Team-Based Care:
A Chronic Disease Management Strategy

June 6, 2019 | 12:00 – 1:00PM

Wisconsin
Heart Health
Community of Practice

Team-Based Care:
A Chronic Disease Management Strategy

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Co-Hosts

Ashley Green, MetaStar
Rebecca Thompson, Wisconsin Community Health Fund

Team-Based Care – Strategy Overview

BACKGROUND

Team-based care (TBC) is an **evidence-based approach incorporating an inter-disciplinary team** to deliver services to improve blood pressure control, HTN identification, and HTN management. TBC approaches **incorporate interventions to support medication management, self-management of blood pressure, care coordination, medication adherence, lifestyle change, home visits or phone follow-up services**. Community-clinical linkages play a critical role in improving HTN and cholesterol management. Wisconsin is working to **build linkages between health systems, public health departments, providers, clinicians, pharmacists, care coordinators, community resources and programs (i.e. YMCAs), businesses, faith communities, and other local organizations** in creating a comprehensive team-based system of care.

STRATEGY OVERVIEW: We envision optimal health for all Wisconsin communities with improved heart health and controlled HTN and cholesterol outcomes. TBC approaches encourage public health, health systems, hospitals, and other sectors to focus and coordinate collective actions to prevent, detect and control HTN. This is accomplished through **joint education and screening in multiple settings**, greater emphasis on the health risks of uncontrolled HTN and high blood cholesterol, **targeted outreach, heart health promotion with lifestyle modifications**.

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TBC Wisconsin Survey – 2016

Survey Partners – DHS, WNA, WCHQ - 50 hospitals, 500 clinics, and 3 million patients

Benefits & Successes of Team-Based Care [Collected from interviews]

Below highlights the successes and benefits of implementing team-based care that were identified from the health system interviews. The bold/bulleted are themes, and the non-bold/after colon are examples of what the themes are comprised of. Most frequent themes listed first.

- Staff or Team Satisfaction: Increased clinical and non-clinical staff satisfaction, collaboration, improved relationships
- Patient Outcomes/Quality Metrics: Improved patient health outcomes, transparency understood by entire team
- Patient Care/Satisfaction/Access: Decreased wait time, increased level of respect and trust from patient, "one stop shop", patient surrounded by a team that can help
- Communication: Improved communication within the health care team and with the patient
- Screenings/Lab: More comprehensive and timely tests accomplished, increased number of preventative tests
- Top-of-License Practice: Further education and training provided, additional or advanced credentialing achieved ("growing" the staff)
- Interprofessional Collaboration: Workgroups, interaction, and communication established or enhanced among multidisciplinary health professionals

CDC 1815 TBC Grant Goals

Improving the Health of Americans Through Prevention and Management of Diabetes and Heart Disease and Stroke – CDC-RFA-DP18-1815PPHF18

	Required Strategies	Outcomes		
		Short-term (1-2 years)	Intermediate (2-4 years)	Long-term (5+ years)
Category A: Diabetes Prevention and Management	**Diabetes Management:** Improve care and management of people with diabetes	Increased access to and coverage for ADA-recognized/AADE-accredited diabetes self-management education and support programs for people with diabetes Increased use of pharmacists patient care processes that promote medication management for people with diabetes	Increased participation in ADA-recognized/AADE-accredited diabetes self-management education and support programs for people with diabetes	Decreased proportion of people with diabetes with an A1C >9
	Type 2 Diabetes Prevention: Improve access to, participation in, and coverage for the National Diabetes Prevention Program (DPP) lifestyle change program for people with pre-diabetes, particularly in underserved areas	Increased access to and coverage for the National DPP lifestyle change program for people with prediabetes Increased community clinical links that facilitate referrals and provide support to enroll and retain participants in the National DPP lifestyle change program	Increased enrollment and retention in a CDC-recognized organizations delivering the National DPP lifestyle change program	Increased number of people with prediabetes enrolled in a CDC-recognized lifestyle change program who have achieved 5-7% weight loss
Category B: Cardiovascular Disease Prevention and Management	**Track and Monitor Clinical Measures** shown to improve healthcare quality and identify patients with hypertension	Increased reporting, monitoring, and tracking of clinical data for improved identification, management, and treatment of patients with high blood pressure and high blood cholesterol	Increased medication adherence among patients with high blood pressure and high blood cholesterol	
	Implement Team-Based Care for patients with high blood pressure and high blood cholesterol	Increased use of and adherence to evidence-based guidelines and policies related to team-based care for patients with high blood pressure and high blood cholesterol	Increased engagement in self-management among patients with high blood pressure and high blood cholesterol	Increased control among adults with known high blood pressure and high blood cholesterol
	Link Community Resources and Clinical Services that support systematic referrals, self-management, and lifestyle change for patients with high blood pressure and high blood cholesterol	Increased community clinical links that support systematic referrals, self-management, and lifestyle change for patients with high blood pressure and high blood cholesterol	Increased participation in evidence-based lifestyle interventions among patients with high blood pressure and high blood cholesterol	

