CHCANYS DEFINING NEW DIRECTIONS
Community Health Care Association of New York State www.chcanys.org

COMMUNITY HEALTH CENTER FQHC QUALITY

Team-Based Care 101

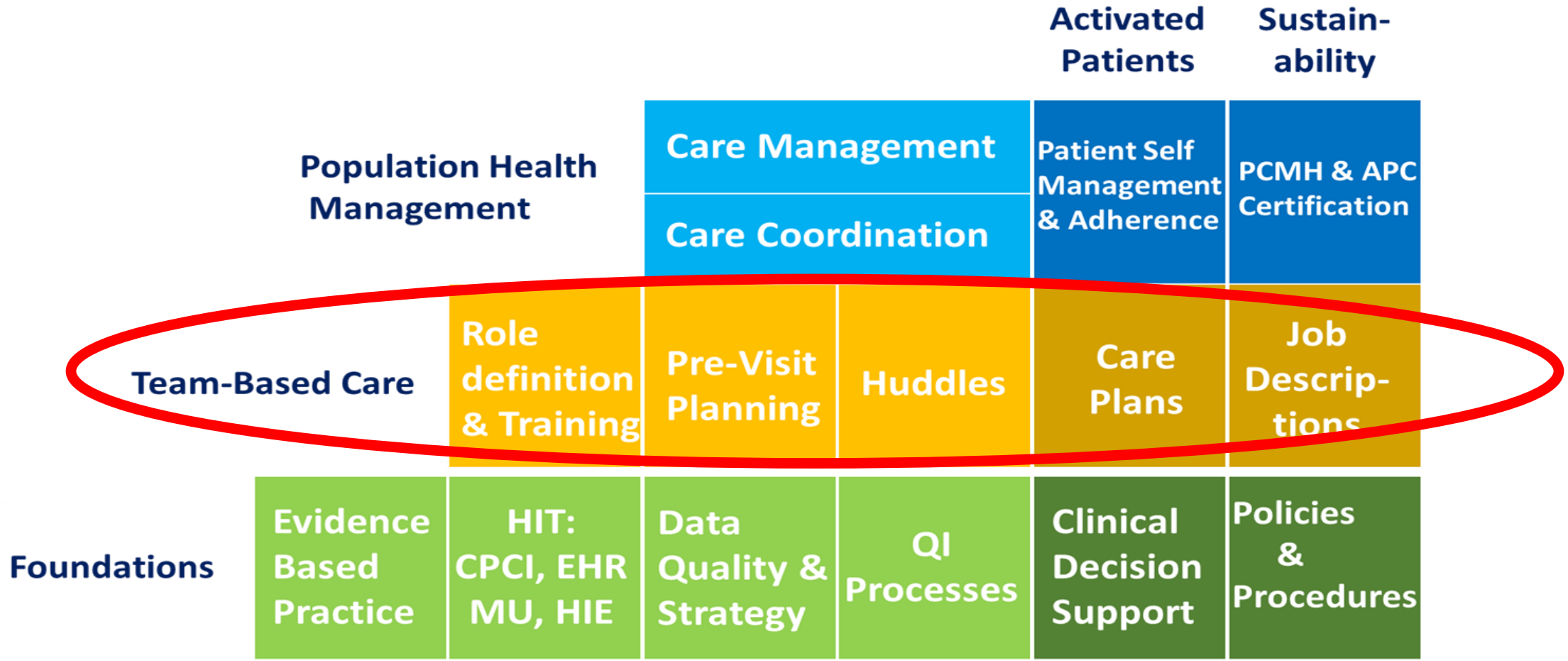
Diabetes and Cardiovascular Disease Prevention and Control Project

Tuesday, November 19th, 2019
12:00-1:30 p.m.

