

CHS Treatment Team Structure and Guidance

WHO: Most CHS offices include behavioral and medical providers, psychiatric nurses, Community Health Coordinators, and an office manager/practice administrator and/or nurse manager.

WHAT: CHS' interdisciplinary treatment teams involve brief, data-driven, solution-focused discussions of 1) clinically complex, high-need, or high-risk patients who need coordinated treatment-planning by multiple team members and/or consultation amongst providers, 2) ethical/legal issues related to patient care, and 3) complex patients for the purposes of clinical quality improvement. Common topics/questions for treatment team include: effectively managing a disruptive patient, addressing patients who have been non-responsive to interventions, coordinating treatment for a complex patient with an upcoming appointment, improving the adherence of a patient with multiple psychosocial needs, brainstorming psychiatric medication recommendations, addressing patient/staff safety concerns, and making reports to APS/DCS.

WHEN: 30-60 minutes (depending on the size and volume of the clinic) each week of dedicated (blocked) time – ideally at the beginning of day or immediately after lunch so that team members are able to arrive on time.

WHY: To enhance communication among team members, coordinate patient care, and improve clinical outcomes for our patient population. Treatment team is intended to be a time in which participants can offer support to one another and contribute to the resolution of clinical challenges. The facilitator should review the treatment team process when new staff join so that all members feel included, invested, and able to productively contribute.

HOW: Set Agenda: A few administrative/operational announcements are appropriate, but most of these issues should be discussed via other avenues (email, individual and/or staff meetings). The treatment team facilitator may ask providers to task EHR record numbers to him/her in advance or he/she may take an inventory of clinical needs at the beginning of the meeting. If a team struggles to discuss all of the identified cases in the allotted time, a strategy to prioritize needs (i.e., urgency rating of 1-5) can be established. Some facilitators distribute a list of topics/cases for discussion in advance so that team members can prepare appropriately. In clinics with psychiatric consultation for primary care, the psychiatric provider often gives a brief overview (update on medication and follow-up) of any patients seen between medical visits.

Engage Team Members: Facilitators start meetings promptly, and participants do not engage in individual tasks (reviewing labs, completing documentation) during meetings. Members with laptops are encouraged to bring them so that immediate patient questions can be answered (i.e. number of missed appointments, medication prescribed, future appointments). Meetings may end early if time remains after all clinical issues have been addressed.

Discuss: Staff members bringing cases to treatment team should provide the EHR #, patient demographics, a succinct summary of diagnoses and the course of treatment, current providers/services, and a specific question for discussion. Other clinical history can be provided, as needed, to help the team address the question at hand. The facilitator's role is to clarify the presenting question (when needed), manage the time spent discussing case, move discussion along if it stalls or is no longer productive, clarify an action step(s), if needed, and ensure that a specific team member is assigned to complete the action plan. If discussions are not solution-focused and productive, it may be appropriate to pause conversation with the plan to revisit the

case at a future meeting; during the interim time, concerns may work themselves out and new solutions may emerge.

Document: Treatment teams document attendance and discussion via sign-in sheets with the date, office location, names of participants and the topics discussed, including patient EHR numbers. The sign-in sheet is to be faxed to the Credentialing Department (Attn: Joann Hayes, 423-714-2355) after each meeting. A designated member of the treatment team should document patient-specific decisions/discussions using the “Tx Team Note” template under “Other Templates” in NextGen. These clinical notes (which are official components of the patient record) should include the clinical question, agreed-upon action steps, and/or the clinical plan. Treatment teams may also keep a paper record of case discussions, although this is not required. Paper sign-in sheets can easily facilitate week-to-week comparisons and follow-through of team decisions; these sign-in sheets should be securely stored.