IMPLEMENTATION OF INTEGRATED TEAM-BASED CARE MODELS:
BEST PRACTICES TO DRIVE CLINICAL OUTCOMES AND PATIENT EXPERIENCE

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OBJECTIVES

1. Explain terminology associated with integrated care and team-based care in a population health setting

2. Provide strategies to implement a new team-based care activity or service

3. Identify team-based care activities and/or services that demonstrate improvement of clinical outcomes and patient experience

4. Equip healthcare providers with tools and resources that support team-based care activities and/or services

EDUCATION

THE UNIVERSITY of NORTH CAROLINA at CHAPEL HILL

PROFESSIONAL

WakeMed

Advance Community Health

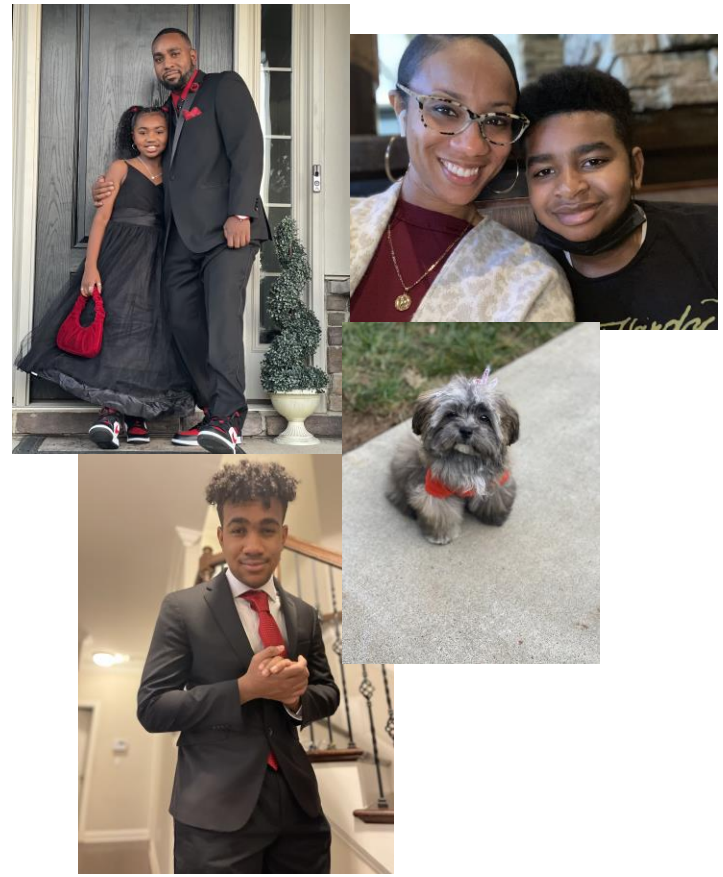
NCDHHS
NC Medicaid
Division of Health Benefits

CAPE FEAR VALLEY HEALTH

EXTRACURRICULAR & SERVICE

ΔΣΘ

FAMILY



OBJECTIVE 1. EXPLAIN TERMINOLOGY ASSOCIATED WITH INTEGRATED TEAM-BASED CARE

- **Patient-Centered Medical Home (PCMH):** ***Model*** of care that puts patients at the forefront
  - 1967: The American Academy of Pediatrics introduced the medical home concept
  - 2007: Leading primary care-oriented medical professional societies released the Joint Principles of the PCMH
  - 2008: National Committee for Quality Assurance releases recognition program
- **Integrated Care** or "Interprofessional health care": ***Model*** of ***Team-Based Care***
- **Team-Based Care**: ***Philosophy*** of Transforming/Guiding Delivery of ***Patient-Centered Care***
- **Patient-Centered Care**: ***Approach*** that requires true partnership between patients and HCPs

PATIENT-CENTERED MEDICAL HOME (PCMH)

- **6 overarching concepts or standards**

- **Team-Based Care and Practice Organization:** Helps structure a practice's leadership, care team responsibilities and how the practice partners with patients, families and caregivers.
- **Knowing and Managing Your Patients:** Sets standards for data collection, medication reconciliation, evidence-based clinical decision support and other activities.
- **Patient-Centered Access and Continuity:** Guides practices to provide patients with convenient access to clinical advice and helps ensure continuity of care.
- **Care Management and Support:** Helps clinicians set up care management protocols to identify patients who need more closely-managed care.
- **Care Coordination and Care Transitions:** Ensures that primary and specialty care clinicians are effectively sharing information and managing patient referrals to minimize cost, confusion and inappropriate care.
- **Performance Measurement and Quality Improvement:** Improvement helps practices develop ways to measure performance, set goals and develop activities that will improve performance.

Why PCMH?

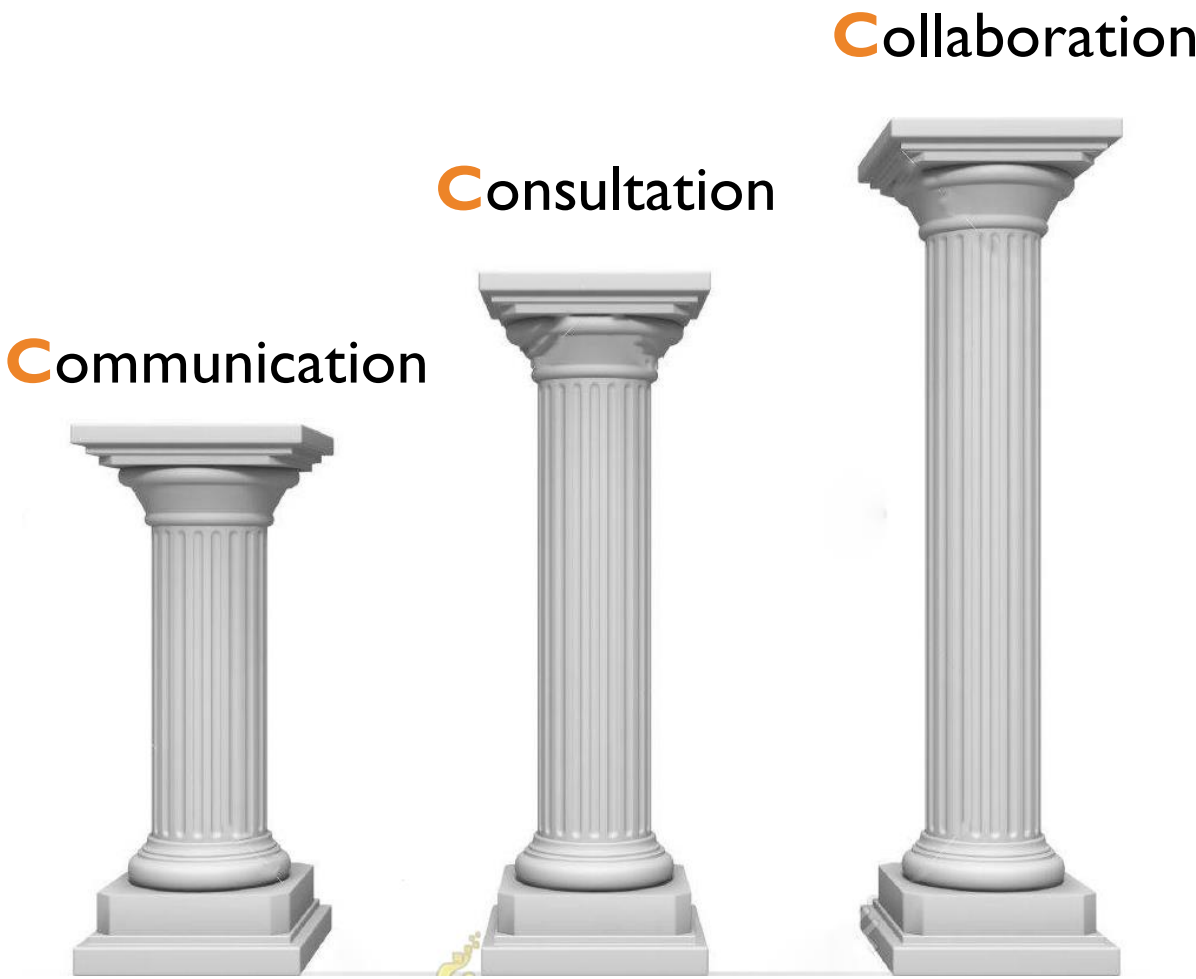
- Align with payers
- Align with state/federal initiatives
- Improve patient experience
- Improve staff satisfaction
- Reduce fragmentation
- Better manage chronic conditions
- Lower healthcare costs
- Improve patient-centered access

