COMPREHENSIVE AND TEAM-BASED CARE

2025-2026 NTTAP Community of Practice

HEALTH CENTER DESCRIPTION

Since 1981, Morris Heights Health Center (MHHC) has had a record of distinction as the major provider of health care to Morris Heights and the surrounding areas. Our health center has always been proud to stand at the forefront in our local and medical communities. MHHC is recognized as a Level III Patient Centered Medical Home by the National Committee for Quality Assurance (NCQA). MHHC was the first federally funded community health center in New York City to be accredited by the Joint Commission.

GLOBAL AIM STATEMENT

Increase our childhood immunization rates by _20 percentage points_ from 60% to 80% by the end of 2026.

SPECIFIC AIM STATEMENT

We aim to _decrease_ the no show rate by _10 percentage points_ for 0 to 24 months from 27% to 17% by September 30, 2026 in the pediatrics location in Burnside.

KEY PARTNERS

Internal

- ⇒ Operations (practice manager)
- ⇒ Finance (revenue)
- ⇒ Quality (UDS measure)
- ⇒ Pediatricians and Care Team

External

- ⇒ Community (herd immunity)
- ⇒ Day Care (unable to attend day care without immunizations)

PDSA REFLECTIONS

- ⇒ **Highlights staffing challenges (unable to collect data when MA out)**
- ⇒ **Highlights intricacies of all the elements that go into scheduling and follow-up for the patient**
- ⇒ **Opportunity to standardize team-based operations across all sites**

VOICE OF THE TEAM

"I learned the different methods to improve pediatric immunizations."

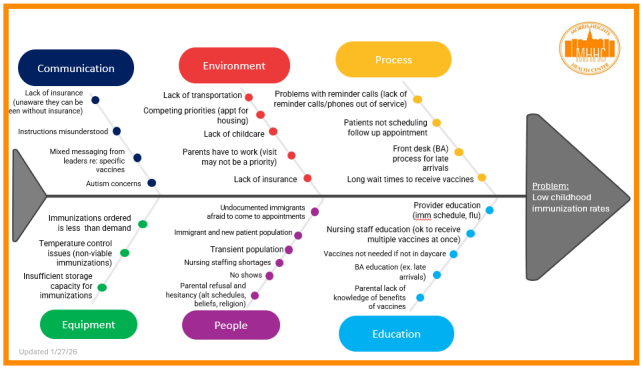
— Jessica Padilla, Medical Assistant, Pediatrics

VOICE OF LEADERSHIP

"This was a meaningful learning experience for our Burnside Pediatric Clinic at MHHC and provided the team with a valuable hands-on experience in foundational quality improvement (QI) methods. The QI tools during this learning experience supported thoughtful discussion, improved team collaboration, and enhanced our ability to approach challenges in a more structured and analytical way. Although this work occurred within a small pediatric team, the lessons learned will help elevate future improvement efforts, and we plan to expand this knowledge more broadly across the organization to support more effective and sustainable performance improvement initiatives."

— Primerose Vernet, RN MBA FACHE CPHRM CPHQ LSSGB, Managing Director of Quality/Risk and Value Based Care

FISHBONE DIAGRAM



'AHA' MOMENT

One of the perceived barriers to childhood immunizations which was identified was prolonged wait times for the nurse to administer the vaccine(s).
However, when we looked at the data, patients were waiting 10 minutes for vaccines, which was no longer considered a barrier.

RECOMMENDATIONS

1) **Need staff who will be committed to the project – personally invested in the outcome of the improvement project**
2) **Select staff who are motivated to make changes**
3) **Select staff who are interested in professional growth**

INNOVATIONS

- ⇒ **Focused on revitalizing pre-visit planning**
- ⇒ **Re-implemented Azara DRVS for team to have easy access to data**
- ⇒ **Increasing collaborative efforts with MCOs so that we can align our goals**

COMPREHENSIVE AND TEAM-BASED CARE

2025-2026 NTTAP Community of Practice

CHDC
Community Health & Dental Care
Your Health. Our Community.

