Care Teams Practice Module

March 2023

Implementation of Quality Improvement Initiatives to Improve Diabetes and Hypertension

DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

1973-2023 50 years Quality Insights

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Purpose of Module

Quality Insights developed the Care Teams Practice Module to highlight evidence-based information related to the development and long-term sustainability of team-based care in the primary care setting. As an active participant in the Delaware Division of Public Health's Implementation of Quality Improvement Initiatives to Improve Diabetes and Hypertension project, health care providers and staff are encouraged to review and implement the included resources as actionable means of promoting and improving quality improvement initiatives.

Note: Guidelines referenced in this module are provided in brief, summary format. Full recommendations should be reviewed in the original publication(s) and utilized with physician/clinician judgment, with consideration given to a patient's unique needs and circumstances.

Introduction

Health care is changing at a rapid pace. The COVID-19 pandemic in combination with the shift from fee-for-service (FFS) payment to value-based payment models (which reward providers for the quality of care provided) highlight the importance of a team approach to improve the health of individuals and populations, and to improve the safety, quality, and efficiency of health care delivery.

The American Medical Association (AMA) (2015) defines team-based care as "a collaborative system in which team members share responsibilities to achieve high-quality and efficient patient care." In this model, physicians, nurses, nurse practitioners, physician assistants, pharmacists, social workers, community health workers, case managers, medical assistants, and other health care professionals coordinate responsibilities, such as pre-visit planning, expanded intake activities, medication reconciliation, updating patient information, and scribing, to provide better patient care.

> *"Of all of the changes envisioned as part of the transformation to improved and more patient-centered primary care, perhaps none is more promising and more challenging than the transition to team-based delivery of care."*
>
> Source: Agency for Healthcare Research and Quality, 2016.

Key Features of High-Performing Teams

According to the American Hospital Association (AHA) (2021), "even before COVID-19, the rapid pace of change in health care was significantly contributing to burnout." While provider burnout is not new, COVID-19 has highlighted the challenges faced when administrative burden, sub-optimal communication systems, and unbalanced teams collide with an extended crisis. In addition, the traumatic impact of COVID-19, in particular on care providers in hard hit areas, has amplified the need for support and efforts to improve wellness and well-being.

Evidence-based practices can help create a cohesive organizational culture that prioritizes and promotes well-being. Released February 2021, the AHA's *Well-Being Playbook 2.0* offers resources on mental well-being, addressing burnout, and operationalizing peer support, as well as a guide to well-being program development and execution.

A 2018 National Academy of Medicine Discussion Paper, *Implementing Optimal Team-Based Care to Reduce Clinician Burnout*, highlights a number of studies providing existing evidence in support of high-functioning teams and their link to increased physician well-being as well their cost-effectiveness resulting in reduced emergency department utilization and hospital readmissions.

To illustrate how teamwork may act as a resource, the chart below examines the components and qualities that characterize high-performing teams.

Principle	Definition	Impact on Clinician Well-Being
Shared Goals	The team establishes shared goals that can be clearly articulated, understood, and supported by all members.	
Clear Roles	Clear expectations for each team member's function, responsibilities, and accountabilities to optimize team efficiency and effectiveness.	Role clarity has been associated with improved clinician well-being. A fully staffed team that is not over patient capacity is associated with decreased burnout.
Mutual Trust (psychological safety)	Team members trust one another and feel safe enough within the team to admit a mistake, ask a question, offer new data, or try a new skill without fear of embarrassment or punishment.	A strong team climate promotes clinician well-being and member retention.
Effective Communication	The team prioritizes and continuously refines its communication skills and has consistent channels for efficient, bidirectional communication.	Effective communication is associated with decreased clinician burnout. Participatory decision making is associated with lower burnout scores.

Principle	Definition	Impact on Clinician Well-Being
Measureable Processes and Outcomes	Reliable and ongoing assessment of team structure, function, and performance that is provided as actionable feedback to all team members to improve performance.	Emotional exhaustion is associated with low personal accomplishment, so reiteration of accomplishments could decrease burnout.

Adapted from "Implementing Optimal Team-Based Care to Reduce Clinician Burnout," by Smith et al., 2018.

Effective leadership is key to a successful team. The AMA recommends physician-led team-based care in which "members of the team share information and assist in decision making based on their unique skills – all with the common goal of providing the safest, best possible care to patients." The model of care delivery will vary based on the clinical situation and the composition of the team.

Take the Next Step: Would you describe your practice as a high-functioning team?
Check out this AMA Steps Forward® podcast, *Improve Patient Care With Collaborative Care Team Models.*

Chronic Disease: Care Team Workflow Solutions and Interventions

Team-based care complements value-based care because it is designed to improve health outcomes. The following workflow interventions are provided to help facilitate quality improvement initiatives, evidence-based guidelines, and engagement of multiple care team members.