INTEGRATED CARE DEFINED (APA, 2022)

"…any attempt to fully or partially blend behavioral health services with general and/or specialty medical services"

3Cs OF INTEGRATED CARE (APA, 2013 & TUCKER 2022)

- **Communication**: Sharing of information among team members related to patient care (e.g. EHR integration)
- **Consultation**: Establishment of a comprehensive treatment plan to address the biological, psychological and social needs of the patient
- **Collaboration**: Interprofessional health care team including a diverse membership including physicians, nurses, LCSWs, and other HCPs, depending on the needs of the patient (e.g. warm hand-offs, care team huddles)

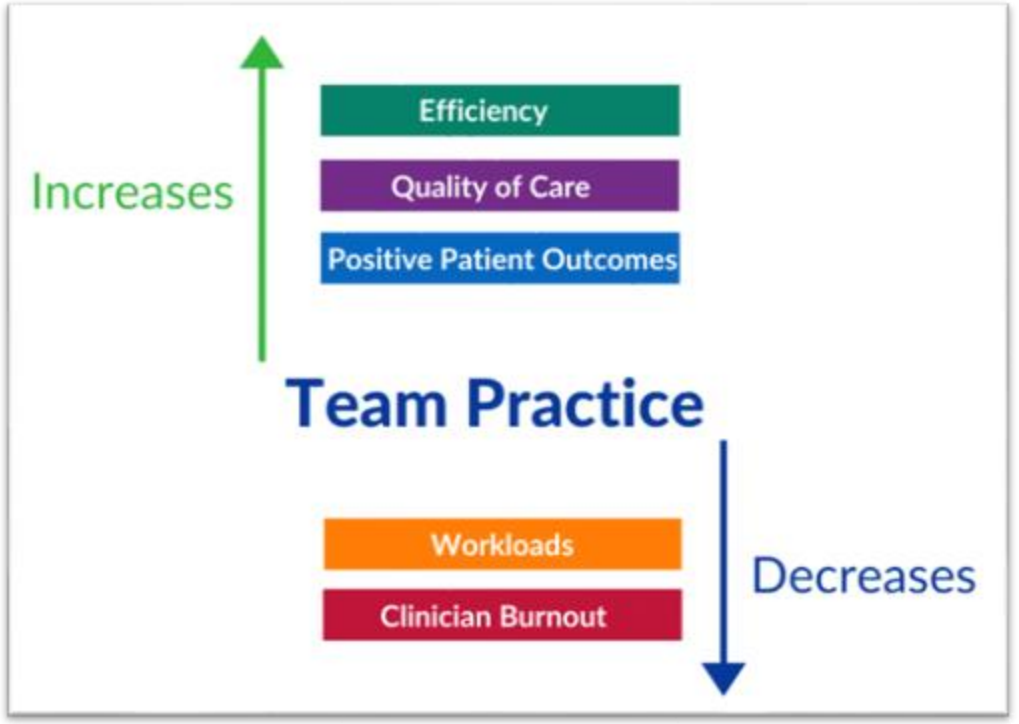


TEAM-BASED CARE DEFINED (NATIONAL ACADEMY OF MEDICINE, 2014)

"…the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient—to accomplish shared goals within and across settings to achieve coordinated, high-quality care."

TEAM-BASED CARE ADVANTAGES (ACP, 2022)

- Increased ***efficiency***
- Improved ***quality of care***
- Improved patient ***outcomes***
- Decreased clinician ***burnout/turnover***
- Decreased ***workloads***



TEAM-BASED CARE MEMBERS (ACP, 2022)

- Physicians
- Nurse practitioners and physician assistants
- Medical assistants
- Pharmacists
- Social workers
- Patients and their families
- Others

PATIENT-CENTERED CARE DEFINED (NATIONAL ACADEMY OF MEDICINE, 2014)

"Providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions."

PATIENT-CENTERED CARE ADVANTAGES (AHRQ, 2016)

- "the right thing to do"
- Physician-patient ***communication*** and relationships
- Higher ***patient satisfaction***
- Better recall of information and treatment ***adherence***
- Better ***recovery***
- Improved health ***outcomes***

PATIENT-CENTERED CARE

OBJECTIVE 2. PROVIDE STRATEGIES TO IMPLEMENT ANY NEW TEAM BASED CARE ACTIVITY OR SERVICE (BROMER, 2016)

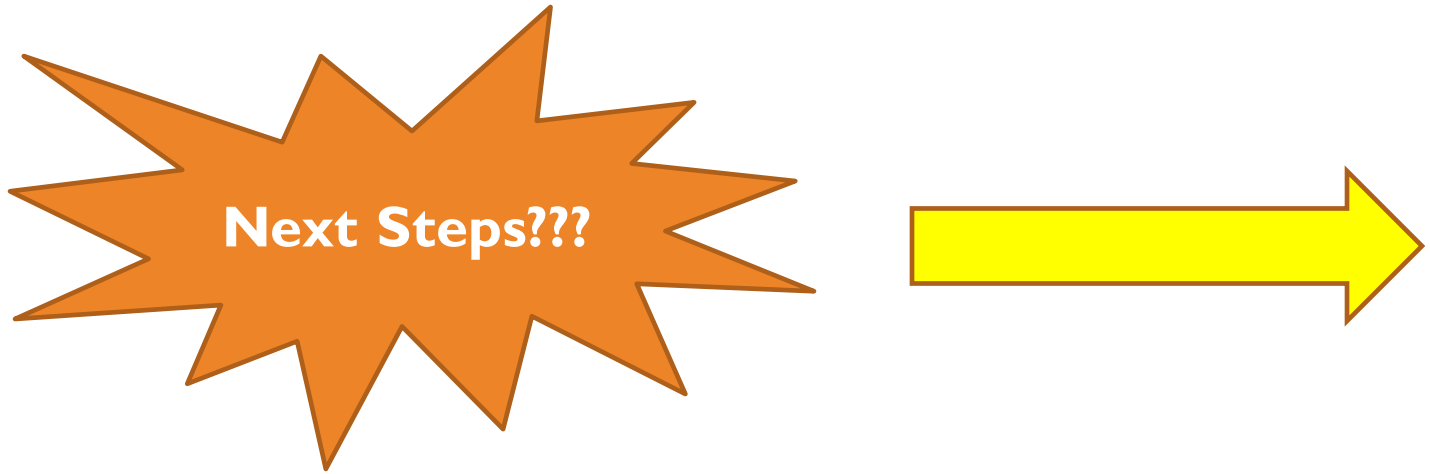
1. ***Organizational Structure*** supports team-based care
   - Leadership aligned to support teams
   - Everyone work at the top of license
   - Everyone on a Quality Improvement team
   - Become a "learning organization"
2. ***Establish stable teams*** that can provide patient-centered care
3. Define team member ***roles and responsibilities***
4. Create standing ***orders/protocols/workflows***
5. Deploy ***Co-location*** model
   - Physical proximity facilitates communication
   - Technology can be used to create virtual co-location
6. Develop effective team ***communication strategies*** (ie. Team meetings, huddles)
7. Develop process for ***training on roles*** and ***create skills checklists***

