Coastal Health Alliance
Your Community Health Center

11/07/2018

Teamlet Model for Improving HTN and HbA1c Levels

Redwood Community Health Coalition
Promising Practice

PROMISING PRACTICE OVERVIEW

Beginning in April 2018 Coastal Health Alliance (CHA) implemented a teamlet model to focus on quality improvement (QI) and improve staff relationships. CHA had a similar model several years ago, however due to staff turnover they were unable to maintain the teams.

CHA currently operates at two different sites, and from April to September 2018 they maintained two teamlets (one at each site). Teamlets consisted of one provider, all medical assistants (MAs), and all nurses at a site. While CHA started with three teamlets in 2018, the health center has since found that maintaining one single teamlet is most appropriate for their organization. The single teamlet now includes all providers, MAs, and nurses.

AIM

Implement a teamlet model to work on QI of selected health measures while improving care team relationships by motivating staff.

MEASURES

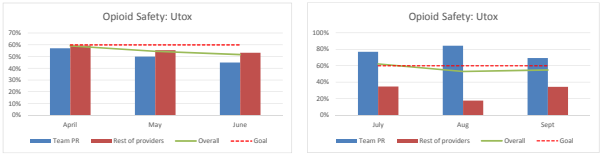
There were three quality measures selected for each teamlet based on the health center's priorities.

1. **Team "Amazing Penguin" Measures**
   - Opioid Safety
   - Hypertension
   - Breast Cancer Screening

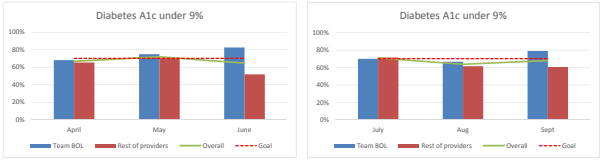
2. **Team "Pink Panther" Measures**
   - Cervical Cancer Screening
   - Diabetes HbA1c
   - Colorectal Cancer Screening

DATA

Opioid Safety - Team "Amazing Penguin"



Diabetes A1c - Team "Pink Panther"



ACTIONS TAKEN

- Created a teamlet model including a provider, all MAs, and all nurses at a single site. Each teamlet selected three health measures for focus.
- Held initial weekly Journey Map meetings during lunch breaks where all teamlet members shared ideas for identifying problem areas and space for improvement.
- Created patient Journey Maps, informed by the staff who see patients. These meetings also functioned as team building.
- Continued to meet monthly as a teamlet to check in on health measure progress and determine where the teamlet wanted to go.

WORKFLOW

PSDA Cycles: create Journey Maps, implement/adjust workflows, look at results for successes, implement successes across the organization

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Create AIM statement and action plan for improvement of each selected health measure

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Hold monthly teamlet meetings including the provider, all MAs, and all nurses

RESULTS TO DATE

Data was tracked from April 2018 through September 2018 for select health measures, comparing teamlet providers to non-teamlet providers. From baseline several measures saw a larger increase amongst teamlets, than non-teamlets, including cervical cancer screenings, diabetes HbA1c, and opioid safety.

Low staff retention levels made teamlets difficult to get started initially and maintain. Still the center has found teamlets to be a benefit for both QI measures and staff bonding. They will likely continue with only one teamlet.

PSDA cycles were useful in the beginning and for continued improvement. CHA was able to put significant time into the "plan" and "do" stages, however have been unable to focus on the "study" and "act" stages yet. They hope to study their results from their teamlets, and implement successful components across the organization.

LESSONS LEARNED

- Creating Journey Maps allowed time for intention, to review charts, and to have empathy for both patients and providers. Staff could identify small things that would make a big difference.
- Teamlets should meet monthly. Skipping a meeting resulted in a drop off of certain measures.
- Requiring patients to make a follow-up appointment with the MA before receiving their opioid prescription, proved helpful.
- Provider encouragement of patients regularly checking their blood sugar levels showed to successfully reinforce this message amongst both patients and care teams.

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Patient Journey Maps

PATIENT JOURNEY MAP – HYPERTENSION

Scheduling Appointment	Huddle	Check - In	Nurse or MA Visit	Provider Visit	Check-Out	Barriers/ Challenges
Multiple appointments are needed for HTN visits but no longer made by patients or team for patients (because RN follow-up no longer in place?) Patients with uncontrolled HTN should come in every 2 weeks Patients NEVER call for a BP check appointment. It is always something else Usually they come in for an acute visit and BP may be high due to stress – i.e. the reason they are there Only change meds if 2 visits are above goal	Review chart Provider reminds MA to check BP manually if patient has uncontrolled HTN The auto BP check is generally higher than the manual check		BP machine takes 2 or 3 BP readings and averages them – set by MA The patient complains The patient says it hurts and the MA stops Patients complain and refuse MA only does the average of several readings if the patient does not complain Average takes time and the MAs generally only do one reading This part of the visit is impacted by patients complaining so there is not consistency in how the machine is used	Provider's goal is to practice good medicine and work with patients based on their individual conditions and problems that cause HTN not just push meds Provider does not consider the patient as hypertensive unless the BP is elevated more than once (although the measure considers only the most recent BP for the quality measure) Provider talks to patient about diet and exercise benefits Provider considers all factors that may impact BP Treatment approach depends on how high the BP, how long elevated, and other factors. This takes time If BP is only mildly elevated, may not mention to patient and follow-up at the next visit If BP is elevated multiple times, provider develops plan with patient BP is impacted by time of day and time patient takes meds Could we offer patients a trusted device to use at home – home is more accurate and better representation of pt's BP Practicing good medicine will not bring the numbers down to "normal range	Patient does not wait to make follow-up appointment Follow-up visits need to be scheduled in 2 weeks Front Office looks for follow-up and makes appointment? Patient needs to know to go to Front Office to check out but Front Office has been told not to do this Nurse appointments are made by the Front Office Patients usually walk out without an appointment Providers want to treat the problem, not just push meds	Activity Ideas Can the MA be more active in the BP discussion with patients Provider communicates with the MA for follow-up appointment Providers need to stop putting "PRN". Put the actual time the follow-up appointment is needed – e.g. 2 weeks. Challenges Inconsistency among MAs in how BP is taken (machine ((1 or 2 times), machine or cuff, repeat at end of visit? Nurse visits no longer happening due to reduction in nursing staff Patients with highly elevated BP are not the problem for provider, patients with slightly elevated BP are Treating the problem may not help the numbers Everyone is still putting home BP in charts

