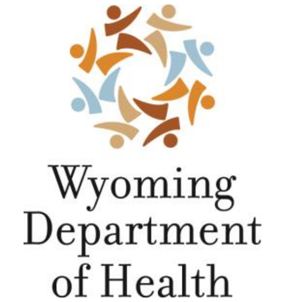
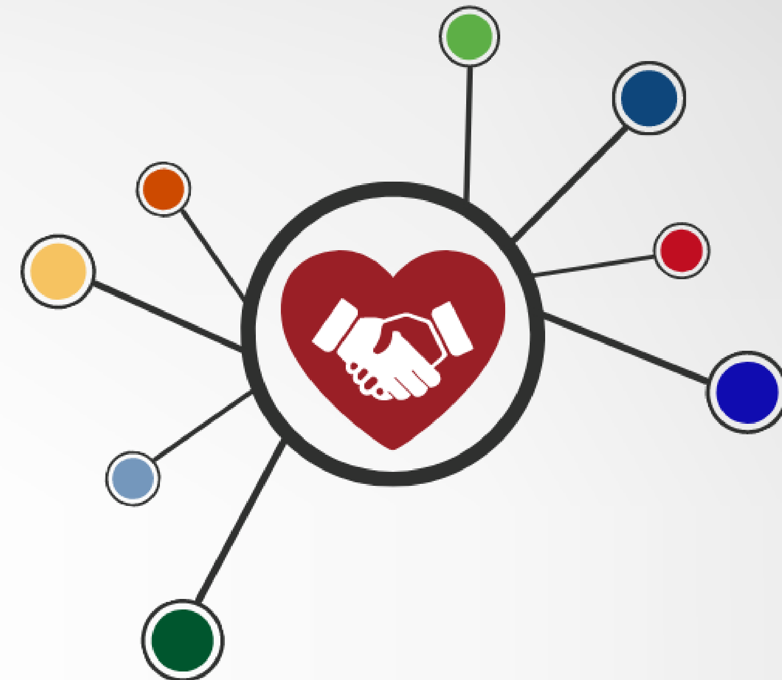



# Team-Based Care

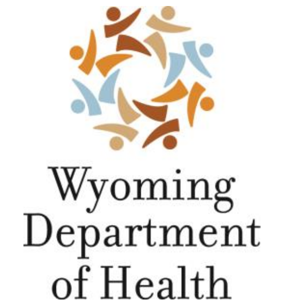
## Re-Establishing Team-Based Care Workflows: Creativity that Leads to Sustainability

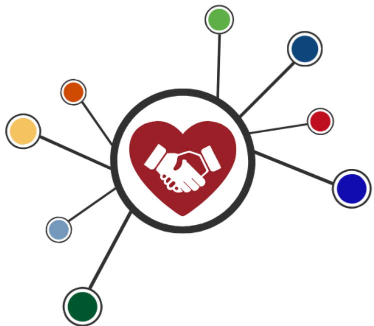
Regional Chronic Disease Collaborative

November 9, 2022

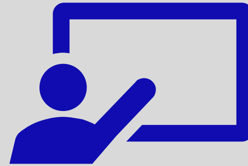


# Regional Chronic Disease Collaborative Partners

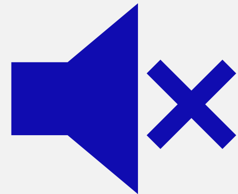


# Housekeeping

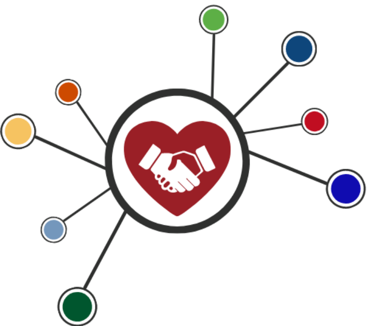


Be prepared to share.



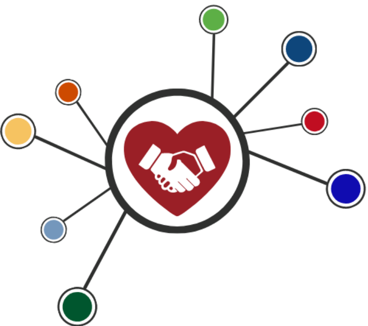
Mute microphone when not speaking.

Put your questions in chat.



# Agenda

- Team-based care (TBC) overview
- Key elements of TBC
- How to use TBC, Annual Wellness Visits (AWV), chronic care management (CCM) and transitional care management (TCM) for re-engagement
- Practice presenter – peer-to-peer sharing
- Strategies for adding value to TBC
- Leaving in action

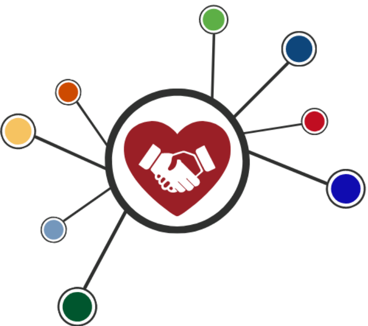


# TBC: Chronic Disease

**All patients benefit from team-based care approaches.**

**For patients with chronic conditions (diabetes, cardiovascular disease [CVD], etc.), team-based care approaches can greatly:**

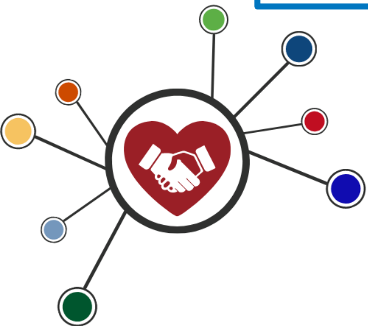
- Help patients self-manage
- Improve outcomes
- Reduce progression
- Improve patient experience



# Re-Engagement Objectives

Identify processes that can help re-engage patients in the treatment and management of their chronic conditions

Share examples of and provide strategies to re-engage your patients in their care



# Thank You, Wyoming Center on Aging

# Today's Presenter

## Faith Jones, MSN, RN, NEA-BC

Ms. Jones is the director of care coordination and lean consulting for HealthTech and is sponsored by Wyoming Center on Aging (WyCOA) for today's presentation.

She currently implements care coordination programs focusing on the Medicare population and teaches concepts related to care coordination and team-based approach to care nationally. She has held a variety of leadership positions in the profession of nursing having completed seven years of service on the American Nurses Association Board of Directors as a Director at Large and the Vice President.

She holds a certification from the American Nurses Credentialing Center (ANCC) as a nurse executive advanced, is a fellow of the American Nurses Advocacy Institute and the American Nurses Association Political Action Committee Leadership Society and is certified in advance care planning and lean for health care.