Objectives

- Define team-based care
- Review team-based care attributes for the team and patient care
- Review the tools that make team-based care seamless
- Identify roles and responsibilities for your core team members (ie MA and LPN)

The Building Blocks of Team-Based Care



*Adopted from Bodenheimer's 10 building blocks to primary care. http://www.annfammed.org/content/12/2/166.full.pdf

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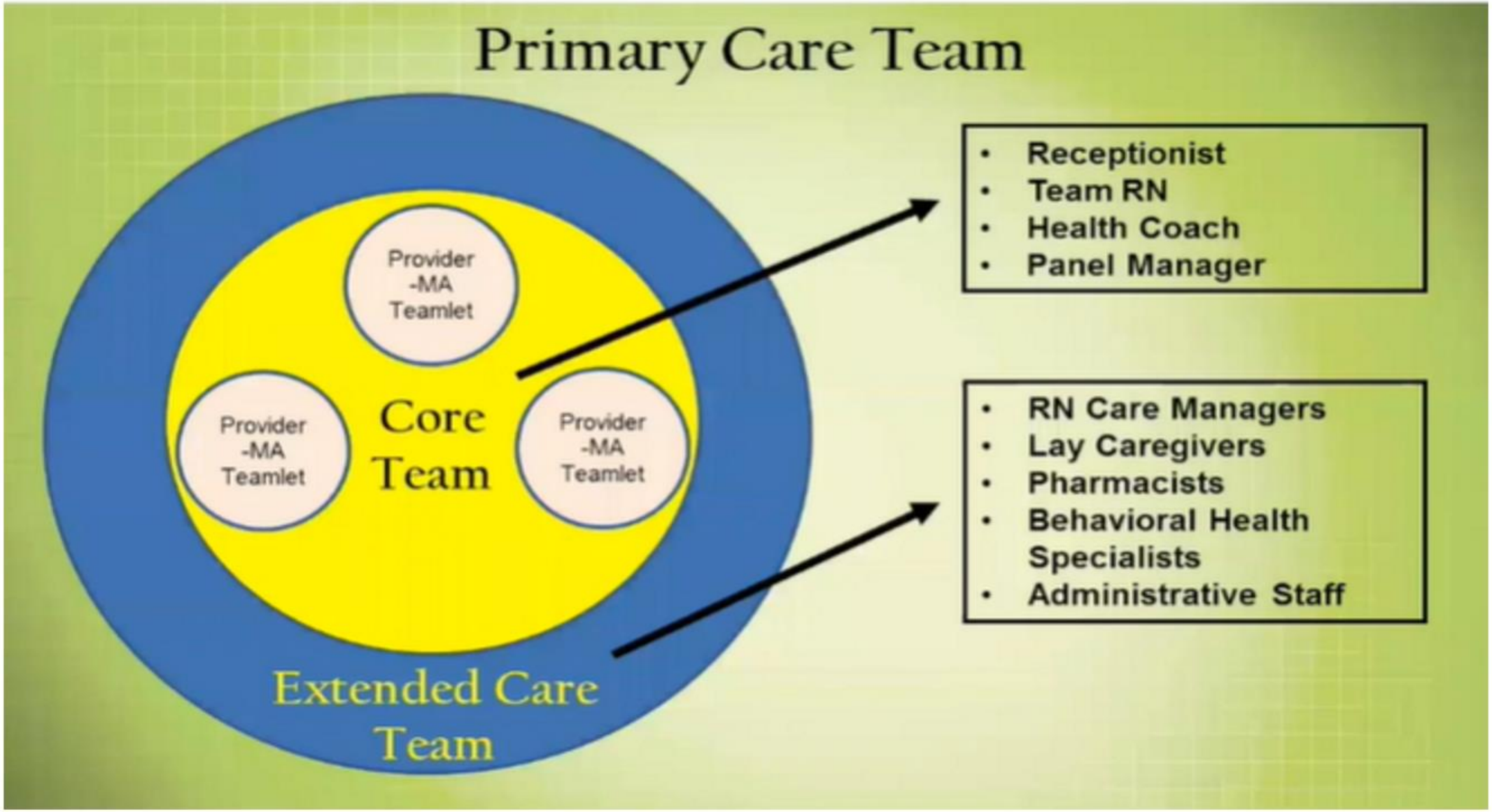

Primary Care Team
Provider -MA Teamlet
Provider -MA Teamlet
Provider -MA Teamlet
Core Team
Extended Care Team
Receptionist
Team RN
Health Coach
Panel Manager
RN Care Managers
Lay Caregivers
Pharmacists
Behavioral Health Specialists
Administrative Staff

Why?

When things don't fit in our day, it's tempting to "pass the buck" and assume a co-worker will take care of it. But often that does not happen.

Types of Huddles

Huddle Type	Issues Addressed	Frequency
Administrative	Who is here today? What's the day look like and what should I be prepared for?	Daily
Clinical	Address gaps in care for patients being seen today to receive care. Avoid duplicated work.	Twice a Day
Case Review	Address gaps in care for patients not seen today not receiving care.	As Needed

What Does Team-Based Care Look Like?

