Educational materials
- DVD, Depression book
- Patient booklet
- My HealthCare
- AHA/ADA materials

Phase of intervention
- Move to maintenance

Core Components



Case Management Workload

- 96 patients in steady state for full FTE nurse case manager
- 2.5 hours weekly of internist and psychiatrist case review supervision per 96 patients
- Psychiatrist 10 hours per month, internist 10 hours per month per 96 patients

Does it really work?

The NEW ENGLAND JOURNAL of MEDICINE

Free Abstract

ORIGINAL ARTICLE

Collaborative Care for Patients with Depression and Chronic Illnesses

Wayne J. Katon, M.D., Elizabeth H.B. Lin, M.D., M.P.H., Michael Von Korff, Sc.D., Paul Ciechanowski, M.D., M.P.H., Evette J. Ludman, Ph.D., Bessie Young, M.D., M.P.H., Do Peterson, M.S., Carolyn M. Rutter, Ph.D., Mary McGregor, M.S.N., and David McCulloch, M.D.

N Engl J Med 2010; 363:2611-2620 | December 30, 2010

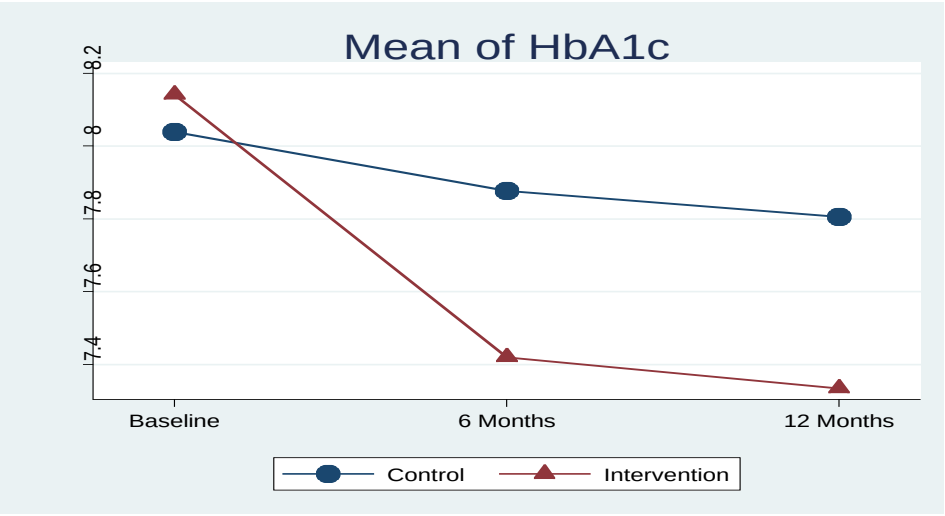
BACKGROUND

Patients with depression and poorly controlled diabetes, coronary heart disease, or both have an increased risk of adverse outcomes

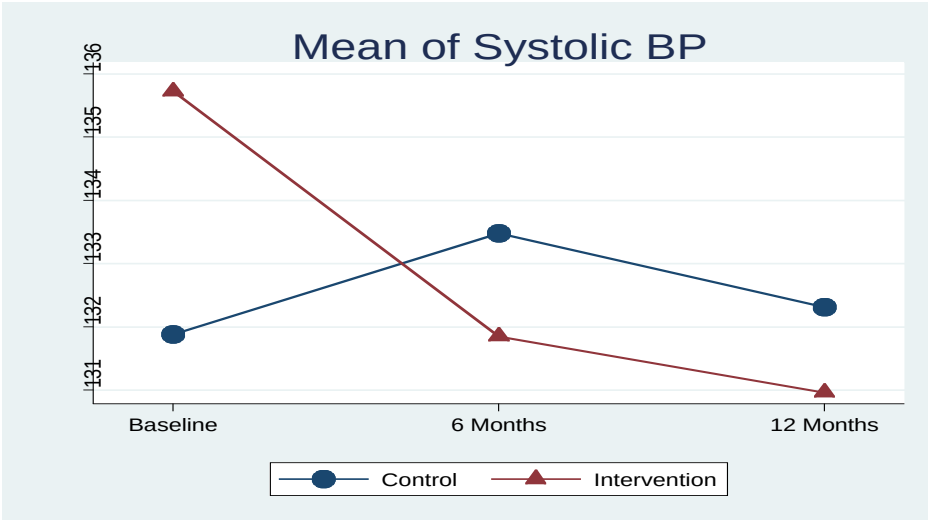
MEDIA IN THIS ARTICLE

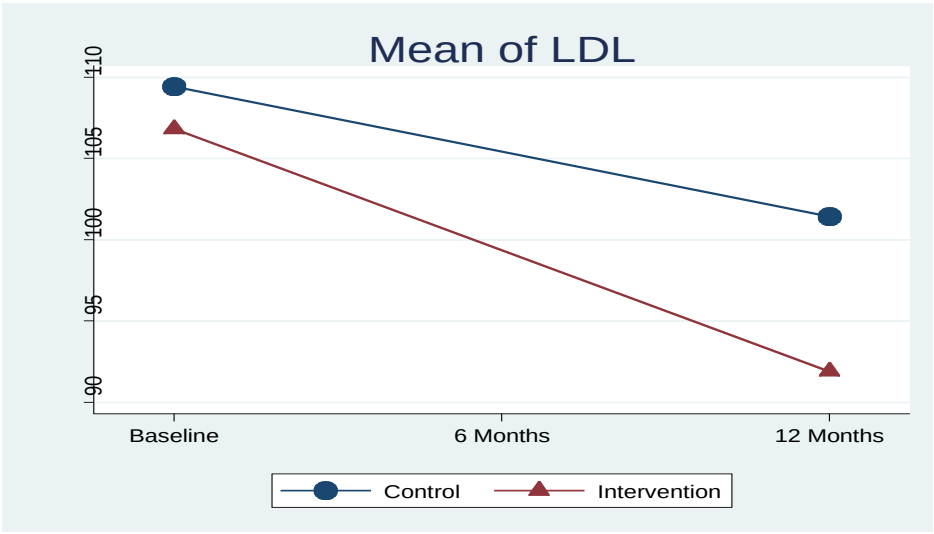
FIGURE 1

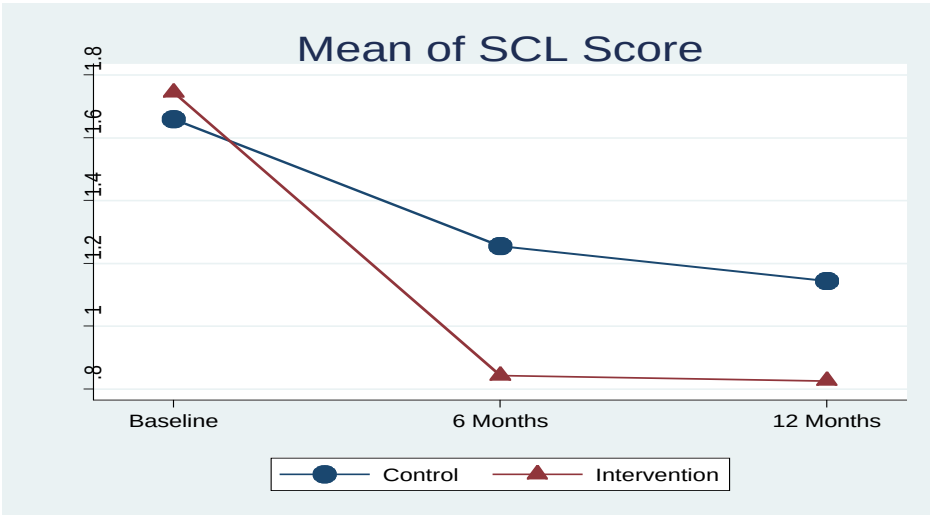
A


Mean of HbA1c
8.2
8
7.8
7.6
7.4
Baseline
6 Months
12 Months
Control
Intervention

B


Mean of Systolic BP
136
135
134
133
132
131
Baseline
6 Months
12 Months
Control
Intervention


Mean of LDL
110
105
100
95
90
Baseline
6 Months
12 Months
Control
Intervention


Mean of SCL Score
1.8
1.6
1.4
1.2
1
.8
Baseline
6 Months
12 Months
Control
Intervention

C

D

A1c

Blood pressure

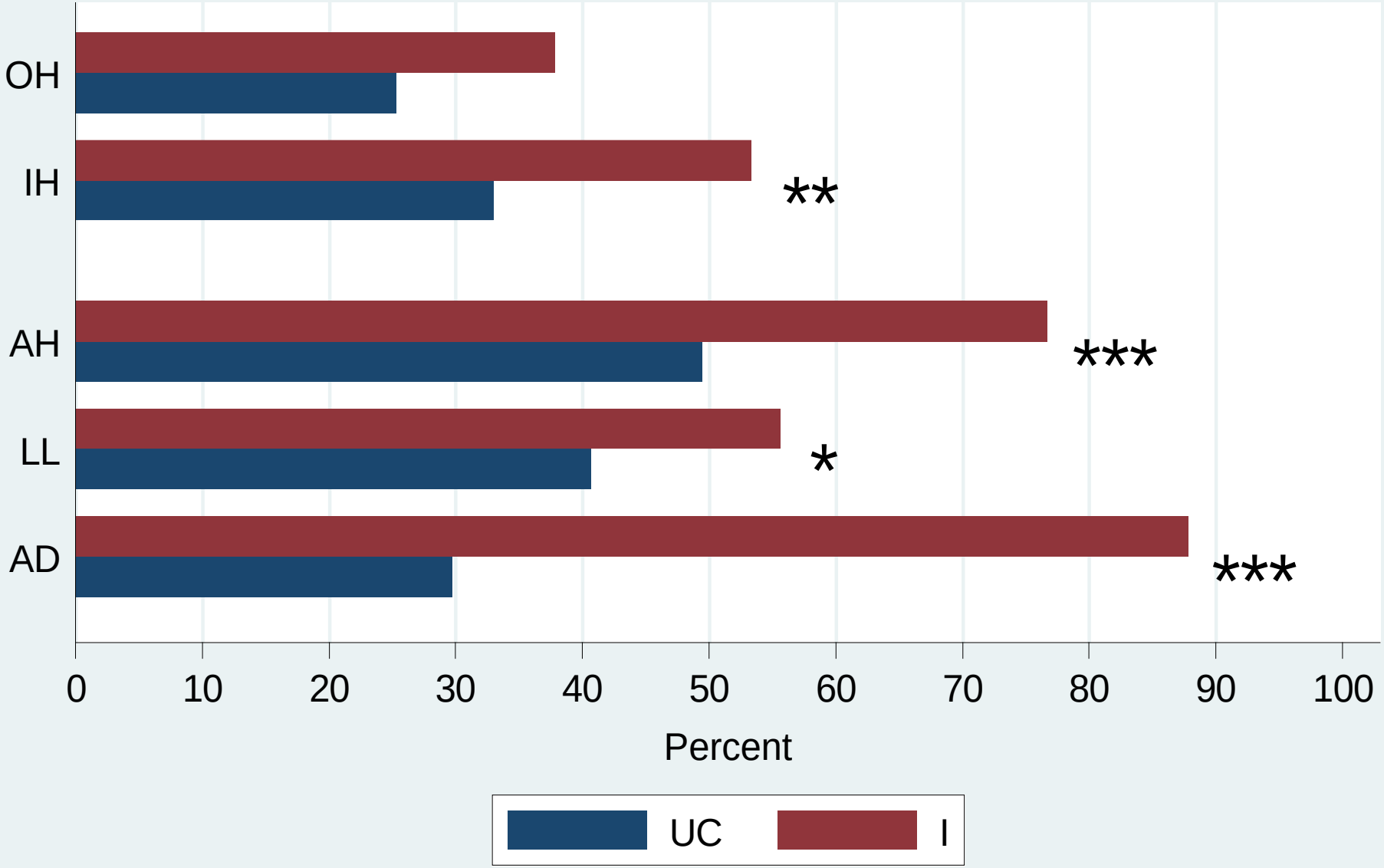
Cholesterol (LDL)