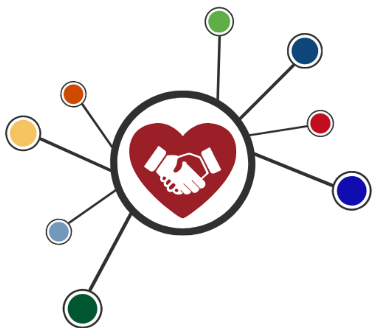
# Why

Better health for the population

Work-life improvements for those who deliver care

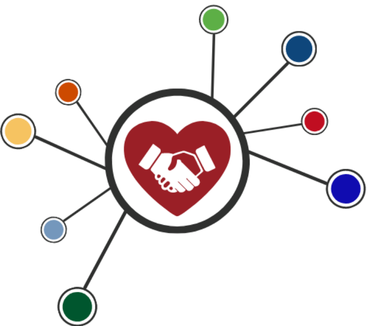
Lower costs through improvements

Better care for individuals



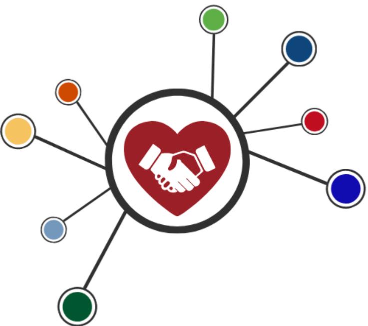
# Why do we need to re-engage?

| Disconnected | Re-Engagement |
| --- | --- |
| **Why** | **How** |
| ☐ Quarantine | ☐ Identify gaps in care |
| ☐ Fear of illness | ☐ Annual wellness visits |
| ☐ Unawareness of time | ☐ Follow-up on preventative plan |



# Key Elements

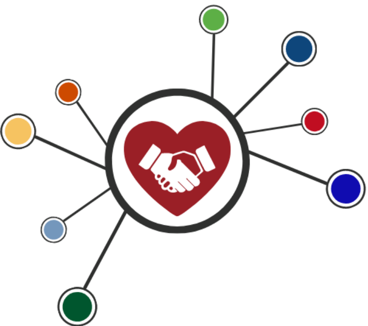
- Shared Goals
- Clear Roles
- Effective Communication
- Mutual Trust
- Measurable Process and Outcomes



Mitchell et al. 2012

# Who is on your team?

Patient
Family
Discharge Planners
Pharmacists
Physician
Medical Assistant
Social Worker
Nurse
Care Coordinator
Patient Care Tech
Community Resources



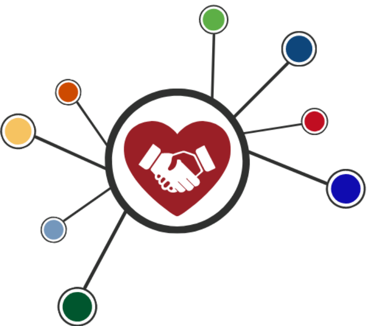
# Keeping the Team on the Same Page

## What Matters

- Shared goals
- Clear roles
- Effective communication
- Mutual trust
- Measurable process and outcomes

## What to Ask

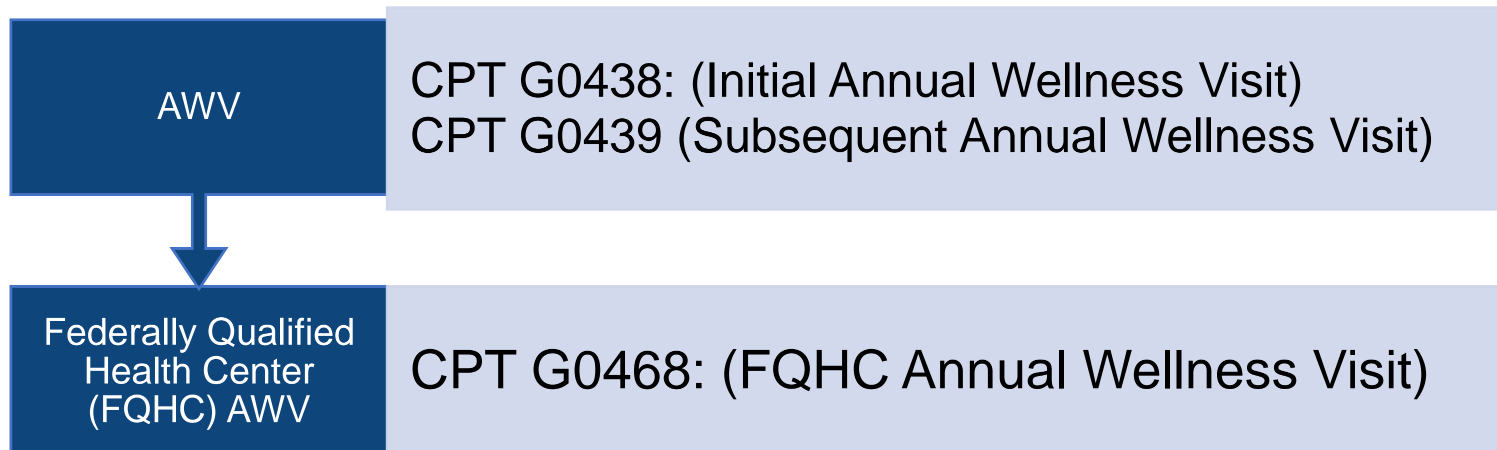
1. How are these communicated?
2. Do they change?
3. Is there a model?
4. Is there a philosophy of care?

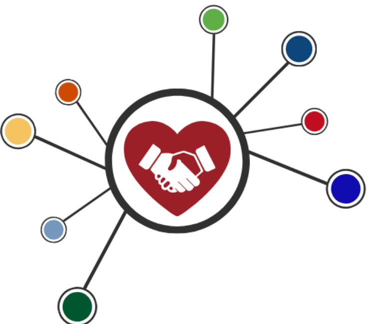


# Annual Wellness Visits

## Who is eligible to provide the AWV?

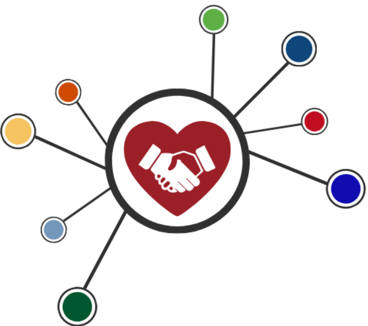
- A physician who is a doctor of medicine or osteopathy (as defined in section 1861(r)(1) of the Social Security Act (the Act); or,
- A physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5) of the Act); or,
- A **medical professional** (including a health educator, registered dietitian or nutrition professional or other licensed practitioner) or a team of such medical professionals, working under the direct supervision (as defined in CFR 410.32(b)(3)(ii))



# Team-Based Care for the AWV

- Shared goals – What is the goal of the AWV?
- Clear roles – Who is responsible for what part?
- Effective communication – How is the visit documented?
- Mutual trust – Where are decisions made?
- Measurable process and outcomes – What is measured?