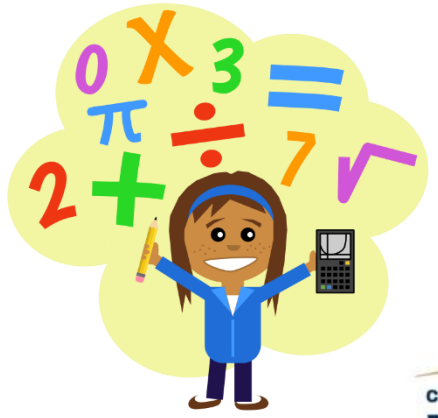
Pre-Visit Planning Process
and
Care Team Huddle

Discussion!

The Value of Using a Pre-Visit Planning Report

Facilitates more efficient pre-visit planning sessions by allowing care teams to review alerts for patients with upcoming appointments

- Does the work MAs/ LPNs already do manually, using EHR data and electronic calculation of alerts
- Displays ***only*** relevant and actionable items to help teams prepare for visits
- Displays active diagnoses and relevant risk factors



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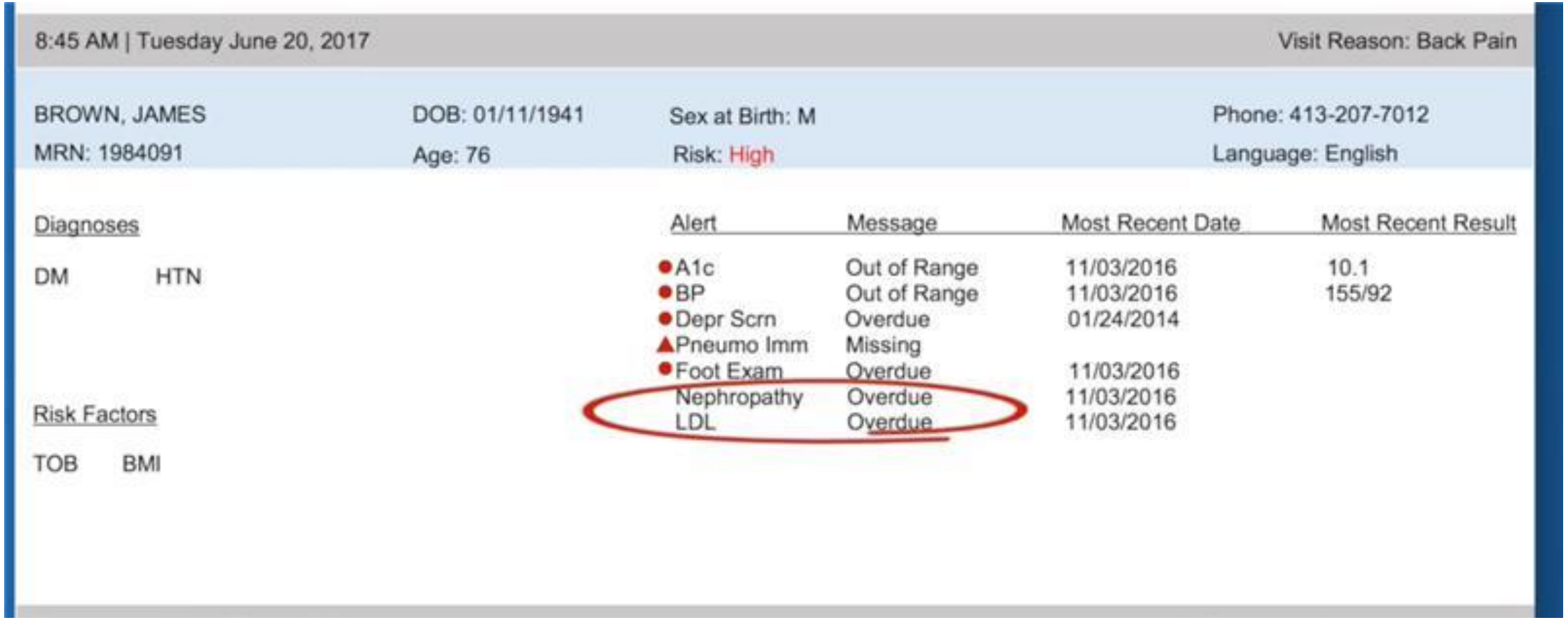
Roles & Tasks for the Pre-Visit Planning Report