OBJECTIVE 3. IDENTIFY TEAM-BASED CARE ACTIVITIES AND/OR SERVICES THAT DEMONSTRATE IMPROVEMENT OF CLINICAL OUTCOMES AND PATIENT EXPERIENCE

- Hepatitis C Program
- HIV Pre-Exposure Prophylaxis (PrEP) Program
- Medication Assisted Treatment (MAT) Program

HEPATITIS C (HCV)

- CDC estimates, 2.4 million people in the US are living with the HCV
- Most prevalent amongst "Baby boomers" (adults born between 1945-1965)
- Highest incidence of new HCV cases amongst young adults aged 20-29 years
- Health centers report data on HCV testing and diagnoses as part of the UDS
  - 2019: 1.18 million patients tested
  - 2020: 0.77 million patients tested



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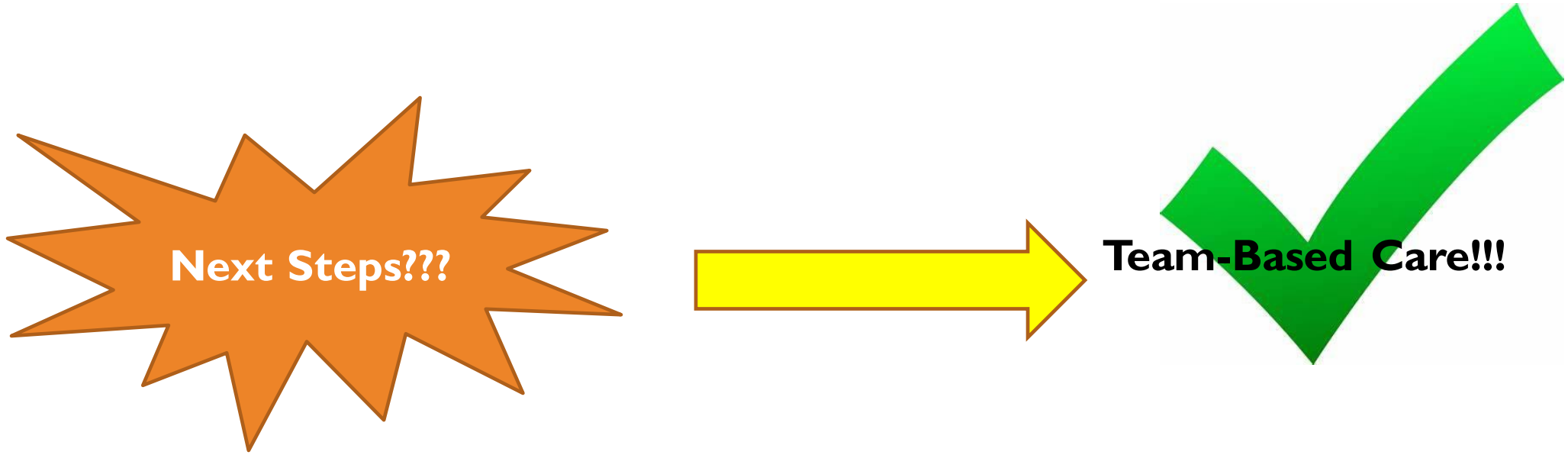


HEPATITIS C TREATMENT (CDC, 2020)

- **Who is at risk for HCV infection?**
  - HIV infection
  - Injection drug use
  - Selected medical conditions
  - Prior recipients of transfusions or organ transplants
- **How is HCV treated?**
  - Oral antiviral medications
  - Usually once daily tablets
  - Attack the virus and keep from multiplying
- **Why is HCV treatment important?**
  - High cure rate 95% overall!!!
  - Minimal side effects
  - Slows or stops liver damage and cirrhosis
  - Decreases risks of liver cancer, liver failure, and transplant
- **What are the medications used to treat HCV?**
  - 1st Line Therapy
    - Mavyret
    - Harvoni
    - Epclusa
    - Zepatier
  - 2nd Therapy: Vosevi
- **How long is HCV treatment?**
  - Usually 8-12 weeks
- **How is HCV treatment monitored?**
  - Periodic blood tests
- **What are other considerations of HCV treatment?**
  - Drug-drug interactions
  - Medication Adherence/Completion of Therapy
  - Side Effect Management
  - Compliance with laboratory visits
  - Reinfection or Late Relapse

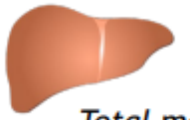
CASE STUDY:

Sustained Impact of Public-Private Partnerships on HCV in Wake County

Wake County Health & Human Services: Hepatitis C Program

(Oct. 2016 - July 2022)

- HCV Tests Performed: 32,399
- HCV RNA+ Results *(Referrals)*: 764
- Completed Intake Assessments: 526
- Clients Linked to Medical Care: 439
- Clients - Completed HCV Tx: 297
  (of 304 who initiated Tx)
- **Clients - Hep C Cured/Clear: 330**



= $878,400

*Total medical cost for **1** liver transplant in US*

WCHHS - Hep C Program: 330 clients achieved HCV cure/clear. **Preventing 330 HCV primary diagnosis liver transplants**. A savings of:

$289,872,000

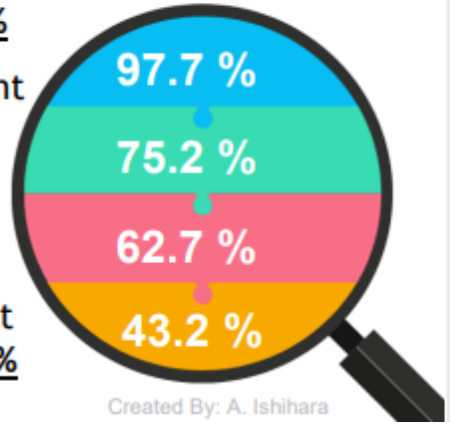
"Point in Process" (PIP) HCV Cure Rate

Clients reaching the Completion of HCV Treatment point in the process (PIP): have a Hep C cure rate of **97.7%**

Clients reaching the Linked to Medical Provider point in the process (PIP): have a Hep C cure rate **75.2 %**

Clients reaching the SW Intake Assessment point in the process (PIP): have a Hep C cure rate of **62.7 %**

Clients reaching the Referral to Hep C Program point in the process (PIP): have a Hep C cure rate of **43.2 %**



Created By: A. Ishihara

Sustainability of Hep C Program via County Funding

In September 2016, **Wake County was selected to join the Gilead: FOCUS Program and awarded the funding that launched HCV screening & linkage to care efforts.** The implementation of client-centered interventions & systems level collaboration with stake holders were key factors in generating overall successful program outcomes.

In October 2021, the **Wake County Board of Commissioners approved an expansion request for $126,634** permanently securing 2 HCV clinical social workers and further increasing the sustainability of the WCHHS - Hepatitis C Program.