Effective AWVs take 1 – 1 ½ hours

# Preventative Plan of Care (example)

Patient Name Ms. Beatrice Well    Chronic Conditions Diabetes and Hypertension    Date February 23, 2022

| January 2023 | February 2023 | March 2022 | April 2022 |
|---|---|---|---|
| Dietitian (MNT) | Annual Wellness Visit After February 23, 2023 | Bone Mass Measurement<br>Appt with Primary Care Provider<br>• Alcohol screening (15 min)<br>• Cardiovascular risk (15 min)<br>• Foot Exam<br>• Discuss Hep B Vaccine<br>• *Follow up* for Diabetes and hypertension (med refills – labs)<br>Diabetic Educator (DSMT) | Appt with Dr. Smith<br>Glaucoma check<br>Dietitian (MNT) |
| **May 2022** | **June 2022** | **July 2022** | **August 2022** |
| | Diabetic Educator (DSMT)<br>Mammogram | Dietitian (MNT) | |
| **September 2022** | **October 2022** | **November 2022** | **December 2022** |
| Appt with Primary Care Provider<br>• Depression screening<br>• Flu Shot<br>• *Follow up* for Diabetes and Hypertension (med refills and labs)<br>Diabetic Educator (DSMT) | Dietitian (MNT) | | Diabetic Educator (DSMT) |

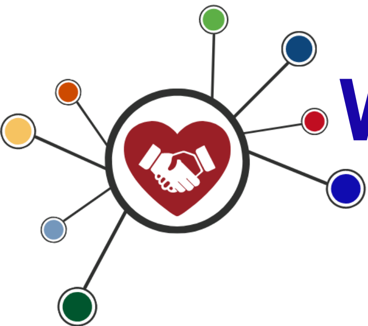
Screening to be done in the future: Pap and Pelvic until 2024 and Colonoscopy for 2025

*Goal: Increase exercise*    *Interventions: Find a walking buddy, Go to the rec center, participate in community walking program*

# AWV: Re-Engagement

**The foundation of all re-engagement is relationship!**

- Start with patients who you have an existing relationship with
  - Care Coordinated Patients
  - Transitional Care Patients

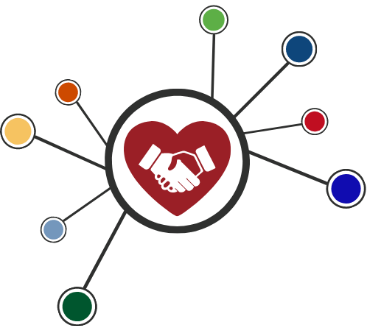


**Why? Relationship is the foundation of TRUST.**

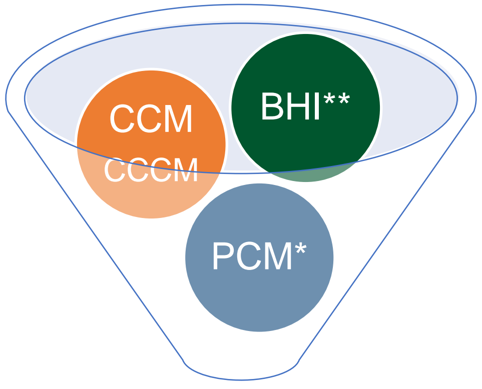
# Chronic Care Management

"We acknowledged that the care coordination included in services such as office visits **does not** always **describe adequately the non-face-to-face care management work involved in primary care** and may not reflect all the services and resources required to furnish comprehensive, coordinated care management for certain categories of beneficiaries"

Centers for Medicare & Medicaid Services (CMS) CFR 7-15-2015



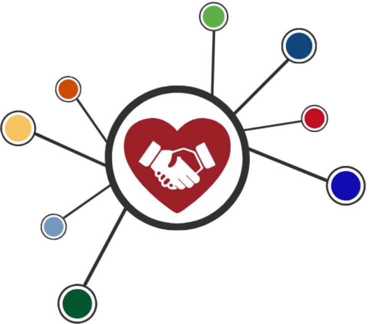
# Chronic Care Management




Care Management

FQHCs and Rural Health Clinics (RHCs)

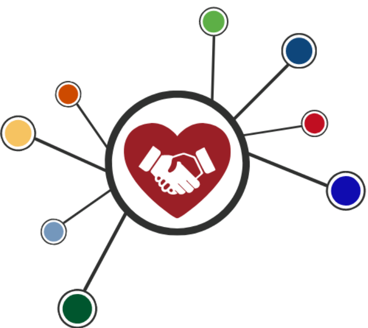
| CCM | CPT 99490: (at least 20 minutes of clinical time<br><br>CPT 99439: (additional 20 minutes of clinical time per month/max of two) |
|---|---|



**Behavioral Health Integration
*Principal Care Management
CCCM = complex chronic care management

# Team-Based Care for the CCM

- Shared goals – What is the goal of the CCM?
- Clear roles – Who is responsible for consenting, time tracking, etc.?
- Effective communication – How is the care coordination documented?
- Mutual trust – What care protocols do you have in place?
- Measurable process and outcomes – What is measured?



Every enrolled patient should receive care coordination EVERY month

# CCM: Re-Engagement

## Current Care Coordinated Patients

- Contact every month with PURPOSE
  - Have a reason to call
  - Continues to build the relationship

## Future Recruitment

- Connect with the discharge planning team
- Meet potential patients in hospital

**Why? Relationship is the foundation of TRUST.**

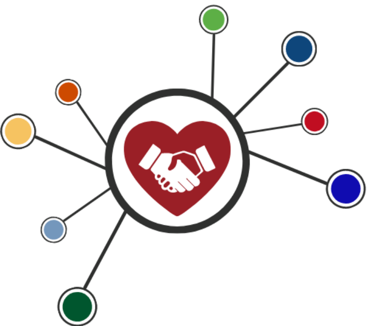
# Transitional Care Management (TCM)

The goal of TCM is to oversee management and coordination of services, as needed for all medical conditions, psychosocial needs and activity to support daily living.

| | |
|---|---|
| TCM | CPT 99495 (Moderate medical complexity and seen for a visit within 14 days of discharge) |

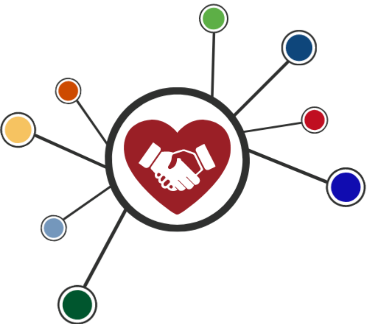
| | |
|---|---|
| TCM | CPT 99496: (High medical complexity AND seen for a visit within seven days of discharge) |

**For a Full 30 Days**



# Team-Based Care for the TCM

- Shared goals – What is the goal of the TCM?
- Clear roles – Who is responsible for scheduling the visit, the pre-visit planning, the 30 days of care coordination?
- Effective communication – How are the required elements documented?
- Mutual trust – What does the hand-off look like from facility to primary care provider?
- Measurable process and outcomes – What is measured?



## Time Sensitive Tasks

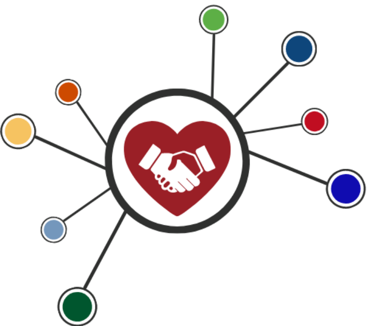
# TCM: Re-Engagement

Know your patient migration patterns

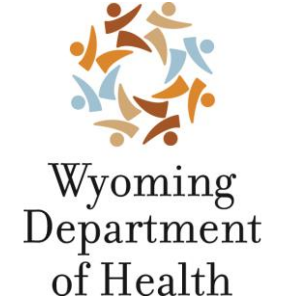
Connect with the discharge planning team

- At local hospital
- At the regional hospital
- At local skilled nursing facilities

