Interprofessional care teams

CORNERSTONES FOR VALUE-BASED OPERATIONS

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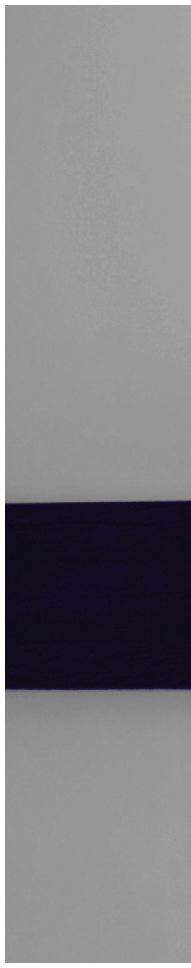

The model of coordinating patient care among clinical disciplines historically has often been composed of separate and distinct clinical departments and programs. Hand-offs took place through clinical order sets and modalities — from physician to pharmacist, nursing, social work, etc.

Academic literature provides ample evidence of the shortcomings of these traditional care models and segmentation in scope of practice among clinical professionals. Furthermore, looming and current labor shortages of clinical providers, coupled with cost pressures, provides a fitting climate for new and imaginative interprofessional care delivery models.[1]

The emergence of value-based care, including the formation of accountable care organizations (ACOs), has spurred efforts to curb costs and reduce waste. The cornerstones to continuing to build upon this movement and migrate from traditional fee-for-service are the effective deployment of interprofessional education (IPE) curricula and the formation of interprofessional practice (IPP) delivery teams.[2]

Applying this team concept offers potential to reduce waste and cost and improve outcomes in patient care and population health. A team-based care delivery model can provide patients with navigation assistance that may otherwise be left to the patient to solve. This smooth transition within a team, from provider to provider, reduces barriers to care for patients and may lead to improved patient satisfaction results when compared to results from patients who did not receive navigation assistance.[3]

Further, team-based care provides clinicians with the opportunity to gather and access more data about their patient population, leading to better-informed decision-making and the opportunity for both retrospective analysis and prospective revision to care delivery. Academic literature also supports informed decision-making and corollaries with better outcomes for patients within the team's patient population.

Perhaps most important is a patient's preference for continuity in care delivery. Patient engagement is a critical component in reducing overall cost of care and improving health outcomes. A positive correlation exists between increased patient activation and improved health outcomes as well as increased patient activation and reduced overall costs.[4] Patients have the best opportunity to be engaged in their health in a team-based care model in which there is continuity of communication between clinicians, consistent feedback from clinicians and a single, easy-to-use portal for patient information.

A team-based approach is great for the provider as well. Team-based approaches such as

ACOs provide the opportunity for health systems to merge and collaborate for the benefit of the patient population. For example, the recently established Southwestern Health Resources Clinically Integrated Network between UT Southwestern and Texas Health Resources in Dallas allowed two large systems, through modified incentives for quality and cost reduction, to combine resources, share data, improve quality and patient experience and save nearly $70 million in Medicare Shared Savings since its inception.[5]

To continue advancing the benefits of team-based healthcare, healthcare organizations should embrace continuous quality improvement. Through the incorporation of the aforementioned data resources, the overall effectiveness and utility of the team-based care delivery model may be objectively examined. This is already taking shape in smaller limited initiatives between government and commercial payers and organizations (See Table 1 on page 120 for specific examples).

Objective improvement occurs when one achieves a different result on a performance indicator than previously achieved. To enable this for team-based healthcare, team members — from physician to social workers — require concise performance data. Further, making this data transparent for everyone provides team members with a baseline for improvement and helps hold team members accountable for poor performance.