Collaborative Partner

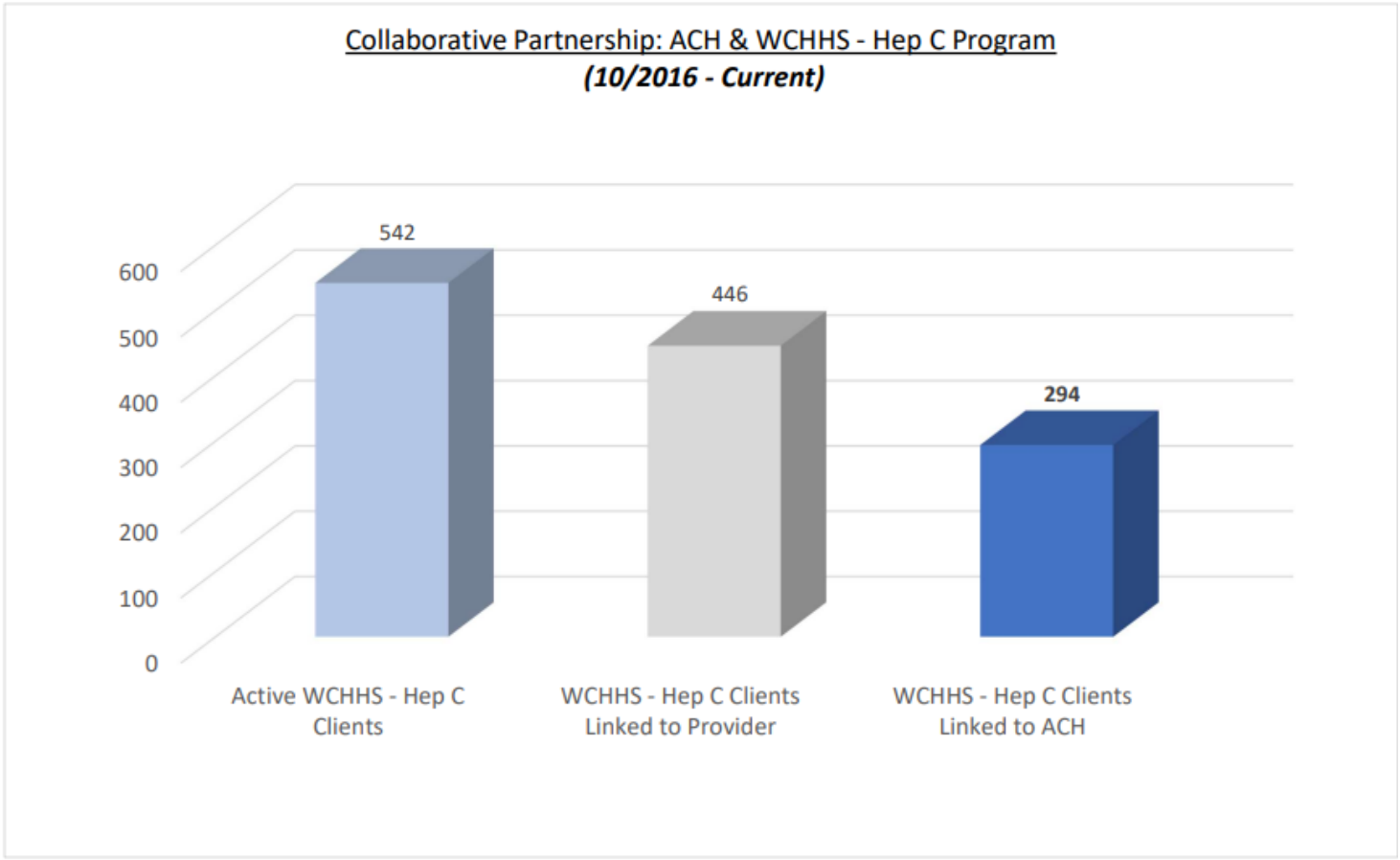
Project Access (PA) & UNC Charity Care links uninsured patients to specialty providers at no cost. Since the collaborative partnership was established in June 2019, it has yielded:

- Access to enhanced medical care for **89.7% of uninsured clients** in the WCHHS - Hep C program
- The launch of the WCHHS - Hep C Clinic in Oct. 2020 providing HCV treatment to Wake County residents
- Saving of approx. $60,150 in the cost of HCV labs for WCHHS Hep C Clinic uninsured patients

WCHHS - Hep C Program: Dissemination of Outcomes

- National Association of Counties (NACo) Achievement Award - July 2019
- WCHHS - Hep C Program submitted an abstract & was featured in the NVHR (National Viral Hepatitis Roundtable) January Newsletter *(2022)*
- Presentation at the NC Viral Hepatitis Task Force Meeting *(February 2022)*
- Presentation given to the Wake County Public Health Commission *(May 2022)*
- Presentation given to the Wake County Board of Commissioners (Calendared - *Fall 2022)*

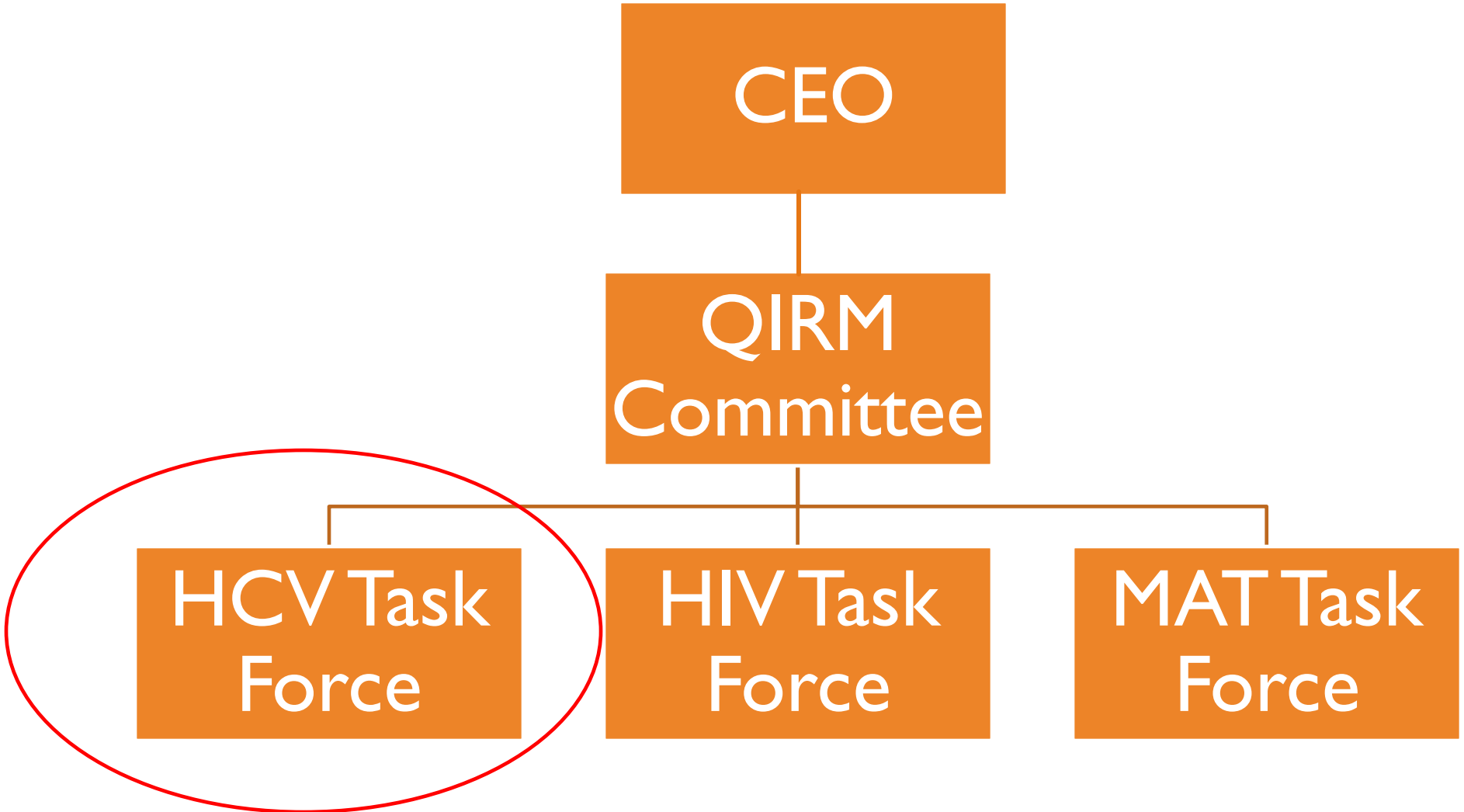
HEPATITIS C PROGRAM (ISHIHARA, 2018)