PATIENT JOURNEY MAP – VISIT WITH DIABETIC PATIENT – HbA1c < 9% INITIAL CUT

Schedule Appointment	Huddle	Reception	Nurse or MA Visit	Provider Visit	Check-Out	Barriers/ Challenges
Patients with Diabetes make the 3-month follow-up appointment at each visit (rather than call to make it)	Team checks for lab and results	Visit is for a lab or a medication refill	There is confusion around glucose. Patients are not checking at home	Patients are engaged. Thinking of food as medicine Focus on upstream things that can be improved – be relentless Provide culturally sensitive recommendations – i.e. smaller portions rather than eliminating foods	MA makes Follow-up appointment	1. Language 2. Absence of Nutritionist 3. Is glucometer covered 4. No Shows 5. Parse #s by language to see if Latinos have more difficulty 6. Need ultralight needle – easier for sliding scale 7. Portions and exercise.

PATIENT JOURNEY MAP: Visit with patient who is prescribed opiates.

Scheduling	Reception	Nurse or MA Visit	Provider Visit	Check-Out
Patient asks for/demands refill without appointment Calls for appointment when medication is exhausted Provider not available when appointment is needed stressing front desk and patient Frustrated, Sense of helplessness Angry because they cannot be seen when they want Tries to gain control through subterfuge	Anxiety about process, feels judged Triplicates are lost Upset because we are behind and become angry if we are late Does not want pictures and does not want to fill out forms Crappy Sidetracked with psych issues/conversations	Just want to talk to provider Want a different medication, to try something else Do not understand why they need their BP and pulse taken Want stronger meds Depressed, chronic pain, feel like being held hostage Anxious about taper Don't know what different medications are for When forwarded to a nurse on telephone and nurse reminds them about agreement, they say they have not read the agreement Offended when asked for urine sample, Don't remember signing an agreement Say they did not agree to a utox and did not read the agreement	Blast you with their symptoms and pain Angry and scared Don't admit they are there for pain meds Resigned to tapering Incredulous, cannot believe that we are taking away a dose that works Think we assume they are a drug addict	Don't check out, grab prescription and run out the door
CHALLENGES – "TUGGLE"	❑ "Tuggle" - Visit is stressful and difficult, need accuracy on prescriptions, careful review, easy to make mistakes. ❑ Education – Patients do not understand the medications, the purpose, why step down is needed, why BP/Pulse is needed, what will happen next ❑ Patients are on best behavior with provider but not with rest of staff making visit stressful for staff ❑ Appointment required every 3 months but difficult to get patients to make next appointment			

PATIENT JOURNEY MAP: Opioid Safety – Pain Agreement, Medication Safety, Utox

Scheduling	Huddle	Reception	Nurse or MA Visit	Provider Visit	Check-Out
Patients need to be reminded to bring their list of meds to the appoint-ment	Population of patients over 70 years old are the patients who may not have a contract Polypharm and Multiple complicated conditions Pain med may be small part of the visit Utox alert MA checks to see if patient is due for Medication agreement and Utox	Patients need help getting into the clinic if they are older and mobility impaired This is a community with many mobility impaired patients Geriatric patients need help. It is time consuming Patients generally think/say we are kind and gracious	Patient asks why the utox is needed. MA approach is to tell the patient that the utox is needed to check if the medication is working. MA does not tell the patient that it is a drug or med screen because this would upset the patient Patients comply with the utox screen because they need the meds Can the MA give the Medication Agreement to the patient to review Patients ask the MA how to use medications and if they can use them together, will this work with that, etc.	It is hard to give attention to the contract because so many other things are going on -- Visit focus is not the contract sleep disorder and depression are common issues Focus on CURES and Utox and sometimes overlook agreement Agreement does not seem as important for patients who are not abusing the system i.e. Don't lose meds or ask for refills Concerned about "false positives" put in their record	Patient has to wait at the end of the visit MA makes next appointment for patient and gives them prescription This is in place and working. Patients have not complained
CHALLENGES –	1. Alert Fatigue – so many things wrong or irrelevant (check settings in eCW) 2. Patients do not have the literacy to understand meds 3. Medication Agreement is threatening – especially the part about our right to call anytime day or night 4. Hard to deal with mobility issues in our small clinics 5. Confronting patients on false positives from screens creates problems in the patient – provider relationship 6. Everything not possible with home visit patients 7. Sometimes med does not show up in screen 8. Alcohol is an issue for these patients 9. Do we have age parameters for the Utox (not needed if over 70?) 10. Opiates are like having a loaded gun in your house				
Activities --	1. Providers need training – include how to manage false positives with patient and medical record 2. Robust phone reminders for appointments 3. Different agreement for older patients? 4. Include write in for specific meds in agreement 5. Provider visit more often, once per month, anytime the med changes and longer – twice the length of other appointments? Providers need time to do the medication reconciliation in the visit., more time for safety 6. Update the agreement so that patients can understand it. Agreement should clarify the risks of the medication 7. Provide robust handouts 8. Need longer appointments for these patients are needed				