8:45 AM | Tuesday June 20, 2017 — Visit Reason: Back Pain

BROWN, JAMES — DOB: 01/11/1941 — Sex at Birth: M — Phone: 413-207-7012

MRN: 1984091 — Age: 76 — Risk: High — Language: English

Diagnoses

DM HTN

Risk Factors

TOB BMI

Alert	Message	Most Recent Date	Most Recent Result
● A1c	Out of Range	11/03/2016	10.1
● BP	Out of Range	11/03/2016	155/92
● Depr Scrn	Overdue	01/24/2014	
▲ Pneumo Imm	Missing		
● Foot Exam	Overdue	11/03/2016	
Nephropathy	Overdue	11/03/2016	
LDL	Overdue	11/03/2016	

Pre-Visit Planning: Team Roles Defined

Role	Tasks
Front desk	1) Runs CPCI PVP report for walk-ins daily
MA/LPN	1) Runs PVP report daily 2) Leads the huddle 3) Identifies missing data for DI or lab tests 4) Assists provider with completing alerts for patients, supported by standing orders*
RN/Case Manager/BH/Health Educator	1) Attends huddle when possible to identify pts in need of addt'l services, in need of being seen F2F or f/u by phone 2) Shares any special patient circumstances
Provider	1) Delegates tasks to team members 2) Ensures huddles are happening

Team-Based Care 101: Cornerstone Family Healthcare

Presented by:

Charyto Sanchez, Assistant Director of Quality Improvement

IM Team & Roles/Responsibilities

- **2 clinicians: MD and NP**

  -participates in morning care team huddle

  -review & finalizes care plan w/ patient & orders labs/medications/bp machine

  -reviews BP & IDs if additional readings needed

  -links to ancillary services & "warm hand-off" completed when available i.e. health education, care coordination

  2 MAs & 1 LPN

  -prepares PVP w/ clinician either day before or morning of & participates in morning care team huddle

  -completes intake i.e. vital signs, chief complaint

  -initiates care plan w/ patient to develop goals & targets related to chronic condition(s)

  -IDs barriers i.e. transportation, language, insurance, financial, social support, literacy

  *when barriers ID'ed resources are provided i.e. handouts, coordinating appointments, referrals

  -completes "exit process" i.e. coordinates f/u, reinforces education r/t medication(s) & TX plan, confirms pharmacy & if bp machine is needed

  -dedicated MA conducts f/u to cohort to insure f/u is scheduled, obtains home bp readings, completes recommended labs prior visit, has understanding of d/c instructions & medications

- **Project Leads: MD (Clinician Champion), RN (Lead for Primary & Preventative Services), LPN (Clinical Coordinator)**

  -oversees PVP process completed on daily basis

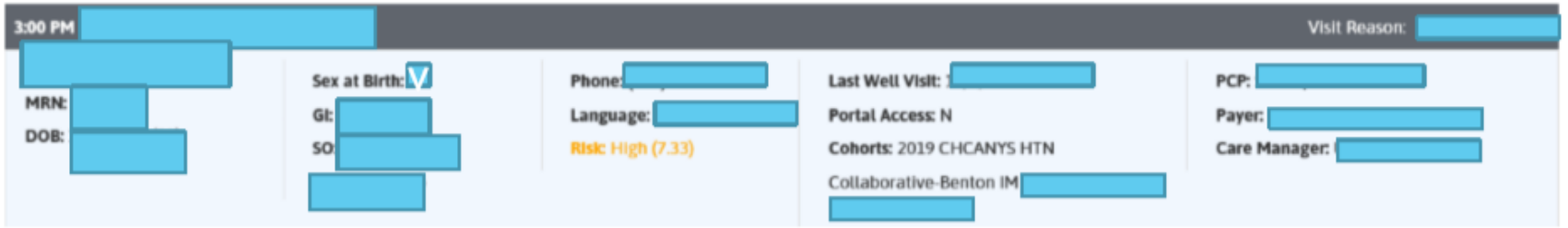
  -participates in CHCANYS meetings r/t project