From 10/2016 – 10/18/2022, approximately **65.92%** of all WCHHS – Hep C program active clients have been linked to Advance Community Health for HCV medical care

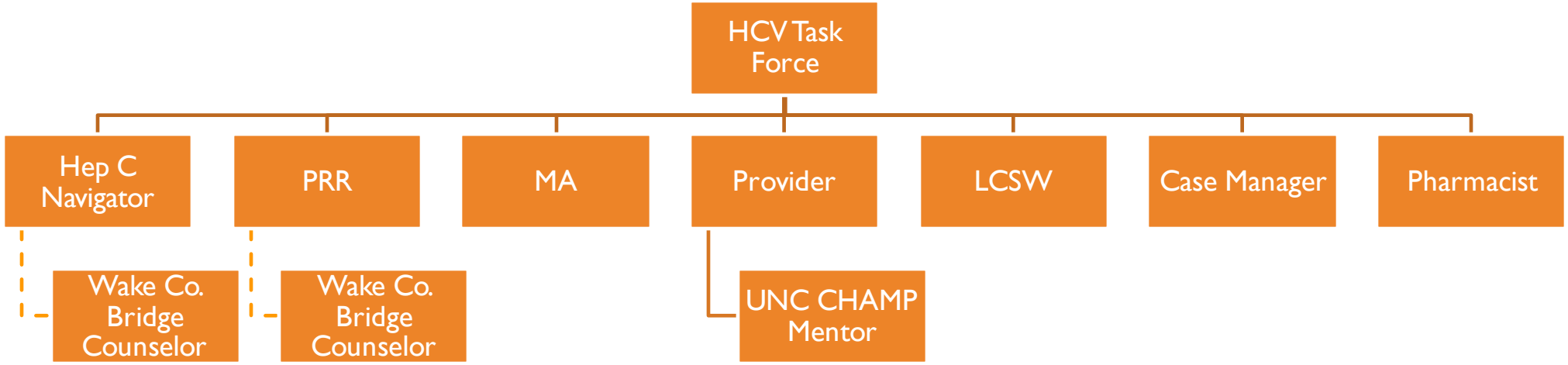
HEPATITIS C PROGRAM

1. ***Organizational Structure*** supports team-based care



HEPATITIS C PROGRAM

2. ***Establish stable teams*** that can provide patient-centered care



HEPATITIS C PROGRAM

3. Define team member ***roles and responsibilities***

Provider	PharmD	Team Assistant	Reception	Behavioral Health
Care Delivery • Medical/MH Dx • *Follows provider script* • Therapeutic plan for urgent/chronic problems • Determines clinical monitoring schedule • Determines need / schedule for tracking for high risk • Manages abnormal tests • Determine overall patient education needs • Decisions regarding comprehensive care to panel	Collaborative Practice • Collaborative drug therapy management • Medication therapy management • Consultation on complicated medication regimens • Controlled-substance agreements • Refill authorizations • Immunizations Education • Patient education about disease • Patient education about overall health and	• Monitors schedules in advance for problems and works collaboratively with care team to maximize access • Schedules appointments with team providers • Primary responsibility for reminder calls • No show f/u and mgmt • Acts as communication liaison between patients and providers & MA's to maximize efficiency and effectiveness of patient appointments • Makes f/u scheduling calls at providers' request,	• Confirms insurance coverage and schedules appointments as indicated with Eligibility or Outreach Eligibility Worker • Patient check-in for appts. • Collects, verifies, and updates demographic information and insurance coverage • Collects co-pays, payments on account balances • Distributes and explains client forms • Customer service	• As outlined in Behavioral Health (BH) charting guide • Determines BH intervention and treatment • Therapeutic plan for urgent/chronic BH problems • Determines need and recommends BH monitoring schedule • Provides consultation to providers and team regarding BH diagnosis and resources • Liaison with Mental Health (MH) and other programs at Health Services regarding MH / BH issues

HEPATITIS C PROGRAM

4. Create standing ***orders/protocols/workflows***

ACH Hepatitis C Workflow					
Screening Visit	Initial Visit	Medication Selection Visit	4 Week Viral Load Visit (4WVL)	8 or 12 week Medication Completion Visit (optional)	SVR 12 week Visit (SVR12)

PROCEDURE	
Medication Management- Hepatitis C Procedure (Louisburg)	
Approval Date:	
Review Date:	

Screening Visit

- Patient identified by PCP and lab work (Hepatitis Panel and HCV Ab with rflx to PCR qualitative) obtained to confirm Hep C Diagnosis

After Screening Visit

- Patient called by MA or CM to discuss Hep C results
- MA or CM schedules Initial Visit with Hep C clinic if patient Hep C +

Day prior to Initial Visit

- MA does Pre- visit planning
- CM does Pre- visit planning
  - Retrieve Hep C education for patient
  - Call patient to confirm appt and introduce Care Management
  - Review insurance

Day of Initial visit

- Huddle

HEPATITIS C PROGRAM

5. Deploy ***Co-location*** model
   - Physical proximity facilitates communication
   - Technology can be used to create virtual co-location

6. Develop effective team ***communication strategies***
   - Clinic huddles
   - Task Force meetings
   - Virtual communication

HEPATITIS C PROGRAM

7. Develop process for ***training on roles*** and ***create skills checklists***

Community Health Center
Phlebotomist and Lab Orientation Checklist
2010

Employee Name: **Date:**

	Patient Care Tasks	Date Sign Off	Signature Approving Task		
1.	Venipuncture:				
A	Read venipuncture section of Manual				
B	Learn Blood draw technique				
C	What to do with different draws When to use a butterfly				
D	Correct tubes used and order of draws How much blood is needed				
E	What tests are fasting and what medications affect results				
F	Questions to ask patient before blood draw: DOB; Are they taking medication; fasting or not include type of liquid consumed				
G	Learn how to fill out forms & ICD9 codes needed				
H	Insurance, Special Fund decisions				
I	Reasons for rejections of the specimen – What tests are affected by hemolyzed or lipemic serum				
J	Where to look for information on specimen collection requirements				
K	How to use lab log				
L	How to evaluate & check off the lab results when they come in. What to do with abnormal results				
M	How to use label printer				
2.	Urinalysis				
A	Read Urinalysis Dip section of the Lab manual				
B	Learn how to read and understand multistix				
C	Learn QC				
D	Learn when sulfosalicylic acid test is used and how to interpret				