HEALTH CENTER DESCRIPTION

We offer affordable healthcare to the whole family, including medical, dental, vision, physical therapy, podiatry, OB/GYN, behavioral health, and more!

KEY PARTNERS

- ⇒ Insurance Companies (payers) for quality-based measures
- ⇒ Administration of our organization – increased earnings from better quality measures
- ⇒ Nurse Care managers within the organization

GLOBAL AIM STATEMENT

We aim to improve our glycemic control and ensure appropriate kidney health monitoring for diabetic patients on the K.T. panel. The process begins with identifying patients who have uncontrolled diabetes and/or are overdue for kidney function testing or reassessment. The process concludes with documented A1C and kidney function results in the medical record, timely communication of results to the patient, and implementation of appropriate follow-up care. Through this focused approach, we expect to improve clinical outcomes by strengthening monitoring, early detection, and timely intervention for our diabetic population.

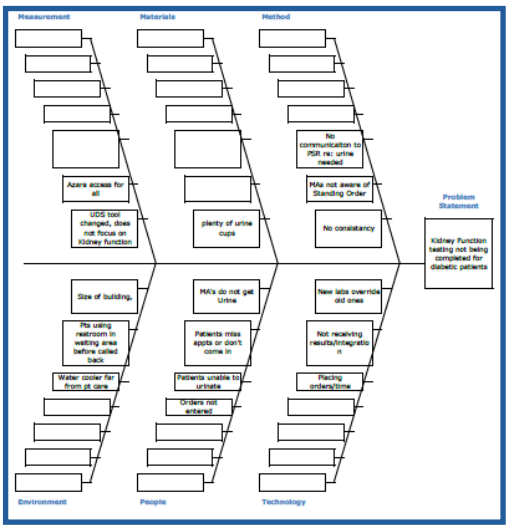
SPECIFIC AIM STATEMENT

We aim to improve kidney health monitoring for diabetic patients on K.T.'s panel from 34% to 60% by CY2026.

PDSA REFLECTIONS

Even without being completely consistent in the process, our numbers improved a lot, just by having this on our mind.

FISHBONE DIAGRAM



MEASURES

The percentage of diabetics in quarter 1 of this year that were appropriately screened for kidney health and up to date on A1C checks increased from 33% first quarter of 2025 to over 50% in the first quarter of 2026.

VOICE OF LEADERSHIP

"Participation in the community of practice created an opportunity for CHDC to take a more structured and proactive approach to kidney health monitoring for diabetic patients. By engaging multidisciplinary teams in shared problem-solving and process improvement efforts, we strengthened coordination, increased focus on preventive care measures, and reinforced our commitment to improving chronic disease outcomes across the organization."

— Candace Neiman, Chief Clinical Officer

VOICE OF THE TEAM

"This work makes me feel good that our diabetics are improving their health."

— Tiffany Kalis, Lead MA

'AHA' MOMENT

In the initial meetings about how to effectively have a meeting and engage the people in it, a lot stuck out about why some of our meetings feel "dead" and lack participation.

RECOMMENDATIONS

We recommend reviewing which person or role is responsible for which tasks, and expect that. Provide reinforcement early on, knowing it'll be an adjustment. Make small steps at a time, rather than a huge overhaul of a system that's been in place.

INNOVATIONS

* We utilize nurse care managers to help close care gaps and educate complex patients.
* Providers and MAs huddle in the morning and review care gaps and screenings that are missing, which then are the responsibility of the MA to complete.

COMPREHENSIVE AND TEAM-BASED CARE

2025-2026 NTTAP Community of Practice

CHDC
Community Health & Dental Care
Your Health. Our Community.

HEALTH CENTER DESCRIPTION

A community-based health center, established in 2008, with a magnitude of services offered including but not limited to Primary Care, Behavioral Health/ Psych, Ob, Pharmacy, and mobile units.

KEY PARTNERS

- ⇒ Clinical Data Management Director
- ⇒ Pediatric Provider Liaison
- ⇒ Lead Pediatric Nurse
- ⇒ Chief Clinical Officer

GLOBAL AIM STATEMENT

We aim to improve UDS measure for vaccination rates for children under 2 years of age. The process begins with data collection to assess our baseline and to compile our list of patients turning 2 in 2026. Interventions to be brainstormed, discussed, and implemented. The process ends with review of data to access for improvement in vaccination rates for children under 2 years of age per UDS guidelines. By working on this process, we expect to improve preventative health for our youngest and most vulnerable patients.