Depression

Comparison with Other Studies

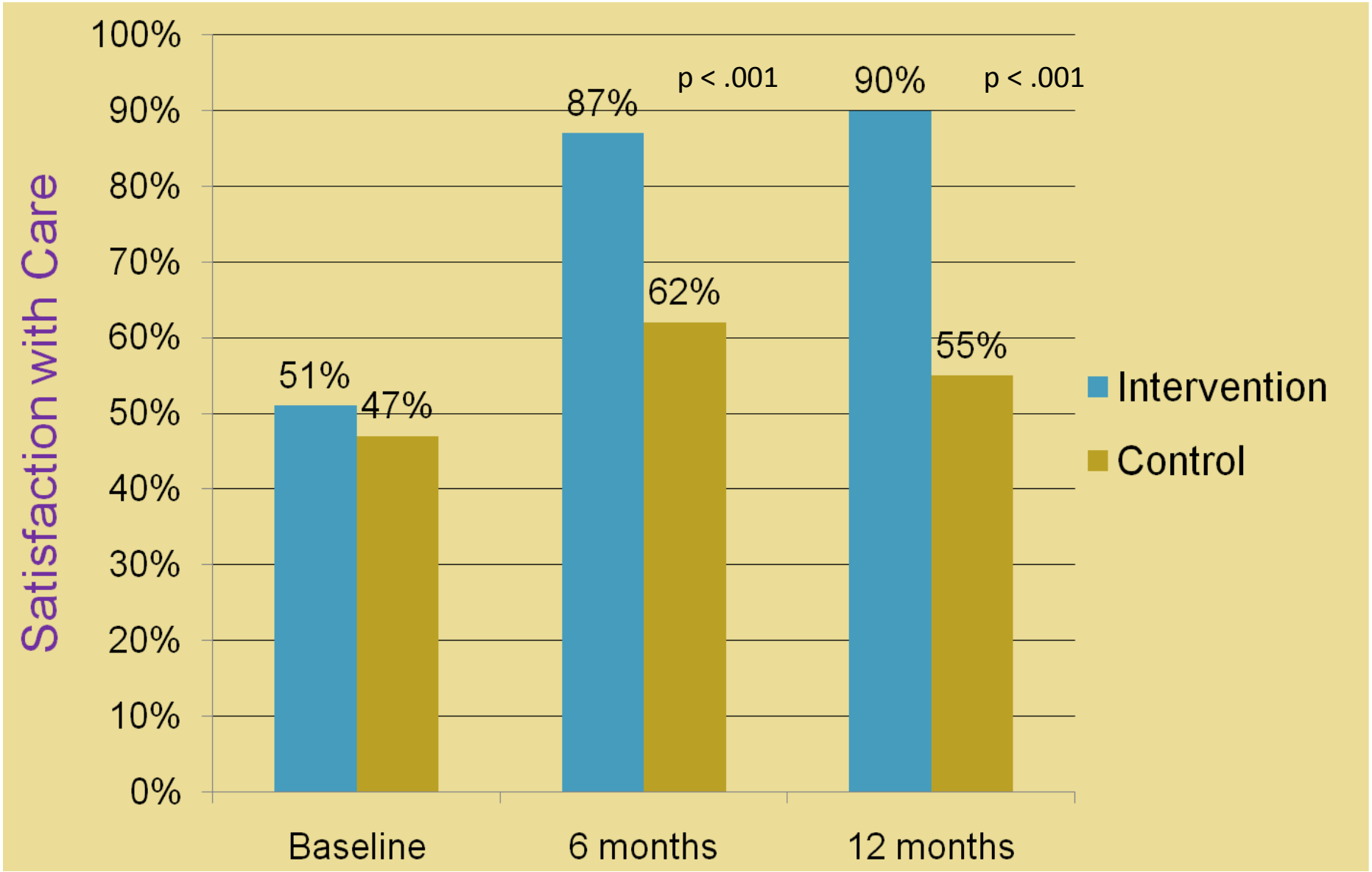
Domain	I vs. C TEAMcare study	I vs. C other studies	Description
Depression	SCL: 0.4 ES: 0.65	ES: 0.25	37 Collaborative Care Trials
HbA_{1c}	0.58%	0.42%	66 Diabetes Care Trials
Systolic Blood Pressure	5.1 mmHg	4.5 mmHg	44 Trials
LDL Cholesterol	6.9 mg/dL		