  -meets w/ care team & QI to discuss barriers & successes r/t project

  -sets goals & targets for care team

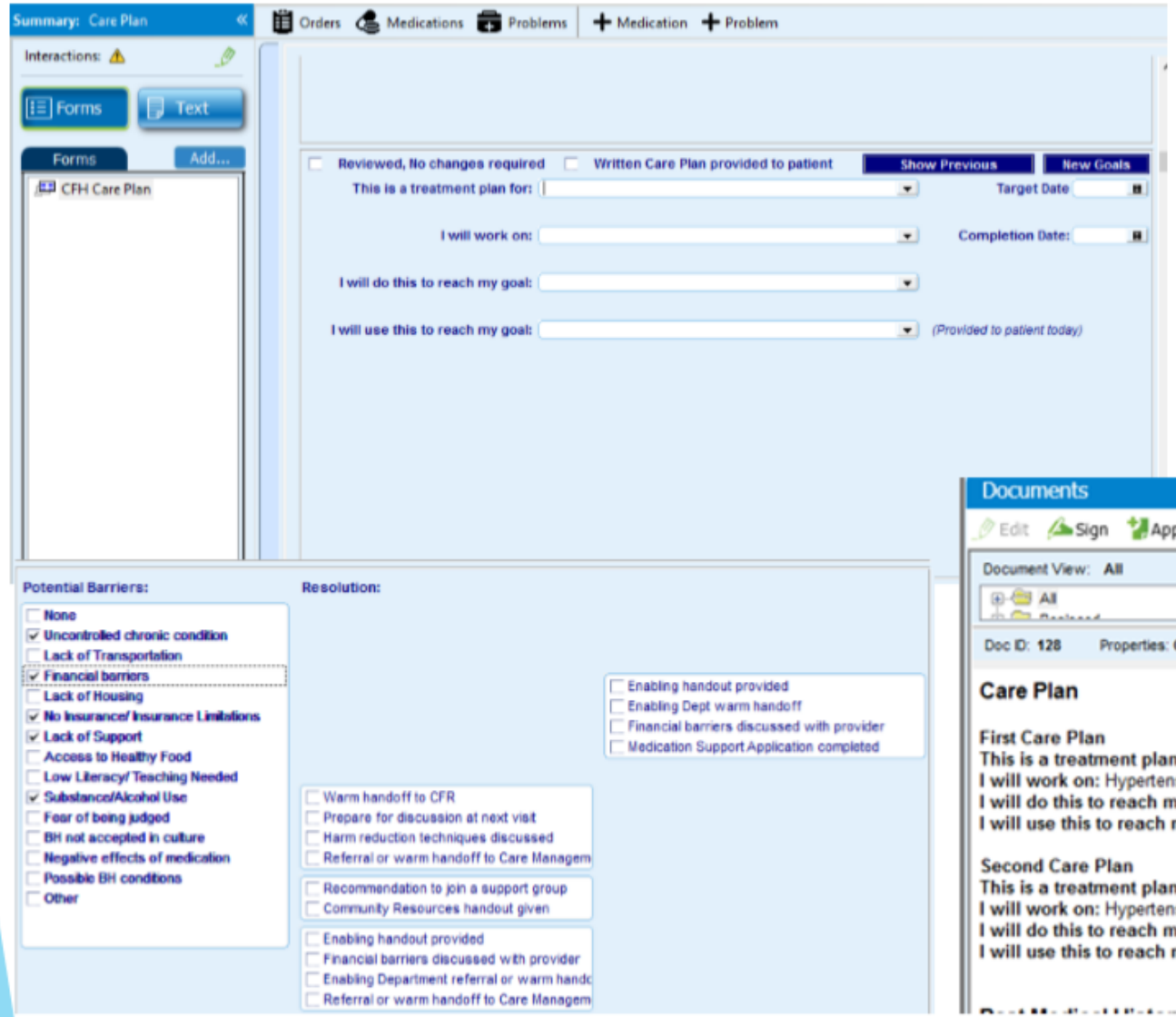
How is PVP Done & How Does it Help?