Unify your team around high blood pressure and cardiovascular disease (CVD) prevention by reviewing Quality Insights' Care Team Interventions to Implement American Heart Association CVD Primary Prevention Guidelines.

Hypertension Management

As explained by the Community Preventive Services Task Force (CPSTF), team-based care is an approach to achieving BP control in which team members work together to help patients manage their medication, increase healthy behaviors, and follow their BP control plan. The CPSTF's systematic review of evidence "shows team-based care increases the proportion of patients with controlled blood pressure and reduces systolic (SBP) and diastolic (DBP) blood pressure." Further, their review of economic evidence found that providing team-based care is cost-effective.

Through team-based care, the CPSTF suggests the following can be achieved:

- Facilitation of communication and care coordination
- Establishment of structured protocols to monitor and follow up on patient progress
- Active engagement of patients through education for self-management

Quality Insights' Home Blood Pressure Monitor Loaner Program

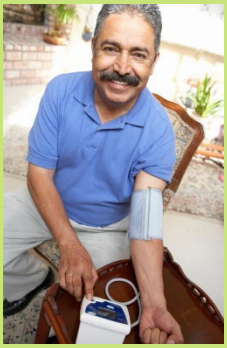
Interested in implementing a SMBP program, but concerned about having adequate resources and assistance? Quality Insights offers a **FREE** Home BP Monitor Loaner Program and training.

Benefits include:

- Participating practices are supplied with up to five automated home BP monitors that can be loaned to patients to monitor their BP at home.
- Loaner monitors are ideal for patients that do not currently own a BP monitor or for those lacking the resources to immediately purchase a device. It may also be useful when a patient is newly diagnosed with hypertension or when a patient experiences a change in BP medication.
- Patients and providers are able to track and monitor the following: pre-hypertensive patients, patients with uncontrolled hypertension, patients on hypertensive drugs, and patients with recent or past history of hypertensive crises.
- Your staff will receive training on educating patients for SMBP and the loaner program.

If your practice is interested in learning more about participating in the program, email Ashley Biscardi or call **1-800-642-8686, Ext. 137**. A recorded overview describing this program is also available.

Healthy Heart Ambassador Blood Pressure Self-Monitoring Program (HHA-BPSM)



Through this no-cost, evidence-based program, participants can partner with a specially trained health coach who will teach them simple ways to better manage and understand their BP, increase physical activity, adopt healthier eating habits, and more.

Explore the details of this CDC-recommended program from the Delaware Division of Public Health (DPH) while earning no-cost CNE/CME credit. Review Quality Insights' webinar flyer for more information, and encourage your patients to take advantage of the HHA-BPSM program by providing them with Quality Insights' informative flyer. A provider-facing flyer is also available.

Take the Next Step: The following resources offer current guidance and resources aimed at promoting team-based care to achieve hypertension control:

- Quality Insights' Screening, Measurement, and Self-Management of Blood Pressure (SMBP) Practice Module
- Million Hearts® *Hypertension Control Change Package*
- CDC's *Best Practices for Heart Disease and Stroke: A Guide to Effective Approaches and Strategies*
- National Association of Community Health Centers (NACHC) SMBP Implementation Toolkit
- Target: BP™ *Collaborative Communication Strategies to Manage Blood Pressure*
- SMBP Training Video: This educational video provides care team and patient training to properly self-measure blood pressure.
- Quality Insights' white paper: *Team Up for Quality Care: The Role of Primary Care Teams in Prevention of Cardiovascular Disease*

Cholesterol Management & Medication Adherence

Cardiovascular (CV) health remains a top public health priority with heart disease and stroke maintaining their stature as the #1 and #5 leading causes of death in the United States. According to the American Heart Association (2022), approximately 38% of adults in America have high cholesterol (total cholesterol ≥ 200 mg/dL). A 2018 *Patient Preference and Adherence* article discussing the importance of cholesterol medication adherence noted that lipid-lowering medications are among the most commonly prescribed medications, and they have been associated with a 25% decrease in the risk of cardiovascular disease. Feingold (2021) reported that low-density lipoprotein cholesterol (LDL-C) levels can be lowered by as much as 60% through the use of statins.

However, adherence rates for statins, as with many other medications, remain less than optimal. An article by Bui et al. (2019), featured in *U.S. Pharmacist,* cites nonadherence to statin therapy as a crucial issue that leads to poor health outcomes such as cardiovascular disease-related emergency department visits, escalating medical care/expenses, and mortality. Within one year, 50% of patients discontinue their statin therapy, and nonadherence continues to increase over time. Bui and colleagues also shared that statin nonadherence over one year has been shown to result in a $400 to $900 increase in health care costs within the following 18 months. A comprehensive care team approach, rooted in an understanding of the causes of nonadherence and a willingness to work with those patients to overcome barriers, may improve future adherence.

