



Tools to Support Care Team Development and Utilization

Workforce Development

This resource was supported by the Grant or Cooperative Agreement, 17NU58DP006361-05-02, funded by the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention or the Department of Health and Human Services.

Purpose

Health centers possess varying care teams within their complex systems. Care teams can be cross functional and utilized interchangeably throughout the health center. Defining each care team’s role, and the role of each care team member, is important when implementing change. The purpose of this document is to: (i) describe a care team; (ii) explain how your health center could utilize a care team to implement the National Diabetes Prevention Program (National DPP) lifestyle change program; and (iii) identify tools to support care team development and utilization.

What is a Care Team?

A clinical care team consists of health professionals with the training and skills needed to provide high quality care to meet patient needs. The efforts of this team need to be coordinated and specific to the individual patient. Utilizing a clinical care team is often referred to as implementing a “team-based model of care.” One component of this model is having different care team members accept specific responsibilities for portions of a patient’s care as the patient’s outcomes improve or as their needs change.

[The American College of Physicians](#) states that clinical teams are essential for the delivery of high value healthcare and have been associated with:



An effective care team can improve the quality and safety of patient outcomes. The need for effective care teams is crucial due to an increasing prevalence of chronic diseases and expanding complexity of care. Achieving these positive outcomes can only be achieved by placing the patient in the center of focus. Aiming towards this goal, team members should implement strategies and practical skills in order to achieve goals and overcome challenges.

The [National Institutes of Health](#) defines different types of care teams, all which may operate within the same health center. While each team has different roles, the combination of these teams works towards the overarching goal of coordinating patient care. These teams include:

Core Teams

- The individuals that make up this team are directly involved in caring for the patient.

Coordinating Teams

- The group responsible for operational management, coordinating functions, and resource management for core teams.

Ancillary Teams

- The group supports services that facilitate patient care.

Contingency Teams

- Formed to deal with specific events.

All of these teams are essential in providing comprehensive care for the patient. For example, in the context of a health center's [National Diabetes Prevention Program \(National DPP\)](#):

- The Core Team may include the Lifestyle Coach and other clinical members such as specialists, providers, and nurses. The Lifestyle Coach leads the lifestyle change program sessions and supports and encourages persons at risk for diabetes. The provider and nurse provide primary care services by managing and treating chronic conditions, including pre-diabetes. When these individuals need services outside the scope of primary care, they may be referred to a specialist such as an endocrinologist.
- The Coordinating Team may be the Program Coordinator and associated staff. The Coordinating Team oversees daily operations of the lifestyle change program, provide support to and guide Lifestyle Coaches, and ensure that the program meets quality performance outcomes.
- The Ancillary Team may include the data collector, who collects and sends data to the Centers for Disease Control and Prevention (CDC), and associated staff.
- The Contingency Team may include the health center's management staff who would be responsible for addressing long-term or permanent disruptions in the health center's National DPP.

Care Teams and the National Diabetes Prevention Program

The focus on individuals with chronic illness or other complex health needs has promoted the idea of team-based care, including persons at risk for type 2 diabetes. Team-based care acknowledges that there are multiple key players treating a person at risk for type 2 diabetes and that each player must effectively communicate and work together in order to drive optimal care outcomes.

While the staff of the National DPP is a care team in itself, there are parallel care teams that also treat persons at risk for type 2 diabetes. The integration of these teams will enhance the individual's ability to minimize the likelihood of disease progression and/or the development of comorbidities. Distinct care teams that may treat individuals in the National DPP are program staff members (e.g. Lifestyle Coach and Coordinator), the medical team, specialists, and ancillary services such nutrition and diabetes education.

Tools to Support Care Team Development

There are several tools that can assist in the development of care teams. Two tools of focus include Pre-Visit Planning and Huddles. These are common tools implemented in settings implementing team-based care models to help promote a patient centric environment.

Pre-Visit Planning

Pre-Visit Planning is a process where you plan for an individual's future appointments and provide a roadmap for the next visit. Health Centers can use Pre-Visit Planning to develop a plan of action for persons at risk for type 2 diabetes and their next visit, and use Huddles to communicate these plans. This process makes everyone prepared to make the most impact at the next encounter with the individual.

When it comes to providing care for people at risk for diabetes, you are often caring for someone with numerous comorbidities. This individual may be receiving care from several providers as well as be receiving other ancillary services. Pre-Visit Planning ensures that all the care teams participating in the individual's care have the appropriate information for assessment and treatment.

At the end of each visit, it is important to have a conversation with the person at risk for type 2 diabetes about the next visit. This provides the individual with the opportunity to be involved in self-management goals. For example, if the individual has not met their weight goal during a check-in with the Lifestyle Coach, the coach may work with the person on strategies to evaluate it at the next visit. It's important that the individual understands and agrees with the plan as well.

Some healthcare professionals use a Pre-Visit Planning Checklist. The checklist includes essential appointments, referral needs, interactions with ancillary staff, specialists, and clinical tests. These tools can assist the care team to be informed and efficient.