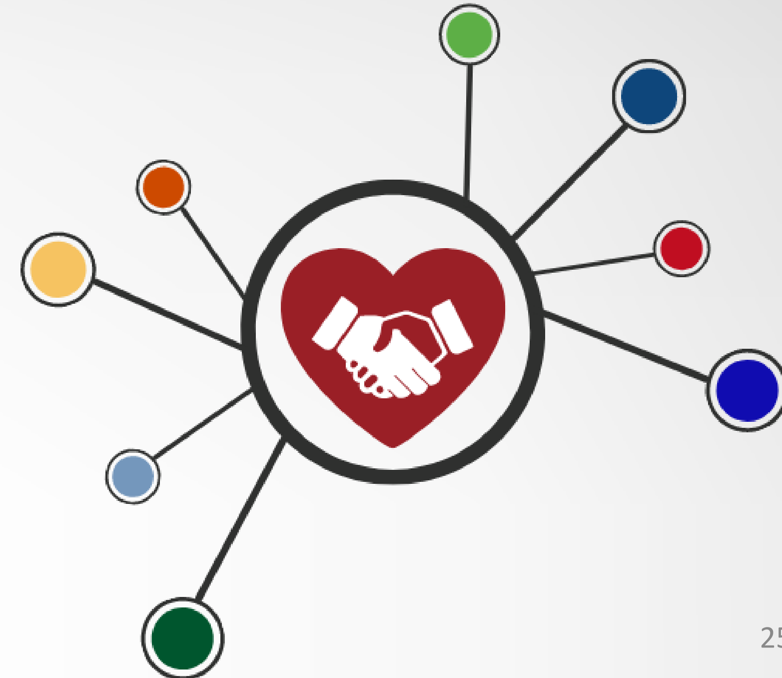
Work to manage warm handoffs



**Why? Relationship is the foundation of TRUST.**



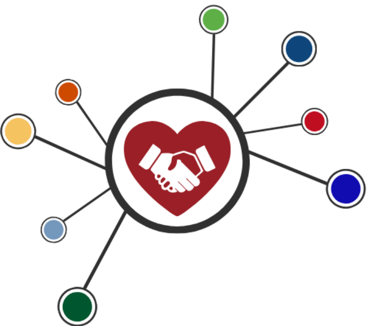

# Practice Presenters



# Practice Presenter

**Marcus Paske, PharmD, BCACP, AE-C, CPP**

- Ambulatory Clinical Pharmacist
- Intermountain Medical Group, Butte, Montana

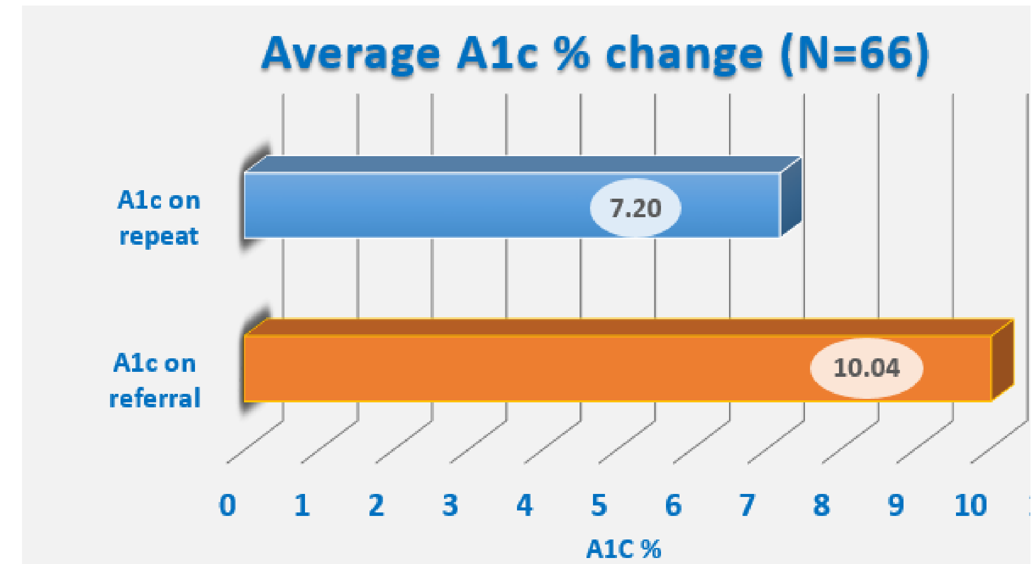


# Intermountain Medical Group: Primary CareTeam Based Approach to Type 2 Diabetes

*By: Marcus Paske, PharmD, BCACP- Clinical Pharmacist*

- **Purpose**: Improve disease control in patients with type 2 diabetes using team-based care approach with clinical pharmacy (new service) and Association of Diabetes Care & Education Specialists (ADCES) nurse
- **Methods**: Improve referrals by education, promotion, data presentation to primary care providers. Utilize new technology (continuous glucose monitor) to make service more robust.
- **Results: 127/172 (74%) of patients with A1c>9% (uncontrolled) referred to RN-CDE and/or PharmD**

**66 patients followed by PharmD with repeat A1c:**



# Intermountain Medical Group- Primary Care Team Based Approach to Type 2 Diabetes

*By: Marcus Paske, PharmD, BCACP- Clinical Pharmacist*

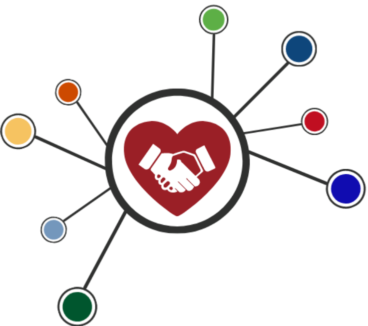
## Successes of team-based care and improved patient engagement

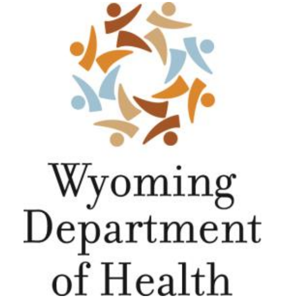
- Engaging primary care provider teams to utilize chronic disease management team and improve collaboration across the team.
- Offering tangible *NEW* service (CGM, specialty, medication class) to re-engage patients with barriers to care
- Remote care (telemedicine/phone) – closer follow up and check-ins, maintaining top of mind awareness
  - Accessibility: Phone and minimal wait time for appointment with clinical pharmacy
- Reinforcement of key interventions across the care team that are patient-centered
- Collaboration with care management
- Collaboration with outpatient pharmacies