Aside from medication adherence, other aspects of care that can improve cholesterol management are dietary changes, smoking cessation, and increased physical activity. Consider extending the care team by referring patients to programs and resources that can further strengthen their chances of making positive, sustainable lifestyle changes.

Take the Next Step: Adopting protocols that activate health care staff to support providers in a team environment can help mitigate some of the common barriers related to medication adherence. Specific tasks that could be delegated to staff include:

- Administering the Adherence Estimator® tool and documenting patient results at every office visit.
- Providing medication reminder wallet cards to patients.
- Encouraging patients to adhere to medications through improved communication practices by distributing AHRQ's Be More Involved in Your Health Care Tip Brochure.
- Referring to pharmacists for medication therapy management, through Delaware Pharmacists Society or Quality Insights, which includes individual goal setting and exploration of barriers.
- Training nursing staff to guide patients through the Statin Choice Decision Aid.
- Assessing social determinants of health (SDOH) by collecting and analyzing race, ethnicity, and preferred language data (using the PRAPARE tool) with the goal of integrating services to meet identified needs of patients.
- Providing educational materials developed in multiple languages and at appropriate health literacy levels.

Prediabetes Management

According to the ADA (2022), 35.4% of the adult population in Delaware has prediabetes. Of those with prediabetes, about 25% will develop type 2 diabetes within three to five years and up to 70% will eventually develop type 2 diabetes at some point in their lives (Hostalek, 2019).

To help prevent type 2 diabetes, the CDC and the AMA created a toolkit health care teams can use as a guide to screen, test, and act by referring patients to in-person or online National Diabetes Prevention Programs (National DPP).

Engage your team by encouraging them to review the components of the toolkit, including:

- Evidence Brief
- Prediabetes and National DPP Lifestyle Change Program FAQ
- Prediabetes Identification and Management Protocols
- Bi-directional Feedback Loop
- Codes: When Screening for Prediabetes and Diabetes
- Optimize Your Electronic Health Record to Prevent Type 2 Diabetes
- For more resources related to Delaware National DPPs, visit the Quality Insights website and review our Prediabetes Practice Module.

Diabetes Management

The American Diabetes Association (ADA)'s *Standards of Care in Diabetes – 2023* (*Standards)* recognizes the important role care teams play in optimal diabetes management when they are patient-centered, void of therapeutic inertia (failure to initiate or intensify therapy when therapeutic goals are not reached), and provide timely and appropriate intensification of lifestyle and/or pharmacologic therapy for patients who have not achieved the recommended metabolic targets. The *Standards* recommend "expanding the role of teams to implement more intensive disease management strategies."

According to the *Standards*, "strategies shown to improve care team behavior and thereby catalyze reductions in A1C, blood pressure, and/or LDL cholesterol include:

- Engaging in explicit and collaborative goal setting with patients.
- Integrating evidence-based guidelines and clinical information tools into the process of care.
- Identifying and addressing language, numeracy, or cultural barriers to care.
- Soliciting performance feedback, setting reminders, and providing structured care (e.g., guidelines, formal case management, and patient education resources).
- Incorporating care management teams including nurses, dietitians, pharmacists, and other health care professionals.

In addition to the care team members mentioned in the bulleted list above, studies have highlighted other important contributors to a patient's diabetes care team.

Family Members

A 2019 TALK-HYPO study examined the burden of diabetes on family members of people with type 1 or type 2 diabetes and found that 66% reported thinking about the risk of hypoglycemia at least monthly, and 64% felt worried or anxious about the risk of hypoglycemia. The authors concluded that family members are essential players in the diabetes care team and conversations facilitated by a health care professional may reduce the burden.

Dining with Diabetes, a program conducted by staff and volunteers from the University of Delaware Cooperative Extension, is a five-class interactive series that includes diabetes education, cooking demonstrations, and tasting of healthy foods. Program participants take home recipes and knowledge about how to manage diabetes in their daily lives. The program understands the vital role that support systems play in one's success with lifestyle changes and encourages family members, caregivers, and other support individuals to attend class sessions along with the person with diabetes.

Digital Diabetes Management Systems

The impact of connected diabetes care as "the newest member of the team" was reviewed in a 2020 article in *Diabetes Technology & Therapeutics*. The authors examined digital diabetes management systems based on smartphone apps, devices with built-in connectivity, and remote human and automated coaching and support. Randomized control trial evidence supporting these systems is limited, in part due to the challenge of keeping pace with emerging technology, but a number of single-arm, real-world prospective and retrospective analyses have been published. These include controlled (but non-randomized) and/or cost-effectiveness analyses. The authors conclude that, despite the limited evidence, the emerging field of connected diabetes care has the potential to help people with prediabetes, diabetes, and related conditions by filling gaps between clinic visits with quality guidance.