Speakers

Dr. Christopher Tashjian
Vibrant Health Family Clinic
Ellsworth, WI

Holly Nannis, RN
Director of Community Health Advancement
Sixteenth Street Community Health Center
Milwaukee, WI

Wisconsin Heart Health Community of Practice

Questions

- A description of the system and members the collaborative care team
- What works – How TBC has evolved the patient health experience and experience for the respective team?
- Heart Health – How has TBC improved heart health statistics and experiences within the clinic?
- Next steps – How do you envision the work evolving?
- Recommendations for groups who want to get started

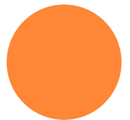
Combining Teamwork and Protocols for Measurably Improved Care

Christopher Tashjian, MD, FAAFP, Million Hearts Fellow

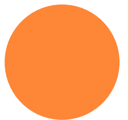
Wisconsin Heart Health Community of Practice
June 6th, 2019

Participants in this Sharing Call will:

- Understand criteria for an effective team; how to build it and sustain it
- Learn how a team-based care model can help physicians/clinicians succeed in the current MIPS and prepare for the Quality Payment Program.
- Identify impact of team-based care on provider ROI



Our Team



EMR Implementation Example

Mike Gonzoles Gender: M DOB: 01/04/1954 MRN: 00000673 FIN: 948847744990 Visit Reason: **Dyspnea/Chest Pain**

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Inpatient Summary

-A +A Collapse All Summary Menu Results

Patient Information

Room/Bed:	3-18/1
Admitting Diagnosis:	Congestive Heart Failure (428.0)
Admit Date:	06/20/2009
Primary Physician:	Angela Brown, MD
Emergency Contact:	Carol Gonzoles
Emergency #:	(913) 123-4455
Code Status:	**Full Code**

Diagnosis (4) Active

- Acute Renal Failure (584.9)
- Congestive Cardiomyopathy (425.9)
- Congestive Heart Failure (428.0)
- Unstable Angina (411.1)

Problems (8) Active

- Alcoholism (303.90)
- Diabetes (249)
- Esophageal Reflux (530.81)
- Esophageal Varices (456.1)
- Hepatic Artery Embolism (902.22)
- Hypertension (997.91)
- Peripheral Vascular Disease (443.9)
- Site-specific Disorder of Skin (709.9)

Allergies (3) Active

	Reaction
ACE Inhibitors	**Lips Swelling**
Peanuts	**Rash**
Dust	Sneezing

Medications (15) Active

Scheduled (5)

Vitals Last 10 days

	Latest	within	Since 06/23 07:00 Min / Max	Previous 24 hours Min / Max
Temp. degC	↑39	15 min	↑36.5/39	37/37.5
Systolic BP mm/Hg	120	15 min	↑120/190	120/120
Diastolic BP mm/Hg	80	15 min	80/115	90/115
RR br/min	18	15 min	18/20	14/20
HR bpm	78	15 min	!60/78	72/76
O_2Sat %	99	15 min	↓90/97	99/99
Glu (POC) mg/dL	--	Ordered	81/110	↑90/170

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Measurements and Weights Last 14 days

	Latest	within	Previous	within	Change
Weight kg	90	1h	91.4	2d	**+1.4**
Height cm	180	2d	180	2d	**0**
BMI	24.4	2d	24.4	2d	**0**

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Intake and Output 06/22/09 09:00 - Current

	Since 06/23 07:00	Previous 24 hours
Total Fluid Intake mL	201.2	1.135
- IV mL	72.5	140
Total Urine Output mL	50	200.4
- Urine mL/kg/hr	0.28	0.625
Stools	0	2
Last Diet Order	2000 kcal 1...	NPO

Diagnostics (7) Last 10 days

	Latest	Status	Previous
EKG (1)			
EKG 12-lead	1 hr	Completed	3 mo
Chest/Abd XR (1)			