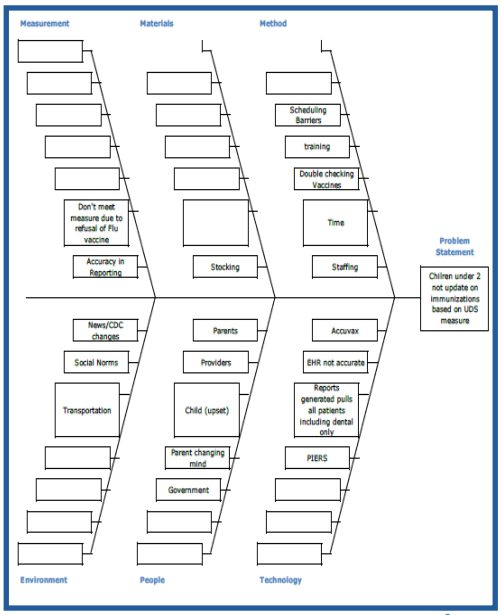
SPECIFIC AIM STATEMENT

We aim to improve immunization rates for children under the age of 2 at CHDC, from 43% to 50% for CY2026.

PDSA REFLECTIONS

We had to be organized around the data in ensuring we closed the loop with families who had missed appointments or who were not easily reached.

FISHBONE DIAGRAM



MEASURES

Through this QI initiative we were not able to meet our goal, but exceeded our goal to 53% in CY26Q1.

VOICE OF LEADERSHIP

"Participation in the community of practice provided CHDC with the opportunity to strengthen our approach to childhood immunizations through collaboration, data review, and workflow improvement. By working together across clinical teams, we were able to identify barriers, implement targeted process changes, and improve our focus on immunization completion rates for children under the age of two. This project reinforced the value of teamwork, proactive outreach, and standardized workflows in supporting preventive pediatric care and improving patient outcomes."
— Candace Neiman, Chief Clinical Officer

VOICE OF THE TEAM

"In the current setting of vaccine hesitancy, it is evermore important for us to be constantly evaluating the best way to serve the families in our population."
— Sarah Spengler, CRNP

'AHA' MOMENT

Learning the importance of looking ahead to see the big picture to identify all the patients turning 2 in CY2026. This baseline data served as the foundation of the project and having accurate data was critical to the project's success.

INNOVATIONS

CHDC already had a fairly strong team-based care model; however, this collaboration enhanced the importance of maintaining team-based care. By working together and leaning on each other we have increased our Warm Hand Offs with our BHCs and through timely communication we have also increased integrated appointments with vision and dental.

RECOMMENDATIONS

- ⇒ Assign roles and responsibilities
- ⇒ Get good data
- ⇒ Meet regularly

COMPREHENSIVE AND TEAM-BASED CARE

2025-2026 NTTAP Community of Practice

Community Access Network

HEALTH CENTER DESCRIPTION

Opened in 2016, Community Access Network was founded with the goal that all patients would receive quality care, regardless of age, income or insurance status. We provide services by appointment or walk-in, and also offer telehealth as an option for our behavioral health and specialty medical care. We offer all levels of healthcare to our patients, including: Primary Medical Care, Behavioral Health, Dental Services, Sexual Health and HIV Care, Specialty Medical Care through UVA Health, Patient Education, and Support Services. The mission of Community Access Network is to ensure exceptional, quality, compassionate and comprehensive healthcare for every member of our community. We work together to break down the barriers that keep our neighbors from receiving the best individualized care.

VOICE OF LEADERSHIP

"Our project helped our organization develop a collaborative, multi-disciplinary work group that was able to create processes to identify, evaluate, and correct opportunities within our quality improvement program."

