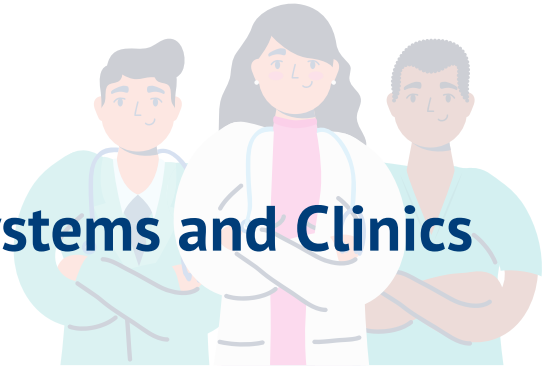
Team-Based Care Tool for Wisconsin Health Systems and Clinics



Background

Heart disease, stroke, and other cardiovascular diseases are among the leading causes of death in Wisconsin, and now kill more than 12,000 adults each year. Of these,[1] over 2,000 are younger than age 65. Two main reasons people have a heart disease or a stroke are high blood pressure and high cholesterol, which are common, deadly, and preventable. Nearly half of adults have hypertension, and only one in four adults with hypertension have their condition under control.[2] About one-third of adults have been told they have high cholesterol.[3] Only about half of adults who could benefit from cholesterol medicine are currently taking it.

The Community Preventive Services Task Force recommends management of patients by interdisciplinary teams to improve blood pressure control.[4] The literature review that this recommendation is based on also found interdisciplinary teams to be effective in improving cholesterol management. Care provided by interdisciplinary teams is often referred to as team-based care (TBC).

TBC is established by adding new staff or changing the roles of existing staff to work with a primary care provider. Each team includes the patient, the patient's primary care provider, and interdisciplinary health professionals such as nurses, pharmacists, dietitians, social workers, patient navigators, and/or community health workers.

Inter-disciplinary teams provide process support such as team huddles and share responsibilities of care to complement the activities of the primary care provider. These responsibilities include medication management, patient follow-up, as well as adherence and self-management support.

Some patient populations are affected disproportionately by high blood pressure and high blood cholesterol in Wisconsin. Evidence shows that TBC approaches to care have significant potential to reduce disparities.[5]

The Chronic Disease Prevention Program (CDPP) in the Division of Public Health is encouraging health systems and clinics to implement TBC approaches for patient populations experiencing hypertension and high blood cholesterol disparities.

This tool can help your health system or clinic plan for implementing TBC approaches for patient populations experiencing hypertension and/or high blood cholesterol disparities. This tool is intended for use in helping implement TBC interventions, and is provided as a resource that does not need to be submitted back to CDPP in the Division of Public Health.

Health System/Clinic and Contact Information

Health System

Clinic(s)

Address **City** **State** **ZIP**

Name and Title of TBC Project Lead

Phone

Email

Patient Population

Describe your current patient population affected by diagnosed hypertension and high blood cholesterol.

Hypertension

Timeframe data represents (ex: May 1, 2020 – May 1, 2021)

Number of patients in your health system or clinic aged 18 to 85

How many of those patients were diagnosed with hypertension

Of those with hypertension, how many patients' most recent blood pressure was < 140/90

Patient Population Continued

High Blood Cholesterol

Timeframe data represents (ex: May 1, 2020 – May 1, 2021)

Number of patients in your health system of clinic aged 21 or over

Of those, the number of patients who meet one or more of the criteria that are considered high-risk for cardiovascular events under ACC/AHA guidelines

Of those, the number of patients who received at least one prescription for statin therapy

Before moving on to the next section...

Consider the following questions:

- What percentage of our patients with diagnosed hypertension are not in control?
- What percentage of our patients at high-risk for a cardiovascular event are not prescribed a statin?
- Are there specific patient populations who are not in control of their hypertension or who have not received a statin but are high-risk? How can you stratify your data to identify disparities?
- What TBC interventions might be targeted to reach the patient populations at highest risk?

TBC Assessment

Select all of following TBC approaches your health system or clinic currently has in place. Select at least one approach you intend to implement or enhance to maximize impact for patient populations experiencing hypertension and/or high blood cholesterol disparities.

TBC Approach	Current	Future
Addressing social determinants of health by integrating data into an action plan to improve clinical access and patient engagement in care.		
Standardized or structural integration of non-physician professionals, such as nurses, pharmacists, dietitians, social workers, patient navigators, and/or community health workers into the delivery of health services with established bi-directional feedback.		
Structured or standardized pre-visit planning/anticipation and planning for upcoming patient visits (i.e., structured communication, dashboard in the EHR, checklist, appointment notes, etc.).		
Structured communication process or regular care-team meetings for sharing patient information, care needs, concerns of the day and other information that encourages efficient patient care and practice workflow.		
Integration and inclusion of the patient/family/caregiver as part of the team in identifying treatment goals and self-management plans.		
Staff involvement in quality improvement that includes care team staff in the practice's performance evaluation and quality improvement activities.		