PATIENT JOURNEY MAP – Visit with Female Patient - Mammogram

Scheduling	Huddle	Reception	Nurse or MA Visit	Provider Visit	Check-Out	Barriers/ Challenges
Could be any appointment with female patient, usually not for acute appointments though	MA and Provider review the medical record and alerts and decide if a mammogram is due Overdue Mammogram could be added to chief complaints	Screening for mammogram Could Front Desk help screen for mammogram so that paperwork if needed could be completed before the visit?	Discussion with patient when mammogram is due. Patients feel hesitant MA asks if patient wants a mammogram. If the answer is yes, it is ordered If yes, MA reviews insurance. If patient does not have insurance (part of Every Woman Counts), patient has to go back to Front Desk and complete 4 or 5 pages of paperwork or The MA brings the paperwork to the patient to be completed while waiting for the visit If yes and patient has insurance, the MA orders the mammogram	Have discussion with patient when mammogram is due Uninsured patients are more willing to have mammogram If patient agrees, they fill out the form in rm Paperwork is lengthy Need someone who speaks Spanish to help patient navigate the next steps. Silvana?, Jasmin?		**Barriers** Language – Spanish speaking patients have difficulty navigating the larger clinic where no one may speak Spanish needed to fulfill order. They call for an appointment and give up because it is so complicated. Paperwork needed for uninsured Patient feels lost in the big facility that does mammograms **Challenges** Orders written and not fulfilled by pts
Actions	1. Alert – Customize it so that is shows when a patient is eligible but does not have insurance 2. Build monthly report (Maria is doing this for Cervical Cancer Screening,) – Christine check 3. More specific data needed 4. Need help for patients scheduling appointments – Christine check workflows 5. Patient Education – They need the process in writing with education materials. The summary has materials. Can the mammogram order include education too? 6. Track patients with insurance versus patients with no insurance to better help them 7. Can we update the diagnosis so that Mammogram shows as needed – Jeanne check with PHC					

PATIENT JOURNEY MAP – Visit with Female Patients – Cervical Cancer Screen

Scheduling	Huddle	Reception	Nurse or MA Visit	Provider Visit	Check-Out	Barriers/ Challenges
Appointment for WWE includes PAP but PAP can be offered at other visits if due. Are patients due for a PAP reached by Recall program? Yes, Can FD become aware of WWE rqmts and check in with provider if one is needed? Can everyone become aware of screening requirements and always consider how to encourage women to have PAP when due?	Alerts reviewed Can we add the PAP to the appointment that the patient has made? If the patient is here for something else, can we also include the PAP when it is due? Can we make sure to schedule a follow-up appointment for the PAP if it is due and cannot fit into the current appointment	There seems to be a mismatch between the reason the patient is actually there for the visit and the reason given for the visit and put into eCW.	MA and Nurse could also take an extra step and check in with the patient about a PAP that is due and let the provider know if patient agrees Can we alert the entire team to be aware of a PAP that is due and include it in discussion with patient? 	Visits go well when there is a long relationship between the provider and the pt. For those pts. there have been many discussions about health screenings and patients are more willing to have the screenings. Can we implement the "Sneak a PAP" -- if an exam is needed anyway on a visit other than the WWE can a PAP be quickly added to the visit? When exam is needed for another reason, provider should check status of PAP so both could be done at the current visit.	Can PAP visit be scheduled at check out if needed? Any time a woman is in for a visit, make sure entire team thinks about screening and steps to take if due. Can PAP Alert be included in the pt. summary: Can we develop pamphlet:	Are the alerts effective? Do patients call? Women sometimes ask for a PAP every year. How should we communicate that the requirement is every 3 years without losing the opportunity to ensure that it is done. Appt. mismatch – Can we improve this so that the appt. reason is real reason for visit. Is a Cervical Cancer Screen paid by insurance if a woman has one more often than every three years? Jeanne sent question to PHP. It is always a challenge to review charts thoroughly and know everything that is needed