Any Medication Adjustment

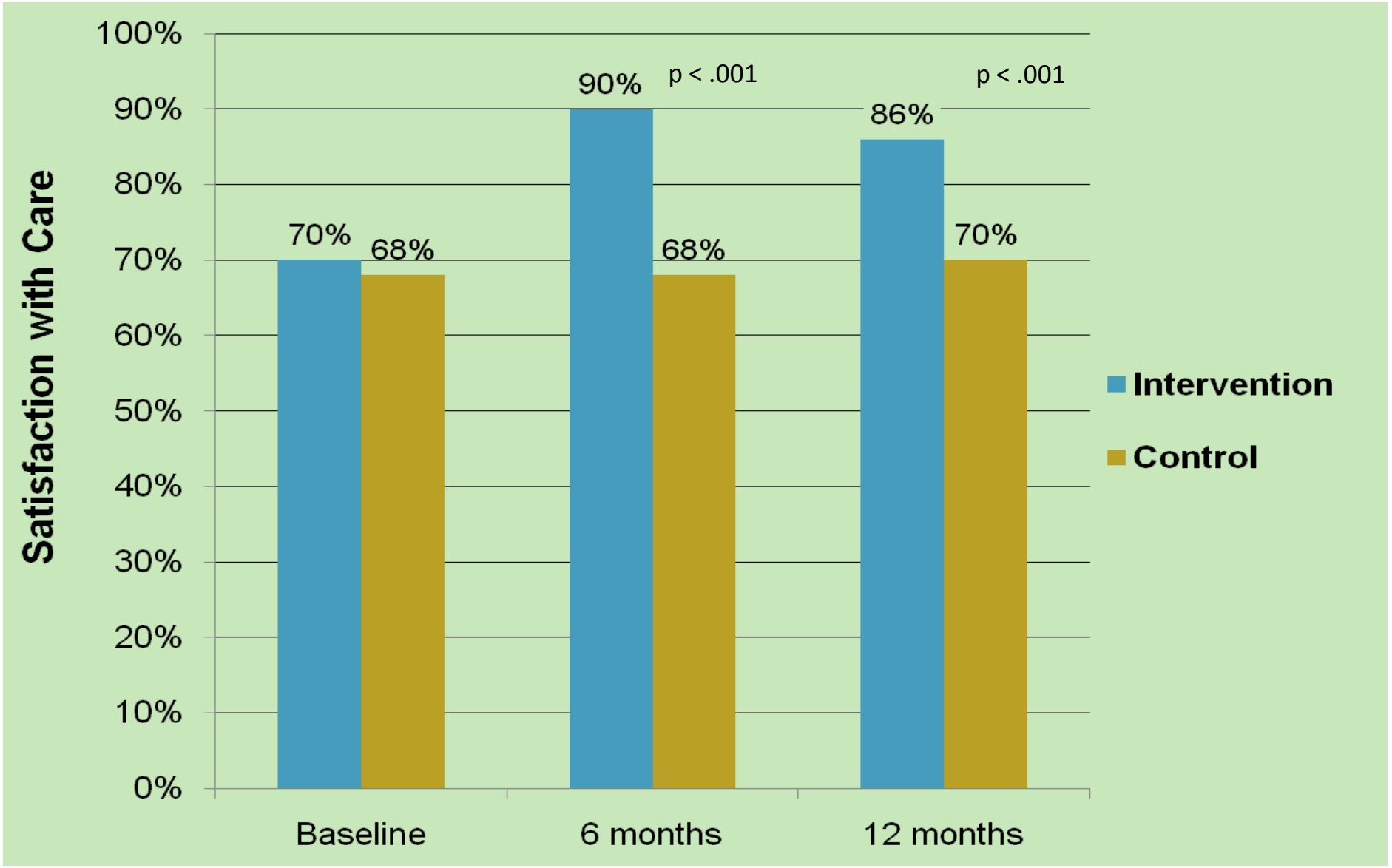


* p-value <0.05 ; ** p-value < 0.01 ; *** p-value < 0.001

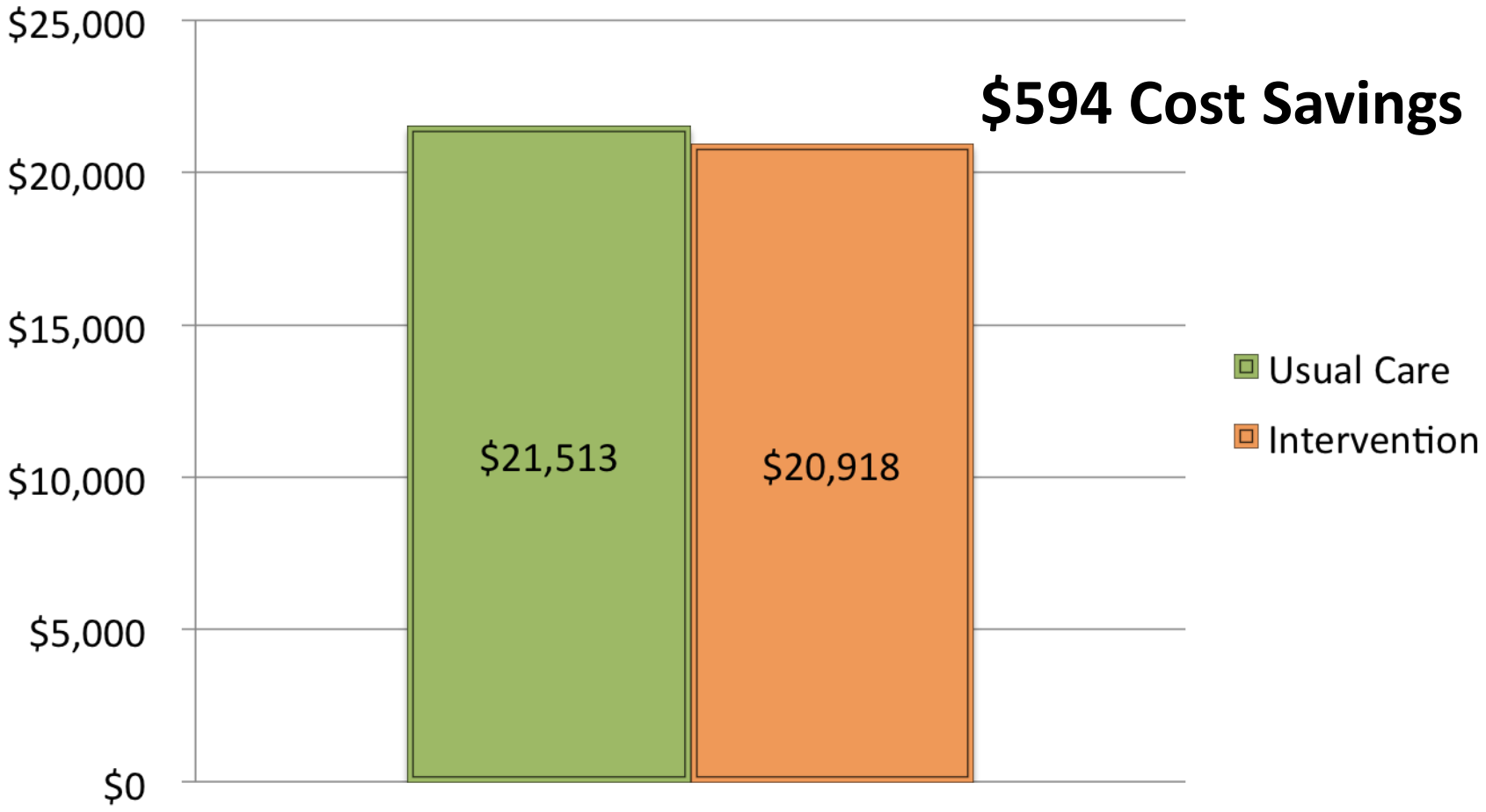
Satisfaction with Care of Depression



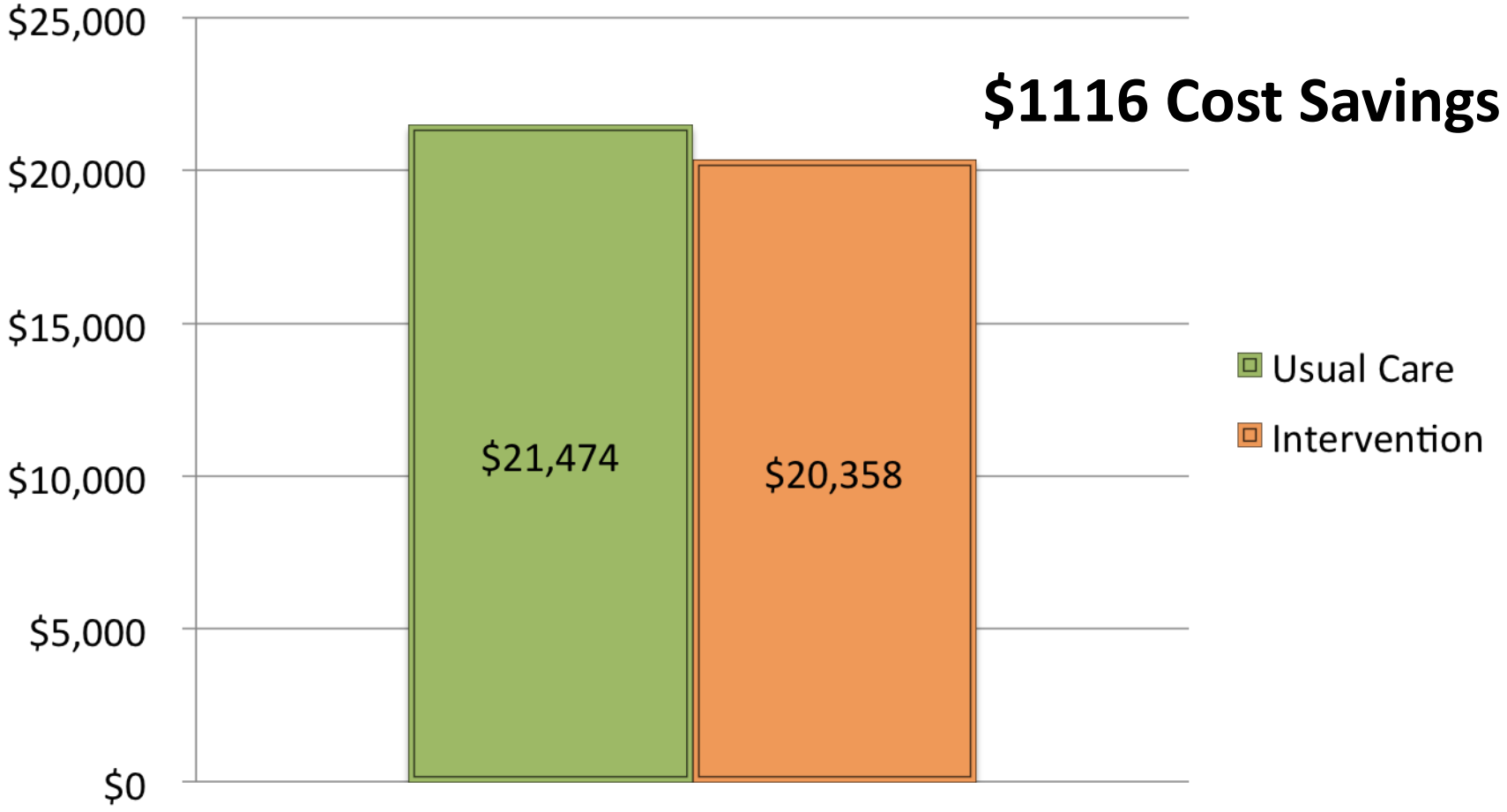
Satisfaction with Diabetes/CHD Care



Adjusted 24-Month Intervention vs. Usual Care Outpatient Costs



24-Month Intervention vs. Usual Care Adjusted Outpatient Costs ($54/visit for 10 visits)



Achieving Level 2 or Level 3 PCMH NCQA Accreditation Depends on Compliance with 10 ***Must-Pass*** Components

Written standards for patient access and patient communication	☐
Use of data to show standards for patient access and communication are met	☐
Use of paper or electronic charting tools to organize clinical information	☒
Use of data to identify important diagnoses and conditions in practice	☒
Adoption and implementation of evidence-based guidelines for two chronic medical conditions and one behavioral condition	☒

Achieving Level 2 or Level 3 PCMH NCQA Accreditation Depends on Compliance with 10 ***Must-Pass*** Components

Active support of patient self-management	☒
Systematic tracking of tests and follow-up on test results	☒
Systematic tracking of critical referrals	☒
Measurement of clinical and/or service performance	☒
Performance reporting by physician or across the practice	☒

Multi-Condition Collaborative Care

An evidence-based strategy for addressing patients with multiple conditions using a team-based approach

Associated with:

- better outcomes
- better quality of care
- lower cost

TEAMcare Collaborative Care at The Polyclinic: Program Description

Elise Ernst, MEd, MSW, MBA
Vice President of Practice Management
The Polyclinic
Seattle, WA

THE POLYCLINIC

TEAMcare™

The Polyclinic Profile

- Independent, physician-owned, multi-specialty clinic since 1917
- Over 200 providers in 30 specialties, 66 are PCPs
- 192,000 patients
- 13 locations
- Primary Care is on the top floor!

When and how did TEAMcare start at The Polyclinic?

- Part of Primary Care Transformation
- Attendance at TEAMcare training led to conversations with Drs. Katon and Ciechanowski.
- Over many months, UW and The Polyclinic designed the initial program.
- RN FTE was “borrowed” as there were no RNs in Primary Care at that time.

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- Contract was negotiated/signed (No cost to patients).
- 2-day RN training was completed.
- Materials were created for patients, PCPs, and clinic staff, including FAQs.
- Presented at IM and FM section meetings to gain physician and administrative approval.
- First case staffing was September 2012.
- To date over 100 patients have been enrolled, utilizing 6 RNs who are parttime to this program (maximum 25% of their time).

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Who is the **TEAM**?

- 6 RN Case Managers
- 1 Pharmacist
- 1 RN Supervisor
- 1 Certified Diabetic Educator
- 1 Internal Medicine Physician
- 1 Psychiatrist

Additional:

- 2 Masters' level Psychology Interns from Seattle Pacific University
- VP of Primary Care

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TEAMcare™

THE POLYCLINIC

TEAMcare™

How TEAMcare works at the Polyclinic

Patients are referred in one of two ways:

1. PCPs refer patients to RNs directly, *or*
2. Diabetes Registry is sorted for all PHQ-9s with score of ≥ 10, along with at least one other clinical value out of control; A1c ≥ 8, **or** LDL ≥ 100, **or** BP ≥ 140 (systolic).
3. Majority of patients are initially found by data sort.
4. As PCPs become more aware of program, they refer additional patients.