Labs Last 10 days

	Latest	within	Previous	within
WBC x10(3)/mcL	6.5	15 min	↓4.0	16 h
Hemoglobin gm/dL	15	15 min	15	16 h
Hematocrit %	45	15 min	45	16 h
Platelets x10(3)/mcL	250	15 min	280	16 h
Sodium mEq/L	↑145	15 min	140	16 h
Potassium mEq/dL	4.0	15 min	3.9	16 h
CO2 mm/Hg	38	15 min	37	16 h
Chloride mEq/L	100	15 min	99	16 h
Creatinine g/24hr	1.0	15 min	1.0	16 h
BUN mg/dL	↓6.0	15 min	8.0	16 h
Glucose mg/dL	↓60	15 min	80	16 h
Magnesium mg/dL	2.0	15 min	1.6	16 h
Phosphorus mg/dl	3.0	15 min	3.0	16 h
Calcium mg/dL	9.2	15 min	10.0	16 h
PT s	13.0	15 min	13	16 h
INR	1.0	15 min	1.0	16 h
PTT s	22	15 min	24	16 h
Troponin ng/mL	--	Ordered	0.3	5 h
CK-MB ng/mL	--	Ordered	2	5 h
CK	--	Ordered	2	5 h

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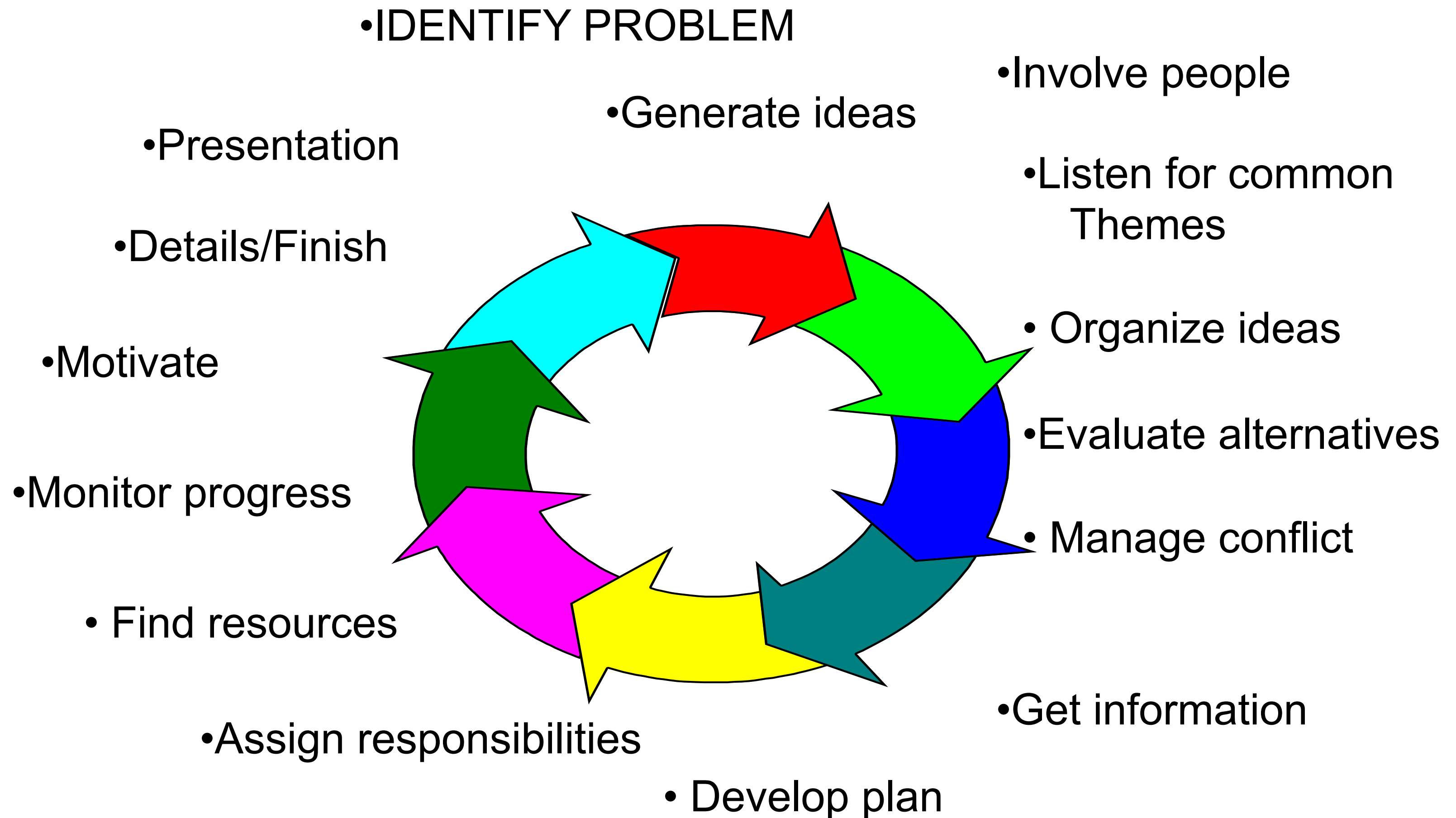
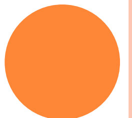
Team Problem Solving



