

2019
Team-Based Care Best
Practices for Patients with
Chronic Conditions



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Introduction

Patients with chronic conditions often see multiple providers, have complex treatments plans, and require regular testing to manage their condition. The team-based care (TBC) model has proven to be successful in treating patients with complex healthcare needs. Primary care providers are increasingly unable to manage their average panel of patients by themselves, which has amplified the need for patient care coordination supported by a health care team.

TBC best practices for patients with chronic conditions is a comprehensive model of health care services delivered by two or more health professionals working collaboratively along with the patient, family caregivers and community resource providers to support shared patient treatment goals across clinical/community settings to achieve safe outcomes, effective, patient-centered and equitable care¹. TBC interventions typically include activities to facilitate communication and coordination among various team members, enhance the use of evidence-based guidelines, establish regular follow-up mechanisms to monitor treatment and management progress, and actively engage patients in their own care by providing them with education about medication, adherence support, and tools for self-management.²

Background

Chronic diseases are the leading cause of death and disability nationally, accounting for seven out of every ten deaths in the United States. In 2018, one of three deaths in the nation was due to cardiovascular disease (CVD). In addition, one in every three adults in the United States has high blood pressure, and approximately 50% of those adults do not have the condition under control.³ To address these alarming national trends, efforts are being developed by health professionals to incorporate patient-centered chronic care management models to better serve patients through effective teamwork. A team-based care model contributes to patient wellness through the active coordination and communication among care team members. New models for patient care teams are central in efforts to redesign health care delivery and improve care for patients with chronic disease. This TBC best practice protocol is designed to increase team member collaboration, expand support for patients, and improve patient adherence to treatments and self-management.

Purpose

In 2018, the California Department of Public Health (CDPH), Center for Healthy Communities (CHC), Chronic Disease Control Branch (CDCB), launched a Centers for Disease Control and Prevention initiative called Prevention Forward with the goal of prevention and management of chronic diseases including diabetes and CVD. Prevention Forward will support statewide coordination for chronic condition improvement by increasing the use of a team-based care approach in California health systems.

The 2019 Team-Based Care Best Practices for Patients with Chronic Conditions resource is designed to reduce death and disability due to diabetes, heart disease and stroke by addressing the leading risk factors that contribute to these diseases. Specifically, this protocol includes best practices and strategies that promote health and reinforce healthful behaviors, support healthy

lifestyles, encourage interventions that improve healthcare delivery, and implement community-clinical linkages.

Team-Based Care Model Best Practices for Patients with Chronic Conditions

The TBC model has proven to be successful in treating patients with complex healthcare needs. Moreover, no primary care provider can manage an average panel of patients by him or herself. According to researchers, a typical primary care provider with an average size panel would need more than 18 hours per day to provide preventive and chronic care to their panel of patients. This does not even account for urgent care, which is the most common reason for people to seek medical care.^{4, 5}

Current and projected shortages of primary care providers, increasing demand for primary care following the Patient Protection and Affordable Care Act, and the increasing burden of care being placed on primary care make it essential to “share the care”⁶ between primary care providers and extended care team members. Team-based care is defined as the provision of comprehensive health services to individuals, families, and/or their communities. Services are delivered by at least two health professionals who work collaboratively along with patients, family caregivers, and community service providers on shared goals within and across settings to achieve care that is safe, effective, patient-centered, timely, efficient, and equitable.⁷

Team-based care interventions typically include activities to:

- Facilitate communication and coordination of care support among various team members.
- Enhance use of evidence-based guidelines by team members.
- Establish regular, structured follow-up mechanisms to monitor patients' progress and schedule additional visits as needed.
- Actively engage patients in their own care by providing them with education about medication, adherence support (for medication and other treatments), and tools and resources for self-management (including health behavior change).

Documented benefits of the team-based care approach:

- Team members interact more closely, which encourages trust and cooperation among them.
- Lower burnout⁸ of provider staff.
- Each patient benefits from the combined skills of the team, in that needs that might not be recognized in the functional system may be identified in a team environment. Patients are more satisfied.
- Ideally, a team model recognizes and uses the different skill levels of each team member.⁹
- Help organizations pursue the Triple Aim, a framework developed by the Institute of Healthcare Improvement that describes an approach to optimizing health system performance, including, improving patient experience of healthcare (quality and satisfaction), improving the health of populations, and reducing per capita costs. For example, an optimized care team will provide the expertise and resources (tools and time) to jointly plan and customize care and provide support for individuals and families to better manage their own health. By redesigning primary care services and structures to work

effectively and efficiently on prevention, health promotion, and chronic disease management, outcomes and the care experience can be achieved in a cost-effective way.¹⁰

Attributes of an optimized care team

In a 2015 study performed by Thomas Bodenheimer, team-based care was observed in order to understand characteristics of high performing care practices.

Site visits were conducted at 29 high-performing primary-care practices. Observations made in these practices were summarized for common elements exhibited by care teams. A limited literature search was done to review corroborating evidence. Care teams observed in the 29 practices were found to exhibit nine elements: a stable team structure, colocation, a culture shift in progress from physician-driven to team-based care, defined roles with training and skill checks to reinforce those roles, standing orders and protocols, defined workflows and workflow mapping, staffing ratios adequate to facilitate new roles, ground rules, and modes of communication, including team meetings, huddles, and minute-to-minute interaction.¹¹

- Each organization has to understand the types of services it provides, then decide how the work should be divided among the care team to “supply” those services. This approach begins with understanding the population base and the chronic and acute care needs of the patients.¹² For which patient populations will care teams be deployed?
- Once the needs of the patient population are captured then a care team may be assembled. Composition of a care team may include: physicians, physician assistants, nurses, dieticians, pharmacists, support staff, patient specialists, social workers, health coaches, community health workers (CHW), and nonclinical staff (peer counselors and receptionists).
- Each care team member should be assigned roles that are appropriate and consistent with the highest level of their expertise and ability.
- Other methods to optimize the care team include using standard protocols, cross-training staff, using huddles to improve communication, and limiting interruptions.

