Interdisciplinary Team Based Care: Tips for Effective Chronic Disease Care

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Objectives

- Review best practices in stratified solutions to meet the needs of a complex chronically ill population
- Discuss scripting and proactive communication as a solution to mitigate delayed pharmacologic intervention
- Discuss alternatives to traditional medical care delivery to close care gaps

Stratified Approaches to Chronic Disease Care

Step 1: Consider your population

- Are their obvious groups that can be looked at separately to ensure a best-fit solution? (i.e. Uncontrolled HTN patients on no agents, single agent, 2 or more agents)
- Review solutions that could be employed with each group

Step 2: Consider your Team

- Who do you have on your team?
- Can you allocate team members to different groups as to who will do the work? Try and only assign each team member to a single group.
- What strategies do you have for ensuring accountable practice? (i.e. Performance scorecards, dashboards, etc.)

Step 3: Think about evaluation

Role of the Medical Assistant

- Planned Care (things that are algorithmic and clearly supported by the evidence as only 1 way to accomplish the item; also think of how they may assist other team members to address what only they can do)
- Delegated Referrals (dietician, smoking cessation, BH, others)
- Panel Management/Care Gap closing

Medical Assistants: Planned Care Dashboard

Patient	PCP and Visit Info	
	Next Medical Appointment: 10/15/2021 10:40:00 AM New Britain Medical Last Dental Visit: Reason for Visit: "MD PCP Recall , fibromyalgia-860.827.9819-mn	

ALERTS	Last Date	Due Date	Value	Notes
Needs Flu Vaccine 2021-2022				
Breast Cancer Screening	3/11/2008	3/11/2009		
*** Colonoscopy Screening	Never Done	Never Done		
*** Cervical Cancer Screening	4/11/2007	4/11/2012		
HCV Screening Needed				Needs HCV Screen
HIV Screen Needed				Once,13-64 yrs old
SBIRT	8/8/2020			Yearly,18+ yrs old
*** Cardiovascular Statin Med				
Annual Chronic Pain Screening	8/8/2020	8/8/2021		If pos (most days/every day), administer PEG
PEG	8/8/2020			Chronic Pain Screen Response: Every Day
*** Quarterly PHQ-9	6/22/2011		15	
Covid Vaccine	4/2/2021		1 dose(s) done	

Bubbles	#
TE	
RX	
Doc	
Lab	3

Team Based Care: the visit

Appointment Facility: CHC of Middletown Medical

9/25/2017

Progress Notes:

Current Medications

Taking

- levothyroxine 125 mcg (0.125 mg) tablet 1 tab(s) orally once a day
- hydrochlorothiazide 25 mg tablet 1 tab(s) orally once a day
- Toprol XL 25 mg Tablet 24 Hour Sustained Release Take 1 tablet by mouth every day
- lisinopril 20 mg tablet 1 tab(s) orally once a day at night
- Calcium 600+D 600 mg-200 units tablet OTC orally 2 tabs daily

Not-Taking

- betamethasone topical valerate 0.1% lotion 1 app applied topically 2 times a day as needed
- hydrocortisone topical 2.5% cream 1 app applied topically 3 times a day as needed
- alclometasone topical 0.05% ointment 1 app applied topically 2 times a day

Discontinued

- methocarbamol 750 mg tablet 1 tab(s) orally twice a day as needed
- Mobic 15 mg Tablet Take 1 tablet by mouth once a day at bedtime
- Medication List reviewed and reconciled with the patient

Past Medical History

Hypertension

Hypothyroidism, h/o graves

Reason for Appointment

1. Pre-op surgery
2. Nutrition Education
3. HCV Screening Needed
4. Declined flu shot

History of Present Illness

Depression Screening:

PHQ-2 Little interest or pleasure in doing things **No**, Feeling down depressed or hopeless **No**.

Behavioral Health:

Substance Use Screening Questionnaire Do you sometimes drink alcoholic beverages? **No (Zero)**, How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons? **No (Zero)**, AUDIT SCORE: **0**, AUDIT Interpretation: **None/Mild Risk**, DAST SCORE: **0**, DAST Interpretation: **None/Mild Risk**, Follow-up care provided based on results below [select all that apply] **No action required based on results,Given brief intervention by MA less than 15 minutes.**

HITS:

How often does your partner: Physically hurt you: **Never (1)**, Insult or talk down to you: **Never (1)**, Threaten you with harm: **Never (1)**, Scream or curse at you: **Never (1)**, Total Score: **4**, Date Completed: **09/25/2017**.

General Cardiology:

Denies : chest pain. dyspnea on exertion. shortness of breath. leg edema.