— Dr. Michael Judd

"Participating in the Community of Practice initiative was an experience I greatly valued, as I have long been a strong advocate for team-based care. Through this project, I gained a deeper understanding of the processes involved in the orders I create and the importance of each step within the workflow. I also developed a greater appreciation for everything that takes place after an order is entered, including the coordination and follow-through required to achieve positive patient outcomes. This experience highlighted opportunities for improving and repairing processes to better support the overall goal of improved patient health and quality care.

— Dr. Stigwolt, Provider

VOICE OF THE TEAM

"I believe our team could improve how we listen to each other's perspectives and communicate what we have heard. Everyone was very invested in finding ways to improve the measure but sometimes needed reminding of our goal, to learn and work the process. When we do that, we can identify and apply what we have learned in other areas of our work. When everyone works together, leveraging each other's strengths, we can create a more innovative and resilient organization."

— Towana Polk, LPN, CCHC, Patient Engagement Coordinator

"Through this project, I gained a greater understanding as a medical assistant of the importance of frequency-based testing for quality measures and how timely testing contributes to quality patient care. I learned that detailed chart review is a key component in determining patient eligibility and the need for quality testing. This experience also improved my ability to locate and interpret difficult-to-find information within medical records and other clinical documentation, strengthening my organizational and analytical skills."

— KJ, Medical Assistant

'AHA' MOMENT

* Recognizing the importance of small work groups to drive change
* Realizing the importance of process mapping

GLOBAL AIM STATEMENT

Community Access Network aims to increase the percentage of eligible patients receiving timely breast cancer screening through mammography. Dr. Stirgwolt's panel of patients will be used to identify patients that qualify for the breast cancer screening but have not completed one. We will measure the process at various intervals with a documented screening in the EMR as our goal and ending point.

By improving access, patient engagement, and care coordination, this initiative seeks to enhance early detection of breast cancer and improve the UDS breast cancer screening rate. CAN has struggled to meet VA health center goals as well as our own quality goals. While we have had significant turnover, we have not had a consistent process with measurable outcomes of success.

Achieving this goal will support and promote preventive health practices and improve overall community health outcomes, while advancing equitable, high-quality care for the populations we serve.

SPECIFIC AIM STATEMENT

We aim to increase the documented Breast Cancer (BC) Screening quality measure to align with Virginia's health center BC Screening rate of 56%.

MEASURES

Many areas that can lead to outcome not been achieved. We have several points that we are measuring to determine where the majority of fails occur. This will help ensure all areas are successful which leads to the result of increased screening.

Mammogram Orders vs Monthly Goal (March—April 2026)

Month	Ordered	Goal
March	15	15
April	14	15

PDSA REFLECTIONS

⇒ The provider used our template to show actions completed from March to the end of April, 29 mammograms were ordered, our goal was 15 a month. MA's used a checklist to document if mammogram was ordered, not needed, ROI requested, or last completed date.

⇒ The Referrals Department has been following up to see if Mammograms have been completed and if results are available.

⇒ A review of Z codes for ordering mammograms showed overall improvement in the ordering outcome.

RECOMMENDATIONS

1) Taking a collaborative approach
2) Create a diverse workgroup that includes all areas of the organization
3) Be patient and trust the process
4) Focus on the process learned and not the measurement

INNOVATIONS

⇒ Implementing teamlets

⇒ Implementing morning huddles

⇒ Providing clinical staff with quality compliance data

⇒ Providing feedback to clinical staff on their progress

⇒ Staff continue to work the process

COMPREHENSIVE AND TEAM-BASED CARE

2025-2026 NTTAP Community of Practice

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.

KEY PARTNERS

Internal:

⇒ Roma Victor, FNP – Provider Champion

⇒ Gentilly Care Team, including the provider Medical Assistant and clinic nurse.

VOICE OF THE TEAM

"As a MA, I have learned that taking the time to do a proper second blood pressure check makes a real difference – Allowing the patient to rest results in accurate reading so patients aren't misclassified as uncontrolled."