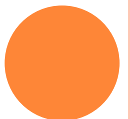
Team Roles:

- Initiating
- Seeking and Giving Information
- Clarifying
- Summarizing
- Consensus Taking
- Accountability



Attitudes for Effective Teamwork

- Appreciation for value of team decisions
- Respect for team members
- Mutual trust
- Openness to feedback
- Reflection on group process and interest in improving
- Shared vision



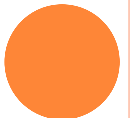
Vibrant Health
FAMILY CLINICS
POWERED BY HEALTH & WELLNESS

Using Protocols to Improve Care

- We changed our overall thinking from:
  - It's a physician problem

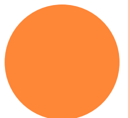
    To

  - It's a team challenge



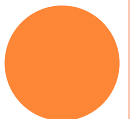
What does that mean?

- Physicians had to give up TOTAL ownership
- Staff had to be trained to understand the problem and implement protocols
  - Nurses
  - Lab
  - Care Co-ordinators
  - Front Office



Why Use Protocols?

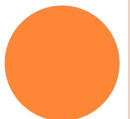
- It enables all procedures to be undertaken in a standard manner.
- It should lead to inter-operator independence, any member of staff should produce same/similar results, colorblind
- It enables all staff to perform titration safely without relying on memory.
- *Can allow for deviations from the accepted department procedure.*
- It enables audit procedure
- It prevents errors



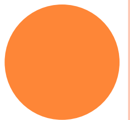
Types of Protocols

- Process Maps
- Titration

- Every visit is a hypertension visit!



Low Tech



New Idea

Date ________

Time ________

BP CHECK

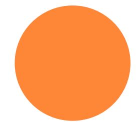
Patient Name ____________________

Date of Birth ________ Account # ________

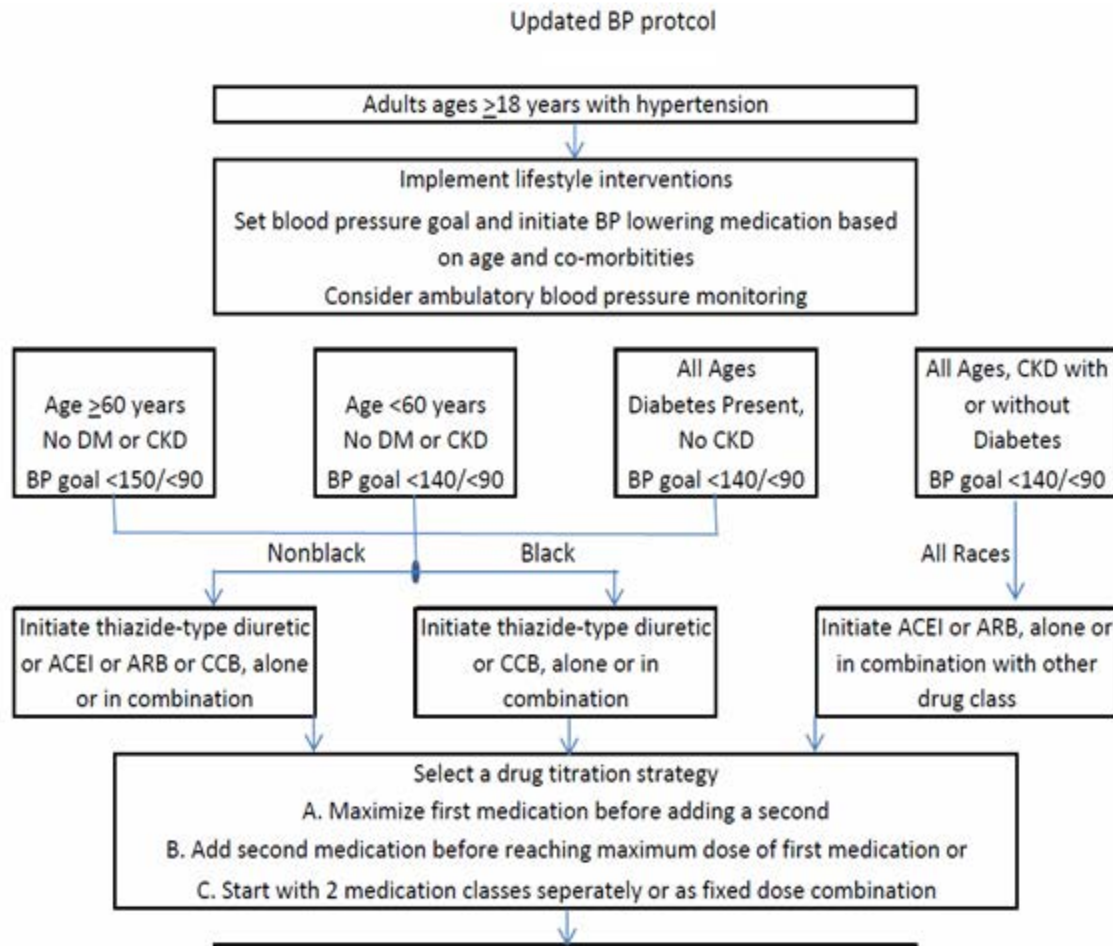
Health Care Provider ____________________