# Practice Presenter

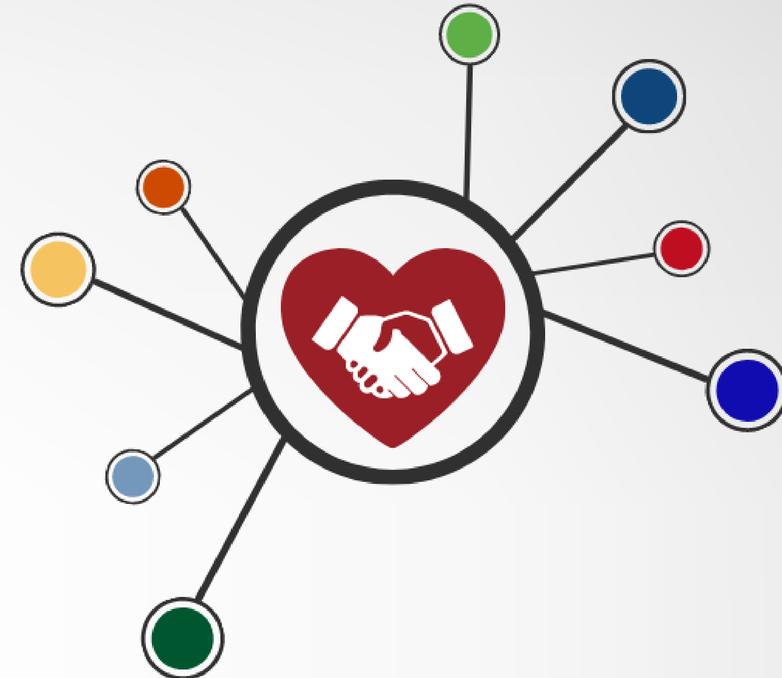
## Austin Mills

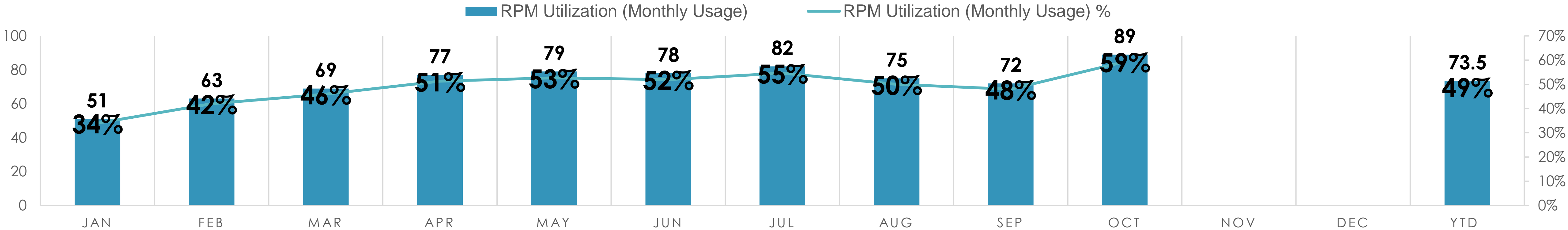
- Manager of Provider Practices Quality and Care Coordination
- Benefis Health Systems, Great Falls, Montana






# Remote Physiological Monitoring (RPM)





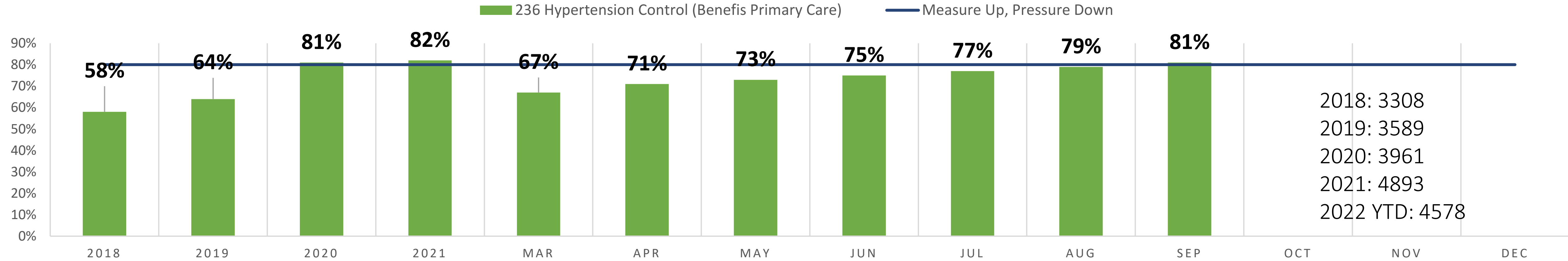

**Interventions**

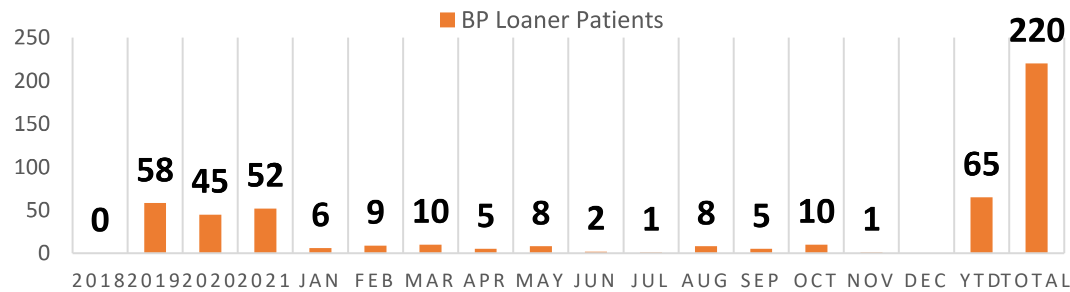
**11/2020** Trialed COVID Pathway with Employees
**12/31/2020** Started Diabetes Pilot 20 Patients enrolled in CCM
**2/2021** Added Hypertension pathway +GO App, for patients participating in our Primary Care Hypertension program.
**4/19/21** Started RPM w/ CHF Clinic
**8/1/2021**Added Hypertension: Gestational pathway for our Women's Health Department.
**8/1/2021** Added Total Joint Post-Op pathway to be available for same-day surgery.
**9/1/2021** Added Chronic Kidney Disease [CKD] pathway.
**10/5/21** Started RPM w/ CHF Clinic Hospital Discharges
**10/2021** Added COPD Pathway
**11/1/21** Hired RPM RN!
**12/1/2021** All Benefis providers to order RPM services from available pathways!
**1/2021** Updated COVID Pathway
**3/2022** Added CABG Pathway
**4/1/2022** Started Billing for Home Kits
**5/24/2022** Flipped kit pool so majority of kits on site do not have glucometer to reduce wasting DM supplies
**8/1/2022** Started Tracking Interventions: Medication Adjustment (Remote), Possible Avoidable ED Visit and Admission

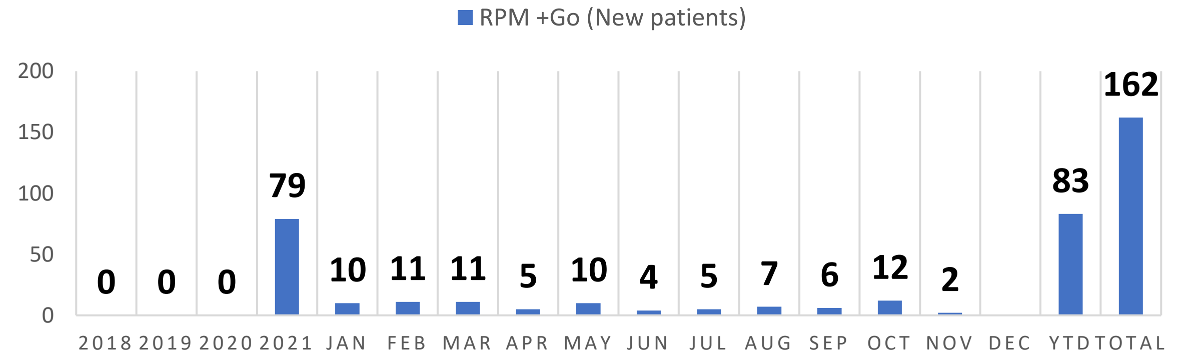
**Pathways Available:**

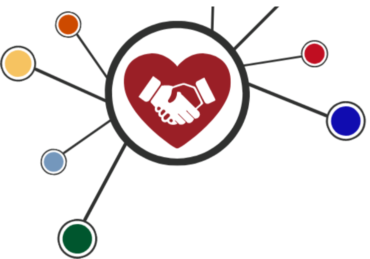
- Acute MI
- CABG (Post-Op)
- **CHF**
- CKD
- COPD
- COVID-19
- CVA
- Diabetes
- Gestational Diabetes
- **Gestational Hypertension**
- **Hypertension**
- Sepsis
- **Total Joint (Post-Op)**

