ADVANCING TEAM-BASED CARE

2023-2024 NTTAP Learning Collaborative

Brockton Neighborhood Health Center

HEALTH CENTER DESCRIPTION

BNHC provides accessible, comprehensive, high-quality healthcare services (including but not limited to: Primary Care, OB/Gyn, Behavioral/ Mental Health, Dental Care, Eye and HRC Services to the residents of Brockton and surrounding area.

We play a crucial role in addressing the Medical and Social Drivers of Health needs of a diverse, underserved population with an emphasis on preventive care and health education.

KEY PARTNERS

- *Adult Med Provider (Pod Lead)
- *Medical Assistant
- *Director of Social Services
- *Pharmacist
- *Hospital Discharge Nurse Coordinator
- *Registered Nurse
- *Patient Outreach Specialist
- *Behavioral Health Clinician
- *Community Health Worker
- *Quality Improvement Manager
- *Intern (University of Massachusetts)

GLOBAL AIM STATEMENT

To use an interprofessional collaborative practice to reduce the rate of frequent (but often preventable) hospital readmissions by 10% among BNHC patients within the next 12 months by addressing a comprehensive range of patient needs, including review of medical history and current status, medication management, addressing health-related social needs, identifying and addressing behavioral health needs, implementing targeted patient education, offering nursing assistance/follow-up and to provide a holistic approach to care and minimize the risk of re-hospitalization.

PROCESS MAP

- Identification: Patients with risk factors for readmission or low acuity ED utilization
- Outreach and Engagement: Patient engagement secialist outreaches and engages patient
- Scheduling: Patients are scheduled for the next available group visit.
- Confirming Patient Appointments and Assessing Transportation Needs
- Group Capacity- 5-7 patients per group

SPECIFIC AIM STATEMENT

To decrease the number of our patients who have high 30-day ED utilization from 6.3% to 4% by December 2024 and/or

Increase the engagement rate for High ED utilizers from 45% to 55%

PDSA REFLECTIONS

Patient engagement and follow-ups after the group visits (by the nurse, patient engagement specialist and the Community Health Worker) are low effort but have high impact on the improvement initiative.

VOICE OF THE TEAM

Collaboration with the local hospital, nurse, social worker, etc. on the team to meet patients where they are, improve patient satisfaction with the system, decrease provider burnout, engage in acts of kindness with patient and creating an environment where patient-centered care impacts outcomes has been great.

— Luisa Schaeffer, Patient Engagement Specialist

'ER Can Wait' is a team-based initiative which was conceptualized by keeping the patients in the center of everything that was planned. The sole aim of the group is to help the patients stay out of the hospital. Project has been going on for more than a year and it has been a great learning with lots of new ideas, concepts and workflows being implemented. There are many more workflows in the pipeline and the future looks exciting.

— Nikhil Gohokar, MD, Team Lead for ER Can Wait

'AHA' MOMENT

- **Seeing the unity and collaboration of the care team as each team member fully understands their role in the process.**
- **Seeing patients becoming empowered to manage their care and be willing to become recovery coaches for others.**

RECOMMENDATIONS

⇒ **Meet the patients where they are at. Some patients need more outreach and need to be engaged more by the care team, be flexible and willing/ready to help patients remove barriers like transportation, food cards etc.**

⇒ **Work with other teams and use the EHR to facilitate real-time information sharing among team members.**

INNOVATIONS

1) We have formed some interdisciplinary care teams such as: The ER Can Wait Group, The Hypertension Team etc.
2) We have regular team check-ins to share updates/progress, troubleshoot, develop or update workflows and strategies.
3) We have streamlined our processes to address the medical, social and behavioral needs of the patients.

VOICE OF LEADERSHIP

Managing and tracking high risk patients who see the ER as their primary care home has always been a challenge within the healthcare sector. This project has now shifted the mindset of so many patients that BNHC is proud to create a model for improving tracking and monitoring of our patients and coordinating care among our health care team.

— Annette Thomas, Director of Quality and Compliance

MEASURES

⇒ **We compared the visits 6 months before and after the group for 105 patients:**

⇒ **Total ED Visits decreased from 166 to 30**

⇒ **Total Inpatient Visits decreased from 87 to 15**

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KLAMATH HEALTH PARTNERSHIP

HEALTH CENTER DESCRIPTION

Today Klamath Health Partnership is the second largest medical provider in the Klamath Basin and beyond — Malin, Merrill, Bonanza, Bly, Beatty, Tulelake, Dorris, Macdoel, and Lakeview — offering residents access to culturally appropriate, high quality, and affordable primary and preventive health care from clinics with two locations in Klamath Falls and one in Chiloquin.