Take the Next Step: Access the following resources to learn how you can promote optimal diabetes care to the patients you serve through enhanced care team collaboration.

- Patient Resource, ADA: Get to Know Your Diabetes Care Team
- Diabetes Self-Management Education and Support (DSMES) Practice Module: Review this Quality Insights resource to learn about connecting your patients with diabetes self-management education and support (DSMES) services.
- Medication Adherence Practice Module: Download this Quality Insights resource for more information related to medication management and adherence across patient populations living with high blood pressure, hypercholesterolemia, prediabetes, and diabetes. Tips for assessing health literacy, cultural competency, and language barriers are included. This module also provides information on effective communication and links for patient education resources in a variety of languages.
- Social Determinants of Health Practice Module: Download this Quality Insights resource for a more in-depth discussion of health literacy. Numerous patient and provider resources are provided.

CME/CNE from Quality Insights

Awareness to Action: Diabetes Prevention and Management

It takes time to educate people about self-care and help them make significant changes. Busy practices and providers don't often have this kind of time to spare. Thankfully, diabetes educators do, and they can keep providers connected with their patients' progress. Join Quality Insights to discover available DSMES and National DPP services and learn how to increase referrals to these programs locally.

The *Awareness to Action: Diabetes Prevention and Management* e-learn was developed through a joint partnership with DPH and CDC grant funding. No-cost Continuing Medical Education (CME)/Continuing Nursing Education (CNE) credit is available for physicians and nurses. Download the course flyer to learn more.

Engaging a Pharmacist as Part of the Care Team

A February 2021 commentary feature in *The Journal of the American Board of Family Medicine* reports that pharmacists are well-prepared to serve in primary care settings as part of the care team, providing clinical patient care services, specifically serving as a drug information resource for patients and staff

while providing patient education on management of chronic disease states. This same feature reports that "by the year 2032, there will be a shortage of 21,100 to 55,200 primary care physicians in the United States." To address the shortage, additional health professionals must be recruited to the care team and allowed to function within the limits of their training, credentials, and licensure. **"Pharmacists are health professionals that can be utilized to ensure patients receive adequate care in primary care settings"** (Moreau, 2021).

The AMA also affirms pharmacists and pharmacy technicians as valuable contributors to a team-based care model. They can work with practices in a variety of roles, ranging from working within a practice to building collaborative relationship with community retail pharmacists. AMA's Steps Forward™ module, *Embedding Pharmacists Into the Practice*, offers assistance related to collaborating with pharmacists to improve patient outcomes.

Some ways pharmacists can assist your practice:

- Optimize drug therapy according to agreed-upon protocols
- Advise on substituting medications with safer and/or less costly alternatives
- Manage drug interactions
- Improve patient and team education
- Improve medication adherence

Did You Know?

Complex patients **see their community pharmacist on average 35 times per year**. These same patients **see their primary care provider (PCP) an average of two to four times per year**.

Learn more about leveraging a pharmacist as part of your care team in this 2021 Innovations in Hypertension Control webinar from the AHA, Missouri Dept. of Health and Senior Services, and Health Quality Innovators.

Take the Next Steps: For practices lacking resources to embed a pharmacist, alternative suggestions for partnering with a community pharmacist could include:

- Connect your patient with hypertension to pharmacists available to provide Medication Therapy Management (MTM) through the Delaware Pharmacists Society. If your patients could benefit from a pharmacist consult, they can email their name and phone number to delawarepharmacistssociety@gmail.com and be connected to this service. Click here to view more information about this MTM program.
- Partner with Quality Insights for no-cost MTM for Medicaid patients living with hypertension and/or diabetes. Review the program flyer for additional information.
- Give your patients copies of their chart or portions of their chart, such as medication lists, visit summaries, lists of medical conditions, and basic labs to share with their community pharmacist.
- If you use OpenNotes, include a request in the note for the patient to speak with their pharmacist about pertinent issues and bring a copy of the note with them to the pharmacy.

Did you know?

Pharmacies in your local community may offer DSMES and National DPP services. Encourage your patients to connect with their local pharmacist to discuss enrollment in these evidence-based, lifestyle change programs by sharing the following flyers developed by the U.S. Department of Health and Human Services:

- Could You Have Prediabetes (English)
- Could You Have Prediabetes (Spanish)
- Do You Have Diabetes

Quality Insights CME-eligible Medication Therapy Management e-Learn

Improving medication adherence is an important way to increase quality and reduce cost, but barriers to medication adherence are complex and numerous. One evidence-based way to address this problem is collaborating with pharmacists as extended members of your care team to provide medication therapy management (MTM).

