# Care Teams Practice Module

## August 2021

### Implementation of Quality Improvement in Hypertension and Uncontrolled Diabetes

Quality Insights

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# Contents

## Purpose of Module

Quality Insights has 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 Quality Improvement in Hypertension and Uncontrolled Diabetes project, health care providers and staff are encouraged to review and implement the included resources as an actionable means of promoting and improving quality improvement initiatives.

***Note: Guidelines and recommendations referenced in this module are to be used along with physician/clinician judgment, treatment, and based on each individual patient's unique needs and circumstances.***

## Introduction

**Health care is changing at a rapid pace.** The presence of COVID-19, 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), highlights 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) defines team-based care as a collaborative system in which team members share responsibilities to achieve high quality patient care. In this model, physicians, nurses, nurse practitioners, physician assistants, pharmacists, community health workers, and/or medical assistants 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 care delivery."*
>
> - Agency for Healthcare Research and Quality (AHRQ), *Creating Patient-centered Team-based Primary Care*

## Key Features of High-Performing Teams

According to the American Hospital Association, the rapid pace of change in health care was significantly contributing to provider burnout even before COVID-19. While 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 American Hospital Association'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 demonstrating 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. |
| **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. |

Source: Smith, C. D., C. Balatbat, S. Corbridge, A. L. Dopp, J. Fried, R. Harter, S. Landefeld, C. Martin, F. Opelka, L. Sandy, L. Sato, and C. Sinsky. 2018. Implementing optimal team-based care to reduce clinician burnout. NAM Perspectives. Discussion Paper, National Academy of Medicine, Washington, DC. https://nam.edu/ implementing-optimal-team-based-care-to-reduceclinician-burnout. doi: 10.31478/201809c

**Take the Next Step:** Would you describe your practice as a high-functioning team? The Primary Care Team Guide offers practical resources and models to help leaders and staff deploy effective care teams to optimize patient care.

Click the links below to learn about:

- Building a Primary Care Team: Find out how expanding roles, increased training, and using standing orders can develop trust, teamwork, and efficiencies in your practice
- Identifying Your Practice Persona: Explore tailored strategies for approaching practices with specific issues
- Paying for Team-Based Care: Learn more about the business case for creating primary care teams

## Chronic Disease: Care Team Workflow Solutions and Interventions

**Team-based care complements value-based care because it's 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.

### Hypertension Management

Team-based care to improve blood pressure control is recommended by the Community Preventive Services Task Force on the basis of strong evidence of effectiveness in improving the proportion of patients with controlled blood pressure and reducing systolic and diastolic blood pressures.

**NEW Program: Healthy Heart Ambassador Blood Pressure Self-Monitoring Program**

Participants can partner with a specially trained health coach who will teach them simple yet proven ways to better manage and understand blood pressure, physical activity, healthier eating habits, and more.

Explore the details of this Centers for Disease Control and Prevention (CDC)-recommended program from the Delaware Division of Public Health, in partnership with the University of Delaware and Quality Insights.

**Recommended activities include:**

- 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

**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 *Promoting Team-Based Care to Improve High Blood Pressure Control*
- National Association of Community Health Centers (NACHC) SMBP Implementation Toolkit
- Target:BP™ Tools and Downloads
- SMBP Training Video: This educational video provides care team and patient training to properly self-measure blood pressure.


New Resource

Unify your care team around high blood pressure control and cardiovascular disease prevention by reviewing the March 2021 Quality Insights white paper, Team Up for Quality Care: The Role of Primary Care Teams in Prevention of Cardiovascular Disease.

## Cholesterol Management & Medication Adherence

A 2018 *Dovepress* journal article discussing the importance of cholesterol medication adherence noted that lipid-lowering medications are among the most commonly prescribed medications and have been associated with a 25 percent decrease in the risk of cardiovascular disease. However, adherence rates for statins, as with many other medications, remains less than optimal. Approximately 33 to 50 percent of patients discontinue statin medication within one year after treatment initiation, and consistency of use decreases over time. Estimated avoidable health care costs due to statin nonadherence may be greater than costs for hypertension and diabetes combined.

**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 that includes individual goal setting and exploration of barriers
- Training nursing staff to guide patients through the Statin Choice Decision Aid

## Prediabetes Management

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 latest Prediabetes Practice Module.

## Diabetes Management

The *American Diabetes Association (ADA) Standards of Medical Care in Diabetes--2021* 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.

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
- Identifying and addressing language, numeracy, or cultural barriers to care
- Integrating evidence-based guidelines and clinical information and tools into the process of 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 providers

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 percent reported thinking about the risk of hypoglycemia at least monthly, and 64 percent 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.

**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 potential to help people with prediabetes, diabetes, and related conditions by filling gaps between clinic visits with quality guidance.