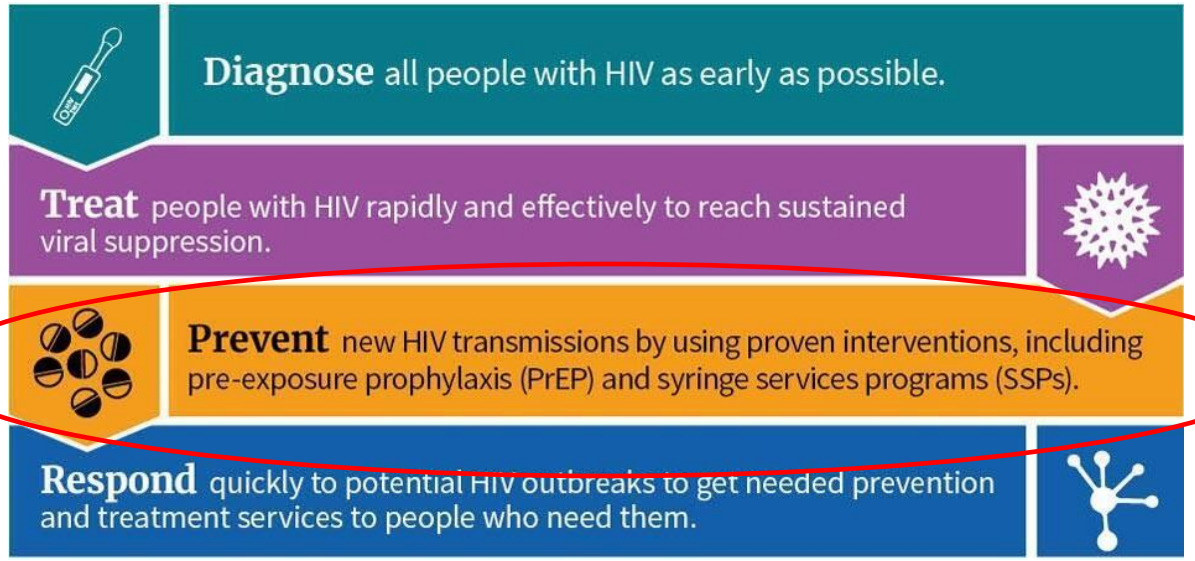
HIV PRE-EXPOSURE PROPHYLAXIS (PrEP) PROGRAM

- More than 700,000 American lives have been lost to HIV since 1981.
- More than 1.1 million Americans are currently living with HIV
- The U.S. government spends $20 billion in annual direct health expenditures for HIV prevention and care
- *Ending the HIV Epidemic (EHE initiative):* HRSA awarded > $48 million to health centers
- Reduces risk of HIV treatment by 99%!!!

GOAL:

75%
reduction in new HIV infections by 2025
and at least
90%
reduction by 2030.

STRATEGIES:



2022 UDS HIV CLINICAL MEASURES:

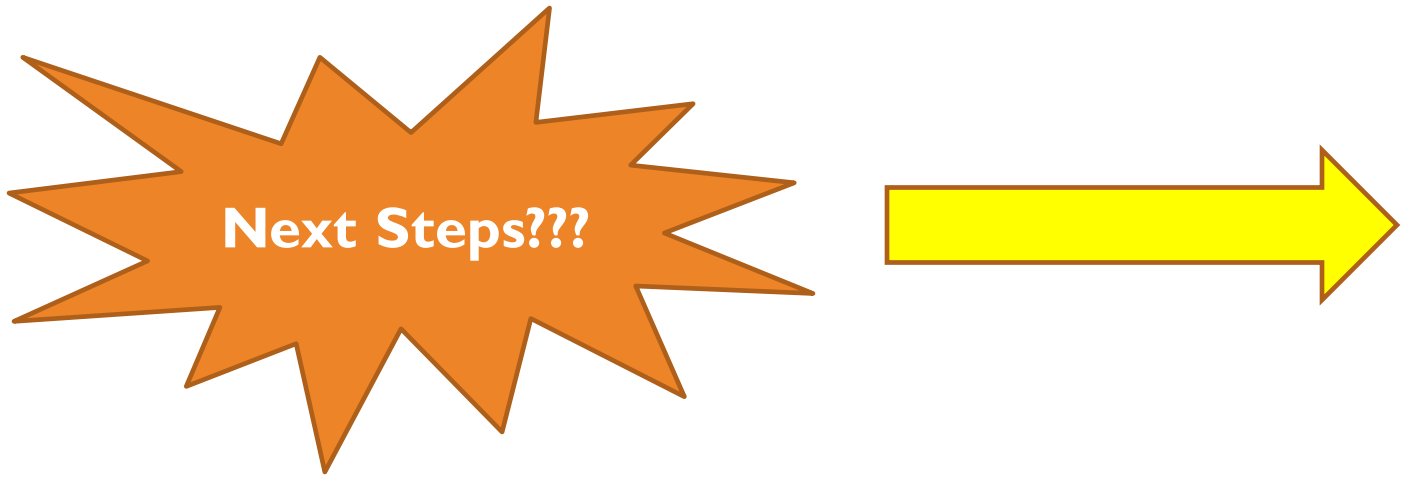
- HIV Screening
- HIV Linkage to Care

HIV PRE-EXPOSURE PROPHYLAXIS (PrEP) TREATMENT

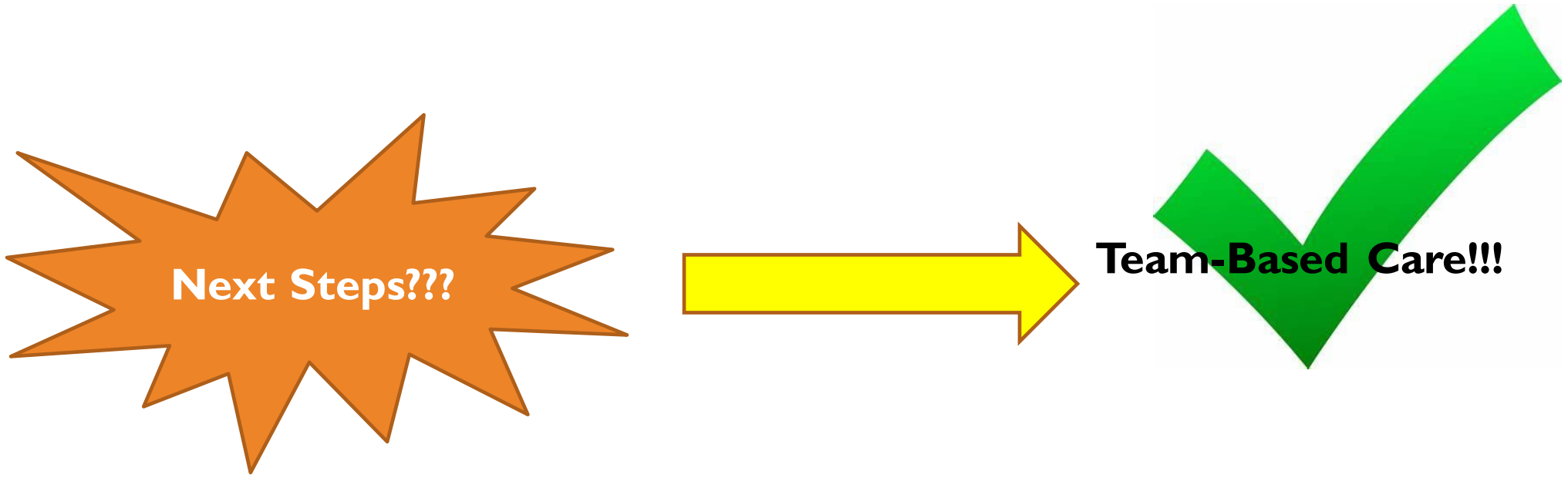
- **What is HIV PrEP?**
  - **PrEP** is short for pre-exposure prophylaxis
  - Use of ARV medication to prevent HIV infection
  - PrEP is used by people without HIV who may be exposed to HIV through sex or injection drug use
- **Who is eligible for HIV PrEP?**
  - Multiple sexual partners
  - Injection drug use
  - Prior STD history
  - HIV+ sexual partner
  - Condomless sex