GLOBAL AIM STATEMENT

We aim to improve our depression screening rates.

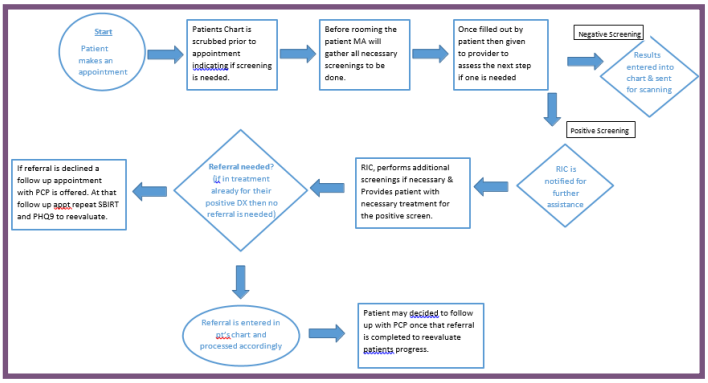
The process begins with: Understanding the current screening process and identifying barriers to the workflow.

The process ends with: Standardized use of workflows, leveraging available tools, and empowering the patient care team to improve depression screening of all patients seen by the organization.

By working on the process, we expect:

- Stronger communication of the patient care team
- Earlier detection of depression (increased surveillance)
- Increased follow-up of depression screenings
- Improved patient satisfaction, engagement (involvement in care, goal setting, care planning), and outcomes.

PROCESS MAP



KEY PARTNERS

Internal:

- ⇒ Provider
- ⇒ Medical Assistant
- ⇒ Population Health Specialist
- ⇒ Analytics
- ⇒ RIC
- ⇒ CHW
- ⇒ RN
- ⇒ Medical Records Manager
- ⇒ Quality Manager

SPECIFIC AIM STATEMENT

We will improve the depression screening rate of Jennifer Rodriguez's patient panel from 2.28%-9.0% by 06/18/2024

VOICE OF LEADERSHIP

Our recent team-based care project provided our organization with an opportunity to deliver patient care in a robust, efficient and collaborative way. As stewardships of the healthcare profession, we were able to assess, plan and execute a collegial plan with prevention and patient satisfaction at the forefront of our global aim goal.

- Jennifer Rodriguez, Provider

VOICE OF THE TEAM

Through this project we have realized how complex the care team is. As we discussed our workflows, we continued to identify team members who need to be a part of the work. The comprehensive team now includes a wide variety of members from all departments. We opened doors to communication throughout this team and hope to continue to expand on this.

— Jacie Zahler, CMA, Quality Manager

PDSA REFLECTIONS

Our team has found some barriers in the workflow that have given us the ability to show better numbers and improving our overall percentage. It takes the whole team in order to make this improvement happen.

INNOVATIONS

- Pine Care team pilot
- Telephone escalation to help improve the turnaround time on patient care.
- Provider schedule change to extend hours to see additional patients.

RECOMMENDATIONS

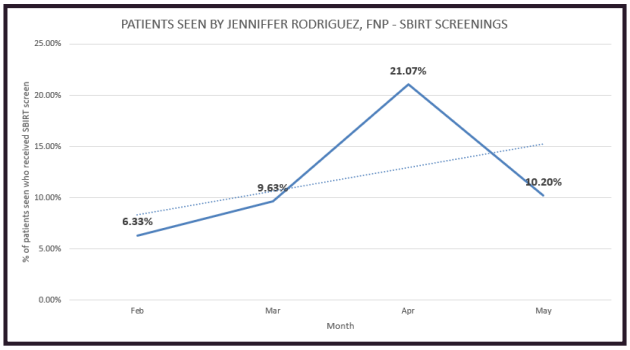
- Putting together a diverse team- MA, BH, Provider, CHW's
- Make sure to gather everyone's input and ideas before deciding on an action plan.

MEASURES

Since the start of this project we have seen a great amount of improvement on our screening rates.

In February we were at 6.33, March we jumped to 9.63, then in April we hit a high of 21.07.

This shows great progress in the care that we are providing to our patient population.



'AHA' MOMENT

⇒ Involving different departments of KHP to this team has allowed us to brainstorm ideas to improve this process from every aspect of KHP.

⇒ This team has brought some very positive and insightful ideas to this forum which in turn brings up other ideas for improvement elsewhere.

ADVANCING TEAM-BASED CARE

2023-2024 NTTAP Learning Collaborative

THE WRIGHT CENTER

HEALTH CENTER DESCRIPTION

The Wright Center for Community Health is a federally qualified look alike health center focused on comprehensive primary care with a care team approach.