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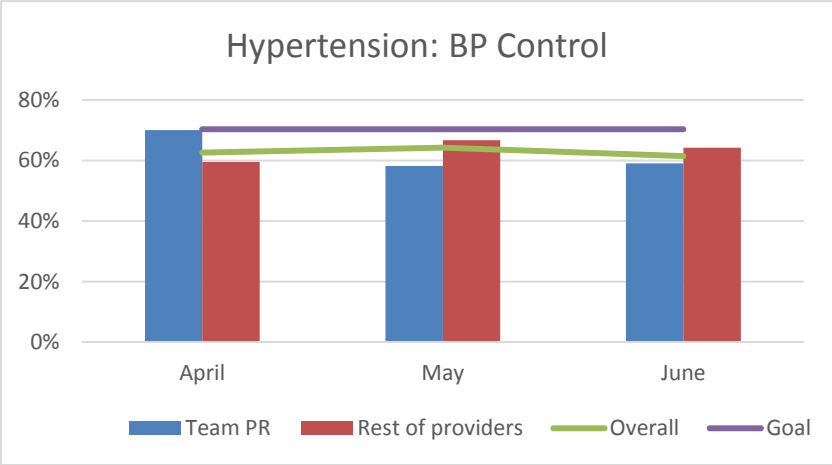
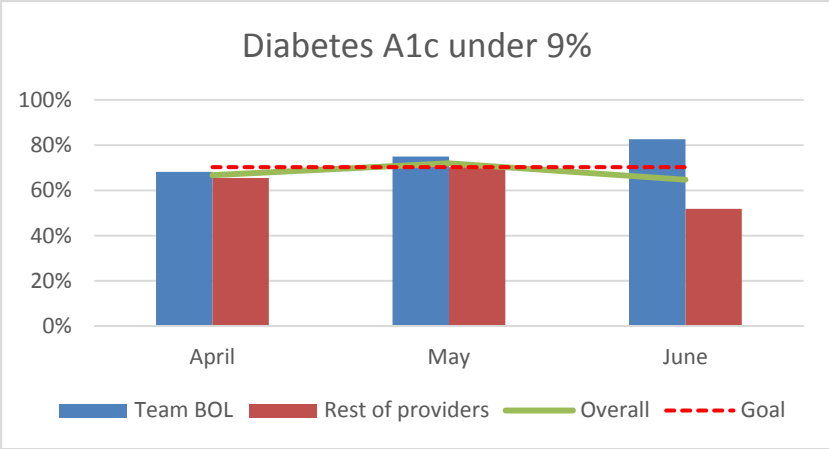
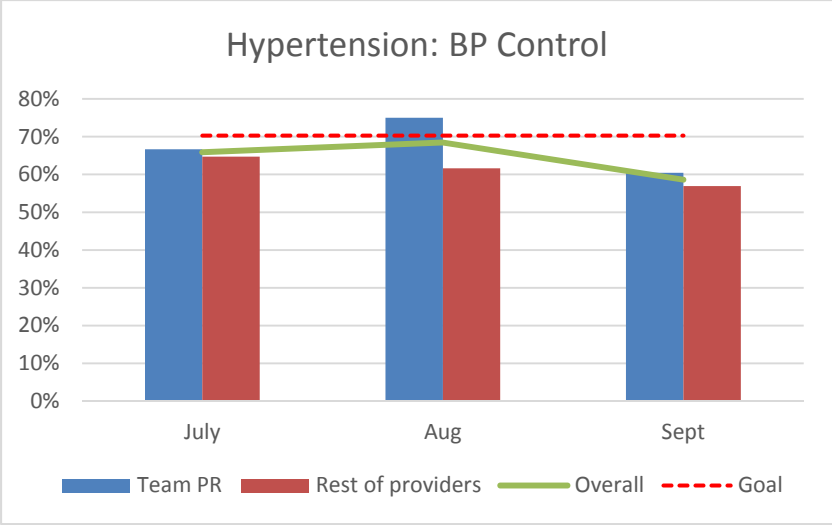
Teamlets - Data

