Team-Based Care

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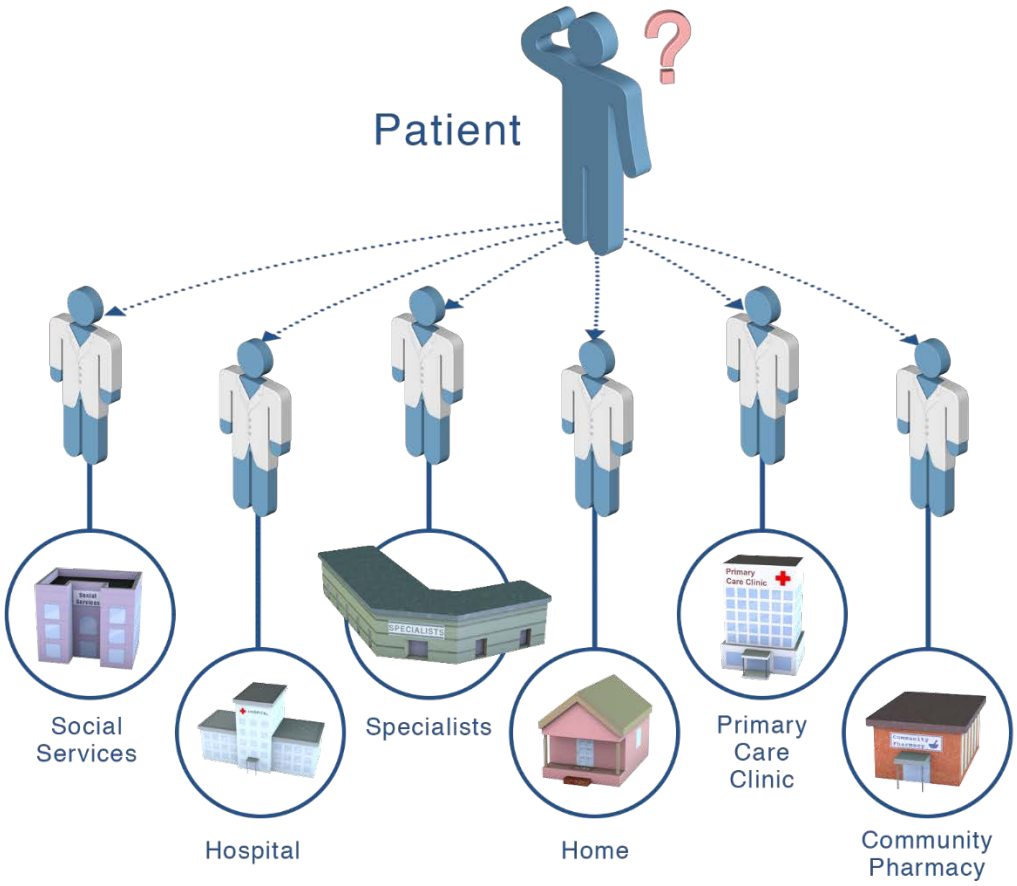
Managing patient health is a complex task, requiring the support of a multi-disciplinary healthcare team. Traditionally healthcare providers have worked independently.



However, the movement towards team-based care and outcomes-based reimbursement requires collaboration between healthcare providers to meet patient-care goals.

Team-based care

Team-based care can be defined as:

> *"…the provision of health services to individuals, families, and/or their communities by at least two healthcare providers who work collaboratively with patients to accomplish shared goals within and across multiple settings to achieve coordinated, high-quality care."*[1-4]

In team-based care, the services offered by one provider differ from—but complement—those supplied by another facility. All of the providers combine their specific skills and knowledge to achieve a common goal: providing optimal healthcare for their patients.

Team-based care is complex. Like the gears in a clock, all of the moving pieces must work together.