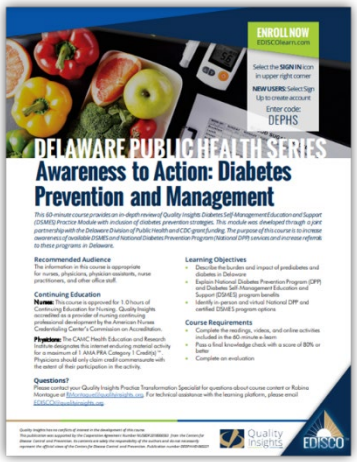
**Take the Next Step:** Access the following resources to learn how you can promote optimal diabetes care to the patients you serve through enhanced care team collaboration.

- 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 assessing health literacy, cultural competency, and language barriers. This module also provides information about delivering effective communication and links for patient education resources in a variety of languages.

## NEW CME/CE Course 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 you connected with your patients' progress. Join Quality Insights to discover available DSMES and National DPP services and learn how you can increase referrals to these programs in Delaware.




The *Awareness to Action: Diabetes Prevention and Management* e-learn was developed through a joint partnership with the Delaware Division of Public Health 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 pharmacists' roles and training have evolved to prepare them to provide clinical patient care services as part of multidisciplinary teams in primary care settings, specifically in regard to serving as a drug information resource for patients and staff while providing patient education on management of chronic disease states. This same feature cites that by the year 2032, there will be a shortage of 21,100 to 55,200 primary care physicians in the United States. Addressing this shortage requires a multipronged approach, including efficient use of health professionals on the care team. **Pharmacists are health professionals that can be utilized to ensure patients receive adequate care in primary care settings.**

**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.

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

**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 diabetes and/or cardiovascular disease with one of forty diabetes certified 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.
- 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.
- CME Course: AMA's Steps Forward™ module, *Embedding Pharmacists into the Practice*, offers assistance related to collaborating with pharmacists to improve patient outcomes.

**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. As a medical provider, you no doubt realize the challenges of medication adherence. 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 the Delaware Division of Public Health's implementation of quality improvement initiatives, we recently released a new e-course, **Medication Management Therapy: Evidence-Based Collaboration to Improve Blood Pressure Control**. Delaware health care providers have exclusive access to this CME-eligible course at **NO COST.**

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

# Social Determinants of Health: Care Team Workflow for PRAPARE Tool Utilization

The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences tool (PRAPARE) is a standardized patient social risk assessment tool consisting of a set of national core measures as well as a process for addressing social determinants of health (SDOH) at both the patient and population levels. By using PRAPARE, providers can better target clinical and non-clinical care to drive care transformation, delivery system integration, as well as improved health and cost reductions.

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
- PRAPARE Social Determinants of Health Screening: Sample Workflows
- PRAPARE Implementation and Action Toolkit (see chapter 5 for workflow implementation)

# Telemedicine: The Case for Advanced Team-Based Care

The COVID-19 pandemic created an opportunity for rapid transition and deployment of telehealth. A February 2021 *Mayo Clinic Proceedings* article candidly cites that while it was widely interpreted that telemedicine was broadly implemented, new subthemes 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 delivery 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.

> "The doctor-does-it-all mentality is no more sustainable in a telemedicine environment than it is in a traditional in-office practice model."
>
> *Quote from Kevin Hopkins, MD, Primary Care Medical Director for Cleveland Clinic Community Care, during an April 2021 AMA webinar, Challenges to Team-Based Care: COVID-19 and Beyond.*

## 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.

| Advanced Team-Based Care (aTBC) Workflow Examples | | |
|---|---|---|
| **In-Office aTBC** | **Telemedicine aTBC with Synchronous (Real-Time) "In-Room" Support** | **Telemedicine aTBC with Asynchronous Support** |
| **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. | **Description:** A video or phone visit with a nurse or MA present from start to finish of appointment. | **Description: A** nurse or MA present during pre-visit and sometimes also during post-visit. |
| **Pre-visit**: Nurse or MA performs agenda setting, medication review, care gap closure, updates the history, performs pre-charting, and obtains vital signs. | **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. | **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. |
| **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. | **Visit:** Nurse or MA stays online, drafting visit note, pending orders and completing billing forms in real time, per provider direction. | **Visit:** Nurse or MA virtually hands off the patient to the physician for an appointment immediately to follow or the following day, and exits. |
| **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. | | **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. |
| **Benefits:**<br>• This model is associated with higher-quality care, better documentation, increased access and productivity, and greater staff and physician satisfaction.<br>• A case example documented 40 percent increase in revenue value unit-based productivity for a single provider. When model expanded to other family physicians, total practice productivity increased by 20 percent.<br>• Quality metrics improved along with significant improvement in patient satisfaction scores as well as physician and support staff engagement and satisfaction. | **Benefits:**<br>• 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 EHR support.<br>• 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.<br>• 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. | |

