Team-Based Care

Team-based care is an evidence-based model that comprises the patient and the patient's primary care provider, and others such as nurses, pharmacists, dieticians, social workers, and community health workers. Team-based care is established by adding new staff or changing the roles of existing staff to work with a primary care provider.

These team members supplement the activities of the primary care provider by providing support and sharing responsibility for hypertension care, such as:

- **Medication management**
- **Patient follow-up**
- **Helping patients adhere to their blood pressure control plan**
- **Monitoring blood pressure routinely**
- **Taking medications as prescribed**
- **Reducing sodium in the diet**
- **Increasing physical activity**

Obesity, Diabetes, Heart Disease and Stroke Prevention (ODHDSP) Project

Team-Based Care

THE EVIDENCE

A review of 77 studies of team-based care by the Community Preventive Services Task Force showed that patients' control of blood pressure improved when their care was provided by a team of health professionals, rather than by a single physician.[1]

Key findings include:

- An increase in the proportion of patients with controlled blood pressure.
- A decrease in systolic and diastolic blood pressure.
- An improvement in patient outcomes for diabetes and blood lipids.

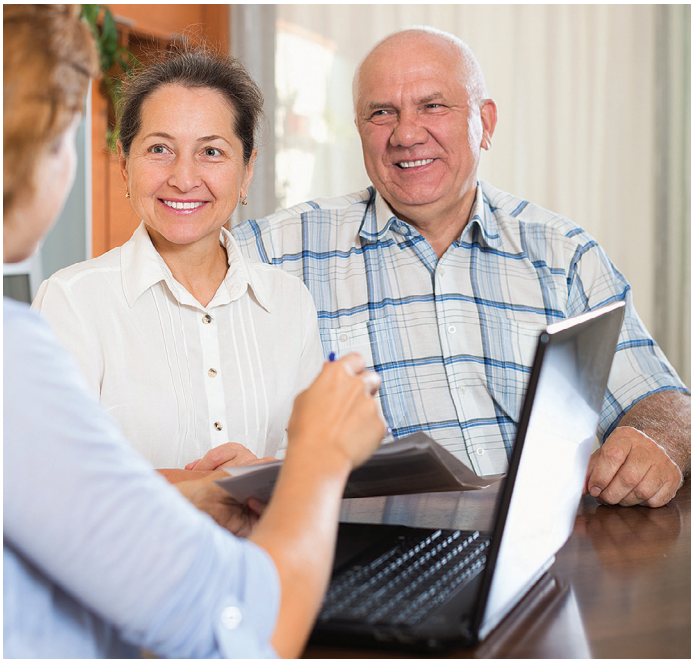
ROLE OF A PHARMACIST IN TEAM-BASED CARE

A pharmacist can counsel patients about proper medication use, administration, storage, and adverse reactions that might occur as well as assist with medication management and adjustments in medication for patients not at goal.

APPROACH

The Division of Public Health is partnering with Community Care of North Carolina to implement Pharmacy Centers of Excellence for Pharmacies participating in the CCNC Innovation Grant. Centers of Excellence is for pharmacies that want to have higher collaboration with their state and local public health partners around the areas of diabetes, pre-diabetes and hypertension. There are three levels of activities for each disease state. The levels are: basic, enhanced and advanced, ranging from providing education materials to implementing evidence-based strategies such as Team Up Pressure Down, Check Change Control, and Diabetes Prevention Programs.

A toolkit will be developed based on this collaboration, which will be utilized by the ODHDSP regional staff to provide technical assistance. Furthermore, the ODHDSP regional staff will recruit an additional 2–5 pharmacies/region and implement this toolkit/program with those select pharmacies.



ROLE OF A COMMUNITY HEALTH WORKER (CHW) IN TEAM-BASED CARE

Community Health Workers—including *promotores de salud*, community health representatives, community health advisors, and others—are frontline public health workers who serve as a bridge between communities and healthcare systems. They are from, or have an unusually close understanding of, the community served. Community health workers are trained to provide culturally appropriate health education and information, offer social support and informal counseling, connect people with the services they need, and in some cases deliver health services such as blood pressure screening.[2]

In a team-based care approach, community health workers partner with patients and licensed providers, such as physicians and nurses, to improve coordination of care and support for patients.

ODHDSP GRANT AND COMMUNITY HEALTH WORKERS

For Prediabetes/Diabetes Prevention

As part of the ODHDSP project, we are recruiting a team of Community Health Workers who have trained in evidence-based Diabetes Prevention Program curricula, whom we refer to as the "Lifestyle Coaches." These lifestyle coaches will deliver the CDC recognized Diabetes Prevention Program to people with prediabetes and help prevent the progression to overt diabetes. We aim to build a network of these lifestyle coaches and the recruitment is an on-going process.

For Hypertension Management/Control

As part of the ODHDSP project, the regional staff will recruit a team of Community Health Workers who will deliver the Check Change Control program, which is a four-month program focuses on increasing physical activity, healthier eating, and better management of high blood pressure through education, tracking, and health mentors who encourage participants to check their blood pressure readings. The trained CHWs will serve as volunteer health mentors for those newly diagnosed or those with uncontrolled hypertension. Each ODHDSP region is expected to recruit 8–10 CHW for this project.

For questions or technical assistance please contact: Sanga Krupakar at Sangamithra.Krupakar@dhhs.nc.gov or 919-707-5221.

1. Guide to Community Preventive Services. Cardiovascular disease prevention and control: team-based care to improve blood pressure control. www.thecommunityguide.org/cvd/teambasedcare.html.
2. Guide to Community Preventive Services. Cardiovascular disease prevention and control: interventions engaging community health workers. www.thecommunityguide.org/cvd/CHW.html

Community & Clinical CONNECTIONS for Prevention & Health Branch NORTH CAROLINA DIVISION OF PUBLIC HEALTH

This handout was produced by the Community and Clinical Connections for Prevention and Health Branch, Chronic Disease and Injury Section, Division of Public Health, NC Department of Health and Human Services. If you have any questions about information in this handout, please email contact@communityclinicalconnections.com. For more information on the Community and Clinical Connections for Prevention and Health Branch, please visit: www.communityclinicalconnections.com.