ADVANCING TEAM-BASED CARE

2024-2025 NTTAP Learning Collaborative

Cherry Health
Comprehensive. Quality. *Healthcare.*

HEALTH CENTER DESCRIPTION

As one of Michigan's largest FQHCs, Cherry Health improves the health and wellness of individuals by providing comprehensive primary and behavioral health care while encouraging access by those who are underserved.

GLOBAL AIM STATEMENT

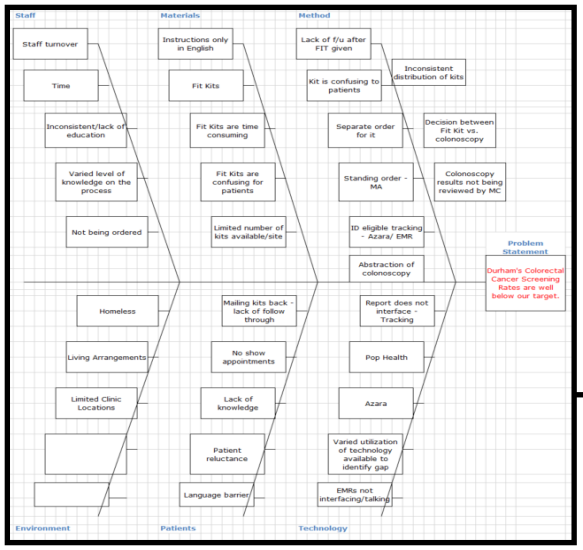
We aim to improve: the process of colorectal cancer screening in our Durham Senior Health Center.

The process begins with: identifying patients who are eligible for the screening.

The process ends with: documenting in the patient's health record that the screening has occurred with the ultimate goal to improve the UDS measure for colorectal cancer screening.

It's important to work on this now because: Identification of patients with colorectal cancer upon screening. Current process isn't meeting the current benchmark. Early detection results in better prognosis for patients and treatment. Increased revenue for meeting payer outcomes and a reduction in morbidity and mortality associated with colon cancer.

FISHBONE DIAGRAM



SPECIFIC AIM STATEMENT

We aim to increase the colorectal cancer screening rate in Durham Senior Health Center patients from 58% on March 1, 2025 to 68% by June 1, 2025 by screening an additional 22 patients.

MEASURES

Unfortunately, we did not see movement on our CRC Screening Rate. It remained at 58% from March through May, but we did see an increase in the number of FIT Kits provided as we began our PDSAs for the learning collaborative.

Month	# of FIT Kits Provided
January	2
February	4
March	1
April	8
May	9

PDSA REFLECTIONS

There were varying levels of comfort with quality improvement processes. It was important to ensure staff did not feel we were targeting their individual performance, but instead looking at improving the process organizationally.

'AHA' MOMENT

* Through this process, we realized how multifaceted improving colorectal cancer screening can be. There are many potential breakdown points between pre-visit planning and a patient successfully completing screening.
* Re-education and demonstrating competency and knowledge of the screening was one of the more valuable improvements made.

VOICE OF THE TEAM

During the collaborative, we realized how iterative the process is to make a lasting impact. Intentional improvement takes creativity and patience — you rarely get it right on your first attempt at quality improvement.

— Dan Grey, Associate Director of Value-Based Care Teams

INNOVATIONS

⇒ Updated scripting for those who are due for Colorectal Cancer Screening utilizing open-ended questions to encourage patient activation in preventive care and screening.

⇒ Improved collaboration among physician, medical assistant, nurses, CHWs, behavioral health, and quality team.

⇒ Recommitment to pre-visit planning and team huddles was an indirect positive outcome through this learning collaborative.

RECOMMENDATIONS

1) We see how team-based care improves health outcomes for patients when staff are focused on their area of expertise in caring for patients at the top of licensure.
2) Increased job satisfaction is reported by staff when right health professional is utilized to meet the varied needs of our patients.
3) The rapport and professional collaboration seen in team-based care has a positive impact on workforce retention.

