Team-Based Care: Overcoming Clinical Inertia to Improve Patient Outcomes

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Major Health Partners

INTRODUCTION

Despite pharmaceutical advancements to treat diabetes and its associated cardiovascular risks, patients with diabetes are still 2-4 times more likely to die from cardiovascular disease than those without diabetes.

Major Health Partners (MHP) has addressed this clinical challenge by implementing a team-based collaborative care model that utilizes evidence-based protocols aimed at improving patients' cardiometabolic health.

Our multidisciplinary team collaborates to address cardiovascular risk factors related to cardiometabolic health, while supporting improved quality of life, and educating patients on the importance of diabetes self-management.

OBJECTIVES

- Improve the quality of health (A1c, Blood Pressure, LDL) and quality of life for our patients with Type 2 Diabetes
- Develop standard treatment protocols and pathways that promote guideline directed medical therapy for the treatment of Type 2 Diabetes and related comorbid conditions
- Increase clinical knowledge-base related to cardiometabolic disease states and risk factors
- Improve communication between primary care and specialty care partners to ensure alignment of care plan and goals
- Improve patient engagement through the promotion of diabetes self-management education
- Create a sustainable program that supports clinical best practice and diabetes self-management via team-based health care

DEFINING TEAM-BASED CARE

The Institute of Medicine defines team-based care as "the provision of health services to individuals, families, and/or communities by at least two healthcare providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient—to accomplish shared goals within and across the continuum to achieve coordinated, high-quality care".

PRIMARY CARE MODEL

PREPARING FOR CHANGE

Partnership - MHP joined the Cardiometabolic Center Alliance (CMCA) in 2021. Founded on the success of the Haverty Cardiometabolic Center at Saint Luke's, the CMCA's mission is to promote team-based care and the use of guideline directed medical therapies to treat Type 2 Diabetes and its comorbid related cardiovascular diseases. As a member of the CMCA, MHP has access to their state-of-the-art treatment guidelines and tools to deliver expert care to our patients.

Workgroups - Primary Care Council was created to support the efforts of the new team-based care model. This forum included key stakeholders from primary care, cardiology, and nephrology, which created a platform to engage the specialists, share the primary care protocols, and discuss avenues for improved coordination.

Assigned Roles - Each team member received clearly defined roles and responsibilities related to the team-based care model.

Disease State Pathways - Each team member received in depth education related to the newly established guidelines and protocols. This education included medication therapies, treatment plans, coordination of care, patient education, and triaging social and economic needs.

Expanded Educational Opportunities - Physicians, advanced practice providers, and registered nurses, were offered additional training through the Foundations of Cardiometabolic Health and Lifestyle Medicine certification courses.

FUNCTIONALITY OF TEAM

As an adjunct to the structured pathways and protocols, the primary care led team customizes individual care plans to meet the specific social, economic, and medical needs of each patient we serve. Our team routinely assess for:

- Diabetes Distress
- Social Determinants of Health
- Affordability of Medications
- Medication Adherence and Tolerance

PROCESS

Pre-visit Preparation - Clinical staff review lab values, specialty care chart notes, diagnostic testing, nursing care plans, and medical care plans. Charts are assessed for gaps in care related to patient engagement, quality measures and guideline directed medical therapy best practices.

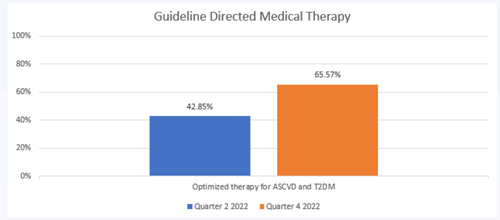
Patient Centered Clinic Visits - Utilizing joint decision making, the patient participates in the creation of their care plan based on informed decision making coupled with their personal healthcare priorities.

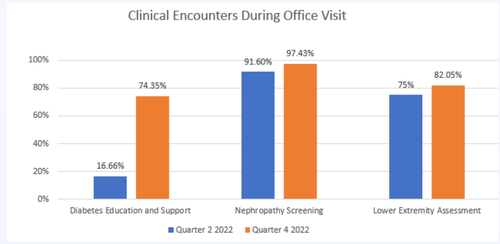
Strategic Education Plans - Staff provide targeted education related to the patient's disease state, medications, self-management, lifestyle modifications, and healthy coping during their visits.

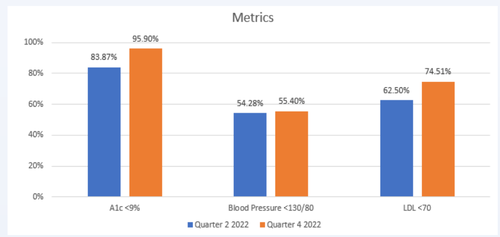
Telephone Encounters - Nurses provide post-visit follow up calls to ensure that the patients understand their plan of care, can afford their medications, and are tolerating their medications well. Titration plans, blood pressure logs, glucose trends and weight management goals are all reviewed during these calls as well.

Post-visit Coordination of Care - Nurses communicate care plan changes with multidisciplinary team members and specialty care providers.

RESULTS







Following best practice pathways and protocols has led to a 65% optimization for our high-risk patients with Type 2 Diabetes and ASCVD. Utilizing our team-based approach has ensured that the medications are affordable, safely administered, and well tolerated. This collaborative approach has improved the quality of care and health outcomes in those living with cardiometabolic disease.

CONTACT INFORMATION

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MHP MAJOR HEALTH PARTNERS

Proud Charter Member of Cardiometabolic Center Alliance. Founded by Saint Luke's Mid America Heart Institute