- **What are the medications used HIV PrEP?**
  - Truvada (oral once daily)
  - Descovy (oral once daily
  - Apretude (Intramuscular every 2 months)
- **What is the monitoring associated with HIV PrEP?**
  - HIV testing every 3 months
  - Kidney function every 6 months
  - Lipid panel annually
- **What are other considerations of HIV PrEP?**
  - Kidney Impairment
    - Truvada CrCl >60ml/min
    - Descovy CrCl>30ml/min
    - Apretude < 30ml/min
  - Drug-drug interactions
  - Medication Adherence
  - Compliance with laboratory visits

HIV PRE-EXPOSURE PROPHYLAXIS (PrEP) PROGRAM



HIV PRE-EXPOSURE PROPHYLAXIS (PrEP) PROGRAM



HIV PRE-EXPOSURE PROPHYLAXIS (PrEP) PROGRAM

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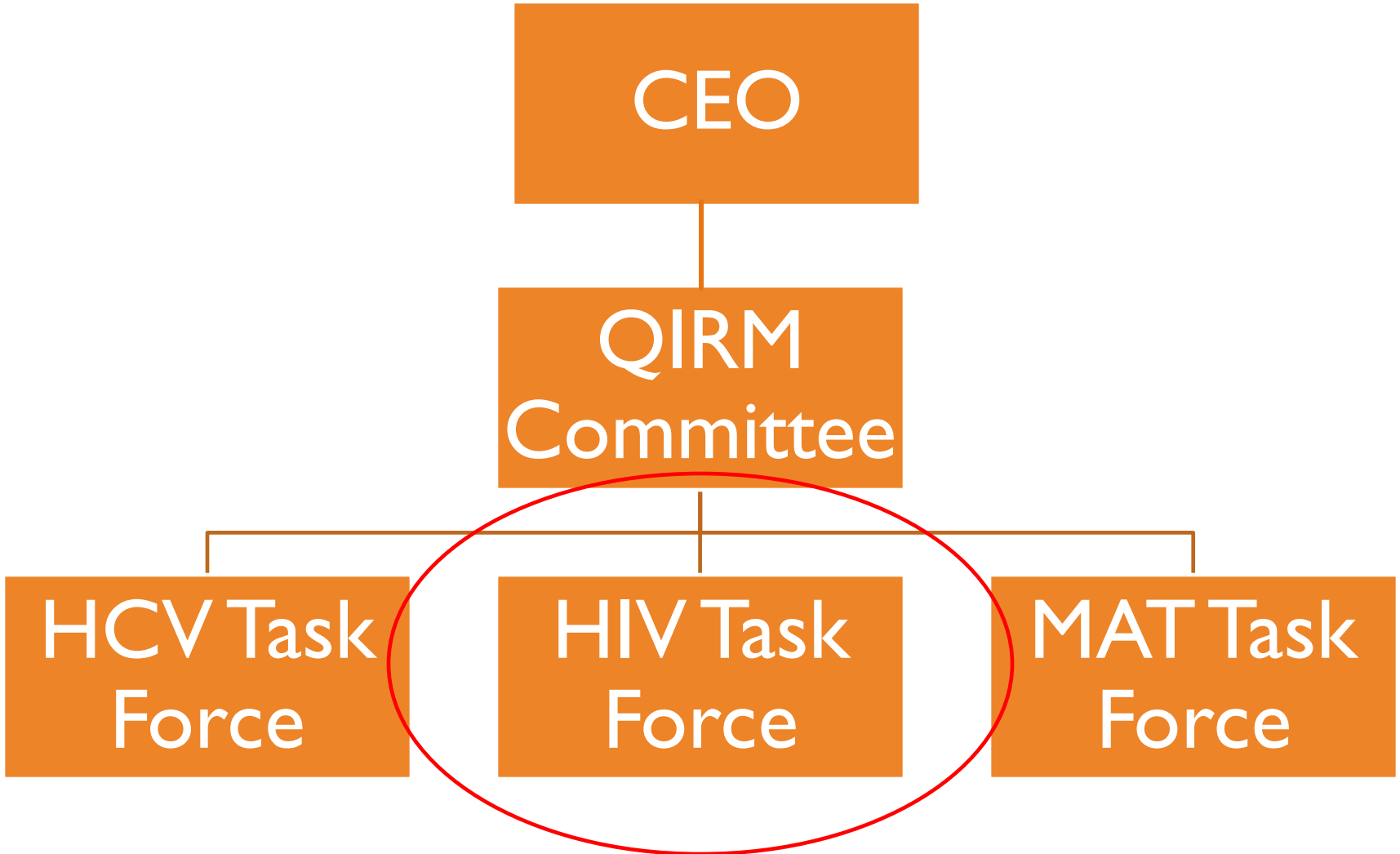
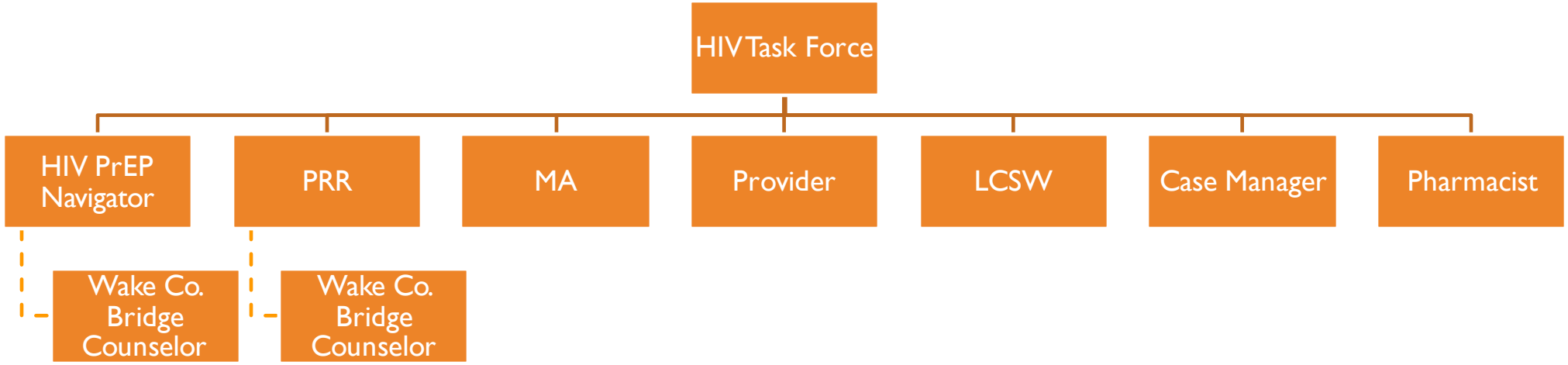


HIV PRE-EXPOSURE PROPHYLAXIS (PrEP) PROGRAM

2. ***Establish stable teams*** that can provide patient-centered care



3. Define team member ***roles and responsibilities***

HEPATITIS C PROGRAM

4. Create standing ***orders/protocols/workflows***

ACH HIV PrEP Workflow		
Pre-PrEP Visit	During PrEP Visit	Post PrEP Visit

Procedure Advance Community Health NOTE: This is an ACH procedure which upon approval cannot be altered without prior approval.	**Subject:** Pre-Exposure Prophylaxis (PrEP): Referral to a Pharmacist		**Related Form(s):**
	Related Procedures - Pre-Exposure Prophylaxis (PrEP) Care Practice Guideline - Drug Therapy Management: Medication Renewal Authorization		**Responsible Department:** Pharmacy
	PROCEDURE AND/OR WORKFLOW		
	Origination Date:	**Revision Dates:**	**Target Review Date:**

I. **PURPOSE**

In an effort to increase the organization's capacity to provide Pre-Exposure Prophylaxis (PrEP) to existing patients, Advance Community Health (ACH) providers may place a **focused** referral to designated ACH pharmacists for continuation of PrEP.