VOICE OF LEADERSHIP

By collaborating with health center leaders across the country, we set out to improve all team members' understanding of the principles of team-based care, as well as each other's roles to optimize workflows.

— Julee Geib, Director of Practice Operations

ADVANCING TEAM-BASED CARE

2024-2025 NTTAP Learning Collaborative

complete HEALTH™

HEALTH CENTER DESCRIPTION

We are located in Western South Dakota and serve ~10,000 unique patients with 3 sites providing the following services:

- ⇒ Medical
- ⇒ Dental
- ⇒ Behavioral Health/Counselors
- ⇒ Sexual Health
- ⇒ Iris Clinic
- ⇒ 340B Pharmacy
- ⇒ CHW's

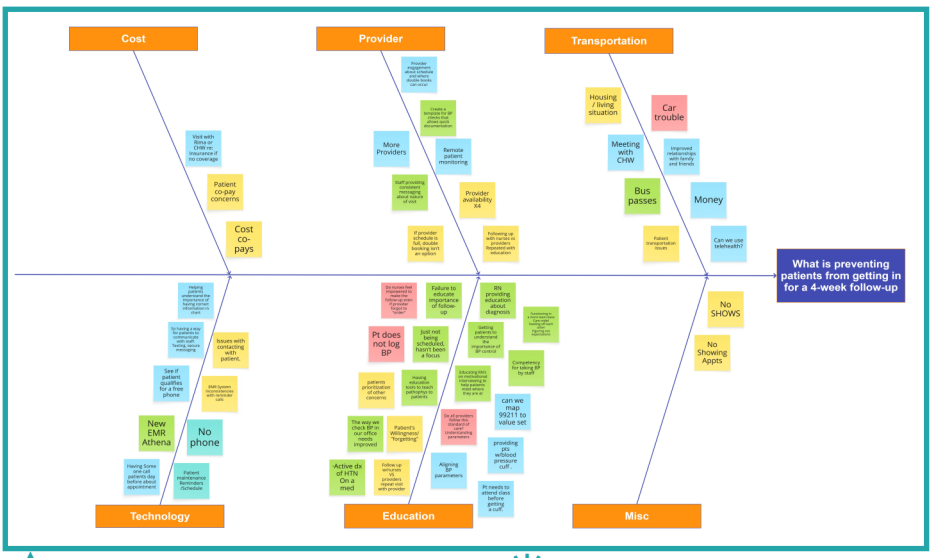
KEY PARTNERS

- Associate Medical Director
- Provider
- Nurse Manager
- Care Coordinator
- CRN
- RN
- MA
- Director of Quality

GLOBAL AIM STATEMENT

We aim to improve patients having a follow-up appointment with uncontrolled HTN at Complete Health. This starts with patients that have a diagnosis of uncontrolled baseline BP (Azara) and will conclude once those patients have a repeat visit for uncontrolled HTN within 4 weeks of their initial visit.

FISHBONE DIAGRAM



MEASURES

We have had a slow uptick of our data related to uncontrolled HTN. Our baseline data was at 14% and currently we are at 16%.

PDSA REFLECTIONS

- ⇒ Initially when we conducted our PDSA in the pilot clinic we had good success. The one provider found it to be very effective and streamlined.
- ⇒ Now that it is rolled out clinic wide, we continue to meet with staff on a regular basis to tweak workflows and adjust roles and encourage open communication.

RECOMMENDATIONS

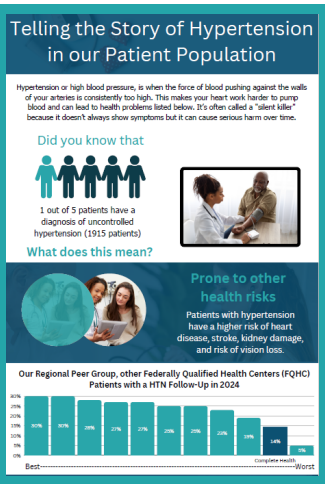
- Understand your purpose in implementing team-based care.
- Know that process is very regimented and arduous at times.