Team-based care success also requires an understanding of how to maximize the licensure, scope of practice and skill set of each member of the patient care team. Emergency medical technicians (EMTs), registered nurses (RNs), social

TABLE 1. VALUE-BASED CASE STUDIES USING INTERPROFESSIONAL PRACTICE MODELS

LOWERING COST AND IMPROVING ENGAGEMENT IN CHRONIC DISEASE

To combat childhood asthma, Mobile Care Chicago (a non-profit organization) utilized team-based initiatives to improve asthma care access and save the local health system an estimated $6.7 million. Mobile Care Chicago begins identification of asthma symptoms at local schools, uses traveling vans to provide convenient access, employs medical assistants and nurse practitioners to evaluate patients, and deploys community health workers to visit patients' homes and discuss their care plan when necessary: **bit.ly/2IyL3mn**.

IMPROVING BEHAVIORAL HEALTH MANAGEMENT, REDUCING ER UTILIZATION

In a study of primary care/behavioral health integration, Intermountain Healthcare reduced emergency department (ED) visits from their patients by 23% relative to the patients who did not receive care at team-based sites. At the team-based sites, Intermountain utilized social workers and psychiatrists to support primary care physicians and noticed lower ED visits, lower hospitalization rates and higher use of self-care plans: **bit.ly/2v8oahH**.

HOME CARE AND READMISSION REDUCTION THROUGH PARAMEDICINE

In Gainesville, Fla., the Community Resource Paramedic (CRP) Program uses EMTs to visit patients in their homes to check up on their health, provide education on improving social determinants of health and refer them to proper levels of care if necessary. The CRP also partnered with four UF Health primary care clinics to facilitate communication between patients and their RN health coaches as well as to ensure patients are following the care plans provided by their physicians: **bit.ly/2UHgwdp**.

TELEBEHAVIORAL HEALTH DEPLOYMENT

Atrium Health established a centralized telemental health service unit that virtually links the health system's primary care offices and EDs with behavioral health experts. A pre-/post-intervention analysis showed primary care patients experienced a decrease in depression and anxiety symptoms as well as avoidable hospitalizations, saving the system $78,000. Virtual access in the ED also decreased ED length of stay: **bit.ly/2v8TyNk**.

CHRONIC DISEASE REMOTE MANAGEMENT

In Louisville, Ky., the Air Louisville Program doubled the amount of symptom-free days for patients with asthma and chronic obstructive pulmonary disease (COPD) through collaborations from multiple entities, including Propeller Health, Louisville Metro Office of Civic Innovation and the Institute for Healthy Air Water and Soil. By providing a sensor on inhalers of enrolled participants, the program could collect data on patient inhaler habits, send health data directly to patients' smartphones and identify areas in the community that were negatively contributing to the quality of life of asthma and COPD patients: **bit.ly/2suTqE7**.

workers, physician assistants (PAs), advanced practice nurses, psychologists and therapists vary in their scope from state to state. Defining how each team member contributes and participates in the care model is key.

In addition to labor shortage challenges, geographical barriers may also limit the ability to care for defined disease states or patient populations. Leveraging technology as part of the team care delivery model is useful, as technologies such as remote patient monitoring and other forms of telehealth can help coordinate care. Telebehavioral health is another example of how the team-based model can succeed with new technology.

Alternate delivery models and the maximization of the skill set and availability of existing clinical staff are the cornerstones to interprofessional teams. Team-based care, in its simplest form, is the provision of health services to individuals and communities by a group of health professionals of different skill sets working collaboratively to achieve the common goal of safe, patient-centered, effective, timely, equitable and efficient care. This care delivery structure — in both small-scale and large-scale environments — is rapidly proving to be the ideal care coordination and delivery model of the future. Healthcare leaders and educators should examine how to best educate and establish care delivery teams as value-based care continues to mature. ■