Source: C. Sinsky, J. Jerzak, K. Hopkins. 2020. Telemedicine and Team-Based Care: The Perils and the Promise. Science Direct. Special Article, Implementing optimal team-based care to reduce clinician burnout. Mayo Clinic Proceedings. Special Article, Mayo Foundation for Medical Education and Research, Rochester, MN. https://www.sciencedirect.com/science/article/pii/S0025619620313793#bib2. https://doi.org/10.1016/j.mayocp.2020.11.020

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

- Quality Insights VLOG: Telehealth with Dr. Scott Lim: Hear from a Pennsylvania-based dermatologist and his experience with telehealth during the COVID-19 pandemic.
- Eleven Telehealth Tweaks that Help Team-Based Care Flourish: AMA article offering 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: Patient and provider partner organizations can communicate with their audiences on how telehealth keeps us connected and increases access to health care. The digital telehealth toolkit from the U.S. Department of Health and Human Services includes downloadable sample newsletter articles and social media content, tip sheets, graphics and animation, web badges, and other resources.
- Telehealth Implementation Playbook: Created by the AMA to assist clinicians with clinical integration of digital tools.
- C2C Telehealth Resources: In response to the increased use and expanded coverage of telehealth during the COVID-19 pandemic, the Centers for Medicare and Medicaid Services (CMS) From Coverage to Care (C2C) released new resources to support patients and 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. Additional field examples of successful implementation of SMBP can be found by visiting the CDC's Self-Measured Blood Pressure Monitoring with Clinical Support website.

## Esperanza Health Center Relies on Empowered Care Teams for Underserved Populations

**The Challenge**

Esperanza Health Centers is a Federally Qualified Health Center (FQHC) in Chicago, Illinois, that cares for more than 23,000 patients, with the largest age group being between 18 and 44-years-old. Patients are from a largely Spanish-speaking and immigrant demographic.

One of the biggest barriers to hypertension control for Esperanza's patients is the cost of medications and related supplies, such as blood pressure monitors. More than three out of four patients are at or below 100 percent of the poverty level, and nearly half are uninsured. Prevalence of diabetes, obesity, and dyslipidemia is high, as is the prevalence of behavioral health conditions such as depression and anxiety.

**The Solution**

Esperanza addresses social and cultural barriers for its patients through financial resources, self-management education, and continual follow-ups. Esperanza also emphasizes hypertension control protocols and the benefits of control by focusing on data transparency and strengthening its team-based care practices. **As a result, Esperanza raised its control rate from 75 percent in 2016 to 82 percent in 2019.**

Esperanza's hypertension control success was based on several specific strategies designed to enhance team-based care, promote data transparency, and address social and cultural factors affecting patient health. Visit the Million Hearts® website to learn more.

## 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 is through helping with insulin treatment, virtual consults, and diabetes management.

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 practice with Providence Medical Group was struggling to help a patient living with diabetes get their hemoglobin A1c below 11 percent. The patient's health literacy posed a barrier to care. To help, the pharmacist created medication lists and diabetes tools with pictures. Within six months of working with the pharmacist, the patient's levels were in control.

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 and hypertension at **NO COST** by signing up to participate. Contact your local Quality Insights Practice Transformation Specialist for more information.

**EDISCO™ Online Continuing Education Courses:** Quality Insights and the Delaware Division of Public Health have partnered to provide a series of interactive and engaging e-learning courses to the practices, health systems, and federally qualified health systems in Delaware. Currently, nine courses are being offered to our participating practices **at NO COST through June 30, 2022**. Some e-learns offer continuing medical education (CME) and nursing contact hour credits. Visit Quality Insights website to learn more.

**Practice Modules**: Quality Insights develops electronic modules for participating practices to access on a variety of topics related to management of blood pressure, cholesterol, diabetes prevention and control. All of these module 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 these modules.

## AMA STEPS Forward™ Team-Based Care and Workflow Modules

Review and learn about what actions are 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.

Some of the featured CME-eligible modules include:

- Managing Type 2 Diabetes: A Team Approach
- Patient Care Registries
- Medication Adherence
- Medical Assistant Professional Development
- Team-Based Care
- Optimizing Space
- Daily Team Huddles
- Team Meetings
- Team Documentation
- Team-Based Care in Resident Clinics

## 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/or 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: 1) Proposes a conceptual framework for the integration of team-based care and patient-centered care in primary care settings; and 2) 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.

**Arizona State University: Interprofessional Primary Care eLearning Modules: Team-Based Care**

The Interprofessional Primary Care Modules emphasize team-based decisions and skills required for current and evolving primary care practice and continuum-based care. They provide up-to-date information and tools for team-based practices central to high quality health care, including care coordination and integrated care, team decision-making, and habits of high-performing teams.

## Contact Quality Insights

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