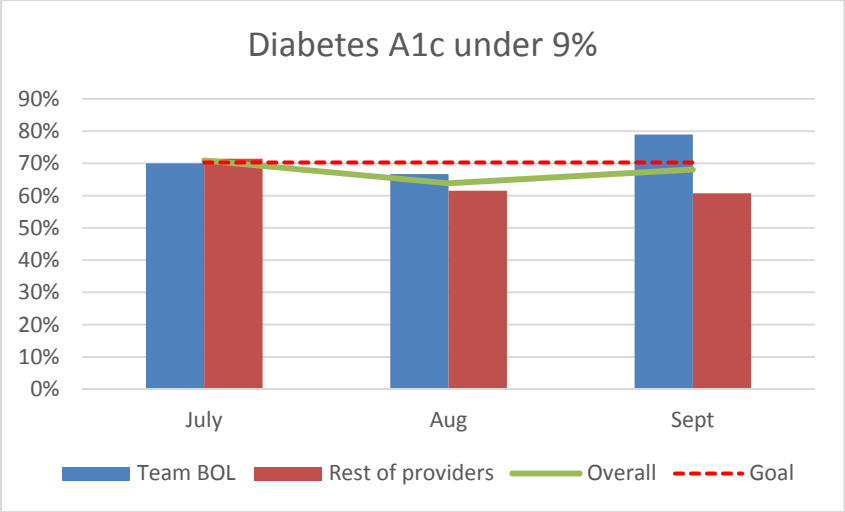
Hypertension - T1



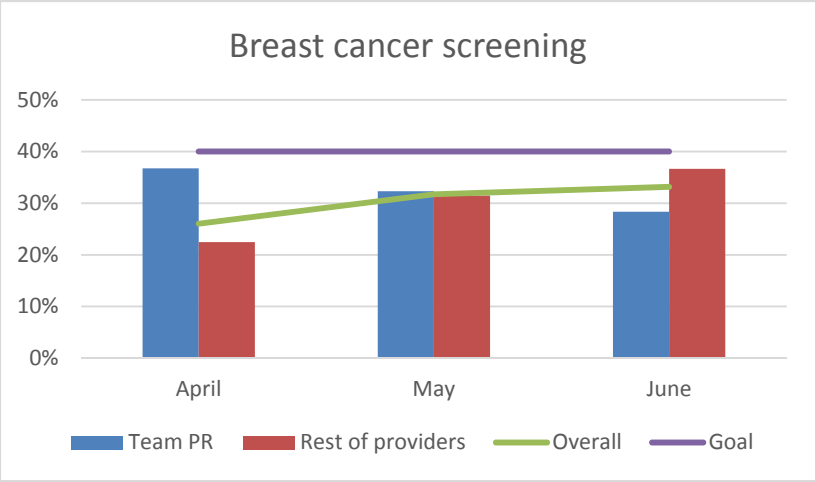
Diabetes: HbA1c < 9% - T2



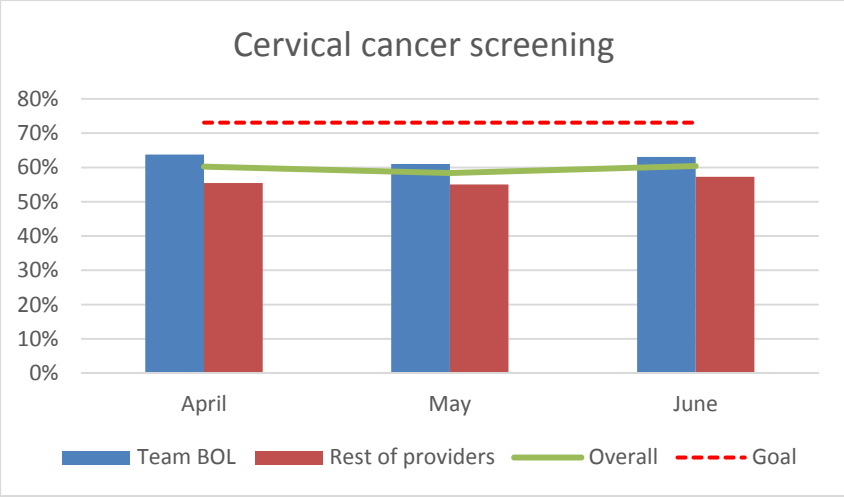


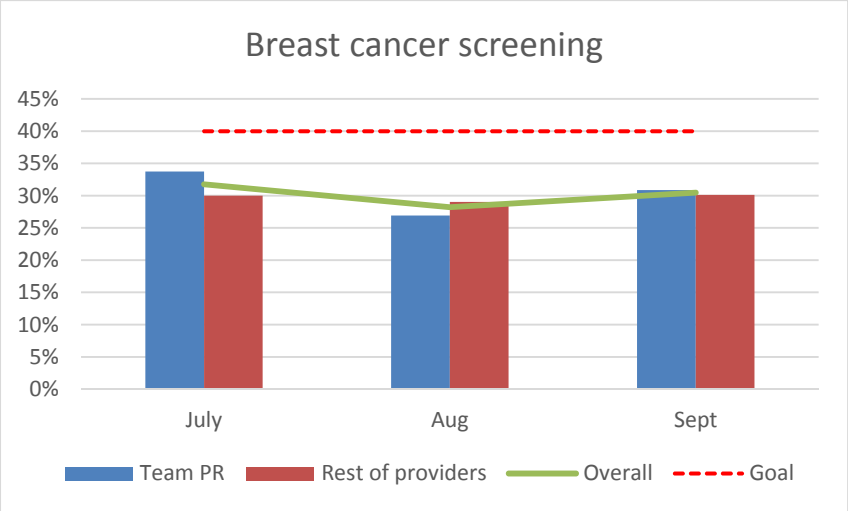


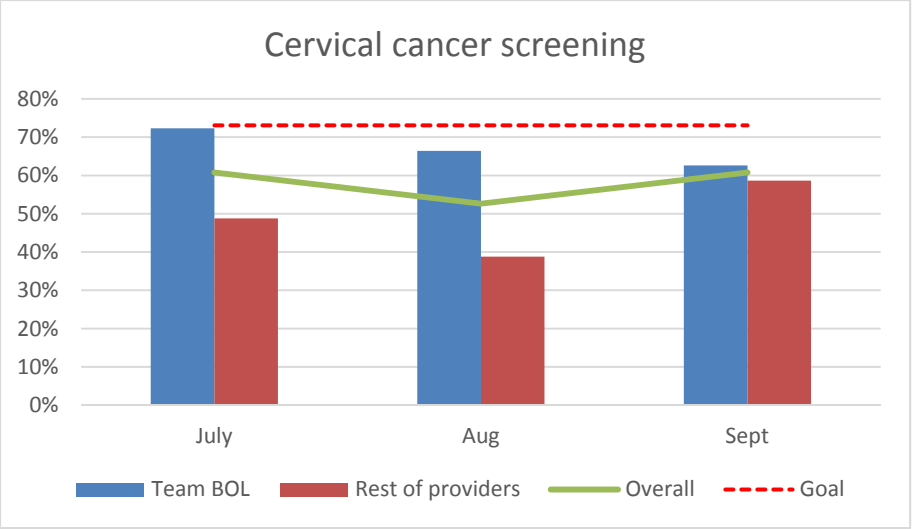
Breast Cancer Screen – T1



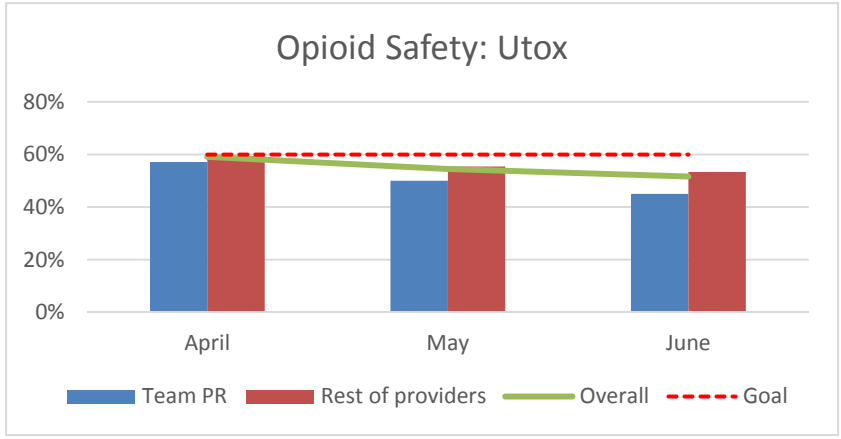
Cervical Cancer Screen – T2

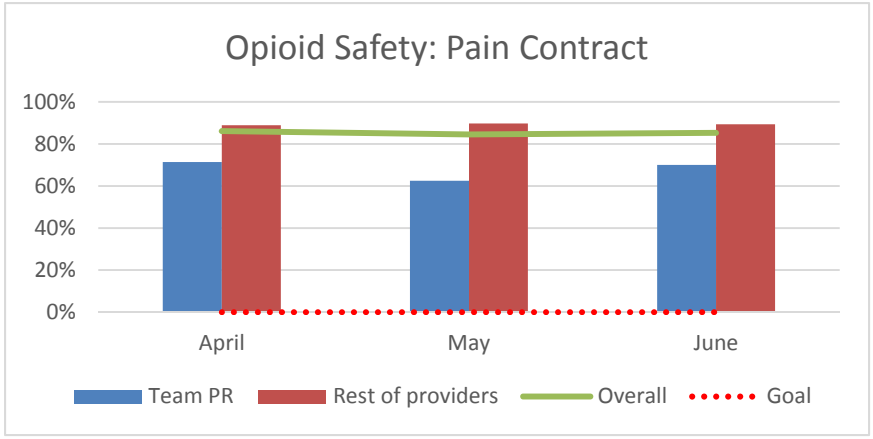


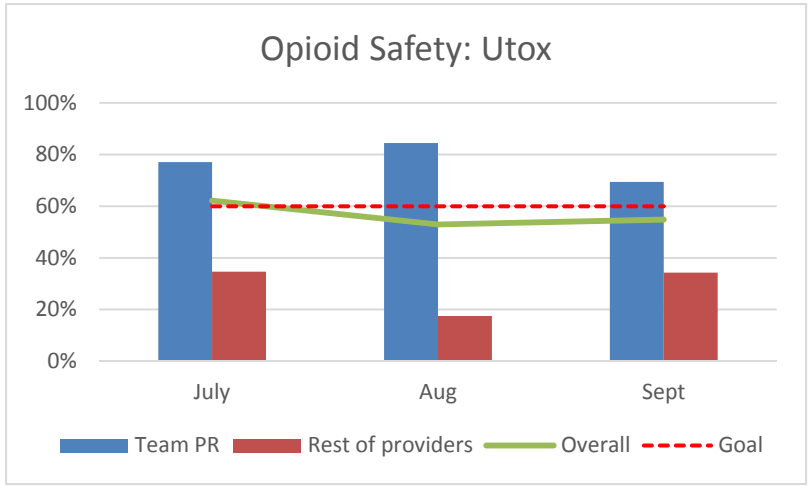


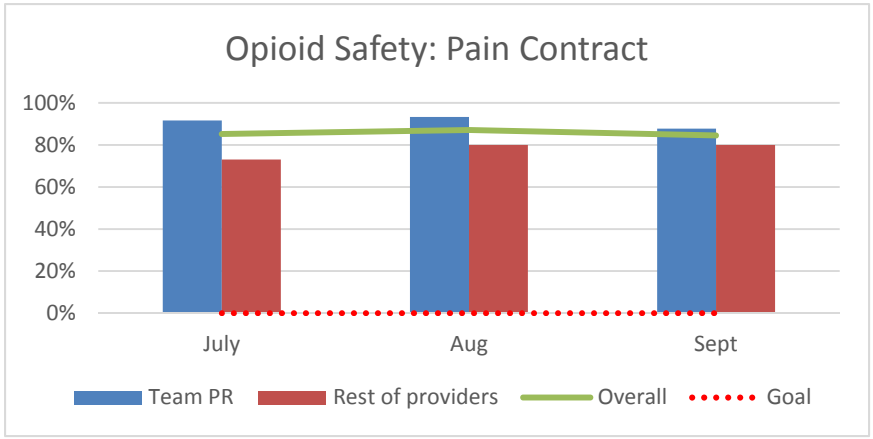


Opioid Safety – T1

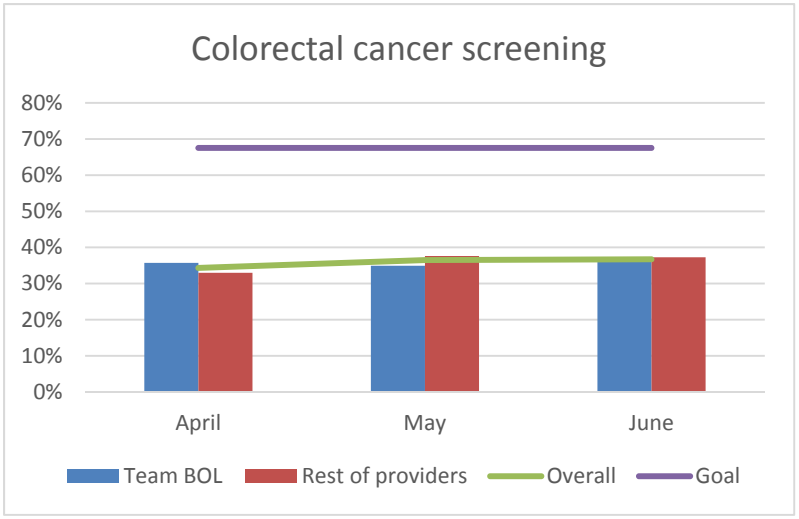


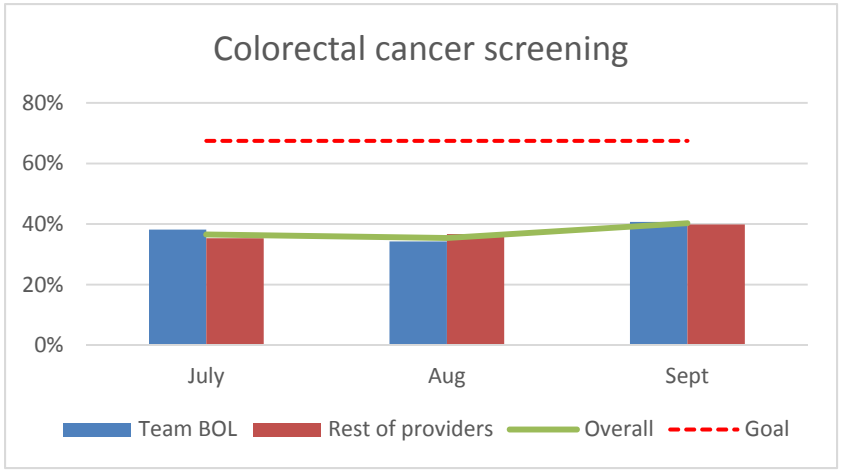






Colorectal Cancer Screening T2





TEAMLET 3: MEETING – 8-10-18

Participants: Gabe, Francis, Nena and Iris

Measures: Opioid Safety; BP Control for patients with HTN; Mammogram Screen

1. Discussion and Questions:

a. Reviewed July data. Results show the following:
   i. Teamlet 3 was 37.5% higher than the rest of the providers for opioid safety, Utox
   ii. Teamlet 3 was 6% higher than the rest of the providers for next appointment scheduled within 3 months
   iii. Teamlet 3 was 13.4% higher than the rest of the provider for Opioid Safety, Pain Contract
   iv. Teamlet 3 was 3.5% higher than the rest of the providers for HTN, BP control
   v. Teamlet 3 was 3% lower than the rest of the providers YTD but 3.8% higher for July

b. Breast Cancer Screening: Need MA follow-us to assure that screens are scheduled. Is Maria doing this for everyone? Alerts have been suppressed because not accurate (will be fixed with Relevant). Patients consistently refuse screen.

c. Need to address in huddle