# Primary Care Hypertension RPM



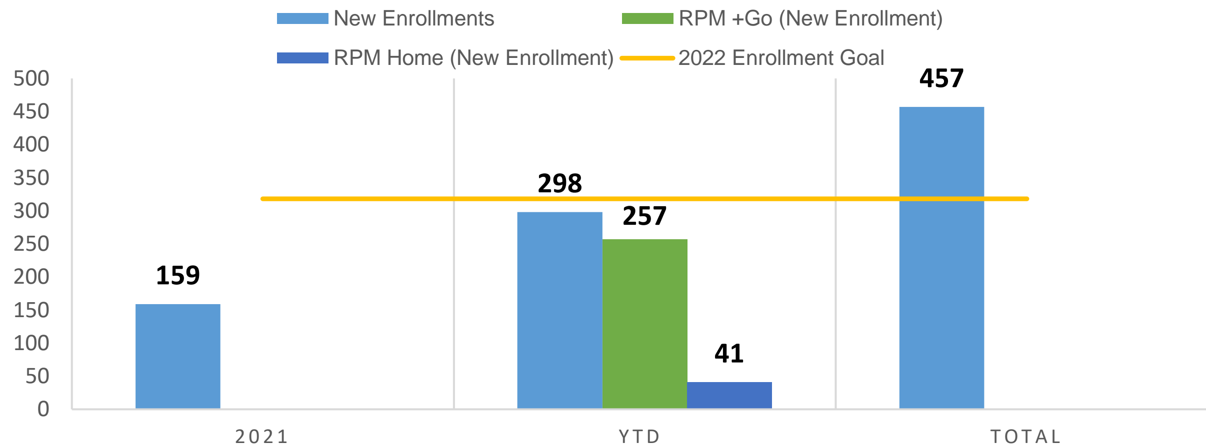



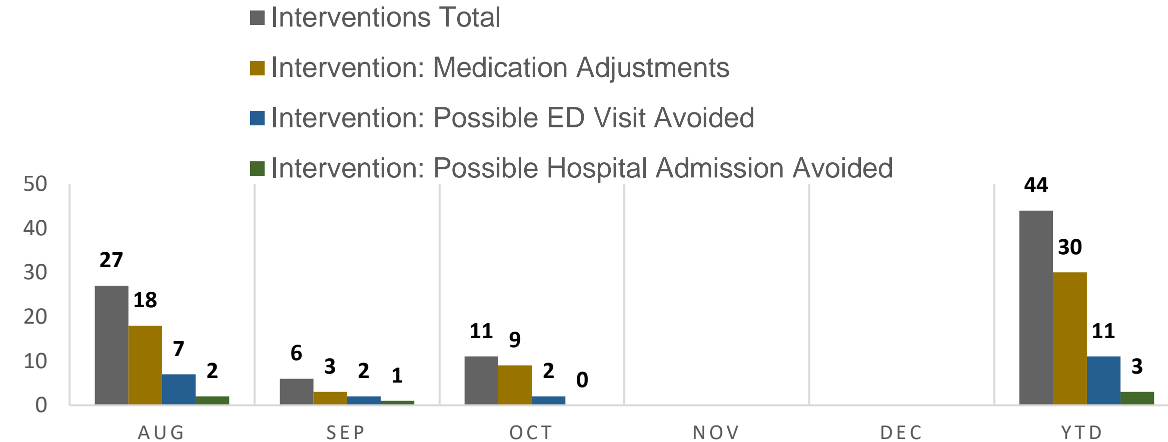



**New Project: Pharmacist Comprehensive Medication Reviews**

# RPM Successes




**Patient Satisfaction**

Overall, I am satisfied with my experience in the RPM program.

**Strongly Agree: 82.6%**

**Strongly Agree/Agree: 94.7%**

The remote monitoring technology was easy to use.

**Strongly Agree: 82.3%**

**Strongly Agree/Agree: 94.3%**

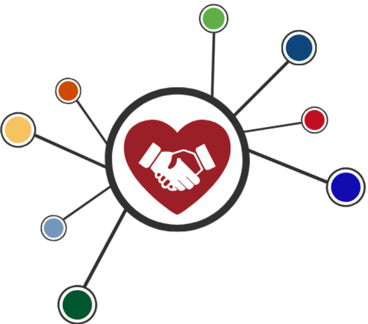
Responses: 171

**Referral Sources:**

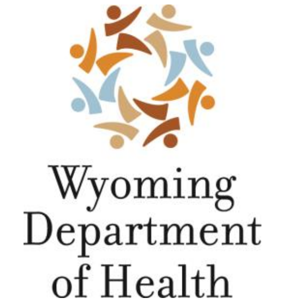
- Hospitalist discharge referrals
- Specialist and primary care providers
- Case managers, TCM RN
- Readmissions committee
- Enroll all same day total joints

# RPM Barriers

- Patients referred upon discharge not established with our providers
- Determining patient compliance upon enrollment
- Occasional delay in return of kits or blood pressure monitors
- Billing is cumbersome and can only be billed for the Home Kits. Currently only using codes (99453 and 99454)
- Utilization of licenses

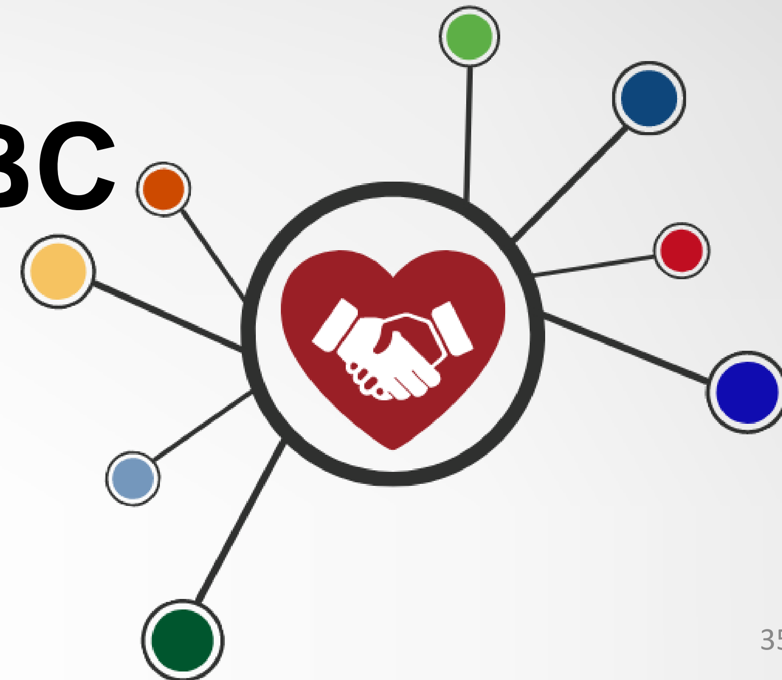


QUESTIONS?