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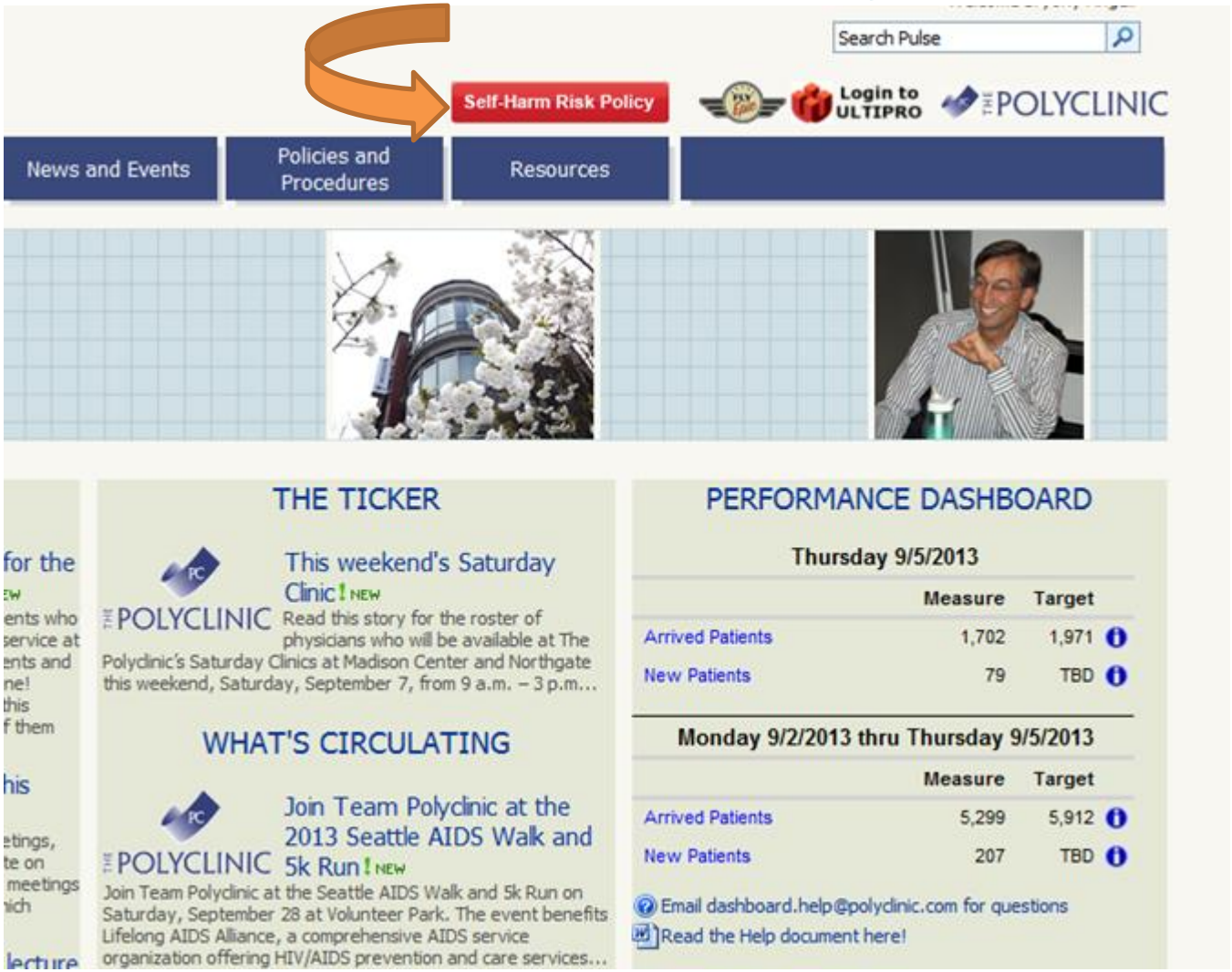
What are some of the Tools?

- PHQ-9 (Patient Health Questionnaire)
- FAQs (customized for your organization)
- Patient handout introducing TEAMcare
- Decision Balance Worksheet (grid)
- Problem Solving Treatment Worksheet
- Motivational Interviewing Techniques
- Goal Setting—How to choose a problem to address
- Shared Decision-Making
- **Self-Harm Risk Assessment Policy**
- **Notes and MyChart in EPIC**

Self-Harm Risk Policy



Case Staffing

- Weekly 2-hour meetings
- Each patient's EPIC record is brought up on screen
- RN presents patient
- Drs. Townsend and Ciechanowski share management of the staffing
- Team has staffed 45-55 patients in one setting.
- RN supervisor uses a timer to keep us moving along!

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Case Staffing, continued

- If a patient is not new, presentation starts with previous week's recommendations.
- Recommendations are made for managing depression, including possible suicide risk, and diabetes, focusing on non-controlled measures.
- Medication lists are reviewed and updated.
- Health maintenance issues are also addressed.
- Team strives to move each patient to **target** on all 4 parameters.
- Humor is helpful!

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TEAMcare in action

THE POLYCLINIC

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Communication with Referring PCP?

- A note taker records all recommendations.
- Immediately following the meeting, RNs enter lab orders into EPIC, send notes to clinic staff, and send notes to PCPs with team recommendations.
- PCP can either:
  1) choose to follow recommendations, or
  2) consult with RNs for further clarity, or
  3) ignore them.

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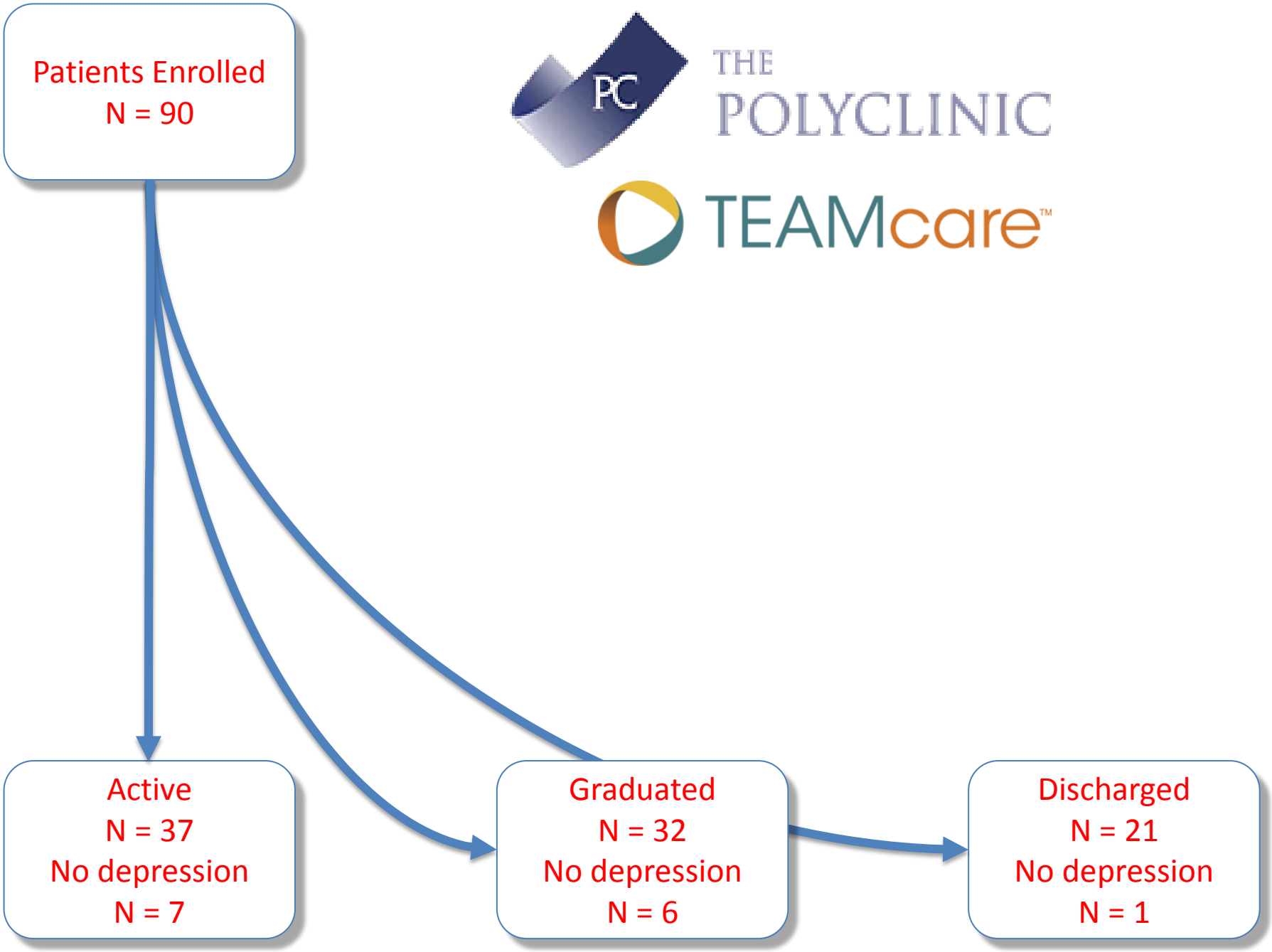
RN contacts with patients are approximately 50/50:

- 50% face-to-face, including “stalking” patients at scheduled clinic visits.
- 50% phone and email contact, including MyChart messaging.

TEAMcare Collaborative Care at The Polyclinic: Clinical Data and Outcomes

Oren Townsend, MD
Medical Director of the Physicians' Care Network
The Polyclinic
Seattle, WA


Patients Enrolled
N = 90
Active
N = 37
No depression
N = 7
Graduated
N = 32
No depression
N = 6
Discharged
N = 21
No depression
N = 1