II. **BACKGROUND**

Continuation of PrEP therapy by an ACH pharmacist may be appropriate for a wide array of patients except for those patients who are pregnant, < 18 years of age, those with creatinine/other comprehensive metabolic panel abnormalities and those having chronic active Hepatitis B Virus or those being Hepatitis C Virus antibody positive. Patients will continue to be seen by the pharmacist for medication continuation every three months unless they require referral back to providers for yearly evaluation, demonstrate medication non-adherence/need for re-initiation of PrEP, are pregnant or demonstrate other laboratory abnormalities as detailed in the following procedure.

III. **PROCESS**

a. Patient referral

HIV PRE-EXPOSURE PROPHYLAXIS (PREP) PROGRAM

5. Deploy ***Co-location*** model
6. Develop effective team ***communication strategies***
7. Develop process for ***training on roles*** and ***create skills checklists***

MEDICATION ASSISTED TREATMENT (MAT) PROGRAM (MEDICAID.GOV, 2014)

MAT Defined:

"MAT as the use of FDA-approved medications, in combination with counseling and behavioral therapies, to provide a "whole-person" approach to the treatment of substance use disorders, including opioid use disorder and alcohol use disorder (AUD)." (HRSA, 2022)

MAT Background:

- Substance use disorders (SUDs) impact the lives of millions of Americans in the general population
- 105 people die every day as result of a drug overdoses
- 6,748 individuals across the country seek treatment every day in the emergency department for misuse or abuse of drugs
- In 2009, health insurance payers spent $24 billion for treating SUDs

Medication Assisted Treatment:

- *Medications for Opioid use disorders (OUDs)*
  - Methadone
  - Buprenorphine
  - Naltrexone
- *Medications for Alcohol use disorders (AUDs)*
  - Acamprosate
  - Disulfiram
  - Naltrexone
- *Behavioral Therapies*
  - Individual therapy, group counseling, and family behavior therapy
  - Cognitive-behavioral therapy
  - Motivational enhancement
  - Motivational incentives
- *Additional Services*
  - Physical health issues
  - Mental health issues

MEDICATION ASSISTED TREATMENT (MAT) PROGRAM

1. ***Organizational Structure*** supports team-based care
2. ***Establish stable teams*** that can provide patient-centered care
3. Define team member ***roles and responsibilities***
4. Create standing ***orders/protocols/workflows***
5. Deploy ***Co-location*** model
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7. Develop process for ***training on roles*** and ***create skills checklists***

OBJECTIVE 4. EQUIP HCPs WITH TOOLS AND RESOURCES THAT SUPPORT TEAM-BASED CARE ACTIVITIES AND/OR SERVICES

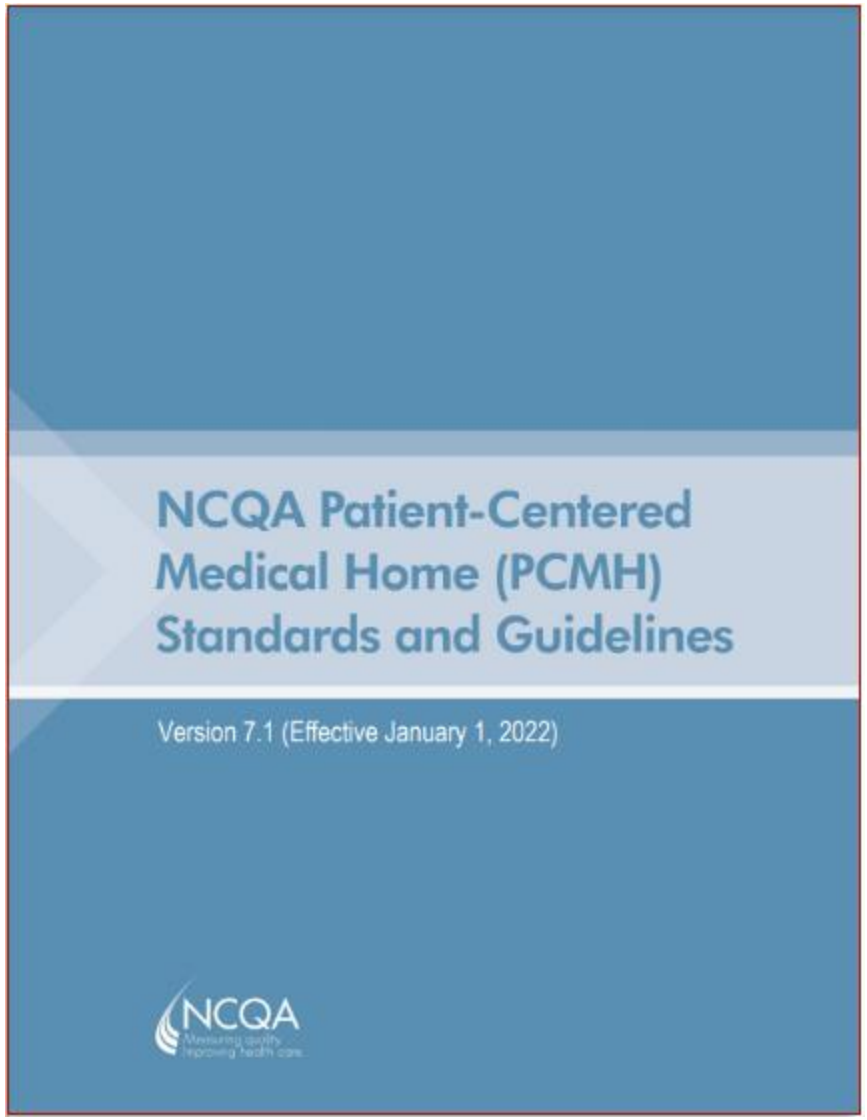
Agency for Healthcare Research and Quality, 2016
Creating Patient-centered Team-based Primary Care (ahrq.gov)

CREATING PATIENT-CENTERED TEAM-BASED CARE

I. INTRODUCTION

Of all of the changes envisioned as part of the transformation to improved and more patient-centered primary care, perhaps none is more promising and more challenging than the transition to team-based delivery of care.

Team-based care is defined by the National Academy of Medicine (formerly known as the Institute of Medicine) as "…the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient—to accomplish shared goals within and across settings to achieve coordinated, high-quality care."[1-3]



Patient-Centered Medical Home Standards and Guidelines, 2021

PCMH Standards and Guidelines (Version 7.1).pdf (chcanys.org)

"A medical home is not a place, but a way to organize primary care so it's "the way patients want it to be." More than 10,000 practice sites and 50,000 clinicians have earned the NCQA PCMH Recognition seal."

THE WAY TO GET STARTED IS TO QUIT TALKING AND BEGIN DOING.

Walt Disney

QUESTIONS FOR THE AUDIENCE

1. What are some of the team-based care activities/services you have implemented at your respective organizations?
2. Do you feel empowered to implement team-based cared activities at your respective organizations?

REFERENCES

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3. Creating Patient-centered Team-based Primary Care (ahrq.gov)
4. UDS Clinical Quality Measures 2021 (bphcdata.net)
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THANK YOU

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