BP/recheck BP ____________________

RFMC-PA90973

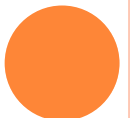


Titration Protocols



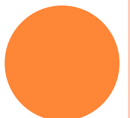
MONITORING PROTOCOL USE

- Care Coordinators review HTN patient panels on a monthly basis:
  - Identify patients who have elevated blood pressures, review record and discuss possible changes with the patient's HCP and with the patient.
  - Follow-up with patients who have had a medication changed or added.
  - Discuss medication compliance, tolerance, current BP readings, ensure labs completed if needed. If BP remains elevated-will communicate to HCP on additional titration needs based off of protocol
  - Educate the Clinical Staff on areas of improvement such as the need to recheck a patient's BP at every opportunity.
  - Graph, distribute and display data quarterly
  - Review data at Quality Leadership Meetings
  - Graph data over time twice per year to identify trends



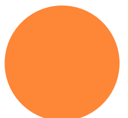
Life Style Changes

- Care Coordinators:
  - Health coaching
  - Patient goal setting
  - Trained in motivational interviewing
  - Discuss life style changes over the phone and when they meet with patients for blood pressure checks at office visits.
  - Review tools such as 2gm sodium guidelines provided by the American Dietetic Association
  - Review diet information provided by our diabetic educator/dietician.
    - Sample menus
  - Personalized HTN education uploaded in our EMR
    - How to measure your blood pressure?
    - What are your BP goals?



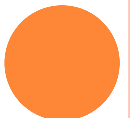
Uncontrolled Patient Management

- Care Coordinators:
  - Meet monthly with each HCP to review BP's that remain out of control.
  - Develop follow up plan including medication titration, follow up, dietician visit, increased contact with the patient between HCP visits, frequent BP checks and ongoing education.
  - Continue to work with patients via the phone, meet with the patient when here for HCP visits, identify patients not presenting for visits and making contact, assuring patients are in our reminder system, assure the entire patient care team is aware of the patients care plan



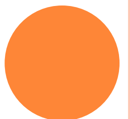
Implementation Strategies

- Strong Quality Leadership group to assist in development and implementation strategies
- Appoint a “provider champion” to lead implementation process
- Flow Chart or Process Map current practice then do it again with the new protocol. Create a visual map.
- Assure Providers and Clinical Staff have a clear understanding of the protocol and agreement to follow
- Staff education:
  - Review the protocol at staff meetings every month during implementation
  - Collect, publish, distribute and display data transparently
  - Skills Fair for staff



Blood Pressure Protocol Evidence

- Recommendations change
  - 150/90 for elderly at risk for hypotension sequelae
  - 120/80 for otherwise healthy patients
  - One size does not fit all
- Expect them to change again
- Protocols must be kept Up to Date

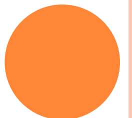


Titration Protocols

"If you fail to plan, you are planning to fail!"