As part of Quality Insights' ongoing efforts to support Delaware medical practices through our partnership with DPH's implementation of quality improvement initiatives, an e-course, Medication Management Therapy: Evidence-Based Collaboration to Improve Blood Pressure Control, was released. Delaware health care providers have exclusive access to this CME-eligible course at **NO COST.**

During this course, participants will explore the methods, goals, and benefits of MTM, as well as evidence that supports its effectiveness. Participants will also learn how to facilitate physician-pharmacist collaboration and refer certain Delaware patients for no-cost, pharmacist-provided MTM. Download the course flyer for more details.

Social Determinants of Health (SDOH): Care Team Workflow for PRAPARE Tool Utilization

Optimal care management requires not only excellent medical care but a recognition of the role SDOH play in successful disease management. Medical care is estimated to account for 10 to 20% of a person's health, while non-medical factors (SDOH) account for the remaining 80 to 90% (Magnan, 2017). Health care organizations nationwide are increasingly looking to integrate SDOH and health equity into value-based strategies. Organizations must identify social needs via screening tools, implement standardized, closed-loop workflows, and connect patients to local assistance resources in order to achieve the Quintuple Aim, described by Oyekan et al. (2022) as "better care; healthier people; smarter spending; care team well-being; and health equity."

The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) tool is a national standardized tool designed for the purpose of aiding health care organizations and community-based organizations in assessing SDOH, with the goal of improving health equity. "By using PRAPARE, providers can better target clinical and non-clinical care (often in partnership with other community-based organizations) to drive care transformation, delivery system integration, as well as improved health and cost reduction" (NACHC et al., 2019).

A successful, integrated workflow that prioritizes SDOH screening, coding, and referrals to community resources truly necessitates the coordination of the entire care team. Access the following resources to learn more about the PRAPARE tool and find workflow recommendations:

- Quality Insights' Social Determinants of Health Practice Module
- Quality Insights' Social Determinants of Health and Your Practice: Tools to Reduce Health Disparities
- PRAPARE Social Determinants of Health Screening: Sample Workflows
- PRAPARE Implementation and Action Toolkit
    - See chapter 5 for workflow implementation

For additional information on the value of screening for SDOH, listen to the February 2023 AMA STEPS Forward® Podcast: *The Importance of Screening for Social Determinants of Health*.

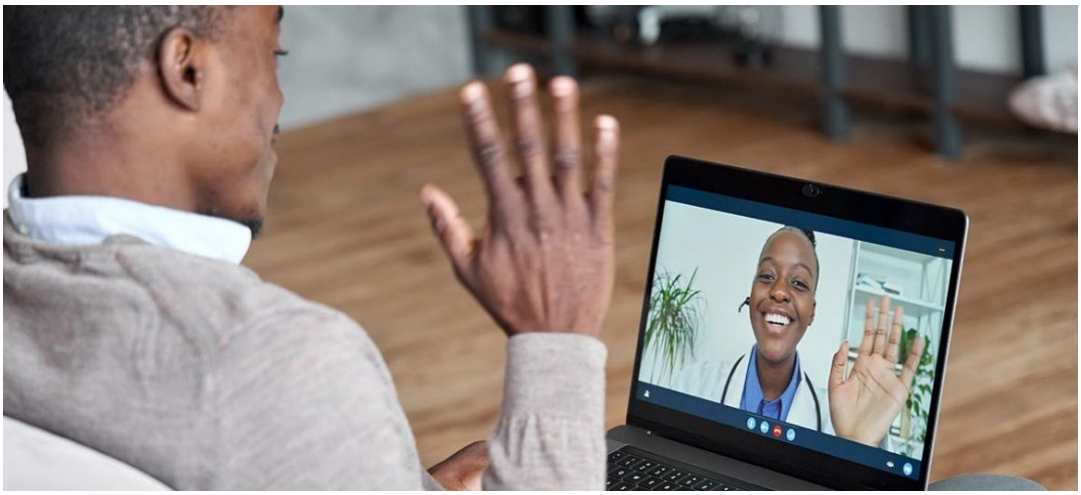
Health Coaching Services

Quality Insights offers no-cost health coaching for patients living with diabetes, prediabetes, or hypertension. With health coaching, patients will receive assistance with addressing modifiable determinants such as medication adherence, lifestyle modifications, goal-setting, self-monitoring, shared decision-making, and SDOH. Quality Insights will work with your practice to develop a health coaching workflow to best meet your practice and patient needs. Access Quality Insights' health coaching flyer for more information. Contact Ashley Biscardi or your current Practice Transformation Specialist to start this service.

Telemedicine: The Case for Advanced Team-Based Care

> *"The doctor-does-it-all mentality is no more sustainable in a telemedicine environment than it is in a traditional in-office practice model."*
>
> Source: Dr. Kevin Hopkins in *Challenges to Team-Based Care: COVID-19 and Beyond*, 2021.