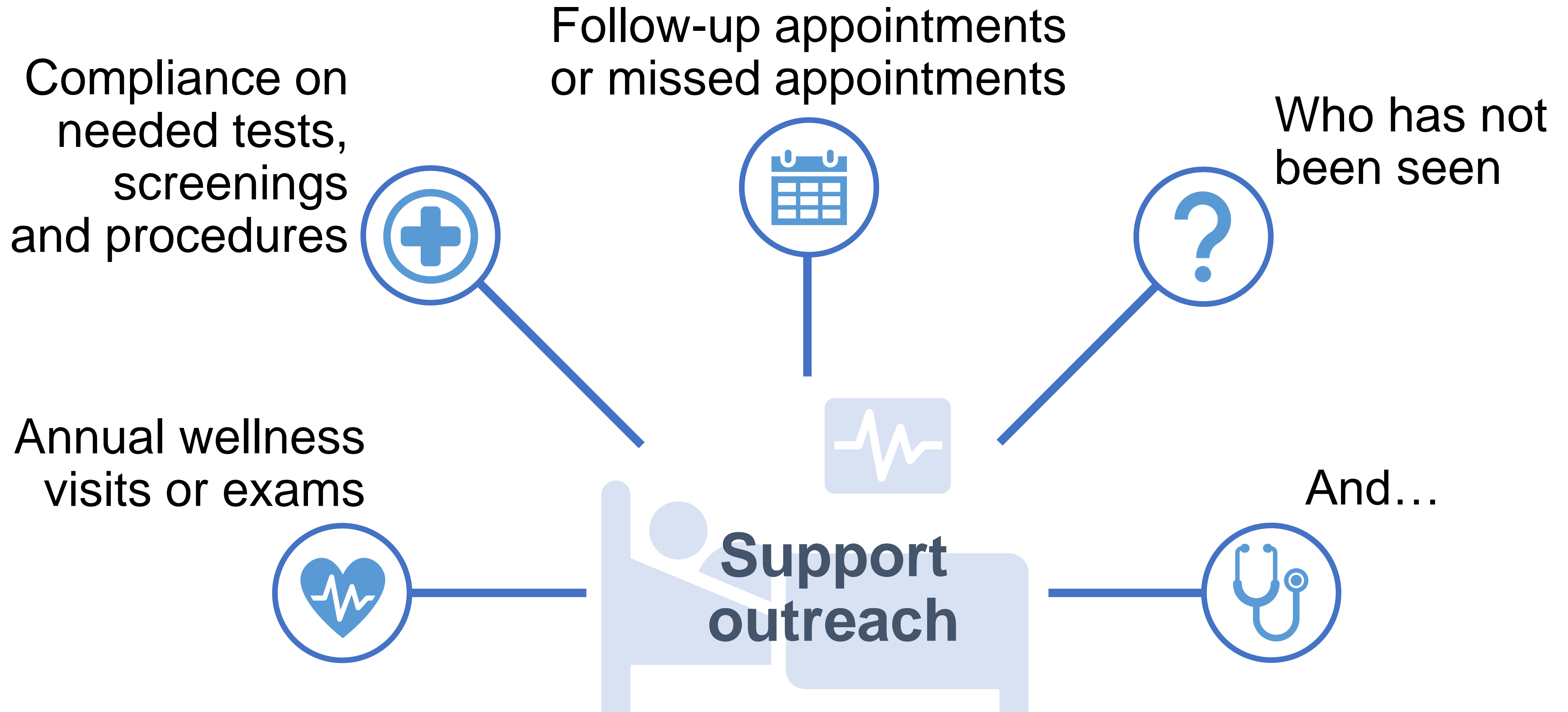



# Strategies: Adding Value to TBC

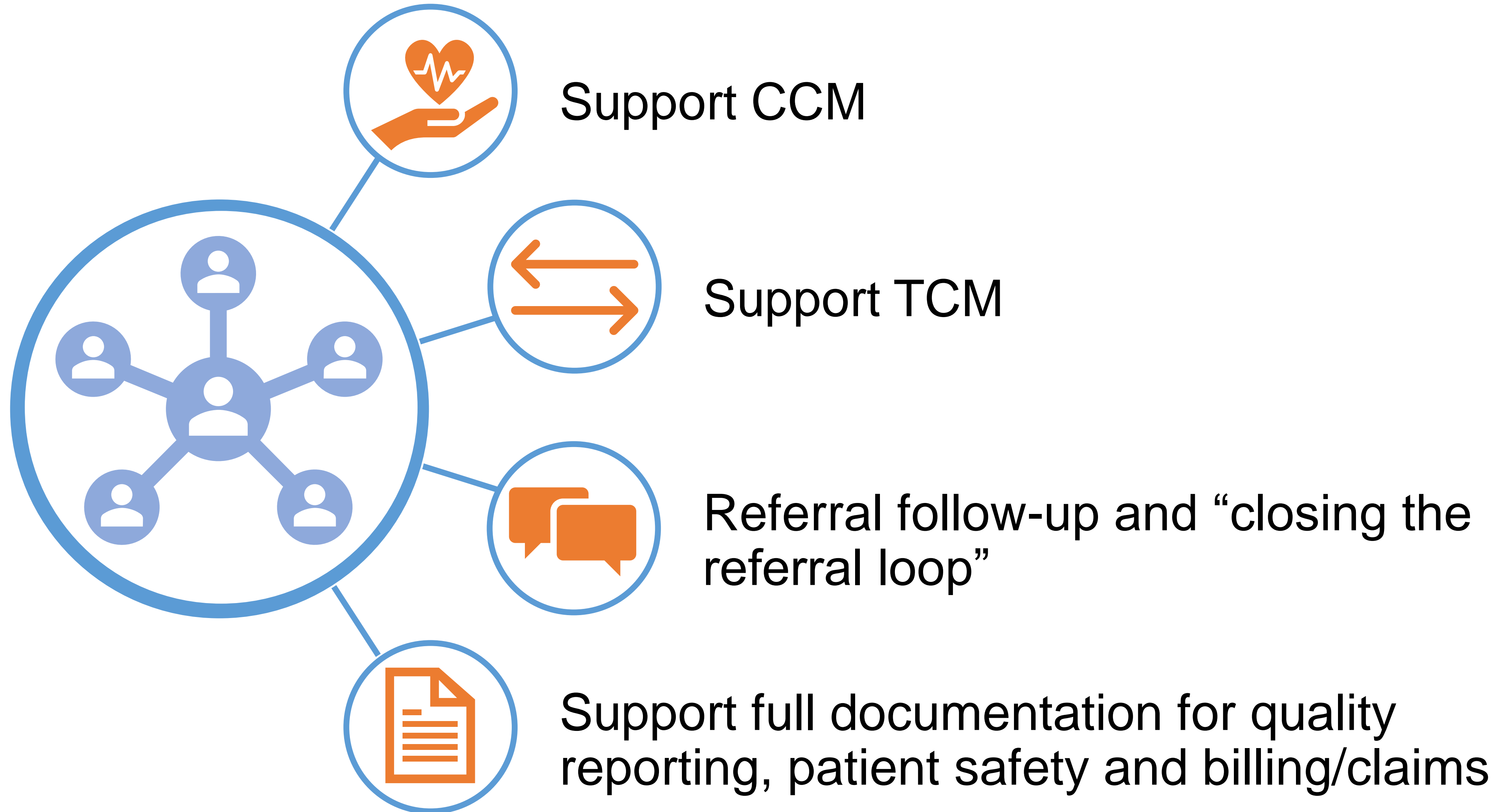
## (suggestions of additional ways to use team members)