1. consult requested by: Dr. Reardon.
2. reason for consult: pre-operative evaluation.
3. planned procedure: right TKR, for 10/2/17. fax to Alycis, 860 894 1887
4. procedure risk category: moderate.

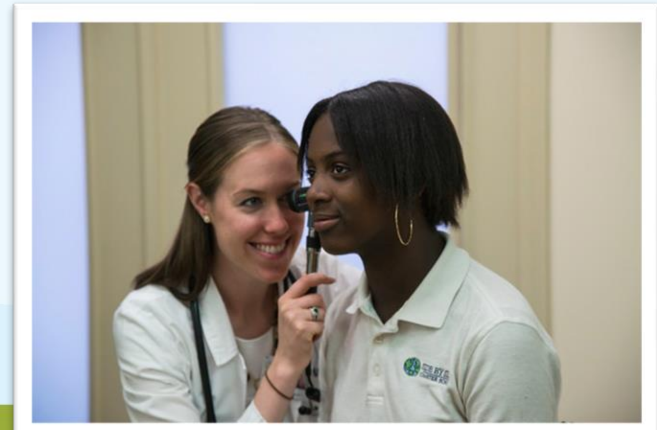
Content: Job Tools

PCD Item	Patient Population	How Often	What MA/LPN Does (or other clinical staff)
HTN	Patients 18+ with Hypertension	Every visit	• MA takes Blood Pressure and enters values into Vitals. If either systolic or diastolic are >=140/90, MA takes BP a second time 5 to 10 minutes later
CAD **(Orange if patient not getting right medication)**	Patients age 18 and older with a CAD or MI or who have had cardiac surgery on problem list Excludes: If last LDL < 130 or contra-indications to LDL lowering meds	Until medication is prescribed	• Document BP in Vitals **[MA]** • Note in chief complaint "CVD-risk add statin, if appropriate" for provider to follow up during visit **[MA]** • Adds current medication (statin) and/or documentation of contraindication **[Prov]**

RN Standing Orders and Delegated Order Sets

Standing orders: authorized by a licensed independent health care provider and authorizes the RN to address, assess, and treat specific conditions across specific populations of patients, with recognition that patients who present with exceptions to the norm are referred back to a health care provider.

Delegated order sets: established by a patient's PCP for a specific patient to be carried out by the RN in visits between the patient and the RN based on assessment criteria.



Role of the RN, Pharmacy, others…A stratified approach

Global Goals:

- **Do not tax any one team, but utilize every set of hands/feet to move rapidly in the desired direction**
- **Ensure every group gets attention and more specific intervention to increase impact**

Group 1 (no medications):

RN or Pharmacist (or both in a co-visit) assess BP in the office; rx cuff for SMBP via standing order, start medication for patient if applicable; schedule for virtual visit with the RN in 2 wks to confirm no issues with medication and also use of SMBP cuff; RN coordinates f/u with the PCP 2 weeks later.

Role of the RN, Pharmacy, others…A stratified approach

Group 2 (single agent):

MA works to get these individuals in the office with PCP for evaluation; ensures accurate BP with repeat; prompts in Chief Complaint: "PCP to add Second HTN Agent." PCP adds second agent, repeat BP check with the RN or PCP to ensure patient has achieved goal.

Group 3 (2+ agents, still uncontrolled):

Allow huddle time for centralized care manager to review the list and determine who may benefit for PCP management versus e-consult to cardiology/pharmacy/nephrology for HTN management. If PCP, then coordinate with the MA to schedule the visit; if in need of e-consult, complete referral. Consult note from e-consultant should be routed back to centralized care manager to implement strategies and coordinate f/u as needed with PCP.

Performance Appraisal Reviews: Clinical Scorecards

Medical Assistant Performance Appraisal Data: Agency and Site Averages with MA Rate for July 2017–June 2018

MA Name:________________________

Measure	Agency Average	Groton Average	Your Rate
Depression Screening	79.9%	82.4%	
Smoking Assessment	99.98%	100%	
Colon Cancer Screening	58.5%	63.3%	
A1c	83.92%	79.1%	
Literacy in Social History	60.78%	**42%**	
Initial appointments documented as Transition of Care Patients	44.56%	**67.2%**	
Chaperone for all Well Woman Visits	68.47%	65.5%	
SOGI	93.4%	**84.7%**	
SBIRT	69.9%	**61.2%**	
PEDS Screening	61.3%	**35.4%**	
HIV	77.0%	79.8%	
Child BMI Percentile	99.78%	99.3%	
Child Weight Education	88.3%	81.9%	
Asthma–ACT	86.9%	83.1%	
Adult BMI	97.96%	98.8%	
Adult Weight Education	66.27%	**77.9%**	
Chlamydia Screening	31.34%	25%	
Planned Care Dashboard			