The COVID-19 pandemic created an opportunity for rapid transition and deployment of telehealth. A February 2021 *Mayo Clinic Proceedings* article candidly suggests that while many perceive telemedicine was quickly and successfully implemented, "new subthemes, however, are emerging that offer an opportunity for a more nuanced view, including the importance of patient choice, appropriately matching encounter type to visit platform, acknowledging hazards associated with care delivered remotely, and adapting existing models of advanced team-based care with in-room support (aTBC) to the virtual environment" to avoid an unsafe "doctor-does-it-all" model.



In-Office vs. Telemedicine Advanced Team-Based Care

The following chart compares both in-office and telemedicine Advanced Team-Based Care (aTBC) workflow models and highlights the benefits of incorporating the aTBC workflow model in both working environments.

<table>
<tr><th colspan="3">Advanced Team-Based Care (aTBC) Workflow Examples</th></tr>
<tr><th>In-Office aTBC</th><th>Telemedicine aTBC
with Synchronous (Real-Time)
“In-Room” Support</th><th>Telemedicine aTBC
with Asynchronous
Support</th></tr>
<tr><td>Description: Two medical assistants (MAs) or nurses are paired with a physician and serve as navigators for the patient. During the office visit, the upskilled MA or nurse stays with the patient from the beginning to the end of each appointment.</td><td>Description: A video or phone visit with a nurse or MA present from start to finish of appointment.</td><td>Description: A nurse or MA present during pre-visit and sometimes also during post-visit.</td></tr>
<tr><td>Pre-visit: Nurse or MA performs agenda setting, medication review, care gap closure, updates the history, performs pre-charting, and obtains vital signs.</td><td>Pre-visit: Nurse or MA virtually rooms patient (agenda setting; medication reconciliation, care-gap closure; home vital signs; preliminary review of pre-visit lab results) and pre-charting, as appropriate.</td><td>Pre-visit: Nurse or MA virtually rooms patient (agenda setting, medication reconciliation, care gap closure, home vitals, pre-visit lab result preliminary review) and pre-charting, as appropriate. This may include pulling up a problem-focused template and drafting the majority of the visit documentation, along with pending the next appointment with pended pre-visit lab.</td></tr>
<tr><td>Visit: When the provider enters the room, the nurse or MA assists with retrieval of information and visit-note documentation, enters additional orders, and completes billing forms. All of this is completed in real time per provider direction.</td><td>Visit: Nurse or MA stays online, drafting visit note, pending orders and completing billing forms in real time, per provider direction.</td><td>Visit: Nurse or MA virtually hands off the patient to the physician for an appointment immediately to follow or the following day, and exits.</td></tr>
<tr><td colspan="2">Post-Visit: Nurse or MA reviews the visit and next steps with the patient, engages the patient in self-management support, as appropriate; and arranges for the next visit, along with specified pre-visit laboratory testing. The provider reviews and signs off on the note, orders, and billing information.</td><td>Post-Visit: The provider may modify the visit note documentation and orders, although much of the data entry is anticipated to be accomplished during pre-charting by the nurse or MA.</td></tr>
</table>

Benefits: • This model is associated with higher quality care, better documentation, increased access and productivity, and greater staff & physician satisfaction. • A case example documented 40% increase in revenue value unit-based productivity for a single provider. When model expanded to other family physicians, total practice productivity increased by 20%. • Quality metrics improved along with significant improvement in patient satisfaction scores as well as physician and support staff engagement and satisfaction.	**Benefits:** • This model increases staff engagement in patient care and frees the physician to give undivided attention to the patient because of the enhanced documentation and electronic health record (EHR) support. • For practices with less robust staffing, or limited experience with aTBC, enhanced virtual rooming by the MA or nurse, including setting up and starting documentation before physician involvement, still provides significant improvement in efficiency and a decrease in the burden of EHR work for the physician. • Care-gap closure, medication review, and updating of the medical history are examples of work that can be done during virtual rooming by the staff, even if they are unable to provide in-room support.

Adapted from "Telemedicine and Team-Based Care: The Perils and the Promise," by Sinsky et al., 2020.

Take the Next Step: Access additional resources to assist your telemedicine implementation journey:

- Telehealth for Chronic Conditions: HRSA created this best practice guide featuring topics that include getting started, developing a business plan and workflow, billing and payment, and disease management via telehealth.
- Quality Insights VLOG: Telehealth with Dr. Scott Lim: Hear from a PA-based dermatologist about his experience with telehealth during the COVID-19 pandemic.
- Eleven Telehealth Tweaks that Help Team-Based Care Flourish: This AMA article offers recommendations to lessen the risk of falling into an unsafe "doctor-does-it-all" model, help provide patient-centered care, and create an overall better telehealth experience for patient and physician.
- Turn to Telehealth Partner Toolkit: The digital telehealth toolkit from the U.S. Dept. of Health and Human Services assists providers by supplying ready-made, customizable content that can be shared with patients to build knowledge of, comfort with, and preparation for telehealth visits.
- Telehealth Implementation Playbook: Created by the AMA to assist clinicians with clinical integration of digital tools.
- Telehealth for Providers: What You Need to Know: In response to the increased use and expanded coverage of telehealth during the COVID-19 pandemic, CMS' From Coverage to Care (C2C) initiatives released new resources to support patients & providers in making the most of virtual care.
- Rural Telehealth Toolkit: Developed by the Rural Health Information Hub, this toolkit compiles evidence-based and promising models and resources to support organizations in identifying and implementing telehealth programs to address common challenges experienced in rural communities across the United States.