Your health center's care team and clinical leadership should collaborate together to plan what a Pre-Visit Planning Checklist will look like within your health center. The main goal of Pre-Visit Planning is to deliver high-quality, efficient patient care. Therefore, you should develop your Pre-Visit Planning Checklist with a clear understanding of what information is most helpful to review to provide the best quality of care for persons in the diabetes prevention program.

Prior to an individual's visit, members of the care team will look at the Pre-Visit Planning Checklist. This review helps identify gaps in care such as annual lab tests, preventive health screenings, or referrals to a Diabetes Care & Education Specialist or other health care professional. Your health center should consider reviewing this information prior to each individual's primary care visits, *as well as* before each session with the lifestyle change program. This information can be relayed to the Lifestyle Coach, who can use the lifestyle change program session to connect with the individual and identify opportunities to further connect the participant in the diabetes prevention program to care. Below, you will find an example of a Pre-Visit Planning Checklist.

Items	Patient Name
	Patient Date of Birth
	Primary Care Provider
	Primary Care Provider Notes
	Patient's Last Weight
	Patient's Last HgbA1c
	Care Plan Goals
	External Referral Follow-Up
	Patient Concerns and Needs

Huddles

Huddles are short meetings to communicate and provide information regarding patients' need for care. These meetings are a valuable tool in creating a cohesive approach within the care team when caring for patient populations.

The Huddles inform the care team of tasks and assigns responsibility to members of the care team. Health centers typically schedule these short interactions at the beginning of the day. Some health centers, however, have found it helpful to conduct Huddles multiple times during the day, such as:

- at the beginning of the day;
- when clinical teams switch shifts;
- at the end of the day in preparation for the following day; or
- midday, which allows care teams to only focus on one-half of their appointments at a time.

The Huddle gives care teams a way to actively manage an individual's overall care plan. Huddles enable teams to review individual's current status and to look ahead to pinpoint concerns proactively by creating a plan of action.

Health centers oftentimes integrate Huddles with Pre-Visit Planning. The information gathered during Pre-Visit Planning informs the discussions during Huddles. Using Huddles in the National DPP means that prior to each lifestyle change program session or individual patient interaction, National DPP staff would gather to discuss the needs of each patient in the cohort. Perhaps a patient needs a referral to a Diabetes Care & Education Specialist due to challenges with their diet. A participant may have an elevated HgbA1c and therefore needs to see their primary care provider to medically manage any contributing factors.

Health centers can also use Huddles to inform a National DPP staff about individuals who may be eligible for the program. For example, a primary care team may identify a person who has an increased BMI and is at risk for developing type 2 diabetes. It may be determined that this person will need to be referred to the National DPP.

In both these instances, the use of varying care teams provides an opportunity for the individual to receive multidisciplinary care.

Using a Huddle agenda is a structured way to organize thoughts of the care team into a communication tool. Below, you will find an example of how to create an agenda based on recommendations of the [Institute of Healthcare Improvement \(IHI\)](#).

Discussion Item	Description
Assessment of the Day	<p>During this time the care team discusses previous successes with patient goals, patient concerns, and opportunities for improvement.</p> <p>Example: Patient retention and appointment adherence, Completion of patient weight loss goals, newly referred patients, and the need to promote telemedicine visits to the patients for retention</p>
Pre-Visit Planning Items	<p>One person previews the patient panel for the day during Pre-Visit Planning and discusses any findings with the care team.</p> <p>Example: Need to refer patients to the primary care provider due to increasing HgbA1cs.</p>
Review of tracked issues: Follow-Up	<p>During this time, the care team discusses follow up items identified either through Pre-Visit Planning or in previous interactions with the patient.</p> <p>Example: Outcome of the patient’s referral to the Certified Diabetes Care and Education Specialist (CDCES).</p>
Any other issues?	<p>This includes add-on agenda items that the care team had not previously been able to discuss.</p>
Announcements	<p>This could include programmatic information that the care team members need to know.</p> <p>Example: Certified Diabetes Care and Education Specialists are the new terminology for Certified Diabetes Educators.</p>

Tools to Support Care Team Utilization

Referrals

Care Team referrals are essential for enrolling and retaining individuals in the National DPP. The CDC has noted that many healthcare professionals are not aware of the program and few refer their at-risk patients. Engaging health care teams in the referral process to the National DPP can enhance access and assist in increased utilization of the program. Tools to assist in engaging other healthcare teams are found [here](#).

Conclusion

The use of care teams is the best approach in managing individuals with complex healthcare needs. Each care team brings different expertise and perspectives on the patient’s status and needs. Use of care team tools such a Pre-Visit Planning Checklist and Huddles provide effective communication tools that improves the cohesiveness of the team. Implementing a referral process provides a means to coordinate care for patients requiring interdisciplinary care. As a result, patients receive optimal care through this holistic approach.