Ben Franklin

Develop a plan and implement it.



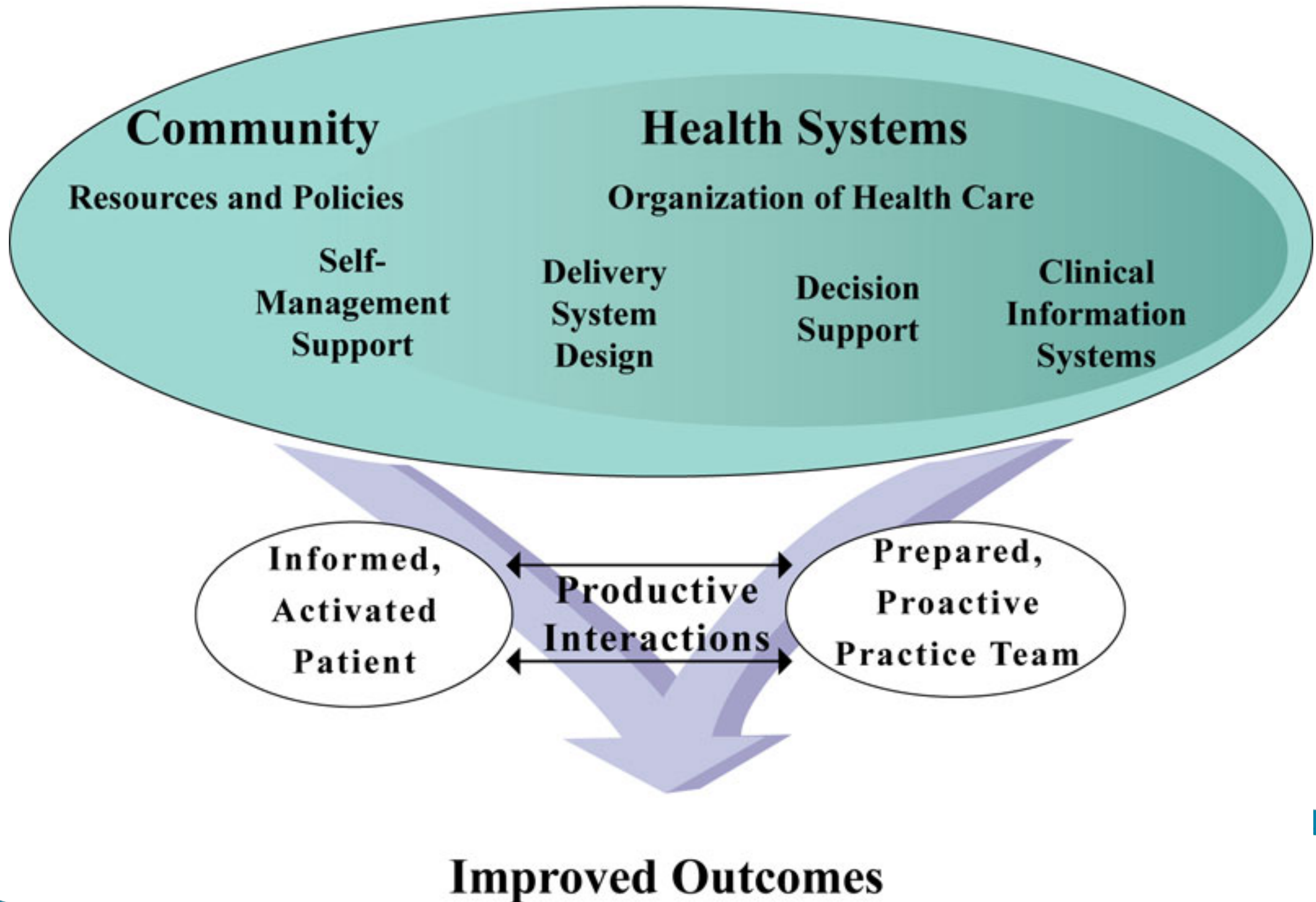
BE BOLD!

Do it as a Team … It's more fun!!