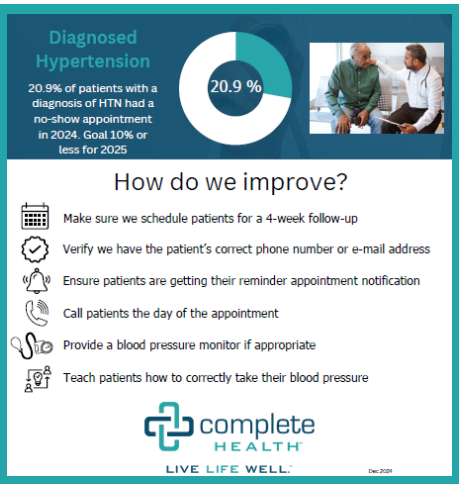
'AHA' MOMENT

All the planning and preparation, no matter how thorough, often results in staff putting roadblocks in place that must be overcome. Know who your informal leaders are and engage them early.

INNOVATIONS

1) Develop a Team Based Care Model.
2) Improve the case management of vulnerable patients.
3) Decrease the number of patients that seek out the ED or urgent care unnecessarily.
4) Improve the number of patients that seen that have a diagnosis of uncontrolled hypertension that have not had a four week follow-up.





Why Statement: We are committed to creating a collaborative team-based care model with an emphasis on communication and education that delivers high-quality, efficient care, with each staff member working at the top of their license to improve patient outcomes and health of the community.

ADVANCING TEAM-BASED CARE

2024-2025 NTTAP Learning Collaborative

HEALTH CENTER DESCRIPTION

The EXCELth Primary Care Network was established in 1991 and serves the residents of New Orleans East, Algiers, Gentilly and Baton Rouge, Louisiana. We offer comprehensive services ranging from primary care, dental, behavioral health, pharmacy, care coordination and social services.

GLOBAL AIM STATEMENT

By the end of the next six months, we aim to reduce the percentage of patients with Hemoglobin A1c levels above 9.0% by 5% within our diabetic population at the Algiers Clinic. This will be achieved through implementing enhanced follow-up protocols, and individualized care plans. We will evaluate the impact of these changes through monthly monitoring of A1c levels.

SPECIFIC AIM STATEMENT

Improve patient compliance with HgA1c testing and treatment follow-up.

KEY PARTNERS

Internal

⇒Associate Medical Director
⇒Primary Care Provider
⇒Medical Assistant
⇒Licensed Practical Nurse
⇒Nutritionist
⇒ Pharmacist

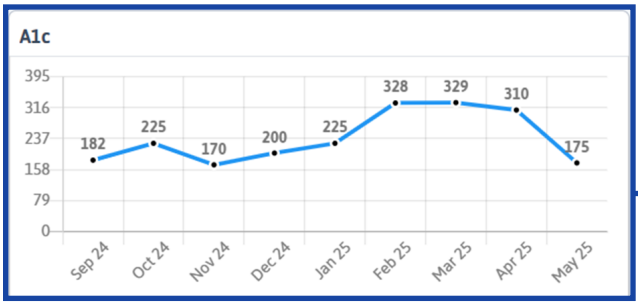
External

⇒Target: Type 2 Diabetes AHA
⇒Tulane University

PDSA REFLECTIONS

Feedback from staff indicated that scanning external results from outside labs was a multi-step process. The process was reviewed by QI and a recommendation was made to establish a contract with Quest Lab to increase patient access to testing. We implemented targeted outreach using our Phreesia platform.

MEASURES: DATA HEALTH — LAB VOLUME



VOICE OF LEADERSHIP

"The Learning Collaborative offered valuable quality improvement resources and tools. It streamlined some of the Medical Assistant and Clinic Nurse responsibilities. We shifted focus from rooming and intake to monitor and closing care gaps."

— Wylea Gray-Winfrey, DNP

VOICE OF THE TEAM

"Participating in the learning collaborative improved our relationships with the Pharmacy and Nutritionist on site. We were not using them to capacity and missed referral opportunities. When we all met the 1st time, it was great to look at each other's role and how we can support each other for the benefit of the patients."