Patients Enrolled
N = 90

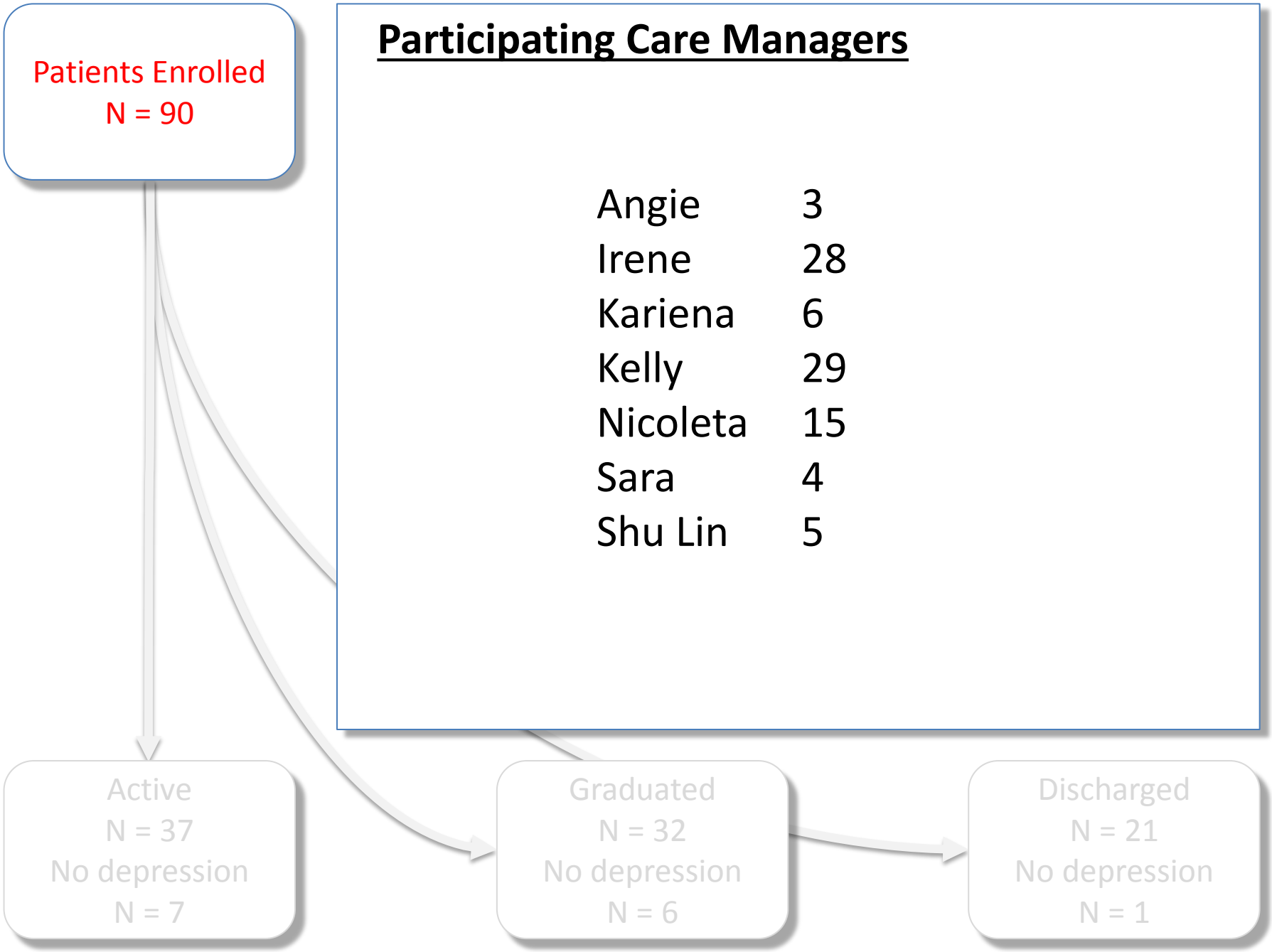
Program Enrollment Criteria

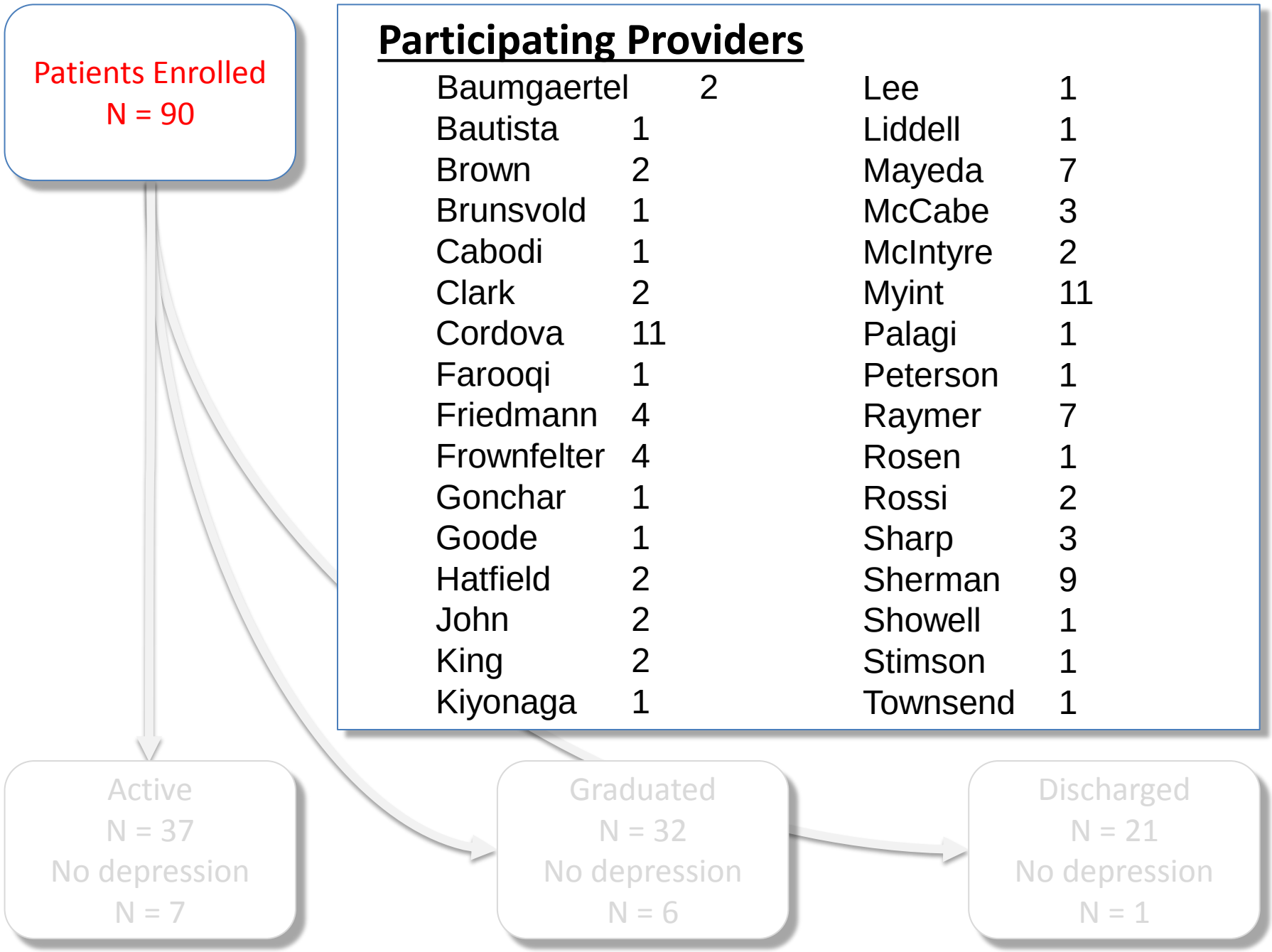
- Automated data (ICD-9) of having:
  - diabetes +/- coronary artery disease
- Poor disease control:
  - $HbA_{1c} \geq 8.0\%$
  - Blood pressure ≥ 140/90 mmHg
  - LDL ≥ 100 mg/dl
- PHQ-9 ≥ 10 = Major Depression

Active
N = 37
No depression
N = 7

Graduated
N = 32
No depression
N = 6

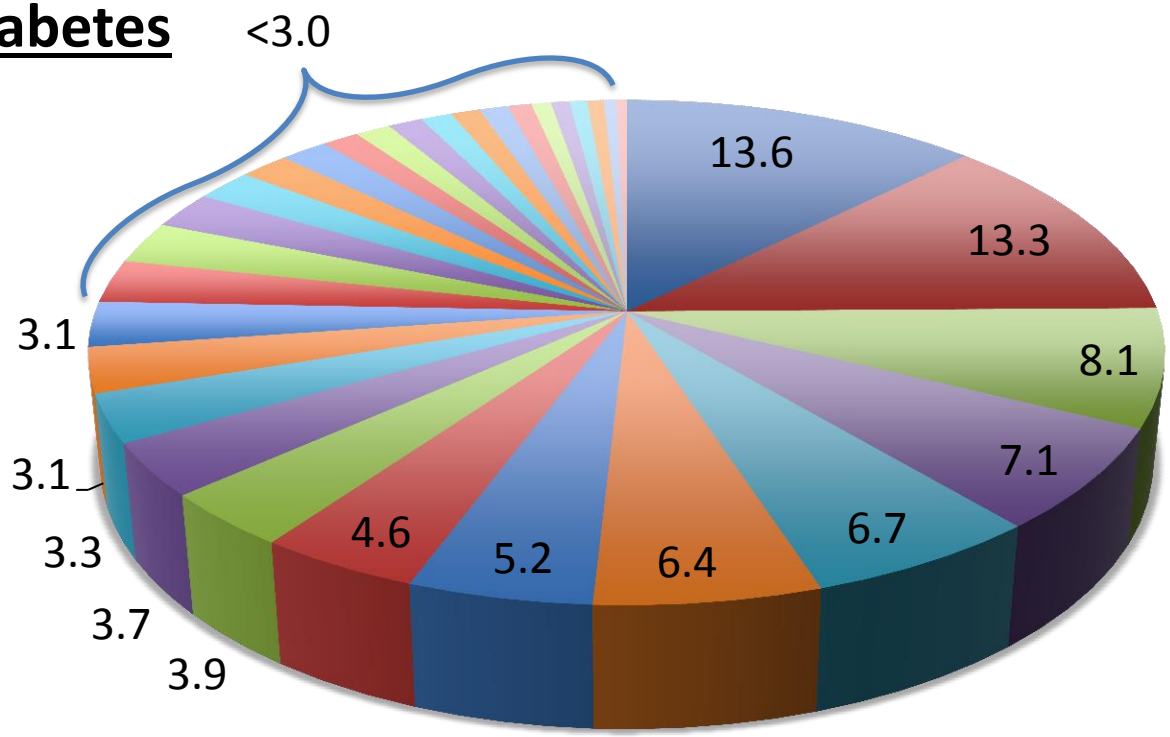
Discharged
N = 21
No depression
N = 1


Patients Enrolled
N = 90
Participating Care Managers
Angie 3
Irene 28
Kariena 6
Kelly 29
Nicoleta 15
Sara 4
Shu Lin 5
Active
N = 37
No depression
N = 7
Graduated
N = 32
No depression
N = 6
Discharged
N = 21
No depression
N = 1


Patients Enrolled
N = 90
Participating Providers
Baumgaertel 2
Bautista 1
Brown 2
Brunsvold 1
Cabodi 1
Clark 2
Cordova 11
Farooqi 1
Friedmann 4
Frownfelter 4
Gonchar 1
Goode 1
Hatfield 2
John 2
King 2
Kiyonaga 1
Lee 1
Liddell 1
Mayeda 7
McCabe 3
McIntyre 2
Myint 11
Palagi 1
Peterson 1
Raymer 7
Rosen 1
Rossi 2
Sharp 3
Sherman 9
Showell 1
Stimson 1
Townsend 1
Active
N = 37
No depression
N = 7
Graduated
N = 32
No depression
N = 6
Discharged
N = 21
No depression
N = 1

Patients Enrolled
N = 90

Percent Patients Enrolled from Each Participating Provider's Panel of Patients with Diabetes