Medical Assistant Performance Appraisal Data: Agency and Site Averages with MA Rate for July 2017–June 2018

MA Name:________________________

Measure	Agency Average	Meriden Average	Your Rate
Depression Screening	79.9%	83.4%	
Smoking Assessment	99.98%	100%	
Colon Cancer Screening	58.5%	60.6%	
A1c	83.92%	81%	
Literacy in Social History	60.78%	61.8%	
Initial appointments documented as Transition of Care Patients	44.56%	**69.6%**	
Chaperone for all Well Woman Visits	68.47%	**91.1%**	
SOGI	93.4%	98.1%	
SBIRT	69.9%	**77.9%**	
PEDS Screening	61.3%	68.3%	
HIV	77.0%	**81.6%**	
Child BMI Percentile	99.78%	99.3%	
Child Weight Education	88.3%	**97.7%**	
Asthma–ACT	86.9%	89.5%	
Adult BMI	97.96%	98.1%	
Adult Weight Education	66.27%	61.7%	
Chlamydia Screening	31.34%	33.8%	
Planned Care Dashboard			

Scorecard Key: **Green box** indicates the site average is statistically significantly higher than the agency average.
Red box indicates the site average is statistically significantly lower than the agency average.

Proactive Communication to Support Specific Interventions

Create Scripting and train teams to use specific asks when communicating with providers:

- Report what you have done:
  - "I sent the rx for the SMBP cuff, have started lifestyle modification with tobacco cessation, and also referred to an RD to begin work on salt reduction"
- Deliver specific language as to your ask:
  - For no meds: "Which medication(s) would you like to add?"
  - For single agent: "Which medication would you like to add?"
  - For 2+ agents: "Would you like to add a medication, or would you like me to coordinate an e-consult or referral to Cardiology?"

Using Data and the Interdisciplinary Care Team to Close Care Gaps

Agency Overview

BAM

Patients by City and Day

	Tuesday 4/5/2022	Wednesday 4/6/2022	Thursday 4/7/2022	Friday 4/8/2022	Saturday 4/9/2022	Monday 4/11/2022	Tuesday 4/12/2022
Danbury	_	2	1	_	_	2	1
Enfield	1	2	1	_	_	_	1
Groton	_	3	_	_	_	_	_
Hartford	8	23	_	3	_	15	6
Meriden Dental	33	21	22	20	_	21	15
Meriden Mental Health	8	10	9	4	_	6	6
Middletown	30	29	27	12	17	21	24
New Britain	42	58	31	28	5	34	34
New London	47	44	38	31	7	32	34
Norwalk	9	14	5	9	_	12	4
Stamford	10	13	13	14	_	13	6
Stamford Fifth Street	-	1	-	-	-	-	-
Waterbury	_	4	_	_	_	2	_

Using Data and the Interdisciplinary Care Team to Close Care Gaps

Patient	Provider and Visit Info	ALERTS	Last Date	Due Date	Value	Notes
Sex: F Age: 52.0	Middletown Dental Appointment: 4/5/2022 2:30:00 PM	Needs Flu Vaccine 2021-2022				
		DM Retinopathy	8/21/2018	8/21/2019		
		HTN	3/25/2022		146/93	
		Colon Cancer Screen (FOBT)	Never Done	Never Done		
		Micro Albumin	8/21/2018	8/21/2019		
		Quarterly PHQ-9				

Bubbles	#
TE	2
RX	
Doc	
Lab	1

Patient	Provider and Visit Info	ALERTS	Last Date	Due Date	Value	Notes
Sex: M Age: 51.0	Middletown Dental Appointment: 4/5/2022 3:30:00 PM	Needs Flu Vaccine 2021-2022				
		HTN	3/15/2022		137/92	
		Colon Cancer Screen (FOBT)	Never Done	Never Done		
		Depression Screening				

Potential Points of Friction

- Physical plant space for longer teaching sessions vs. use of the virtual environment
- Gatekeeping vs Top of license/training practice
- The art of medicine vs. evidence basis
- Duplicative work/duplication of efforts
- Feedback seen as punitive instead of routine
- Others?

Managing Culture

- Create an environment of team-based care that is based on the value of every role (not just as a downstream catchall to support providers)
- Focus on measurement in everything that you do
    - Normalize feedback and data as an invitation to partner and troubleshoot (Create a Measurement Culture)
- Embrace failure as just another data point on the way to a best practice
- Celebrate success (often!)

Questions?