Strategies for Providing Team-Based Care within Your Organization

Approach the development of a team-based care program from every level of the organization:

- Engage patients in setting practice-level procedures and policies—this process can help to build a shared understanding of patient-centered team-based care among patients and providers. Among other topics, practices can seek patient input on:
 - How all members of the patient-centered care team should function and communicate to best serve patients' needs.
 - What patients need and want to know about patient-centered team-based care (and the best ways to share this information).
 - Ideas for maintaining and strengthening patients' relationships with providers as a practice transitions to team-based care.
- Achieve buy-in from leadership. Engaging leadership in developing and reinforcing guiding principles can foster the adoption of the principles throughout the organization.

- Use the philosophy to guide decision-making. When making decisions about changes to care design and delivery, practices can assess how well proposed changes align with their philosophy and patient preferences.

Prepare providers to apply the practice's philosophy of TBC in clinical encounters.

- In addition to an organizational commitment to patient-centeredness, a patient-centered approach to team-based care requires provider team members to: regard patients as important partners in care, take steps to foster relationships with patients, commit to seeking out each patient's needs and preferences, listen to patients' input, and work closely with patients to ensure that the team is responsive to their expressed needs when delivering care.
- Viewing patients as partners in decision-making and seeking and responding to patient input can be new to some providers who are accustomed to being solely responsible for determining the best course of action for patients (and some patients may still prefer that type of relationship).

Create the practice-level infrastructure needed to support ongoing learning and improvement of team-based care.

- Ensure proactive support from leadership.
- Define and track measurable and specific goals related to providing team-based care.
- Provide access to an Electronic Health Record for all team members for improved integration and information sharing.¹²

Leverage existing resources to assemble high performing teams.

Promote the care team as an identifiable and well-functioning entity to patients.

- In this model, patients feel known and cared for by the whole team over time. Developing the identity of the provider team, so that the team looks and feels like a coherent entity to patients, is an important stepping stone for building smooth and continuous team relationships with patients.

An Institute of Medicine of the National Academies published discussion paper is an additional resource to guide the optimization of care teams.¹³ The paper features “core principles that embody ‘teamness.’” The authors go on to describe each principle and how each plays out in team environments. The principles are listed below:

- **Shared goals:** The team—including the patient and, where appropriate, family members or other support persons—works to establish shared goals that reflect patient and family priorities, and can be clearly articulated, understood, and supported by all team members.
- **Clear roles:** There are clear expectations for each team member’s functions, responsibilities, and accountabilities, which optimize the team’s efficiency and often make it possible for the team to take advantage of division of labor, thereby accomplishing more than the sum of its parts.
- **Mutual trust:** Team members earn each other’s trust, creating strong norms of reciprocity and greater opportunities for shared achievement.

- **Effective communication:** The team prioritizes and continuously refines its communication skills. It has consistent channels for candid and complete communication, which are accessed and used by all team members across all settings.
- **Measurable processes and outcomes:** The team agrees on and implements reliable and timely feedback on successes and failures in both the functioning of the team and achievement of the team’s goals. These are used to track and improve performance immediately and over time.

Sustainability

Non-physician team members, such as Community Health Workers (CHWs), can provide much needed support to provider organizations utilizing a team-based methodology. Non-physicians can take on expanded roles that include patient engagement and advocacy, health education, and care management. CHWs can play a critical role in providing services to patients between clinical visits such as healthy eating education and outreach.

A major challenge of this approach is finding a “financing mechanism” to sustain continued support. The following paper outlines strategies for and provides examples of state Medicaid financing of non-clinician services in fee-for-service, managed care, medical home or health home, and accountable care organization (ACO) settings: <http://www.astho.org/Community-Health-Workers/CHW-Certification-Financing/>

Resources

The following resources are available as evidence of effective strategies and to help primary care practices build high-functioning teams.

<http://primarycare.imedpub.com/building-high-functioning-clinical-teams-through-quality-improvement-initiatives.pdf>

https://chs.asu.edu/sites/default/files/3.6.18_creating_high_functioning_teams_in_primary_care_leap.pdf

https://www.integration.samhsa.gov/about-us/High_Functioning_Teams_Kickoff_Webinar.pdf

[CVD: Community Health Workers | The Community Guide](#)

Additional Reading

Resource	URL
Center for Primary Care Excellence, University of California San Francisco	http://cepc.ucsf.edu
The MacColl Center for Health Care Innovation	http://improvingprimarycare.org/
The Cambridge Health Alliance	http://www.integration.samhsa.gov/workforce/team-members/Cambridge_Health_Alliance_Team-Based_Care_Toolkit.pdf
AHRQ's TeamSTEPPS® for Primary Care	http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/primarycare/
The Safety Net Medical Home Initiative	http://www.safetynetmedicalhome.org/
National Academy for State Health Policy, Strategies for Supporting Expanded Roles for Non-Clinicians on Primary Care	https://nashp.org/strategies-support-expanded-roles-non-clinicians-primary-care-teams-two-state/

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