— Jackie Williams, MA

VOICE OF LEADERSHIP

"The community of practice showed us that strong team collaboration — especially around consistent second blood pressure checks — improves communication, accountability, and patient outcomes. "

— Wylea Winfrey, DNP
Associate Medical Director

RECOMMENDATIONS

1) **Standardize blood pressure workflows and define teams clearly**
2) **Use population health tools and registries proactively, not just for reporting**
3) **Identify and Empower a provider champion to model evidence-based hypertension management, reinforce standardized workflows, and support staff engagement**

GLOBAL AIM STATEMENT

Within the next 12 months, EXCELth, Inc. will increase the percentage of adult patients ages 18–85 with controlled blood pressure (<140/90 mmHg) by at least 5 percentage points across participating clinics by implementing standardized BP measurement and recheck workflows, strengthening team-based care roles, and using data-driven outreach to address care gaps.

SPECIFIC AIM STATEMENT

Within 6 months, EXCELth, Inc. will ensure that most adult patients with an elevated blood pressure receive a documented repeat BP and follow-up action at the same visit through standardized, team-based workflows to improve UDS hypertension control rates.

PDSA REFLECTIONS

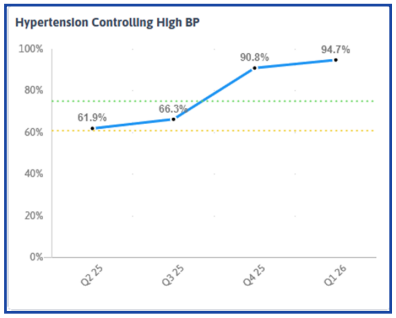
Our PDSA revealed that consistently performing and documenting a second blood pressure for initially elevated readings improved accuracy and timely follow-up actions during the visit.

'AHA' MOMENT

We realized that uncontrolled blood pressure was often the result of workflow gaps, such as inconsistent measurement and missed rechecks.

MEASURES

The most significant data was improving on the recheck rates. By adding the measure to the daily huddle sheet as a focused measure ensured that patients presented to the clinic with hypertension had an accurate reading and flagged for 2nd BP check needed.



INNOVATIONS

⇒ **Implemented hypertension registries such as the AMA MAP Confirmatory BP Measurement and reiterated the use of pre-visit planning for the providers to identify patients with uncontrolled blood pressure and proactively address care gaps during the visit.**

⇒ **Implemented standardized blood pressure measurement and repeat BP protocols to ensure accurate readings are obtained, documented and flagged when elevated to support reliable reporting.**

⇒ **Quality Improvement and Care Coordination Staff monitored team-level hypertension control data, shared performance feed-back, and facilitated continuous workflow improvements to include implementing the Care Management Passport (Azara product) for a deeper dive into each patient encounter.**

COMPREHENSIVE AND TEAM-BASED CARE

2025-2026 NTTAP Community of Practice

MedNorth HEALTH CENTER

HEALTH CENTER DESCRIPTION

Two site - urban health center established in 1993, located in Wilmington, New Hanover County, NC serving almost 8,800 patients offering medical, dental, behavioral health, pharmacy and soon to add vision services.

KEY PARTNERS

CEO & Senior Leadership; Board members; PAC Team; Care Management Team; Providers; Transportation team, MAs, Nurses; and Patients

VOICE OF LEADERSHIP

"As the 2nd iteration of this collaborative, the work propels staff to: think different, act different and engage different with how their daily work is performed. The foundational concepts can be applied throughout their daily work, which makes for the organization being a "Preferred Provider."

— Sharon Brown-Singleton, MSM, LPN, Chief Strategy Officer

VOICE OF THE TEAM

"Although we all work within the same organization, we do not often have opportunities to combine our specialized knowledge across departments—from scheduling to the clinical team—to improve outcomes for both patients and the organization. It was valuable and eye-opening to better understand the workflows and policies of teams outside my own."