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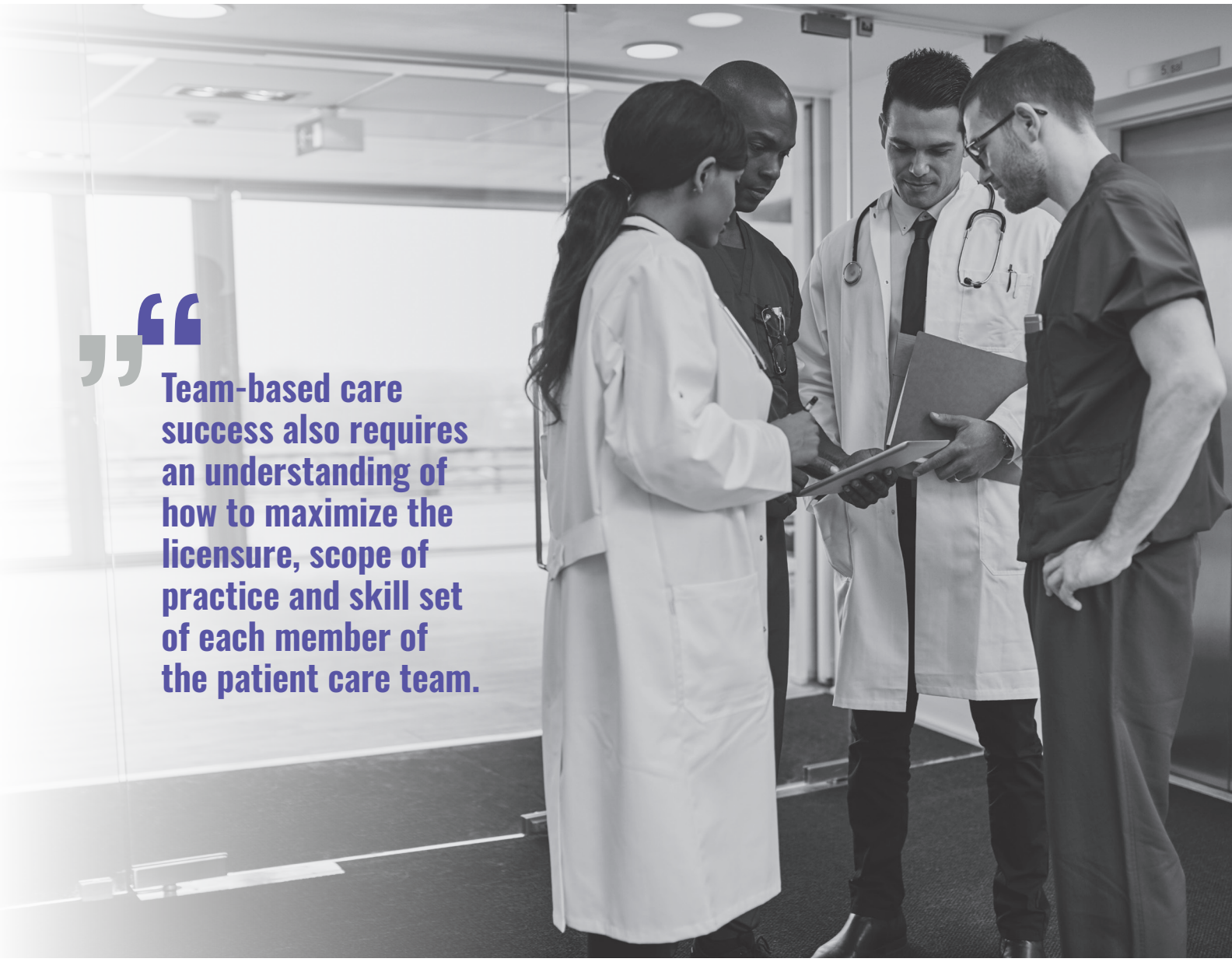

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NOTES

1. Reiss-Brennan B, Brunisholz KD, Dredge C, Briot P, Grazier K, Wilcox A, Savitz L, James B. "Association of integrated team-based care with health care quality, utilization, and cost." *JAMA*. 2016 Aug 23-30;316(8):826-34. doi: 10.1001/jama.2016.11232.
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