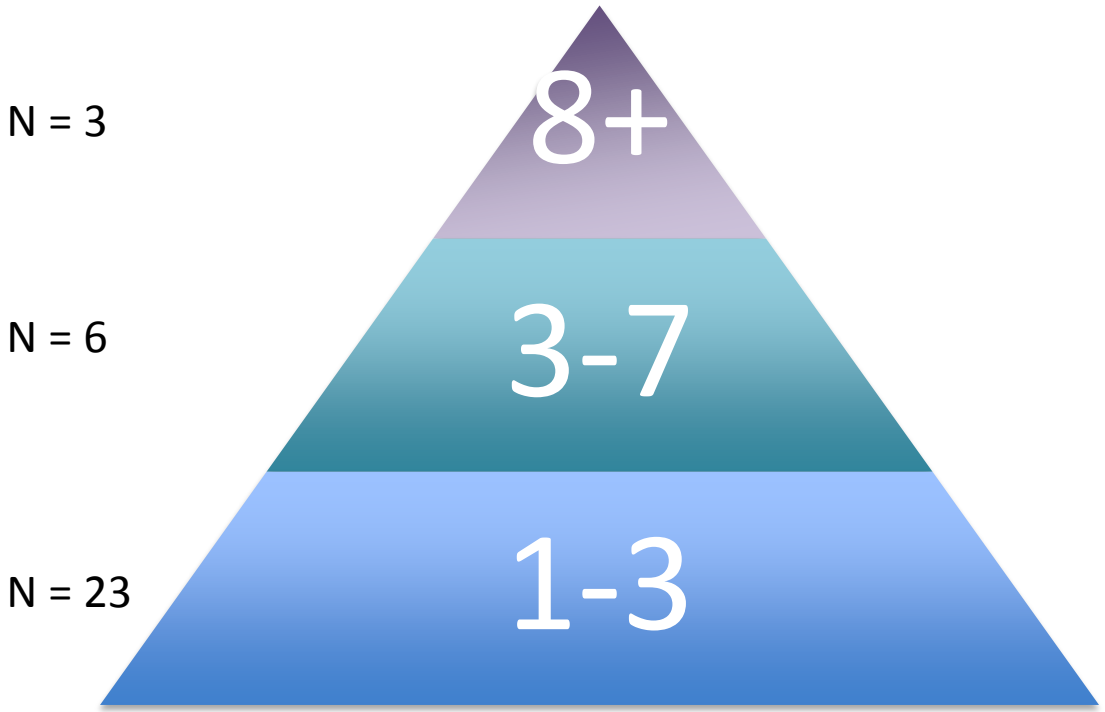
Active
N = 37
No depression
N = 7

Graduated
N = 32
No depression
N = 6

Discharged
N = 21
No depression
N = 1

Patients Enrolled
N = 90

Number of Patients per Provider



Active
N = 37
No depression
N = 7

Graduated
N = 32
No depression
N = 6

Discharged
N = 21
No depression
N = 1

Patients Enrolled
N = 90

Patient Demographics

Mean Age +/- SD (yrs)	60.5 +/- 11.5
Age Range (yrs)	27 to 88
Female Gender (%)	62 (68.9%)
Male Gender (%)	28 (31.1%)

Active
N = 37
No depression
N = 7

Graduated
N = 32
No depression
N = 6

Discharged
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No depression
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Patients Enrolled
N = 90

Baseline Patient Clinical Characteristics

Mean HbA1c (%)	8.5 +/- 2.1
Mean Systolic BP (mmHg)	130.3 +/- 15.7
Mean Diastolic BP (mmHg)	77.2 +/- 10.0
Mean LDL (mg/dL)	110.2 +/- 42.3
Mean PHQ-9	13.7 +/- 5.2

Active
N = 37
No depression
N = 7

Graduated
N = 32
No depression
N = 6

Discharged
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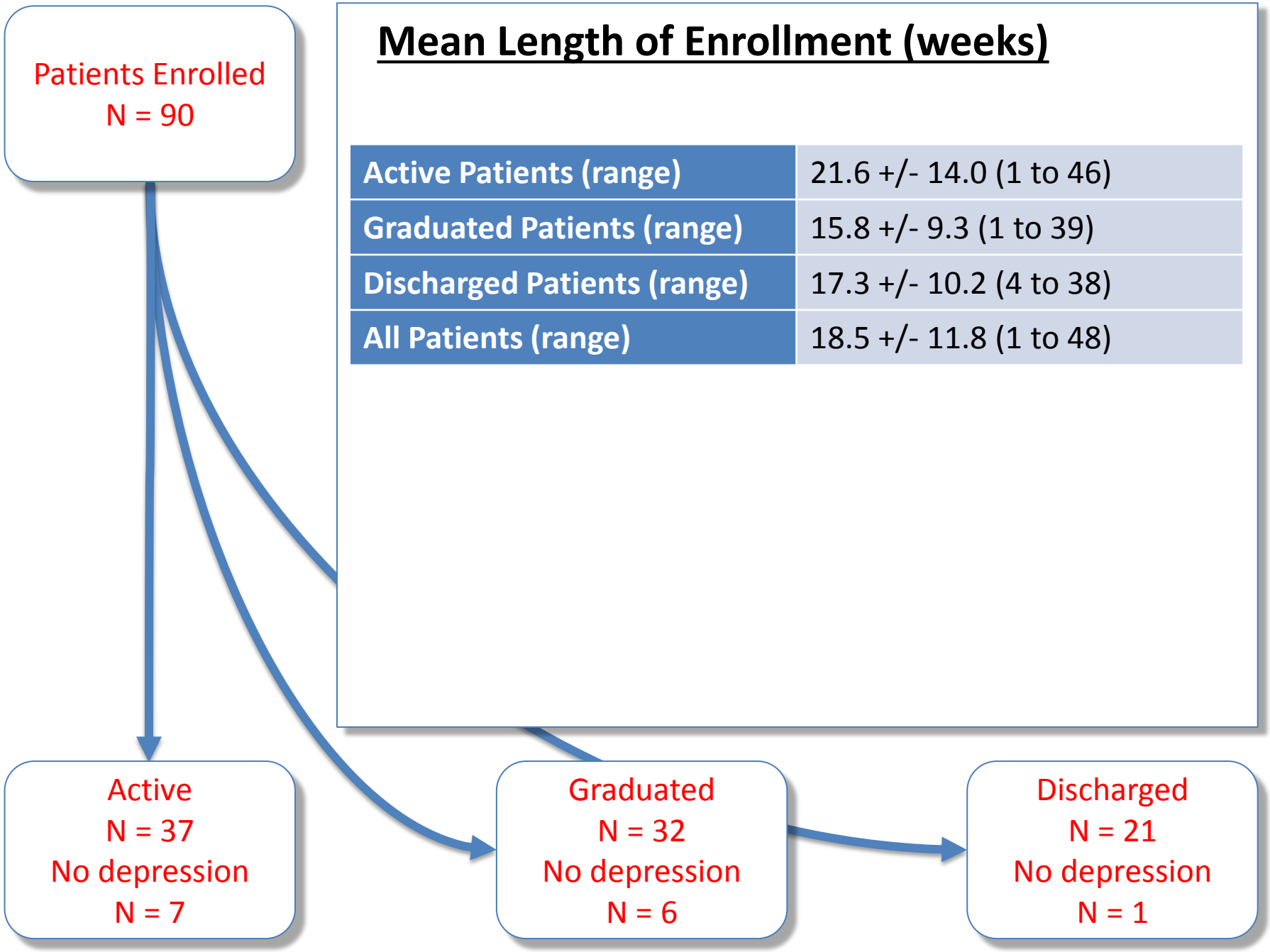
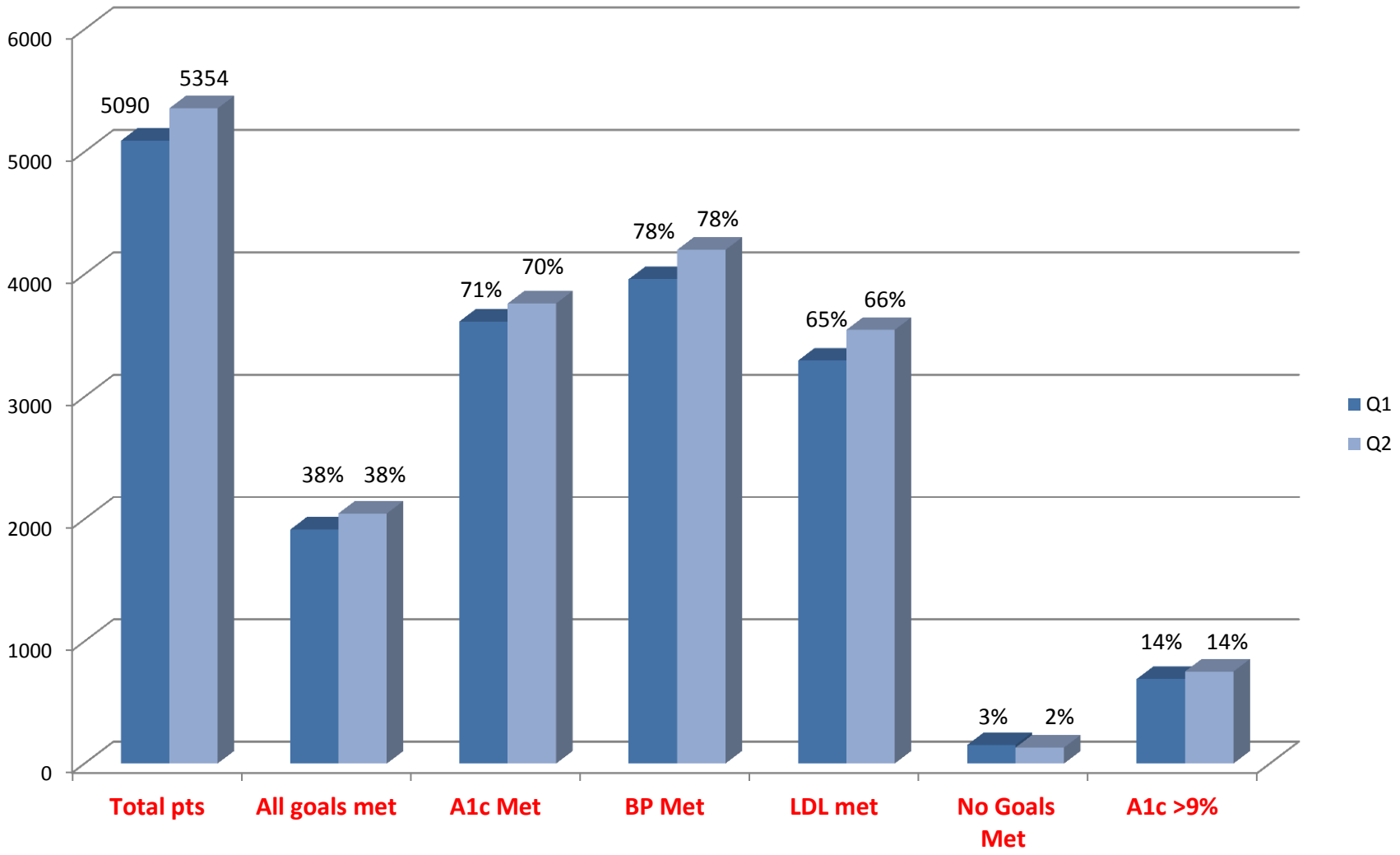
No depression
N = 1