— Tomasena Slaughter, LPN, Clinic Nurse

'AHA' MOMENT

Staff were not maximizing population health tools that included registries and pre-visit planning forms to coordinate patient visits.

RECOMMENDATIONS

* Clarify roles and expectations of all members on the team.
* Assign a team leader and co-leader to divide responsibilities.
* Schedule team meetings in advance to reduce rescheduling and ensure deliveries are met.

INNOVATIONS

⇒Implemented a bi-weekly meeting with the LPNs only to provide a communication platform for feedback and positive reinforcement.

⇒We implemented a measure of the month for each team that aligned with health awareness months.

⇒We resumed clinic level meetings at each health center that were discontinued due to COVID-19.

ADVANCING TEAM-BASED CARE

2024-2025 NTTAP Learning Collaborative

NORTH SHORE COMMUNITY HEALTH

HEALTH CENTER DESCRIPTION

North Shore Community Health delivers high-quality, comprehensive primary care, including medical, dental, behavioral health, and substance use disorder treatment services in Salem, Peabody, and Gloucester. Our mission is to build healthy communities by providing exceptional care to all.

GLOBAL AIM STATEMENT

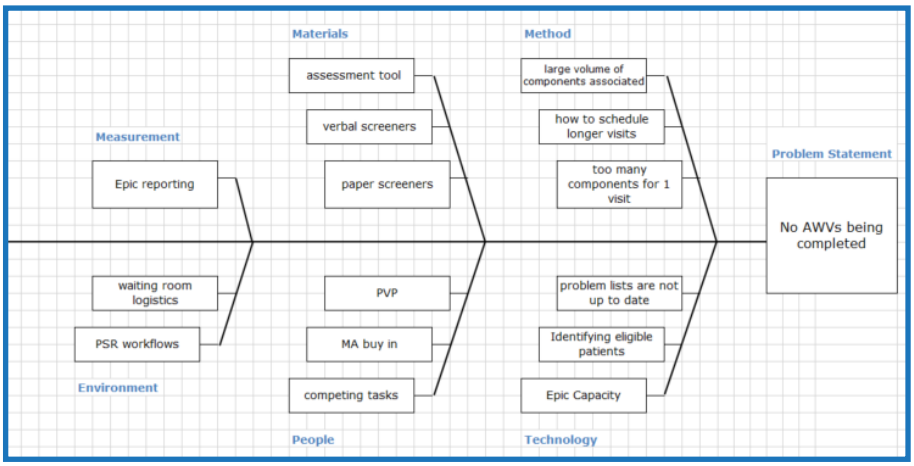
We aim to create a process that engages all members of the care team in the successful scheduling and completion of annual wellness visits for our Medicare population.

KEY PARTNERS

The piloting care team:

- ⇒ Provider
- ⇒ RN
- ⇒ MA
- ⇒ QI Manager

FISHBONE DIAGRAM



VOICE OF LEADERSHIP

Our recent project is working toward identifying the roles needed to complete Annual Wellness visits. The goal is to create structures that empower MA and RNs to increase ownership in patient care management and amplify the MA role's voice in patient care processes.

— Dr. Kristin Darden,
Medical Director,
Salem Family Health Center

RECOMMENDATIONS

- Encourage feedback from all members of the team.
- Be flexible!
- Don't wait for the system to be perfect – start the process to move progress forward.

Our end goal shifted over the course of our participation with the TBC collective a handful of times. Being able to re-group and shift focus proved to be an invaluable tool towards moving this work forward.

INNOVATIONS

1) Created systems to promote care team members working to the top of their license.
2) Collaboration between ops and clinical leaders.
3) Talk up teams! Created an environment where talking about team-based care is present in day-to-day activities

'AHA' MOMENT

Recognizing the following as our internal project mantra:
I am, I can, I need.

I am already doing this (piece of the work) in relationship to the goal, we've set (status quo).

I can meet this need another role has expressed/add this process toward the goal (changes I already have the time/resources/ skills to implement).