Wisconsin Heart Health Community of Practice Webinar

June 6,2019

Holly Nannis, RN
Director of Community Health Advancement
(Director of Chronic Conditions Health Education Program)
holly.nannis@sschc.org
414-897-5172


The Chronic Care Model
Community
Resources and Policies
Self-
Management
Support
Health Systems
Organization of Health Care
Delivery
System
Design
Decision
Support
Clinical
Information
Systems
Informed,
Activated
Patient
Productive
Interactions
Prepared,
Proactive
Practice Team
Improved Outcomes
Developed by The MacColl Institute
® ACP-ASIM Journals and Books

Team Composition

Health System

Prepared Practice Team: Provider, MA's, Pop Health, Educators

Information Systems/Decision Support: EHR data & encounters

Delivery System Design: EHR referral and education encounters

Self-Management Support: Educators, patient & families, tools

Community

Community Health Workers, healthy public policy, built environment, action groups, schools, businesses, partners

Pharmacies: Medication management, education, support

Sixteenth Street
COMMUNITY HEALTH CENTERS

Developed Blood Pressure Self-Management Education Encounter

Reason for visit | Translation or Learning Needs | Soc Hx | HPI | Diet | Blood Sugar | Barriers | Glucometer teaching | Basic DM Teaching 1 | Detailed DM Ed/Class | Insulin Teaching Adv 1 | Insulin Teaching Adv 2
Insulin Titration | Educational Outcomes | Plan & Goals | Self Management Goals | Self Management Goals 2 | Mandatory | B/P Education | B/P Education 2

Reason for Visit

- Y Blood Pressure Education
- Y Blood pressure screening
  - Y Full set of vital signs obtained and documented (Temp, wt, ht, BMI, BP)
  - Y Reviewed/compared current vitals against baseline. Document any wt change >4#'s in the last 6 months or other abnormals in text box

Education

- Y Patient Education - Hypertension
- Y Patient Education - Lifestyle Regarding Hypertension
- Y Patient Education - Low Salt Diet
- Y Maintain Healthy Diet
- Y Patient Education - DASH Diet
- Y Patient Education - Low Cholesterol Diet
- Y Patient Education Dietary Low Fat Cooking

Assessment

- Y Task Provider with results. Alert PCP or On-call provider if BP is > than 180/90. Be prepared to give this pt's usual baseline BP and why the pt is here for BP check. Also, is the pt complaining of any symptoms (Headache, blurred vision, chestpain/pressure, dizziness, etc.)
- Y Normal blood pressure (90-139 systolic, 60-89 diastolic)

Plan

- Y Follow-Up Visit to Rescreen Blood Pressure within 4 weeks
- Y Follow-Up Visit to Rescreen Blood Pressure within 1 year
- Y Follow-Up as scheduled, and prn
- Y Discussed with Provider:

Patient Goals

- Y Patient Goals - Maintain Normal Blood Pressure

Normal Blood Pressure
Less than 120 / Less than 80
No follow up required

Pre-Hypertension
Systolic more than 120, less than 139
Diastolic more than 80, less than 89

1. Rescreen within 12 months
2. Introduce following lifestyle modifications
   - Weight reduction
   - Dietary approached / Dash diet
   - Sodium reduction
   - Increased physical activity
   - Moderation in alcohol consumption
   - cease tobacco use
3. Referral to PCP
4. Offer nutrition appointment
5. Education on reducing risks; prevention

First and Second Hypertensive Reading
Systolic more than 140
Diastolic more than 90

1. Rescreen within 4 weeks
2. Introduce/ reinforce following lifestyle modifications
   - Weight reduction
   - Dietary approached / Dash diet
   - Sodium reduction
   - Increased physical activity
   - Moderation in alcohol consumption
   - cease tobacco use
3. Referral to PCP
4. Offer nutrition appointment
5. Education on reducing risks; prevention

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COMMUNITY HEALTH CENTERS

Blood Pressure Self-Management Education Encounter

Reason for visit | Translation or Learning Needs | Soc Hx | HPI | Diet | Blood Sugar | Barriers | Glucometer teaching | Basic DM Teaching 1 | Detailed DM Ed/Class | Insulin Teaching Adv 1 | Ins
Insulin Titration | Educational Outcomes | Plan & Goals | Self Management Goals | Self Management Goals 2 | Mandatory | B/P Education | B/P Education 2

How to take your B/P Education

Y N Functional Exam Use Of A Blood Pressure Machine

Make sure you're relaxed, sit in a chair with your feet flat on the floor with your back straight and suported

Don't smoke, exercise, drink caffeinated beverages or alcohol within 30 minutes of mesurament.

Rest in a chair for at least 5 minutes with your left arm resting comfortably on a flat surface at heart level, sit calmly and don't talk.