d. Should it be added to chief complaint? MA puts need for screen in chief complaint. MA asks patient in MA part of visit if a screen can be schedules.

e. Utox should be discussed n huddle.

f. Need Pain Contract workflow, time for discussion with patients. This is provider, not MA role.

2. Uncontrolled Hypertension Journey Map (see page 3)

3. Identified HTN Activity Recommendations

1. Home BP machine provided to patients
2. MA become more active in BP discussion with patients
3. Provider communicate with MA (Front Office?) to assure follow-up appointment in 2 weeks
4. Providers stop putting PRN in TE and instead give exact days for next visit to be scheduled.

AIM STATEMENT: MAMMOGRAM SCREEN (from 6/14 Notes)

To help women patients at CHA improve their health and reduce the risk of later stage breast cancer by assuring that all women who are due for a mammogram understand its value and are easily able to navigate the system to complete it.

ACTIVITY I: Mammogram Referral

WHAT IS THE ACTIVITY?	Support uninsured women patients who have language or other barrier navigate the system and easily complete mammograms.	WORKFLOW REVIEW RECOMMENDATIONS
WHO WILL DO IT?	Christine will develop a workflow with our referral coordinators	EXISTING: Mammogram orders will be faxed to patient's radiology location preference as they are now. NEW: The **MA** will mark the order received and assign it to someone for Pap Tracking in eCW. The Pap tracking staff member will Follow-up with the patient to make sure they have scheduled their appointment with radiology. Team asked these questions: 1. **Which MA is doing this (Amy?)** 2. **When and how often (monthly?)** 3. **With which provider teams? All?** 4. **Would like more specificity, detailed workflow please** 5. **Then we will establish baseline and track**