Developing a team

To develop and maintain a multi-disciplinary healthcare team, team members must:

- Effectively and efficiently provide help, assistance, and/or exchange needed resources (i.e., information) within the team
- Perceive that patient care goals can be met if, and only if, members work together as a team
- Utilize appropriate social skills, such as effective communication, trust, support, and conflict management

Integrating the team

It has been said that it "takes a village" to raise a child. This metaphor applies to the healthcare industry, too: it takes a medical neighborhood to successfully care for patients. A medical neighborhood:

> *"…consists of the patient's primary care provider and the other healthcare providers who provide health services to patients within it, along with community and service organizations. It is important to note that the neighborhood is not necessarily a geographic construct, but instead of set of relationships revolving around the patient and his or her healthcare needs."*[5]

While the healthcare providers who care for a patient vary depending upon the situation, the principles of team-based care remain the same regardless of the provider. Researchers at the UNC Eshelman School of Pharmacy interviewed community pharmacists, prescribers, and care managers to understand how these principles impact medical neighborhoods like the one shown below.

Team-based care in a medical neighborhood

Team-based care is based upon six guiding principles that influence the interactions between providers. These principles apply to all providers, with each provider integrating each principle into its day-to-day operations. The six principles are described below.

1. **Identify the best method for communication and your point person at the practice.**

   Seek the best approach to sharing medical information. Some practices might prefer that you send them a fax with a specific cover page to catch their attention, while others might prefer a phone call. Some practices might have an electronic medical record that allows you to securely message them.

It is also important to determine who on the team will be communicating with you regarding a patient's care plan. Some prescribers might want you to contact them directly, while others might want you to contact their nurse or front desk staff.

"Each practice that you deal with has a preference for how they like to communicate, so it's helpful to talk to them and find out what they like. That way they won't wind up with 10,000 faxes on their desk that they don't have time to read."– Community Pharmacist

2. Identify the roles for all members of the care team.

The care team includes the community pharmacist, pharmacy technician, prescriber, nurse, care manager, etc. Community pharmacist roles may vary based on the specific team needs, patient type, and reimbursement opportunities available.

"I just think everybody has to understand what their role is and be open to having a multidisciplinary team and being okay with missing things and making mistakes every once in a while. We all do." – Physician

"And too, the primary care provider knows that we've already done the medicine part, but there are things that we cannot do, so I think it is knowing your role. And our role is medication, and sometimes there are living conditions that may or may not affect medication. So, we need to have our own separate roles, but then at the same time we need to recognize where they overlap, and to me that is the other piece that's huge" – Community Pharmacist

"It really helps us to talk to that doctor and say, 'What is your A1C goal for this patient?' We can then meet with the patient one-on-one to really focus on adherence and lifestyle modifications, and we can say, 'This is what we want your goal to be after three to six months.' When we check—or have the doctor recheck—a patient's A1C, we're able to say, 'Hey, this is what happened.' So it's just basically an extension of what the doctor provides as far as goal setting. It's more like a health coaching kind of thing" – Community Pharmacist

3. Measure impact and conduct continuous quality improvement.

The impact of team-based care can be measured in a variety of ways, including:

- Clinical outcomes (improved blood pressure control or decreased A1c levels)
- Process metrics for a defined population (falls risk screening for patients ≥ 65 and on four or more unique medications)
- Improvement in medication adherence

Consider scheduling quarterly or annual meetings to review the measurements and determine a plan to improve outcomes going forward.

"We know our collaboration with physicians and nurses is working when we see patients meet their goals. For example, we'll talk to a doctor and ask about her goals for a patient. We then meet with the patient one-on-one to focus on adherence and lifestyle issues. We can also look at certain labs, such as hemoglobin A1c, to see if the patient is meeting the goal. We share our success stories with the physicians and nurses at the practice to let them know what we accomplished in a certain period of time." – Community Pharmacist

4. **Determine resources needed by team members.**

   Work with other team members to determine the resources needed. For example, primary care practices might need a patient's adherence to prescribed medications, or they might request home delivery for a patient. Let team members know what you need to conduct patient care (i.e., medication changes, hospital discharge information).

   "We had a patient who was a poorly controlled diabetic. I kept augmenting insulin, and it didn't really matter what I did because nothing was working. It turns out he wasn't filling his diabetes medication except for when it was time for an office visit. He would fill them then so he could bring in his pill bottles and show me that he had his medication. The community pharmacy had access to his billing record, of course, so when I talked to them, we demystified a lot of things." – Physician

5. **Communicate with patients.**

   Let patients know that you work with other members of their care team. Encourage the prescriber or care managers to let their patients know you work together to improve their health.