Use properly calibrated and validated instrument. Check the cuff size and fit.

Every time you measure, take 3 readings, separated by at least 1 minute and record all the results

Try to take readings in the early morning and evening

Y N Demonstrate Blood Pressure Technique

B/P Machine

Y Blood Pressure Device (Omrom)

Y Blood Pressure Device

Increased focus within Diabetes Education

Sixteenth Street

COMMUNITY HEALTH CENTERS

Blood Pressure Self-Management Education Encounter

test, test T.
11/11/2000 16y 2m F

Chart | Flowsheets | split | Note | Orders/Charges | OB Chart

CC Short Visit HTN with RosarioPet

Documents ? — All Providers ▾ — All Document Types ▾

Document	Date
[Patient Encounter] DeWaters, Mary E. D.O.	02/01/2017 In Progress
Blood Pressure Reading RosarioPeterson, Alba	02/01/2017 Archived
CC Short Visit HTN RosarioPeterson, Alba	02/01/2017 In Progress
M Correspondence DeWaters, Mary E. D.O.	02/01/2017 In Progress
CHOW Psych & BH Arana, Emilia L MD	01/27/2017 Archived
[Patient Encounter] Huang, Alina MD	01/25/2017 Archived
[Patient Encounter] Huang, Alina MD	01/25/2017 Archived
[Patient Encounter] Wilson, Pamela D. MD	01/25/2017 Archived
Consults Soboleski, Lisa M. PA	01/18/2017 Archived
Coumadin Flowsheet Cabral, Patricia MD	01/16/2017 Archived
aaWork Excuse Waters, David MD	01/13/2017 Archived

Forms
Last Form
Marker
Draw
Text
Vitals
Cite
E & M
Favorites
Prev. Enc.
Fam. Hx
Intake
Section
Save
Done
Print

Draft | Search | Outline | Preview

SSN:

Date: 02/01/2017 12:07
Provider: RosarioPeterson, Alba
Encounter: CC Short Visit HTN

REASON FOR VISIT

- Explanation of BP performed /Education

PHYSICAL FINDINGS

Musculoskeletal System:

Functional Exam:

General/bilateral: • Able to use a blood pressure machine Patient educated on proper techniques to monitor B/P at home.

THERAPY

- Demonstration of blood pressure performed Patient demonstrated proper B/P monitoring technique
- Follow-Up Visit to Rescreen Blood Pressure within 1 year.
- Blood pressure device Patient was given Omron blood pressure machine by the clinic.

Sixteenth Street
COMMUNITY HEALTH CENTERS

Patient #1 with Diabetes after Hypertension Self-management Education

Before 7 of 9 readings ≥ 140/90 (77%)

Date			Morning		Noon		Evening		Night	
Month	Day	Year	Systolic	Diastolic	Systolic	Diastolic	Systolic	Diastolic	Systolic	Diastolic
January	11	2017	122	88						
January	12	2017			126	86				
January	13	2017			135	91				
January	16	2017	131	91						
January	17	2017	131	87						
January	18	2017			141	97				
January	19	2017	139	97						
January	20	2017			139	92				
January	24	2017			146	98				

After 2 of 15 readings ≥ 140/90 (13%)

Date			Morning		Noon		Evening		Night	
Month	Day	Year	Systolic	Diastolic	Systolic	Diastolic	Systolic	Diastolic	Systolic	Diastolic
May	01	2017	109	76						
May	02		125	80						
	03		140	70						
	04		130	79						
	05		135	81						
	06		130	85						
	07		120	80						
	08		123	87						
	09		130	80						
	10		136	80			136	80		
	11		123	91						
	12		109	76						
	13		123	87						
	14		136	89						

Sixteenth Street
COMMUNITY HEALTH CENTERS

TBC KEY RESOURCES

- WNA Overview of Patient-Centered Team-Based Care (PCTBC)
- Wisconsin Collaborative for Healthcare Quality (WCHQ) Toolkits
- Wisconsin ASTHO work: Set Your Heart on Health: a toolkit for local health departments and communities
- The Community Guide, Community Preventive Services Task Force's Team-Based Care to Improve BP Control
- Million Hearts® Action Guides: Series for Clinicians, Public Health Practitioners, and Employers
- WCHF Take Heart Tote 2019

Wisconsin Heart Health Community of Practice

Coming Soon! **Team-Based Care Webinar – Take 2**

June 27th, 2019 | 12 – 1pm