— Shalane Moore, NP-C

MEASURES

* **Patients who were reached by phone were more likely to complete their appointments compared to patients who were not reached.**
* **The total no-show rate for office visits in targeted provider appointments during the PDSA cycle was 16.6%, compared to the baseline for those providers/appt types of 20.6%.**
* **Live contact appears to strengthen follow-through, either appointment completion or proactive cancellation .**

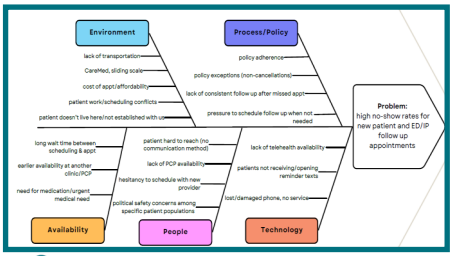
GLOBAL AIM STATEMENT

Theme for improvement: No-show rates/appointment compliance
We aim to improve: Percentage of completed appointments
In: New and existing patients who schedule appointments at MedNorth's main clinic location
The process begins with: Scheduling (initial patient outreach)
The process ends with: Appointment attendance or documentation of "no-show" in EHR
By working on the process, we expect: to reduce the number of patients who miss appointments or cancel within 24 hours of appointment time
It's important to work on this now because: The population size that we serve is steadily growing, increasing the need to provide timely and accessible care for our established and new patients. Further, the clinic is supported by a competitive grant that has goals for new, unduplicated visits. To continue to serve our community, we need to ensure that we meet those goals and improve our clinical processes to sustain that growth.

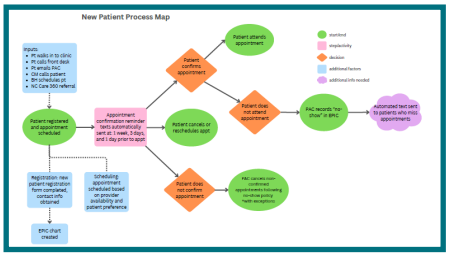
SPECIFIC AIM STATEMENT

We aim to improve appointment reliability and reduce no-shows for appointments with Orange Team providers by between 5-10% by increasing patient engagement and addressing barriers to access.

FISHBONE DIAGRAM



PROCESS MAP



PDSA REFLECTIONS

Cycle 1 Outcomes:

* Of patients who were reached by phone, 65% completed appointments.
* Of patients who were not reached, 38% completed appointments.

Cycle 2 Outcomes:

* Of patients who were reached by phone, 84% completed appointments.
* Of patients who were not reached, 53% completed appointments.
* The no show rate of patients reached by phone 13%, compared to 24% in patients who were not reached.

'AHA' MOMENT

⇒ **We learned that patients are much more likely to attend appointments if their barrier is addressed proactively and immediately. This is less likely when they are given information on how to address barrier themselves rather than completing it during the phone call.**

⇒ **All of our patients who no-showed during the PDSA cycles had previous no-show incidents, indicating that it could be a behavior pattern or reoccurring instances of the same barriers.**

⇒ **-We have encountered problems with our interpreter service when making phone calls- patients often don't accept the call because they don't recognize the number. We discussed and standardized a different method utilizing this service for more consistent communication with our non-English-speaking patients.**

RECOMMENDATIONS

1) **Establish a firm commitment from staff to the learning collaborative and make a conscious effort to keep all members engaged.**
2) **Team Based care concepts should be fully understood from the top down before implementing.**
3) **Engage all staff at all levels and all disciplines and job roles to ensure success (like the Ritz Carlton model).**
4) **Ensure that members all have an understanding of each other's roles and responsibilities.**

INNOVATIONS

⇒ **All staff know the term team-based care**

⇒ **All clinical and ancillary staff are assigned to an interdisciplinary team**

⇒ **Established "team" huddles outside of the morning huddle during designated Think Tank Thursday (all-staff weekly meeting) time**

⇒ **Integration of behavioral health and care management into primary care**

⇒ **Employing the use of data and community health management to identify care gaps, track outcomes and proactively manage patient populations.**

⇒ **Utilization of MAs for clinical tasks**

COMPREHENSIVE AND TEAM-BASED CARE

2025-2026 NTTAP Community of Practice

Total Health Care
SINCE 1968

HEALTH CENTER DESCRIPTION

Total Health Care is a health center dedicated to caring for Greater Baltimore's most underserved communities. We deliver health care to nearly 30,000 adults and children annually, regardless of their ability to pay.

