Preparing an Inter-Professional Team to Care for Multiple Chronic Health Conditions
Why Chronic Health Conditions?

- The cost of care for people with a chronic health condition is disproportionately high.

- The cost of care for people with multiple chronic health conditions is higher still.

- People with chronic health conditions are often poor, in pain, and die prematurely.
The Chronic Care Model

Community
Resources and Policies
Self-Management Support

Health Systems
Organization of Health Care
Delivery System Design
Decision Support
Clinical Information Systems

Improved Outcomes

Informed, Activated Patient

Productive Interactions

Prepared, Proactive Practice Team

Developed by The MacColl Institute
® ACP-ASIM Journals and Books
Why an Inter-Professional Team?

- Is the Chronic Care Model the most effective approach we have to help a person manage a chronic health condition?

- Does it make sense to help a person address multiple chronic health conditions, including psychiatric conditions, together rather than in a separate program for each condition?
Purpose of the Team

To help a person manage his or her health conditions well enough so that those conditions don’t interfere with how that person wants to lead their life.
Typical Patient

- Morbid Obesity
- Osteoarthrosis
- Benign Hypertension
- Schizoaffective Disorder
- Diabetes, type 2
- Sleep Apnea
- Fybromyaglia
The Team Staff

- Internal Medicine Physician (1 FTE)
- Psychiatrist (0.5 FTE)
- Physician’s Assistant (0.5 FTE)
- Health Coach (5.5 FTE)
- Nurse (1 FTE)
- Medical Assistant (2 FTE)
- Case Manager (2 FTE)
- Peer Support/Recovery Coach (1 FTE)

Also available:
- Pharmacist, Dentist, Nutritionist, benefit acquisition, housing and transportation referral
Some Key Characteristics

- Unwavering attention to the Team’s Purpose.
- One EHR based treatment plan, created and used by all team members within their scope of practice.
- Every team member contributes as an equal.
- Daily huddle of the entire team to share relevant information about the day’s appointments.
- As much is done on the team as possible. Care becomes seamless, convenient, and effective for the patient.
The Learning Curve

- Get the right people.
  - Ability to act, and let others act, as equals.
  - Unwavering focus on the Purpose of the team.
  - Welcome constant change – CQI, seriously.

- Learn a new language, and maybe create one – MI is not an MI, a note is not a note, objective is not an objective, biopsychosocialwhatsit?
  - Respect for each other’s interventions.
  - Willingness to practice communication.
The Learning Curve

- So many disease states, so much to learn, so much that used to be ‘not my problem.’
  - For the care of the patient, everyone is responsible for everything.
  - Know enough about all of the conditions and their treatment so that there are no silos, no gaps, no conflicts.
  - Interventions don’t belong to just one profession.
  - Constantly learn and teach. Everyone participates in all team training.
The Learning Curve

- Learning about something is not the same as learning how to do it.
  - Start with patients. Learn the concept from the experience.
  - Training and practice are forgotten if one’s not doing it. The two are inseparable.
  - Ongoing practice under expert coaching. That means everything, from specific interventions to the language used to talk about patients. New skills need to be modeled and reinforced, sometimes over and over again.