Putting it All Together: Care Team Success Models

Care Team in Action for Blood Pressure Control: Delaware Primary Care, LLC

The family practice of Delaware Primary Care, LLC in Dover, Delaware was recognized in 2020 as a Million Hearts® Hypertension Control Champion. As the first clinic in the state of Delaware to achieve this designation, the practice achieved successful outcomes by updating procedures to accommodate a care team approach and began offering hypertension education provided by Quality Insights. They also increased self-measured blood pressure (SMBP) utilization in their practice by loaning blood pressure 13 monitors to patients who were unable to purchase their own, thereby providing patients with an opportunity to better manage their blood pressure readings from home. Read more about this practice's journey to improved hypertension management in the November 2020 Quality Insights e-bulletin.

American Academy of Family Physicians: Myth-Busting Success Story

Team-Based Care: Do What You Do Best, a web page of According to the American Academy of Family Physicians (AAFP), shares that "effective team-based care looks different for different practices." Utilizing certain fundamentals, practices can create their own successful models given their practice size, staffing levels, and employee skill sets. Also discussed are some common myths that may affect staff and provider buy-in. In addition to sharing a brief description of the aspects of successful team-based care visit in Dr. Peter Anderson's office, the web page links to a *Family Practice Management* article that further details how Dr. Anderson's practice transformation improved the job satisfaction of nurses, quality of care, patient visit volume, and financial performance.

FQHC Success Story

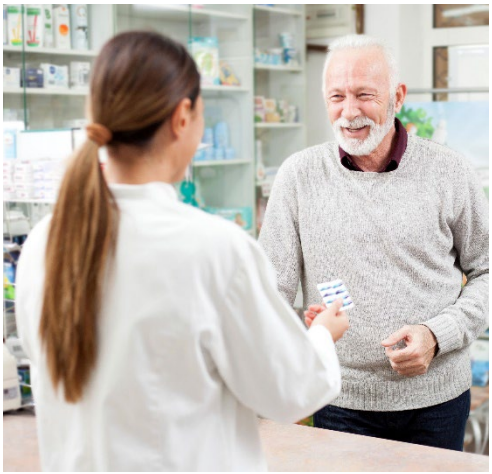
Read about Esperanza Health Centers' improved hypertension control rates in underserved populations. Their strategies for success included strengthening team-based care, promoting data transparency, and addressing social and cultural factors affecting patient health. The Esperanza Health Centers story is featured on the Million Hearts® website.

Podcast: Medication Therapy Management Program: A Pharmacist's Perspective

Quality Insights released a podcast in 2020 featuring Dr. Leslie Bawuah, a pharmacist who partners with Westside Family Health Care to offer patients medication management therapy (MTM). In this podcast, Dr. Bawuah gives her perspective on what MTM is and how it benefits patients. She provides insight into what an efficient workflow looks like between the pharmacist and medical providers. Dr. Bawuah is a true champion of this work and provides anecdotes and facts that help paint a picture of what MTM can offer to patients and practices. Click here to access the podcast.

Leveraging a Pharmacist for Diabetes Management: Providence Medical Group

A 2018 Scope of Practice feature from the AMA highlights Providence Medical Group in Oregon, where pharmacists have been part of the care team for more than 20 years. Some of the key ways they assist include helping with insulin treatment, virtual consults, and diabetes management.



According to Berg (2018), "Providence grew from one to 21 pharmacists in about 43 patient-centered medical homes. Many clinics have a full-time embedded pharmacist, while others share, depending on the size of the practice."

One of Providence Medical Group's practices was struggling to help a patient who was living with diabetes, an elevated A1C, and illiteracy. To overcome the patient's main barrier to care, illiteracy, the pharmacist created medication lists and diabetes tools featuring pictures. These resources enabled the patient to achieve blood sugar control within six months.

Visit the AMA website to learn more about the Providence Medical Group and the value of integrating a pharmacist in primary care.

Build Your Team: Additional Learning & Growth Opportunities

Quality Insights Team-Based Care Resources

Academic Detailing: Your care team can take advantage of academic detailing on the topics of diabetes prevention and management, cholesterol, and hypertension at **no cost** by signing up to participate. Contact your local Quality Insights Practice Transformation Specialist for more information.