   "We let our patients know that we work closely with their community pharmacist, especially when there's a specific goal we're working on. For example, if we're trying to get a patient's blood sugar down, then we tell the pharmacist what we're trying to accomplish—and the patient knows that we do this. That way everyone is pulling in the same direction." – Physician

6. **Identify shared goals.**

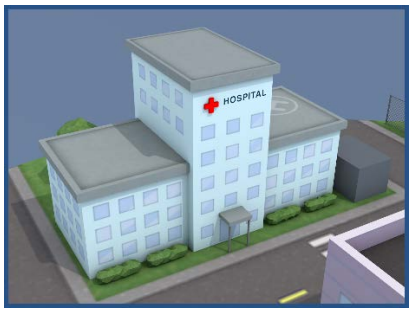
   Schedule a face-to-face meeting with a local medical practice to determine shared goals. During this meeting, share your community pharmacy's goals and identify the services you can offer to help the practice.

   "We took the time to sit down face-to-face and get to know each other. We talked about the services the pharmacy offered—and its goals—and then we realized that of course our goals align. We all want what's best for our patients." – Physician

An example

Bob is a 67-year-old man who has chronic obstructive pulmonary disease (COPD). He has been in the hospital for a COPD exacerbation and is being discharged today. This is his third hospitalization in the past two months.

The discussion that follows illustrates how his healthcare team works together to provide team-based care and prevent his rehospitalization.



Hospital

During his hospital stay, Bob was prescribed a new maintenance medication for his COPD. The hospital sends a prescription for the new medication to the community pharmacy. Per an earlier agreement, the hospital also sends a copy of Bob's discharge summary. Using the information on the discharge summary, the pharmacy performs a medication review to ensure that Bob is on the correct medication. The pharmacy also provides medication education as necessary.

Pharmacy

When Bob goes to the pharmacy to pick up his medication, the pharmacist performs a comprehensive medication review (CMR) and discovers that Bob cannot afford his medication. She also finds out that Bob has been using a rescue inhaler multiple times a day instead of his maintenance inhaler. Additionally, Bob reveals that he does not own a car, which makes transportation to the pharmacy and to the doctor challenging.

Social services

The community pharmacist refers Bob to a care manager who helps him fill out an application to receive extra help. The care manager will conduct home visits to ensure that Bob has everything he needs. She will also arrange transportation for follow-up appointments with his primary care provider (PCP) and his pulmonologist.

Primary care clinic

The community pharmacist lets Bob know that she works with his care manager, primary care provider, and specialist to make sure that he receives the best care possible. She sends a message to Bob's PCP to let him know Bob has been in the hospital for a COPD exacerbation and has started on a new medication. She lets his PCP know she already conducted a CMR, provided medication education for his new medication, reconciled his active medication list, and identified medication-related problems. She sends this list to the PCP's nurse via

electronic health record secure messaging. In previous meetings, it was determined that Bob's PCP prefers this form of contact when communicating with patients.

Specialist

The community pharmacist contacts Bob's pulmonologist and provides a message similar to the one she shared with his PCP. That is, she tells the pulmonologist that she conducted a CMR, provided medication education for his new medication, reconciled Bob's active medication list, and identified medication-related problems that pertain to the specialist.

When Bob visits his pulmonologist next week, the doctor will inform him that he has received an active medication list from Bob's community pharmacist. This information will help the pulmonologist spend most of the appointment assessing Bob's COPD.

Home

Bob's healthcare team monitors his hospital visits and notices that he has not been readmitted after 30 days. This exciting news suggests that their collaboration is working!

Summary

Providing excellent healthcare requires a multi-disciplinary team, where all members of the team work together towards a common goal: optimal health for their patient.

While creating an integrated healthcare team can take time and effort, the end result—better patient outcomes—is worth it. We hope that you agree, and we encourage you to make steps towards building a medical neighborhood in your pharmaceutical practice.

Resources

The following resources were accessed during the creation of this module.

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5. Taylor EF, Lake T, Nysenbaum J, Peterson G, Meyers D. Coordinating care in the medical neighborhood: critical components and available mechanisms. White Paper (Prepared by Mathematica Policy Research under Contract No. HHSA290200900019I TO2). AHRQ Publication No. 11-0064. Rockville, MD: Agency for Healthcare Research and Quality. June 2011.