INNOVATIONS

⇒ Involving all members of the care team, not just the provider. From front desk to medical assistant, nurse and the learners in the clinic.

⇒ Educating reason why to all members of the team to help with patient promotion. Moving past 'just another task' to goals for patient outcomes.

⇒ Shared ownership. The team is committed to the overall results and all owning the piece of the outcome.

GLOBAL AIM STATEMENT

We aim to improve colorectal screenings in the Blue Team with patient that are due for screenings between the age of 45 — 75.

SPECIFIC AIM STATEMENT

We aim to increase the colorectal screening rate for the blue team to 45% completion rate.

PDSA REFLECTIONS

* Verbal education was needed
* Texting helped remind patients to complete the test

RECOMMENDATIONS

⇒ Communication is key. Regular, focused talking points to keep an eye on the outcome.

⇒ Review the data regularly and keep it focused.

⇒ Highlight what is working well and using patient examples to motivate team. We are in the healthcare field because we are motivated by helping others.

'AHA' MOMENT

The main 'aha' moment was the drill down for focus on the specific goal to help with the overall team focus.

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Brooklyn Plaza Medical Center, Inc.

HEALTH CENTER DESCRIPTION

As an FQHC, Brooklyn Plaza Medical Center (BPMC) has provided comprehensive quality health care and support services to the Brooklyn community since 1978. Recognized as a Patient Centered Medical Home, BPMC increases positive health outcomes and decreases healthcare disparities in medically underserved communities at 3 sites which includes our main site, a public housing site and a school-based health center.

INNOVATIONS

Processes/Workflow

⇒ Implementation of Cologuard

⇒ Implementing workflow for the "To Do List" feature in the EMR

Collaboration

⇒ Collaboration with medical records team to obtain, track and document resulted colon cancer screenings

Cologuard Education

⇒ Educational video displayed in in triage area

⇒ Education material and Cologuard displays in lobby and triage area

⇒ Colon cancer screening poster in exam room

VOICE OF THE TEAM

The organization must continue to improve workflows to ensure orders are being accurately entered.

— J. Wilson, Medical Records

Impact- Quality care was provided to all patients. We increased the number of patients captured through follow-up, education and improved workflows for all involved.

— D. Parris, Director or Nursing

GLOBAL AIM STATEMENT

We aim to increase our colorectal cancer screening rates for patients ages 45-75 to 50% in provider NP Joseph's patient population by May 30, 2024.

This will be done through comprehensive outreach, education, and streamlined access to screening modalities.

We will increase our screening rates by offering our patients colorectal cancer screenings such as Colonoscopy and Cologuard, thereby reducing the incidences of late-stage colorectal cancers diagnosis and prevention through early detection and intervention.

VOICE OF LEADERSHIP

I am very pleased with this team and the work that has been done. They focused on and embraced guidelines and put them into practice. As we continue to practice team-based care, we learn that patient care is not just the role of a provider. We all play a role in providing care.

— Dr. Kersaint, CMO

'AHA' MOMENT

⇒ Confirming patient demographic information to ensure patient receive screening kits

⇒ Reminding staff to follow the workflow for attaching Cologuard orders

⇒ Educating patients on the difference between a consultation visit and the actual colonoscopy.

KEY PARTNERS

Internal

⇒ Chronic Care Manager
⇒ Chief Medical Officer
⇒ Director of Nursing
⇒ Information Technology
⇒ Nurse Practitioner
⇒ Medical Assistant
⇒ Medical Records
⇒ Quality Improvement Specialist

External

⇒ Exact Science

RECOMMENDATIONS

* Ongoing education to patients about the importance of CRC screening, describing the available methods.
* Educating providers and patients regarding NY Cancer Services for underinsured and uninsured patients

MEASURES

Cologuard Ordered from NP Joseph/ Total # Cologuard Ordered from BPMC*

Jan – 0 / 1
Feb – 25 / 35
Mar – 50 / 69
Apr – 58 / 89
May – 67 / 120
June 7 – 74/ 126

BPMC has seen an increase in Cologuard orders after continuous provider education. Providers are educated on the advantages of Cologuard as opposed to Fit-Kits when a patient declines a colonoscopy.

*Cumulative

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HEALTH CENTER DESCRIPTION

Migrant Health Center Inc is a 330FQHC 501c providing primary and integrated behavioral health in the western region of PR through fifteen clinical sites. We've served over 36,000 patients via one-stop shop model providing general, internal and family medicine, OB/GYN pediatrician, oral health, mental health RWPC HIV services, opioid dependency, pharmacy, laboratory, radiology and optometry.

