Team-based Care

Creating Workflows

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The Challenge

- Nearly half of US residents live with one or more chronic conditions
- The average Medicare beneficiary sees two primary care providers and five specialists in a year and takes numerous medications
- Understanding and complying with complicated and sometimes conflicting instructions can be overwhelming and confusing, resulting in suboptimal care and treatment and landing patients in the emergency room or hospital

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Structuring

In order to provide comprehensive, coordinated care for this growing population of patients, the work can be efficiently split into:

- Care coordination
  - a role created for deliberate organization of patient care activities between two or more participants in a patient's care to facilitate the appropriate delivery of health care services
- Care management
  - a role designed for the engaging and managing of the more complex medical, social, and behavioral health conditions of a caseload of patients

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Activity

- Based on these descriptions share ideas on where you envision your role fitting?
  - Care Coordination
  - Care Management

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Team-based Care

- Each member within a care team has specific roles, but they **work together** in an **interdisciplinary manner** to provide seamless, high quality, holistic care for each patient

Types of Teams

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The Approach

Although care coordinators/managers can operate telephonically from centralized locations, randomized control trials suggest that they are most effective when embedded within a primary care center/clinic as part of the care team

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Training

The care coordinator and care manager are trained to:

- follow a standardized method for assessment, planning, and follow-up that improves patient compliance with the treatment regimen

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Care Coordinator Role

The care coordinator can handle a larger volume of coordinator activities with patients and work alongside of a care manager for more complex activities, such as medication reconciliation and treatment plan changes

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Care Coordinator Duties

- Outreach to patient for identification of risk stratification
- Coordinate preventive services and chronic disease services needed
- Coordinate information exchange where appropriate and routine communication linkages for patients and the care team
- Building trusting relationships with patients through follow-up phone calls and in-person contact
- Empathizing, employing motivational interviewing, using change management techniques and exhibiting cultural sensitivity

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Care Manager Role

- The care manager is often the primary point of contact for the more complex patients needing care management,
  - facilitating communication with the primary care physician and other care team members as needed

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Care Manager Duties

- Outreach to patients to engage them in care management services
- Conducting screening and as indicated, comprehensive health risk assessments (HRA) as well as other types of screening when needed
- Creating care plans that follow clinical protocols, standing orders and work flows but also address the felt needs of the individual complex patient
- Building trusting relationships with patients through follow-up phone calls and in-person contact
- Empathizing, employing motivational interviewing, using change management techniques and exhibiting cultural sensitivity
- Connecting with and involving other members of the care team as appropriate to achieve the best care outcomes for patients

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Team-based Approach

- Team-based Care Roles Best Practice
  - Participate in pre-clinic “huddles” to plan the flow of the day, making sure that specific patient needs are addressed
  - Make use of a common medical record, care plan, and standards of care, optimizing the ability of care team members to communicate and collaborate
  - Have clearly defined roles and responsibilities

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Discussion

Now that we've reviewed the care manager and care coordinator role and responsibilities, place yourself in the patient role.

How would you see the practice team interacting with one another?

Under what circumstances would you see different team members being the primary communicator to the patient?

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Activity – Choice 1

Review the sample workflow provided in the training manual.

- Based on your table discussion, identify areas to add to or improve the provided workflow – this can be based on the disciplines represented here today or on your practice care teams where you will be functioning as a team care member
- Where will linkage to community resources fit into the workload and workflow?
- Who will complete medication reconciliation when multiple disciplines are involved? i.e. pharmacist, RN CM, mid-levels

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Activity – Choice 2

Review the CM Guide to making a maintenance or relapse prevention plan.

- Create a workflow demonstrating the CM Process/Patient interactions that incorporates the action of relapse prevention.

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