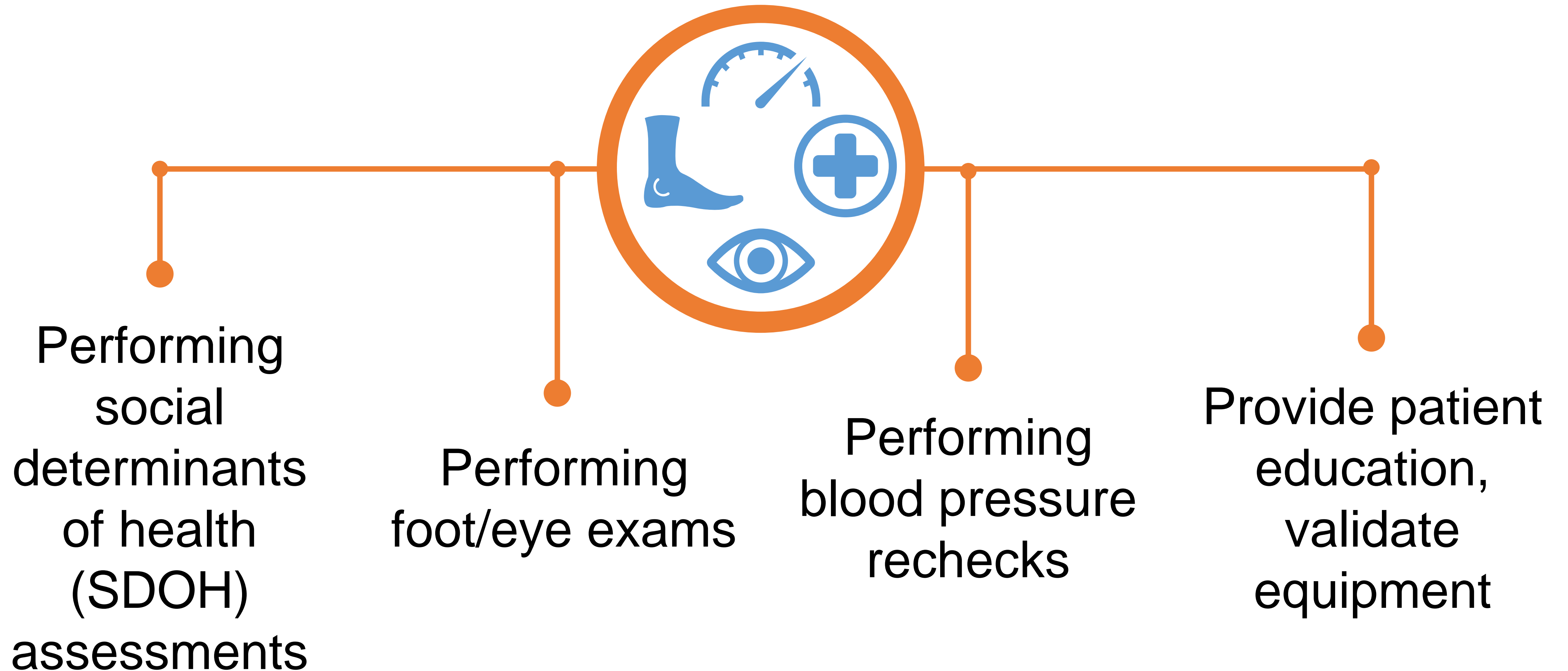
# Adding Value - Ideas: Patient Outreach



# Adding Value - Ideas: Care Coordination



# Adding Value - Ideas: Performing Services



# Adding Value - Ideas: Other

Manage remote patient monitoring programs

Run quality or gap reports to identify gaps in care, quality improvement opportunities, health equity concerns, etc.

Become a "patient navigator" connecting patients with needed services

Connect/establish partnerships with community-based organizations that support your patient needs and organization's goals

# Call to Action

**1**

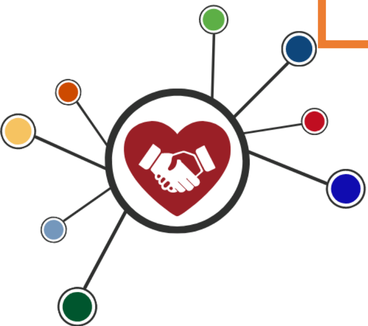
Use AWV process to bring in patients not seen in the last 12 months

**2**

Review your patients eligible for CCM – begin a recruitment campaign

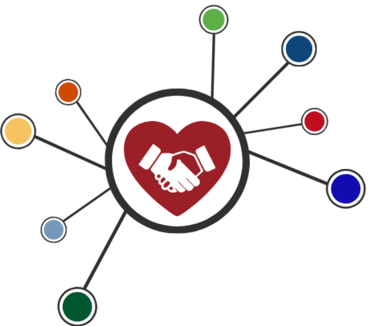
**3**

Identify one new way you can provide value/services to support your team



# Future Education Topics: Polling Question

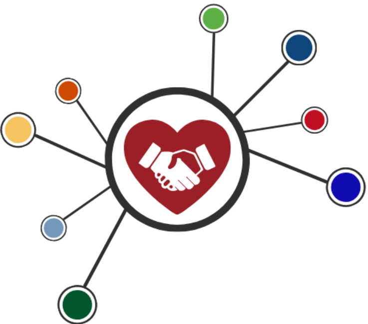
1) Innovative ways to utilize community health workers
2) Addressing behavior health for patients with chronic disease
3) Clinical inertia – what it is and how to overcome it
4) Community information exchanges (CIEs)
5) Expanding your use of community-based organizations (CBOs)
6) Remote patient monitoring for hypertension and diabetes
7) Showcase of innovative approaches to population health



*****Chat in other ideas*****

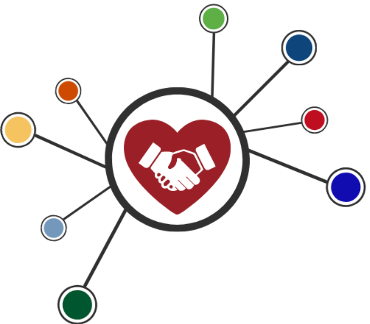
# Patient Care Team Resources

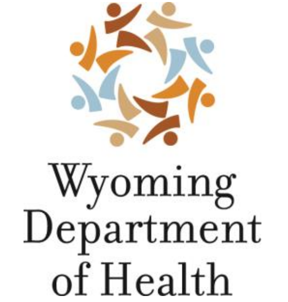
- Wyoming Center on Aging: video on Collaborative Practice Agreements to support TBC
- Center for Healthcare Strategies Inc: Enhance Team-Based Primary Care Approaches
- South Dakota Cardiovascular Collaborative: TEAM-BASED CARE TOOLS
- Institute of Medicine: Core Principles & Values of Effective Team-Based Health Care
- CMS: TCM, CCM and AWV
- Wyoming Center on Aging



# Share your Feedback

Please complete the evaluation survey






# Thank You!