EDISCO™ e-Learn Series: DPH and Quality Insights partnered to offer a series of e-learning courses to the practices, health systems, and federally qualified health systems in Delaware. Eleven courses are offered on demand and at no cost. Some of the courses offer continuing nursing education and continuing medical education credits. For additional information on each course and instructions for accessing them, visit Quality Insights' website. Feel free to print the e-learning course flyer and post it for your staff.

Practice Modules: Quality Insights develops electronic modules for participating practices to access on a variety of topics related to the management of blood pressure, diabetes prevention and control, cholesterol management, and social determinants of health. All of the modules support and promote team-based care and include specific interventions designed to help you achieve your quality improvement goals. Visit Quality Insights' website to review the modules.

AMA STEPS Forward® Team-Based Care and Workflow Toolkit

Review and learn about the actions needed to implement team-based care to save time, redistribute and share responsibilities with your team, and allow you to provide better and timelier care. Included in the AMA STEPS Forward® Team-Based Care and Workflow Toolkit are the recently updated *Saving Time Playbook* and several modules to assist organizations in reaching the aforementioned goals. The major themes discussed in the *Saving Time Playbook* include: stopping the unnecessary work, sharing the necessary work, and making the case to leadership.

Some of the associated toolkit modules include:

- Managing Type 2 Diabetes: A Team-Based Approach
- Patient Care Registries: Proactively Manage Chronic Conditions*
- Medication Adherence
- Medical Assistant Professional Development: Enhance the Skills and Roles of the Care Team*
- Team-Based Care
- Pre-Visit Planning: Save Time, Improve Care, and Strengthen Care Team Satisfaction*
- Pre-Visit Laboratory Testing: Save Time and Improve Care*

- Daily Team Huddles: Boost Productivity and Teamwork*
- Advanced Rooming and Discharging: Optimize Team-Based Visit Workflows*
- Team Meetings: Strengthen Relationships and Increase Productivity*
- Team Documentation: Improve Efficiency of EHR Documentation*
- Telemedicine and Team-Based Care: Improve Patient Care and Team Engagement by Using Team-Based Care in Telemedicine

*Continuing education credits are available.

Agency for Healthcare Research & Quality (AHRQ): Team-Based Care Resources

TeamSTEPPS® for Office-Based Care

TeamSTEPPS® is an evidence-based set of teamwork tools aimed at optimizing patient outcomes by improving communication and team skills among health care professionals. Access the full curriculum, and download the TeamSTEPPS® Pocket Guide App as a quick-reference tool.

White Paper: Creating Patient-Centered Team-Based Primary Care

This 2016 AHRQ white paper proposes a conceptual framework for the integration of team-based care and patient-centered care in primary care settings. It also offers some practical strategies to support the implementation of patient-centered team-based primary care. The conceptual framework emphasizes the importance of relationships as the foundation for high-quality, patient-centered team-based primary care. The strategies and resources are intended to help generate the culture, structure, and processes that support the development and maintenance of good relationships within teams and between teams and patients.

Interprofessional Primary Care eLearning Modules: Team-Based Care

Arizona State University's Interprofessional Primary Care Modules emphasize team-based decisions and skills required for primary care practice and the continuum of care. They provide tools and information regarding the implementation of team-based practices to enhance patient care and team performance. The standalone modules will be phased out this coming summer and replaced with a full eLearning course.

American College of Physicians: Team-Based Care Toolkit

The American College of Physicians (ACP) provides a toolkit the shares best practices and examples of successful models that have been implemented in internal medicine offices. The toolkit provides numerous resources to aid in the development of an effective team-based care model, and information

can be adapted to meet the needs of other types of provider offices. As your practice explores opportunities for growth and change, consider utilizing the appreciative inquiry approach, just one of the many suggestions located in the toolkit's resources.

National Academy of Medicine: Discussion Paper

The National Academy of Medicine's 2018 Discussion Paper, *Implementing Optimal Team-Based Care to Reduce Clinician Burnout*, encourages team-based care as a way to improve the experience of both the patient and the members of the care team as they work together in the prevention of disease, disease management, and health promotion. "A team-based model of care strives to meet patient needs and preferences by actively engaging patients as full participants in their care, while encouraging all health care professionals to function to the full extent of their education, certification, and experience" (Smith et al., 2018). The paper shares principles of high-performing teams and how to address digital, workforce, and payment barriers. Key takeaways include the importance of training, coaching, clear goals, effective communication, good leadership, and defined roles, both individual and shared.

Contact Quality Insights

If your practice would like additional guidance or information about team-based care, or needs help implementing new workflow processes, contact Ashley Biscardi or call **1.800.642.8686, ext. 137.**