TBC Project Description

You've described your patient populations of focus. You've also assessed existing TBC approaches and identified ones you'd like to implement. Now it's time to describe your TBC project in greater detail, including who will be involved and your anticipated timeline.

Briefly describe how you intend to implement the interdisciplinary TBC approach(es) selected in the assessment at your health system or clinic.

Who will be involved in implementing the approaches? Include both internal staff and external organizations providing support.

Explain how your interdisciplinary TBC approaches will be tailored to meet the needs of populations you identified on page three.

What is the estimated timeline for your project?

Monitoring and Reporting

To evaluate your TBC approach(es), consider using the following information and data:

- Description and characteristics (e.g., specific age range, race/ethnicity, gender) of the priority population targeted by your approach(es).
- Documented progress on implementation or enhancement of the intended TBC approach(es) identified. Documentation could include resulting workflows, policies, Plan-Do-Study-Act (PDSA) cycles, etc.
- Blood pressure control and cholesterol management rates for priority population(s), and change from baseline over the course of the project.
- Successes, challenges, and lessons learned from this TBC partnership.
- Intention for sustaining interdisciplinary TBC approaches.

Need more help from CDPP on your TBC Project?

If you're interested in partnering with Chronic Disease Prevention Program (CDPP) on the TBC project you outlined in this tool, we'd love to work more closely with your health system or clinic. Get in touch with us at **DHSChronicDiseasePrevention@dhs.wisconsin.gov**.

What are the benefits of working with CDPP on a TBC project?

The benefits of working with CDPP include technical assistance and guidance on implementing TBC approaches for populations experiencing hypertension and/or high blood cholesterol disparities. This includes:

- Connections to other health systems and clinics implementing TBC.
- One-on-one assessment to determine how to best assist or support (e.g. review existing practices, policies and/or protocols and identify areas for improvement or enhancement).
- Access to subject matter experts, templates, resources and trainings.
- Guidance on interdisciplinary TBC project design, documentation, evaluation, and implementation of approaches for specific patient populations.
- Statewide recognition on our CDPP website.

Resources

Wisconsin Collaborative for Healthcare Quality

- Improving Hypertension Care & Outcomes Toolkit
- Disparities Report

Wisconsin Nurses Association

- Patient-Centered Team-Based Care in Wisconsin: A Working Conceptual Model
- Guidelines for Management of Persons with Hypertension and High Cholesterol Using Patient-Centered Team Based Care, Online Self-Study Program (Continuing Education Credit available, 0.75 contact hours)

National and *Million Hearts*®

- Hypertension Control Change Package (2nd ed.)
- National Association of Community Health Centers Million Hearts® Initiative
- Addressing Social Determinants of Health in Primary Care: Team-Based Approach for Advancing Health Equity

Evaluation and PDSA Support

- Quality Improvement Essentials Toolkit, Institute for Healthcare Improvement
- Tools and Resources for Practice Transformation and Quality Improvement, Agency for Healthcare Research and Quality

Citations

1. Wisconsin Dept. of Health Services, Division of Public Health, Office of Health Informatics. Wisconsin Interactive Statistics on Health (WISH) data query system, https://www.dhs.wisconsin.gov/wish/index.htm, Mortality Module, accessed 06/21/2021.
2. Centers for Disease Control and Prevention. Hypertension Cascade: Hypertension Prevalence, Treatment and Control Estimates Among U.S. Adults Aged 18 Years and Older Applying the Criteria from the American College of Cardiology and American Heart Association's 2017 Hypertension Guideline—NHANES 2015–2018. Atlanta, GA: U.S. Department of Health and Human Services; 2021. Accessed March 12, 2021.
3. "High Cholesterol Facts." National Center for Chronic Disease Prevention and Health Promotion, Division for Heart Disease and Stroke Prevention. Centers for Disease Control and Prevention. Accessed November 23, 2021. Available online at cdc.gov/cholesterol/facts.htm.
4. "Cardiovascular Disease: Team-based Care to Improve Blood Pressure Control." Community Preventive Services Task Force. Accessed November 23, 2021. Available online at www.thecommunityguide.org/findings/cardiovascular-disease-team-based-care-improve-blood-pressure-control.
5. "Promoting Team-Based Care to Improve High Blood Pressure Control." Division for Heart disease and Stroke, Centers for Disease Control and Prevention. Accessed November 23, 2021. Available online at www.cdc.gov/dhdsp/pubs/guides/best-practices/team-based-care.htm.

Direct any questions about this tool to:

DHSChronicDiseasePrevention@dhs.wisconsin.gov
Chronic Disease Prevention Program
Division of Public Health