KEY PARTNERS

Our internal key stakeholders are our:

* CEO
* Quality Manager
* Medical Director
* Special Projects and Clinical Facilities Director
* The physician of the Preventive Program and his team, and the laboratory staff

GLOBAL AIM STATEMENT

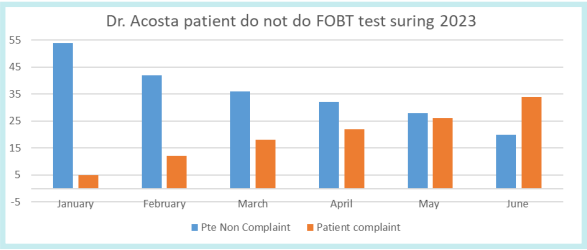
We aim to improve the compliance percentage of Dr. Acosta's patients who are non-compliant with FOBT testing as demonstrated in the 2023 UDS data for the Mayaguez Preventive Program.

The process will begin with a visit by the patient/ family/caregiver to the medical team and **ends with** the result of the FOBT being documented in the laboratory section of the patients EMR.

It is important to work on this because colon CA has increased on PR in patients < age fifty. Early detection and treatment of colon cancer can prevent death.

MEASURES

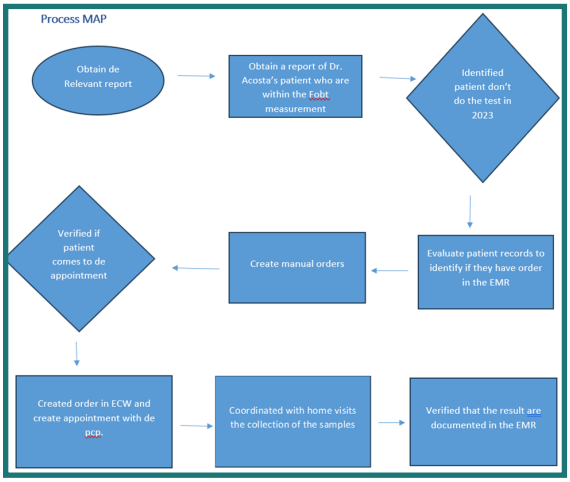
In the first week of starting, we managed to get 5 patients to deliver the OB sample. Changes were made to the strategies to ensure that patients could have access to the delivery of samples.



INNOVATIONS

1) 12 of our clinical sites have PCMH recognition by the NCQA with a distinction for integrated behavioral health. Two of the newer clinics are undergoing an assessment for PCMH transformation early 2025
2) Team-based care has been expanded and remodeled to include two RN's per provider. The RN has the role of scribe allowing the provider more time to evaluate and examine the patient.
3) Three of our clinics are under-going structural changes new buildings, that promote patient -centered care where the providers and ancillary staff meet the patient in the same room.

PROCESS MAP



VOICE OF THE TEAM

Over the past few months one of our clinical teams participated in the NTTAP learning collaborative and learned best practices of care and strategies to implement models of team-based care. Thanks to the learning collaborative the MHC team-based care team will be able to utilize the quality improvement strategies and skills learned to optimize the provision of healthcare services in the Western Region of PR.

VOICE OF LEADERSHIP

The impact of this project has expanded throughout several clinical sites such as the Mayaguez Post clinical site (for all patients), Guanica clinical site as well as the selected indicator for the HP 2030 Champion project. Colorectal CA has affected several athletes and public figures in the island creating awareness of the importance of getting tested as part of their general health workups.

— Wanda Acosta, BSN,
Quality Advisor and Certificates Specialist

'AHA' MOMENT

Listen to what the patient is saying both verbally and non-verbally. Cultural beliefs, myths and other issues regarding feces. Most of the times if you are empathetic and take the time to present alternatives in obtaining and storing the sample, explain the importance and allow the patient to absorb the information, you will have gained the patients trust and be able to get the patient to bring in sample for FOBT testing.

SPECIFIC AIM STATEMENT

We aim to **increase the percentage** of Dr. Acosta's patients at the Mayaguez clinics' Preventive Program with FOBT documented in the patients' EMR.

The increase will be by 8% AND/OR from a baseline number of zero (0) patients to a target number of eight patients (8%) by/between the dates of January to March 30, 2024.

PDSA REFLECTIONS

In the first patients, manual commands are used. The changes made to the PDSA made it easier for the test result to be documented electronically by creating the orders in EMR.

RECOMMENDATIONS

⇒ **Start by establishing what is the problem, identify main cause through a root cause analysis, why you need to do it, use data as a friend. Measure and determine your aim**

⇒ **Make an organizational "inventory", staff, roles, stakeholders (patients, organizational leaders), brainstorm ideas, processes**

⇒ **Pilot a PDSA, remeasure and incorporate new activities in a new PDSA cycle, if it works, institutionalize.**