Patients Enrolled
N = 90
Mean Length of Enrollment (weeks)
Active Patients (range) 21.6 +/- 14.0 (1 to 46)
Graduated Patients (range) 15.8 +/- 9.3 (1 to 39)
Discharged Patients (range) 17.3 +/- 10.2 (4 to 38)
All Patients (range) 18.5 +/- 11.8 (1 to 48)
Active
N = 37
No depression
N = 7
Graduated
N = 32
No depression
N = 6
Discharged
N = 21
No depression
N = 1

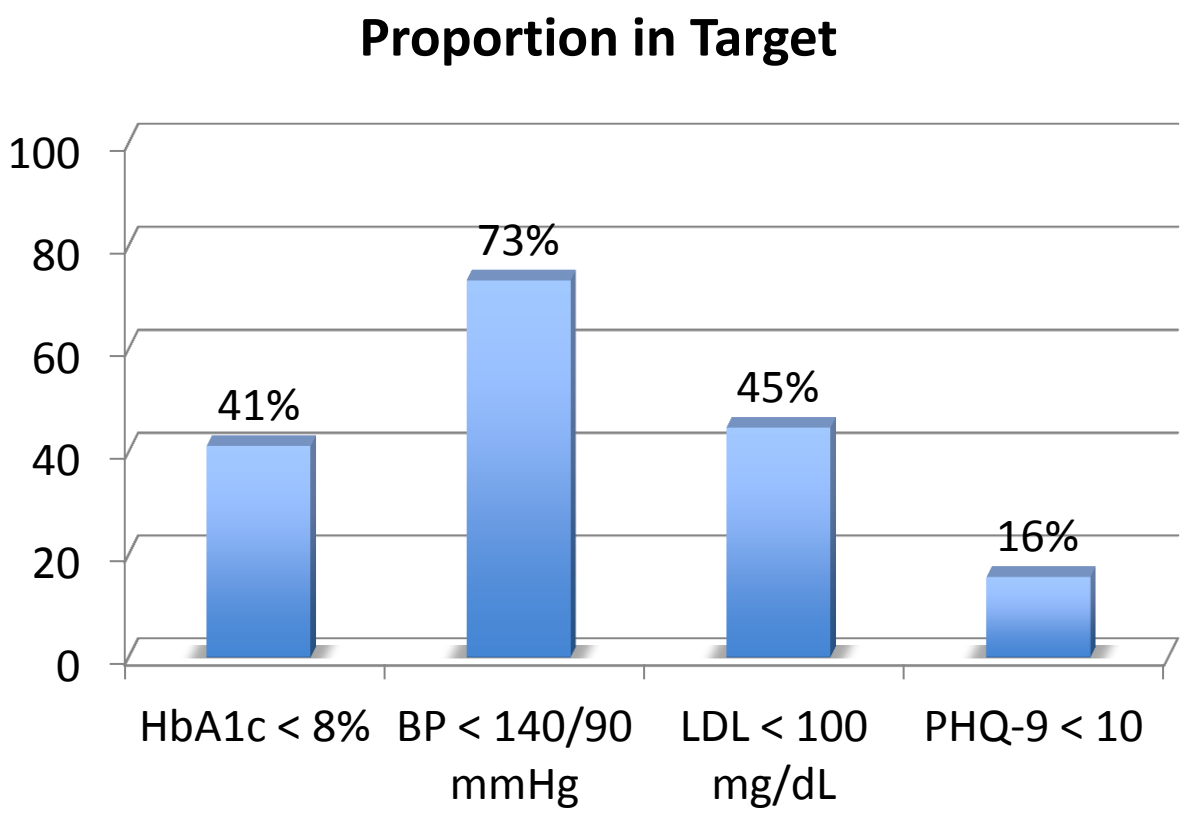
Q1 2013 : Q2 2013 Bundle Data Comparison



Over 300 patients added to registry in Q2 by including diabetes with complexities codes 250.4-250.7

Patients Enrolled
N = 90

Baseline Patient Clinical Characteristics



Active
N = 37
No depression
N = 7

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N = 32
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N = 21
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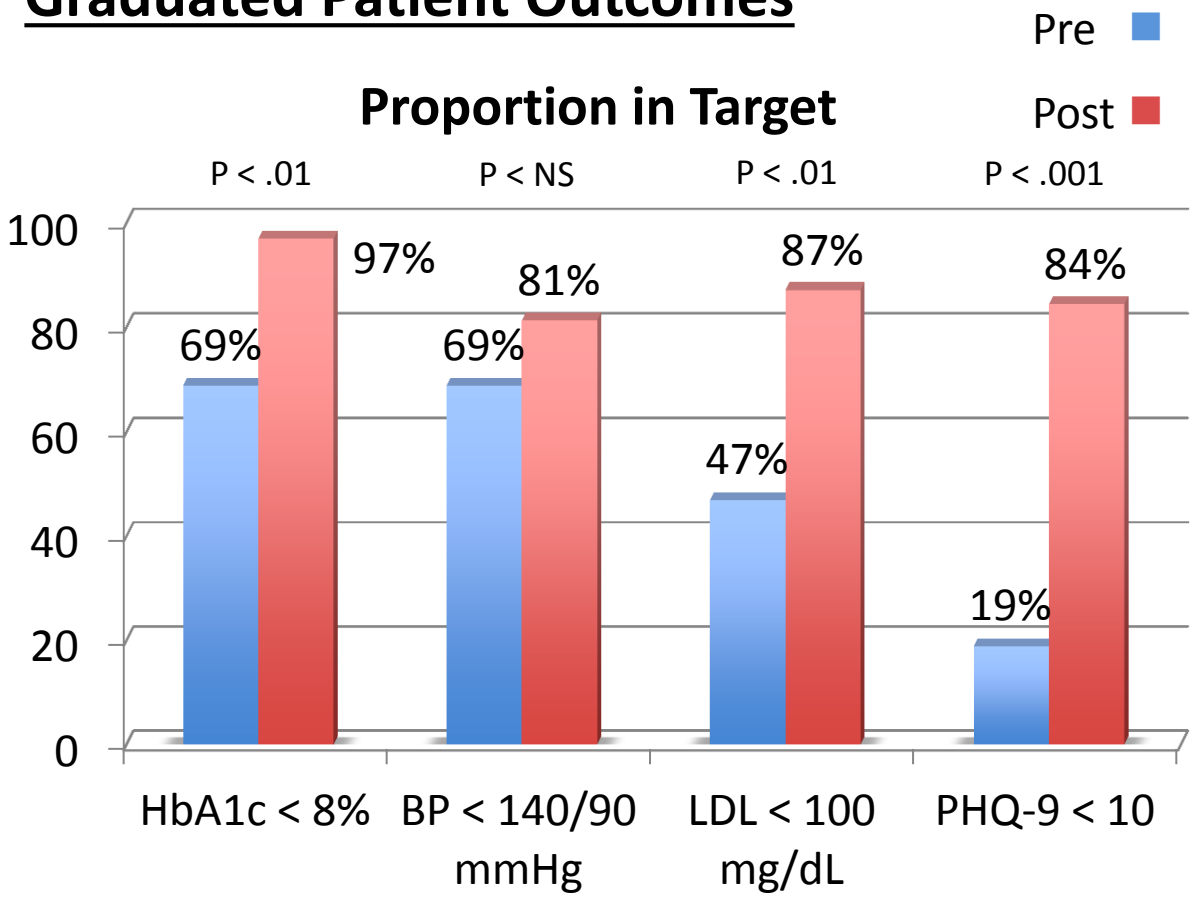
Patients Enrolled
N = 90

Graduated Patient Outcomes



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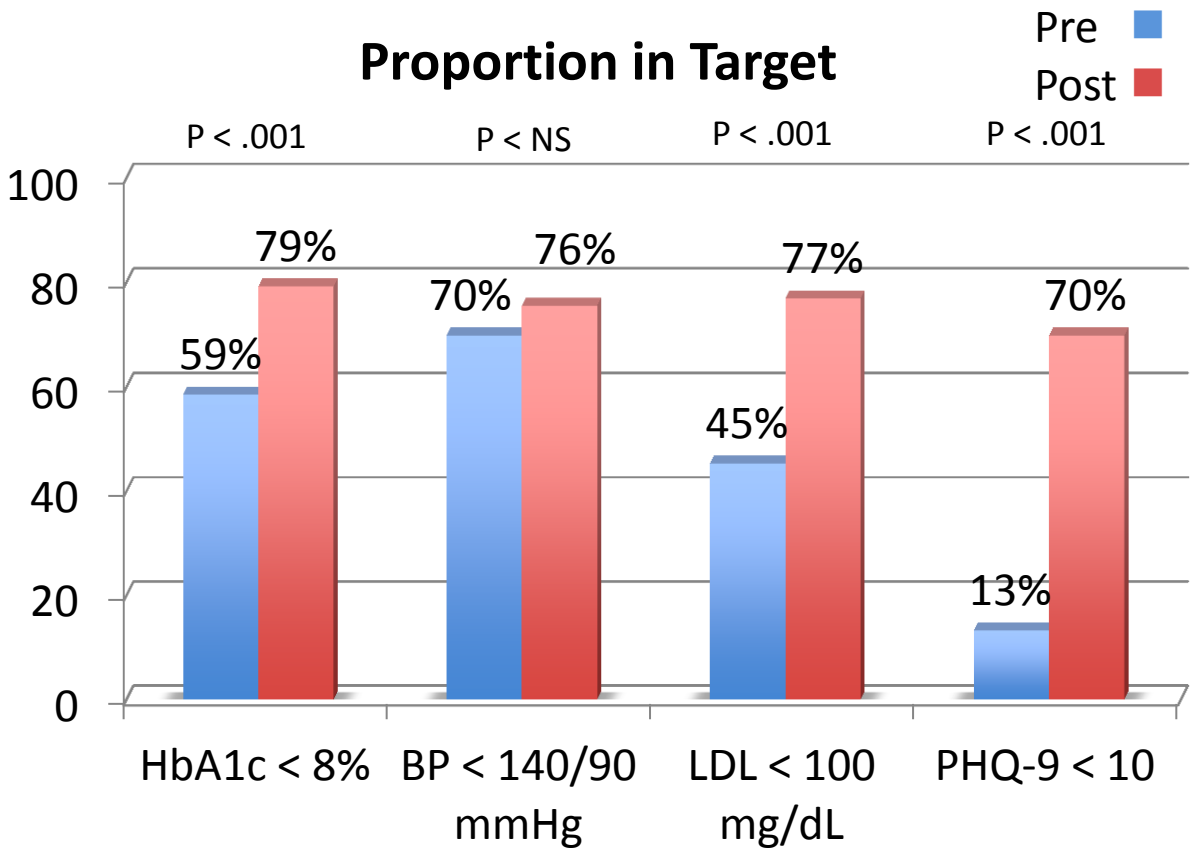
Patients Enrolled
N = 90

