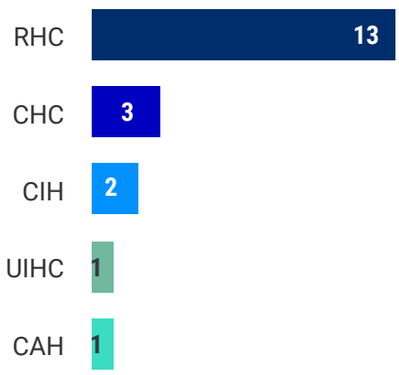
Team-Based Care
1815 Grant Years 1-5

Project Goal: Support engagement of all team members in hypertension AND cholesterol management in clinical settings.

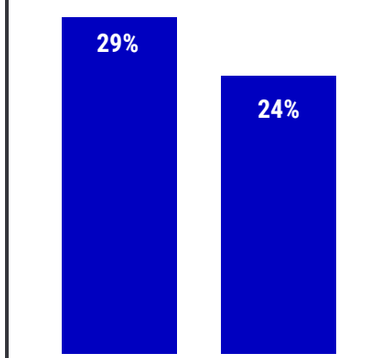
DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Clinic Characteristics

Patient Population: 18 years and older: 58,236 (pre-project)
44,445 (post-project)

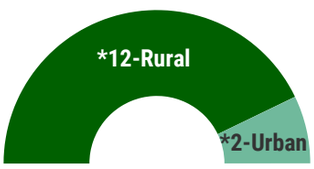


RHCs - Rural Health Clinics
CHCs - Community Health Centers
CIH - Community Integrated Healthcare
UIC - Urban Indian Health Center
CAH - Critical Access Hospital



Prevalence

County Locations of Sub-awardees



*Some counties had multiple sub-awardees

5 facilities have a policy/system to foster TBC: for hypertension management

&

6 for cholesterol management

Team Members

Providers (MD, NP, PA)
Nurses
Medical Assistant (MA)
Receptionists/Front Desk
Clinic Manager
Better Health Improvement Specialist

Dietitian (RD)
Physical Therapist (PT)
Nutrition Counselor
Patient Advocate
Mental Health/Behavior Health
Chronic Care Manager/Coordinator
Community Integrated Healthcare Provider

Outreach Coordinator
Patient Navigator
Dental provider/Dental staff
Pharmacy Technician
Clinical/Community Pharmacists
Laboratory staff
Fitness staff

Barriers

- Lack of communication between healthcare team
- COVID-19
- Staff shortage
- Scheduling
- Electronic Health Record

Facilitators

- Organizational support
- Access to lifestyle change program
- Information technology
- Team support for referrals
- Determine roles and parameters of huddles

Team-Based Care
1815 Grant Years 1-5, cont.

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Strategies

Improve coordination/communication

- Implement a referral system with follow-up documentation
- Create a "whole person" plan addressed at each appointment
- Implement hypertension (HTN) treatment protocol for those not at target
- Conduct daily huddles in all departments
- Increase medical/nursing staff awareness of team-based care (TBC) approaches
- Establish designated roles so everyone knows what they need to do
- Standardize BP/Chol patient education materials
- Create a written care plan for patients to take home
- Improve coordination between provider and Management Service RN
- Implement care team communication program

Add New Team Member(s) or Expand role of an existing team member

Clinical Pharmacist, RD, Healthy Lifestyle Coordinator, Community Health Improvement Manager, PT, Chronic Care Navigator (CCN), Behavioral Health Improvement Specialist

Maximize Scope of Practice

Nurses, RN - design training for MAs, provide patient care coordination and care management

Clinical Coach - provide care management

Pharmacist - evaluate patient characteristics and prescribed medications with appropriate follow-up

Dietitian - help implement and manage the lifestyle change program

Medical Assistants - enter orders on patient based on the protocols, provide outreach support

Care Coordinator - review patient records to identify HTN and high cholesterol (HChol) to proactively address conditions

Provider - develop workflow and add "elevated BP" to visit diagnosis

Refer to healthy lifestyle or community programs

Referrals - Wellness Center, Lifestyle Change Program, Food Farmacy, Behavioral Health, Chronic Care Management

Warm hand offs to a health professional

Health professionals - CCN, Behavioral Health Specialists, RD

Team-Based Care
1815 Grant Years 1-5, cont.

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Results

10 - Maximize Scope of Practice

of at least one member already on team

13 - Improving Communication/ Coordination

12 - New Team Member Referrals

- Community Pharmacist
- Healthy Lifestyle Coordinator
- Dietitian

# of referrals made to new member = 219

7 - Referral to Community Organizations

 # referrals to comm. organizations = 88

9 - Warm Hand-offs

Implementation strategies

- Increased awareness of other providers & services available
- Provided written referrals and electronic health record documentation
- Identified patients needing additional assistance

# of warm hand-offs

- Clinical Pharmacist = 4
- Dietitian = 18
- Behavioral Health = 105
- Chronic Care Navigator = 25
- Other = 20

Impacted by TBC to address

- **BP control:** 15,300 patients (34% of patient population 18-85 years)
- **Chol control:** 1,843 patients (Years 2 -5)

Sustainability Activities

- Offer additional classes with RD and PT
- Change workflow
- Gather benchmark data
- Expand TBC
- Make referrals
- Increase nursing buy-in
- Establish Collaborative Practice Agreements with Clinical Pharmacists
- Continue improving the process
- Improve BP and cardiovascular disease management
- Continue focus on BP and HChol
- Provide chart prep and screening
- Hold team huddles
- Use data analytics and information technology interface with Cross-Tx

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