WHEN WILL THEY DO IT?	After the work order is written, the MA will transfer the patient to the referral coordinator so that the appointment is scheduled and the patient has support in understanding how to complete the order	
ASSURE IT IS BEING DONE?	Noted in patient record	

ACTIVITY 2: Create Detailed Mammogram Reports

WHAT IS THE ACTIVITY?	Design monthly reports that show the number of insured and uninsured patients who have had a mammogram ordered and have fulfilled/not fulfilled the order	WORKFLOW REVIEW RECOMMENDATIONS
WHO WILL DO IT?	Christine will assign	Run a Pap and Mammogram list every month, staff reviews lists, makes sure Mammogram and Pap results are there, anyone who has an order and who has not scheduled will be called to help them navigate getting an appt. Cannot schedule Mammograms at time of order in clinic as it is in radiology hands once we fax the order to them to patient's choice of facilities and this cannot occur at office visit. The monthly; list will have to suffice which will include making sure we have the Mammogram report in the chart. **Team asked for more specificity:** 1. **When is this happening?** 2. **Who is doing it?** 3. **How often?**
WHEN WILL THEY DO IT?	TBD	
ASSURE IT IS BEING DONE?	TBD	

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AIM STATEMENT: HYPERTENSION

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ACTIVITY I: Home BP Machine

WHAT IS THE ACTIVITY?	Home BP machine provided by CHA to patients	WORKFLOW REVIEW RECOMMENDATIONS
WHO WILL DO IT?		
WHEN WILL THEY DO IT?		
ASSURE BEING DONE?		