Graduated and Discharged Patient Outcomes



Active
N = 37
No depression
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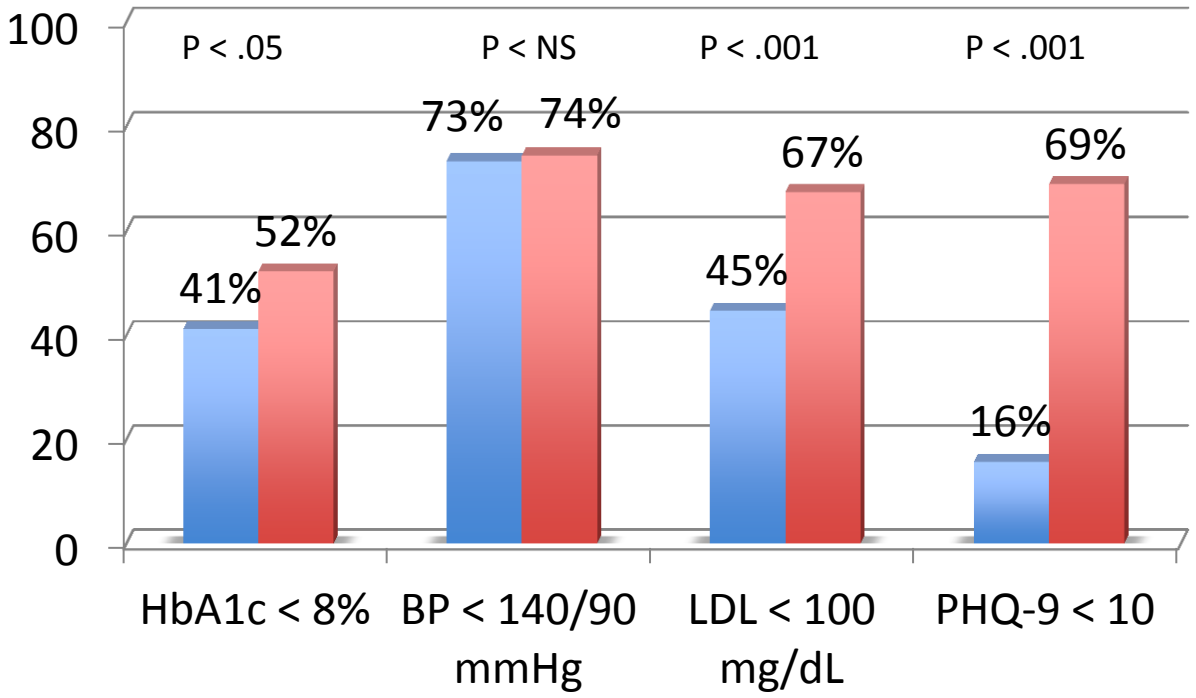
Patients Enrolled
N = 90

Full Sample Outcomes



Active
N = 37
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No depression
N = 6

Discharged
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No depression
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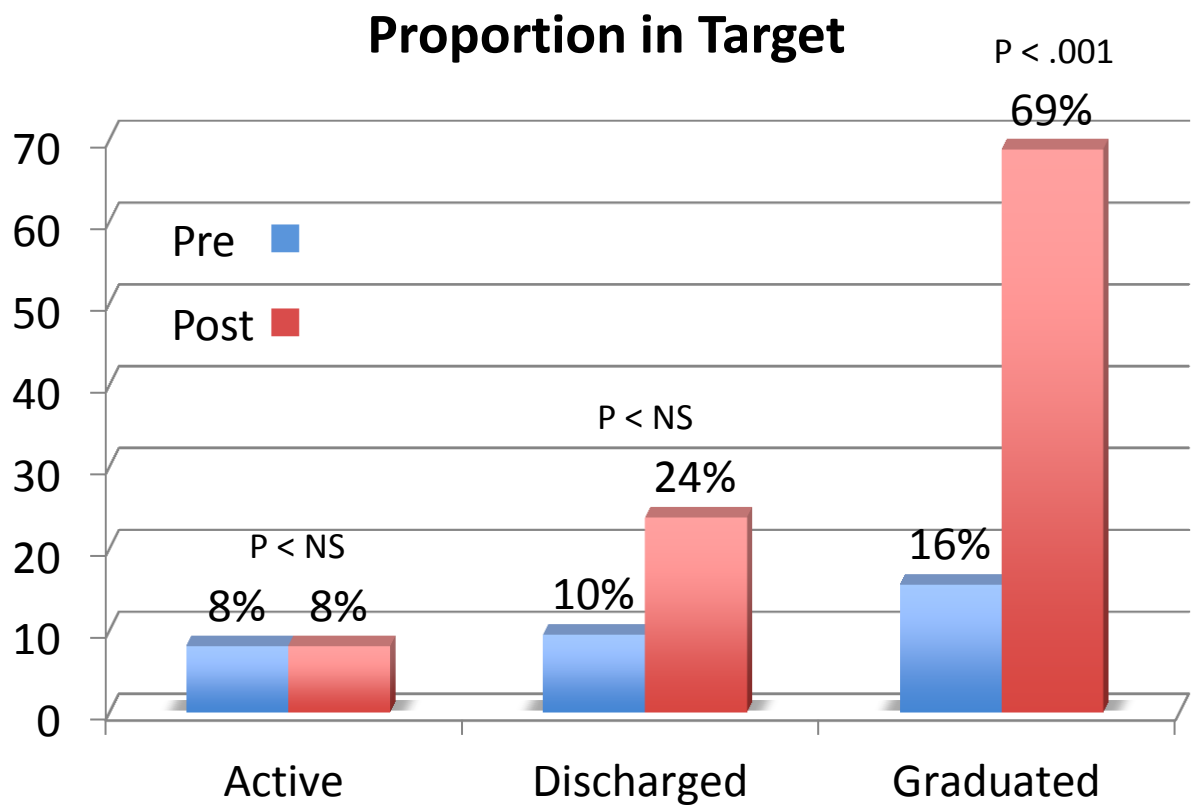
Patients Enrolled
N = 90

Proportion with SBP, HbA1c and LDL in Target



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TEAMcare Collaborative Care at The Polyclinic: Lessons Learned

Oren Townsend, MD and Elise Ernst, MEd, MSW, MBA

What are the challenges the RNs face?

TEAMcare:

- *"Challenges the traditional paradigm of patient-doctor relationship which involves a doctor visit, diagnosis and prescription of a treatment the patient has to follow at home."*
- *"Requires following patients in their day-to-day routines and extending our support to them in areas they identify as needing help."*

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"It is a different RN role to work one-on-one with patients, with weekly follow through. It can be professionally empowering to partner with a patient to formulate and reach goals."

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"It is definitely a different way to care for patients than what you learned in school, quite the opposite. It is not predictable, and there will be times when you have no control over a situation, but the satisfaction is much greater when the most resistant patient will call out of the blue to talk about their diabetes management."

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Role of TEAM MDs—Why does it work?

"It takes a special physician or psychiatrist to be able to step back from the traditional role and be willing to step into a role where everyone on the team is viewed equally."

What has been the response of patients?

- *"The patient response varies. Some patients enjoy the routine and structure while others view it as an intrusion on their lives. Finding a balance with each patient is essential if the goal is for the patient to receive the most benefit from the program."*
- *"This outcome-focused program has partnered with patients in a new way to self monitor their diabetes."*

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Comments from Patients

- *"It's been very helpful for me to have N (the RN)."*
- *"She has definitely been a good addition to my conscience."*
- *"She gives me good reminders I need to keep track of myself."*
- *"The team really took a closer look at my medications."*
- *"I'm losing weight again."*

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Comments from Patients

- *"It's good to know that somebody's out there that knows what you're going through."*
- *"It's good information about my Diabetes that she gives me."*
- *"This program is so good, it touches on everything."*
- *"Before TEAMcare, I was just existing, not really worried about getting myself on track."*
- *"I think it's an excellent choice for a person to make."*

Comments from PCPs

- *"I have sent 11 patients to TEAMcare, and it has been a wonderful help for my patients, and for me. They have all improved their diabetes management."*
- *"They (patients) get regular communication and follow up from the RN, and having all the notes in EPIC is a bonus."*

What defines Organizational Readiness?

- Initial support & ongoing commitment of Leadership
- EMR
- Reliable report generation from registry data
- Psychiatrist (or access to psychiatric consultation)
- PCP (Internal Medicine/Family Medicine)
- RNs who have care management experience and are trained in TEAMcare model
- Administrative support

Organizational Readiness, continued

- RN supervisor/manager
- Organizational willingness to administer PHQ-9 to patients with one or more chronic conditions
- Approved Self-Harm Risk Policy to support PCPs/Staff with suicidal patients
- Co-location of RNs in Primary Care & Endocrinology
- Buy-in and education throughout all of Primary Care, including PCPs

Organizational Readiness, continued

- Policies and Procedures in place to address other behavioral health needs, including social work (The Polyclinic has just approved a small Behavioral Health program for 2014).
- Operations manager to solve day-to-day program issues as they arise.
- Ongoing support of administration as challenges arise.
- An attitude of perseverance and patience--embrace change!

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One year later, what have we learned?

- Write a Self-Harm Risk Policy prior to program inception and train to it.
- Train the team more broadly at beginning of program.
- Schedule regular training updates as team members change.

One year later, what have we learned?

- Use RN care managers to train other clinical staff.
- Create methodology for gathering data that is well defined and agreed to by team, and keep it simple.
- Communicate with larger organization on a regular basis.

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Questions?