Strategies to Implement and Optimize Team-Based Care in Your Practice

An effective teamwork strategy can immediately and positively affect patient safety and outcomes in every health care setting. Care teams should be backed by strategies and practical skills in order to achieve goals and overcome challenges.

Providers and practices who are actively engaged in the Delaware Division of Public Health's Quality Improvement Initiatives to Improve Diabetes and Hypertension have the benefit of scheduling a no-cost workflow assessment with a local Quality Insights Practice Transformation Specialist (PTS). We encourage your practice to **implement at least ONE** of the team-based care workflow improvements that are listed below.

Contact your Quality Insights Practice Transformation Specialist (PTS) to explore which of these workflow modifications and/or training opportunities can benefit your practice. If you are not currently working with a PTS and would like assistance, email Ashley Biscardi or call **1-800-642-8686, Ext. 137**.

Protocol and Workflow Actions

	Refer all patients with hypertension and/or prescribed medications for hypertension (excluding those who have had a cardiac event in the last year, afib/arrhythmia diagnoses, or have/are at risk for lymphedema) to the Delaware Division of Public Health's Healthy Heart Ambassador Blood Pressure Self-Monitoring Program (HHA-BPSM). Download the patient and provider flyers for more information.

	Community organizations can support your care team and enhance patient education. Educate your care team on available evidence-based lifestyle change programs, and establish a referral process to the Centers for Disease Control and Prevention (CDC)-approved offerings, including the National Diabetes Prevention Program, Diabetes Self-Management Education and Support (DSMES), Weight Watchers (WW), and Take Off Pounds Sensibly (TOPS).
	Implement annual staff training to review appropriate procedures for obtaining an accurate blood pressure.
	All members of the care team can play a role in addressing social determinants of health (SDOH) and health literacy. Learn more in the Quality Insights SDOH Practice Module and consider implementing a standardized workflow utilizing the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) tool.

Practice and Clinical Solutions

	Review the "Key Features of High-Performing Care Teams" in the Quality Insights Care Teams Practice Module at a staff meeting. Discuss and evaluate whether your practice is a high-performing team. Utilize the linked resources for further team development ideas.
	Participate in Quality Insights' no-cost academic detailing on the topics of diabetes prevention and management, cholesterol, and hypertension. Contact your local Quality Insights PTS for more information.
	Create a team-based hypertension care management plan: • Partner with the Healthy Heart Ambassador Blood Pressure Self-Monitoring Program (HHA-BPSM), and utilize specially trained health coaches who teach simple yet proven ways to better manage and understand blood pressure, physical activity, healthier eating habits, and more. • Implement a home blood pressure loaner program by participating in Quality Insights' Home Blood Pressure Monitor program. Identify 1) a staff member who can act as a program champion, and 2) roles for other members of the team. Speak with your Quality Insights PTS for assistance.
	Implement a team-based care management plan to address high cholesterol. • Educate all members of the care team on lifestyle change programs such as Weight Watchers (WW) and Take Off Pounds Sensibly (TOPS). Include providers who are key in patients accepting the recommendations.

	Collaborate with pharmacists to improve medication adherence. • Learn how you can refer patients on antihypertensives for no-cost medication therapy management (MTM) through the Delaware Pharmacists Society. Download the MTM e-course flyer for additional information. Patients who would benefit from a pharmacist consult can email their name and phone number to dpsmtmprogram@gmail.com. Physicians may also refer patients by fax. • Partner with Quality Insights to provide no-cost, pharmacist-led MTM for your Medicaid patients living with hypertension or diabetes.
	Partner with Quality Insights to provide no-cost health coaching for your Medicaid patients living with diabetes, prediabetes or hypertension.

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