I need this resource/action/ information (Is there a process someone else has the ability to meet, does this group need to reach out to get those needs met).

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The Primary Health Network
Embracing Excellence in Healthcare

HEALTH CENTER DESCRIPTION

Primary Health Network (PHN) began with one small community health center site in the Shenango Valley, in 1984, with a central focus on providing the highest quality of care to the people we serve. After over 40 years of service, PHN has grown to become the largest Federally Qualified Health Center (FQHC) in Pennsylvania and one of the largest in the nation. Currently, we staff over 150 physicians, dentists, physician assistants, certified nurse practitioners, and other health professionals. Our support staff includes over 450 employees, as well. Last year, we reached over 75,000 patients through health, educational, and enabling services.

GLOBAL AIM STATEMENT

***Theme for improvement*:** UDS measure for diabetes management.

***We aim to improve*:** A1c screening and diabetes management.

***In*:** PHN's patients who have known diabetes and meet screening criteria.

***The process begins with*:** Identifying patients who meet screening criteria and patients who are diabetic.

***The process ends with*:** Documentation of completed A1c in EMR.

***By working on the process, we expect*:** to improve the UDS measure for A1c screening and management.

***It's important we work on this now because*:** Our current rate UDS data for the 2023 year of the network's A1c control and screenings have decreased from previous year. Currently, we are integrating a team-based care model, which throughout this model new responsibilities of staff members to empower more staff involvement in patient care and improve outcomes. As a network, we need to do better with screening and managing diabetes as the disease has detrimental outcomes if not addressed or managed appropriately. As an FQHC, our patient population has a higher risk of developing complications requiring a multidisciplinary approach and integration of the team-based model to address decreased rate of screening and control of diabetes in our patient population.

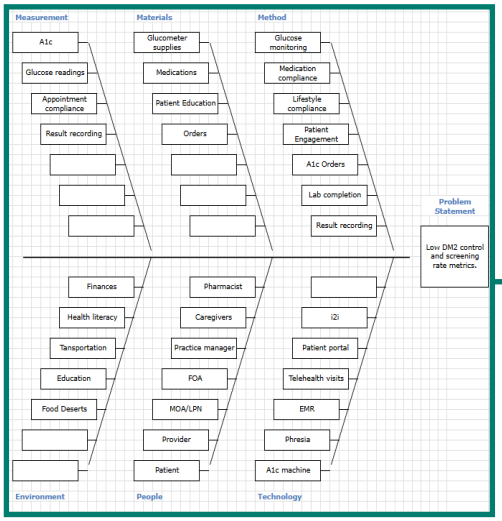
SPECIFIC AIM STATEMENT

We aim to decrease the rate of uncontrolled DM2 patients with an A1c >9% of provider's patient panel by 5 percentage points from baseline of 23% on January 1st, 2025 to 18% by the end of second quarter, June 30th, 2025.

PDSA REFLECTIONS

Implementation of pre-visit huddles have improved the recognition of open care gaps in Diabetic patients.

FISHBONE DIAGRAM



VOICE OF THE TEAM

"Team-based model implementation in our workflow has improved our patients care, and also helped improve the work environment of the office."
— Ryan Ochalek, CRNP

VOICE OF LEADERSHIP

"The teamwork collaborative has opened our eyes to both the need for, and benefits of standardization for both the team members and our patients."
— Dr. Donald Rumbaugh, MD

INNOVATIONS

- ⇒ **Co-locating teams**
- ⇒ **Daily huddles**
- ⇒ **Dedicated teams and roles for each member**
- ⇒ **Updating standing orders**
- ⇒ **Educating staff to perform at the height of their licensure**

'AHA' MOMENT

We have the right people to implement team-based care and we are eager to spread the workflow across the network. How often do we have the ability to change how healthcare is delivered, to improve not only our patients care but also care of our staff and providers.

RECOMMENDATIONS

1) **Change is necessary to better the healthcare system.**
2) **Dedicate as much time as possible to fully participate in the collaborative.**
3) **Make thoughtful considerations on members of the team and how open they are to teamwork and change of workflows.**