

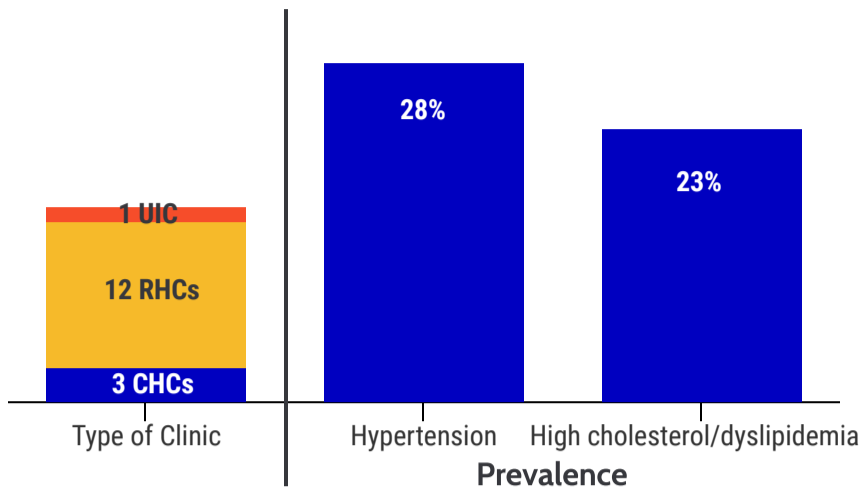
Team-Based Care 1815 Grant Years 1-3

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



Clinic Characteristics

Patient Population: 18 years and older: 49,025



CHCs - Community Health Centers
RHCs - Rural Health Clinics
UIC - Urban Indian Clinic

- Team Members**
- Providers (MD, NP, PA)
 - Nurses
 - Medical Assistant (MA)
 - Receptionists
 - Clinic Manager
 - Dietitian (RD)
 - Physical Therapist (PT)
 - Nutrition counselor
 - Patient Advocate
 - Mental Health/Behavior Health
 - Chronic Care Manager/Coordinator
 - Outreach Coordinator
 - Receptionist/Front Desk
 - Dental provider/Dental staff
 - Pharmacy Technician
 - Clinical/Community Pharmacists
 - Laboratory staff
 - Fitness staff
 - Better Health Improvement Specialist

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

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

Barriers

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

Facilitators

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



Results

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

New Team Members

- Community Pharmacist
- Healthy Lifestyle Coordinator
- Dietitian

of referrals made to new member = 113

Impacted by TBC to address

- BP control:** 11,080 patients (31% of patient population 18-85 years)
- Chol control:** 1,784 patients (Years 2 and 3)

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