ACTIVITY 2: Expand MA – Patient Communications

WHAT IS THE ACTIVITY?	Provider communicates with MA for follow-up appointments in 2 weeks. MA takes more active role in working with patients/communications	WORKFLOW REVIEW RECOMMENDATIONS
WHO WILL DO IT?		
WHEN WILL THEY DO IT?		
ASSURE BEING DONE?		

ACTIVITY 3: Create Detailed Mammogram Reports

WHAT IS THE ACTIVITY?	Providers should stop putting PRN in TE and instead give exact days for next visit to be scheduled.	WORKFLOW REVIEW RECOMMENDATIONS
WHO WILL DO IT?		
WHEN WILL THEY DO IT?		
ASSURE BEING DONE?		

Reports

WHAT IS THE ACTIVITY?	STANDARDIZE BP CHECK WORKFLOW	WORKFLOW REVIEW RECOMMENDATIONS
WHO WILL DO IT?		
WHEN WILL THEY DO IT?		
ASSURE BEING DONE?		

Pink Panther Meeting Minutes: 8-28-18

Participants: Anna, Adriana, Amy, Angela

Measures: Cervical Cancer Screen; HbA1c, 9%; Colorectal Cancer Screen

1. General Discussion:

- ***a.*** Reviewed July data. Results show the following:
  - ***i.*** 5.9% higher than the rest of the providers for Diabetes A1c,9%
  - ***ii.*** 6.7% higher than the rest of the providers for Cervical Cancer Screen
  - ***iii.*** 4.3% higher than the rest of the providers for Colo rectal Cancer screen
- ***b.*** Team discussed the idea of presenting their results to the rest of CHA in an all staff after several more meetings when a benchmark could be compared to results after 3 to 6 months.

2. Diabetic Patients HbA1c less than 9% discussion

Diabetes – HbA1c < 9%. *The measure includes adults between 18 and 75 years of age who have been diagnosed with diabetes and who have been seen in the measurement period. Patients who have a recorded A1c result in the past year and the last result was less than 9% meet the measure.*

a. Population either:
   i. Way out of control, the provider would adjust the insulin dosage
   ii. Less out of control but non-compliant
      1. No Show
      2. Do not follow nutrition or exercise guidelines
      3. Very frustrating for provider
      4. "Tough Love" does not work with these patients. They say "I know I will be blind or lose a leg but still don't care"
      5. They seem to get used to a super high blood sugar level

b. We need to check sliding scale for in-house. Is it properly coded?

c. Majority of these patients are self-pay so referrals are expensive

d. There is resistance to starting insulin, fear of needles

e. Medication is prescribed but patients don't take it.

3. Success Example – Patient way out of control but followed medication, nutrition and exercise recommendations for 4-5 months and was brought in control. The key motivational factor was the support of family members.

4. Ideas

a. Referral to an endocrinologist for sliding scale. Can Jasmin help? Braden Center for Diabetic Education

b. Group visits. Restart Elizabeth groups

c. Work with family members of diabetic patients

d. Referrals to Behavioral Health

e. **Always make next appointment before patient leaves**

Patient Journey Map (Team began Patient Journey Map for HbA1c Control)

Activities Identified

1. Make sure A1c kits are always available in –house (ordered bi-weekly for Point Reyes.
2. Education Pamphlet that includes diet and exercise
3. Ask patients to bring in Glucometer so that we can test its accuracy and home results can be trusted.
4. Suggest to patients that they use glucometer to test blood sugar levels after eating and receive instant feedback on blood sugar level, how it is effected by the food eaten and patterns – "In the Moment" learning
5. Food as medicine – teaching moments
6. Group Visits to provide social and support and address cultural issues.
7. Involve HHS for help. Maria?

Next Steps

1. Review operational feasibility of activities identified. (DCO)
2. Prioritize Activities with Operations input (Team)
3. Pick activity to implement (Team)

PATIENT JOURNEY MAP – Visit with Diabetic Patient – Initial

Schedule Appointment	Huddle	Reception	Nurse or MA Visit	Provider Visit	Check-Out	Barriers/ Challenges
Patients with Diabetes make the 3-month follow-up appointment at each visit (rather than call to make it)	Team checks for lab and results	Visit is for a lab or a medication refill	There is confusion around glucose. Patients are not checking at home	Patients are engaged. Thinking of food as medicine Focus on upstream things that can be improved – be relentless Provide culturally sensitive recommendations – i.e. smaller portions rather than eliminating foods	MA makes Follow-up appointment	1. Language 2. Absence of Nutritionist 3. Is glucometer covered 4. No Shows 5. Parse #s by language to see if Latinos have more difficulty 6. Need ultralight needle – easier for sliding scale 7. Portions and exercise.