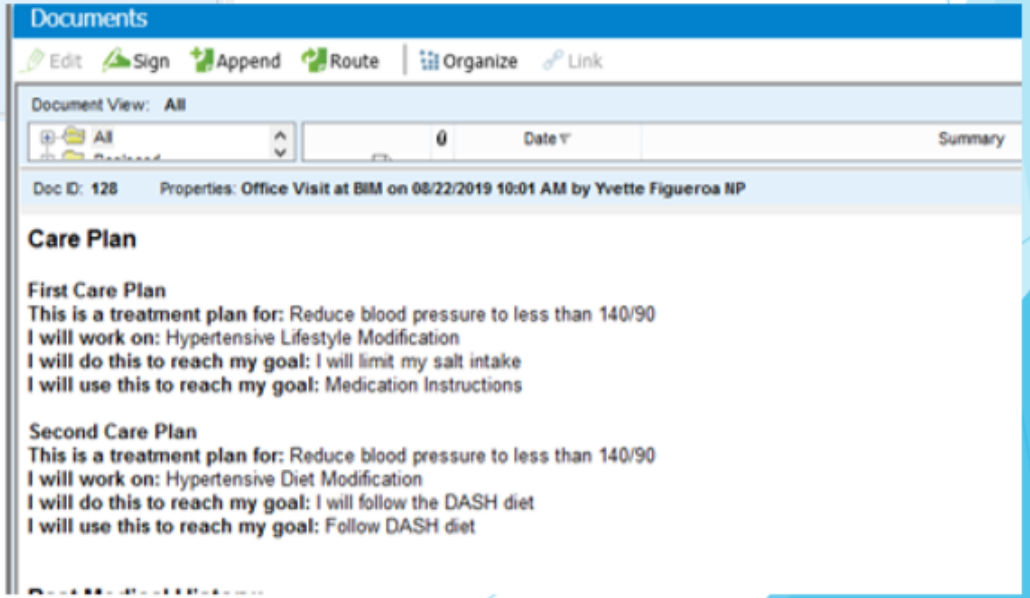
- Utilize Azara to run daily report
- Reviews EMR chart to ID: care plan update, refills on meds, outstanding labs & radiology, open referrals, missing reports i.e. hospital records, consults, preventative screenings needed i.e. cancer screenings, vaccinations, physical
- HTN cohort is reflected on PVP banner



- Information drives conversation between MA/LPN & clinician to focus on what priorities are for visit

What Does Care Plan Consist Of?





Priority Goals for Cohort

- **At every visit:**

*Comprehensive care plan completed or reviewed at every visit to ID goals & current barriers r/t to condition(s)

*At least 2 bp readings completed

*Insuring health education referral in place & “warm hand-off” completed if educator available

*Reconciling medications & labs

*Documenting bp log in EHR or scanning copy of log book in chart

*Offer resources that can help improve condition(s) i.e. health education, care coordination, enabling services

- **On a monthly basis:**

*Updated Azara report is run to indicate current performance

*Reviews charts & conducts telephonic outreach to provide patient reminders for appointments, labs, d/c instructions, medications, obtain bp readings, reinforces education

*Communicates w/ clinician to coordinate care, change medications, share bp readings & identified barriers

Long-Term Goals

- Encourage patients to be part of their care planning process

  Pick a Goal, Take Control

- Streamline communication between clinical & operational team members
- Fortify relationships w/ internal resources & establish rapport w/ community partners i.e. YMCA, ShopRite Nutritionist, CFH & Community Farm Stands, DOH, American Heart Association
- Utilize risk stratification to ID individuals needing higher levels of care or resources

HTN: Controlling BP

Baseline Data TY July 2019: 66%

2019 Goal: 72%

2020 Goal: 75%

Questions?

Contact information

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Guidelines for Effective Team-Based Care

1. Determine what role is **best suited** to perform each responsibility
2. **Equal distribution** of tasks across team members
3. Team members **know their responsibilities**
4. Team members **know each other's responsibilities**
5. Team members **held accountable** to completing their responsibilities

Why?

Prevent work from slipping through the cracks

Why?

Avoid surprises….

….and interruptions

Pre-Visit Planning
DM and CVD-related Alerts

Diabetes-related Alerts	CVD-related Alerts
Diabetes Eye Exam	Aspirin
Diabetes Foot Exam	Lipid-Lowering Therapy
Self-Management Plan	Self-Management Plan
Diabetes A1c	Statin Therapy
Diabetes Nephropathy Screening	BP
Diabetes/HTN LDL	Diabetes/HTN LDL
Elevated Glucose	Elevated BP

Next Steps:

- Review Diabetes and Cardiovascular Disease Azara/CPCI Alerts and assign staff roles

- Team Based Care Series- Dec 10th, and Jan 2020

- Mid-Year Peer Learning Event - Jan 16th, 2020, Empire State Plaza, Albany NY

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