KEY PARTNERS

Providers; Medical Assistants; Nurse; RN Care Manager; and Clinical Pharmacist

PDSA REFLECTIONS

- ⇒ **How important is the need to monitor and reinforce process changes.**
- ⇒ **Have dedicated weekly meeting work group time to review and reflect.**
- ⇒ **Remember there will always be some tweaking to your process.**
- ⇒ **Not hitting a goal isn't a failure; it's often just a sign that the timeline needs to be adjusted.**
- ⇒ **The team identified that structured communication, proactive outreach, and clearly assigned responsibilities improved workflow consistency and reduced gaps in follow-up for patients with A1C levels above 9.**
- ⇒ **The targeted interactions with some of our patients fostered their commitment to their wellness.**

MEASURES

- * **Following the PDSA launch in March, 24 patients were successfully referred to Care Management and the Clinical Pharmacy team. Towards our target of reducing high-HgA1c patient cohort from 30% to 24% by June, April data indicates current standing of 29%.**
- * **Realization of personal capabilities and growth throughout this project.**

'AHA' MOMENT

- * **Navigating the complexities of hardwiring long-term process changes.**
- * **The real proof of success is how the team worked across departments, putting aside silos to ensure the team is doing what is best for the betterment of the patient.**
- * **Identifying, understanding and addressing systemic social and clinical barriers that impact care for patients.**
- * **Recognized that improving outcomes for patients with A1C levels above 9 requires intentional role clarity, proactive outreach, and consistent communication across all disciplines.**

GLOBAL AIM STATEMENT

We aim to improve: Hemoglobin A1C screening and control in Total Health Care Division Adult Medicine Department.
The process begins with: Identifying diabetic patients 18-75 years of age.
The process ends with: Documentation of diabetic control in the EHR.
By working on the process, we expect: Improved UDS for diabetes control
It's important to work on this now because: Our current rate for diabetes control is in the 1st quartile; however, our absolute rate of patient with an A1C >9 currently exceeds the UDS performance goal of 24%, which remains our primary target for continue improvement.

SPECIFIC AIM STATEMENT

We aim to decrease the number of patients 18-75 years of age with a HgA1C >9 from 30% from June 2025 to 24% June 2026 by integrating into the clinical team with RN Care Management and Clinical Pharmacist Team.

VOICE OF LEADERSHIP

"I am extremely proud and grateful of our team's work in the Comprehensive and Team-Based Care Community of Practice (CoP). As we continue on our practice transformation journey, the knowledge and skills our team acquired will be instrumental in promoting high performance comprehensive primary care. We truly appreciated the opportunity to be involved in this collaborative learning experience."

— Dr. Marcee White, MD Chief Medical Officer

"Throughout this project, it has been a pleasure to witness the team's enthusiasm and collective dedication to improving patients outcomes."

— Denotta Teagle Vice President of Clinical Operations

VOICE OF THE TEAM

"This collaborative encouraged our team to become more intentional about communication, accountability, and shared responsibility in patient care. It strengthened collaboration across disciplines and created a stronger sense of teamwork within the clinic. It also reinforced the importance of continuous evaluation, flexibility, and collaboration when implementing practice transformation initiatives."

— Dr. Felicia Sam, DNP, APRN, AGNP-C

RECOMMENDATIONS

1) **Establish a comprehensive understanding of what your baseline workflows to identify areas of improvement and standardization.**
2) **As you are building out your project team. Make it a cross section of staff who will be affected by the project. Establishing clear expectations and roles for everyone at the table early on will prevent confusion later.**
3) **Reinforce workflows by monitoring and providing immediate feedback.**
4) **Pilot with one clinic and condition (like diabetes) to refine roles and workflows before expanding.**

INNOVATIONS

- ⇒ **Established a scalable clinical workflow that will be standardized across the Total Health Care Organization.**
- ⇒ **Embedded quality – driven data metrics into our core operation to ensure consistent clinical excellence.**
- ⇒ **Breaking down inter-departmental silos and working collaboratively between Clinical, Pharmacy and Community Health Team.**
- ⇒ **Scheduled care managers in clinic weekly, improved access and integrated with clinical teams.**
- ⇒ **Facilitated full-scope utilization of clinical pharmacist within the multidisciplinary care team.**