



Teamlet Model for Improving HTN and HbA1c Levels

Redwood Community Health Coalition
Promising Practice

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number H2QCS30258, Health Center Controlled Networks, for \$1,500,000. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.

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

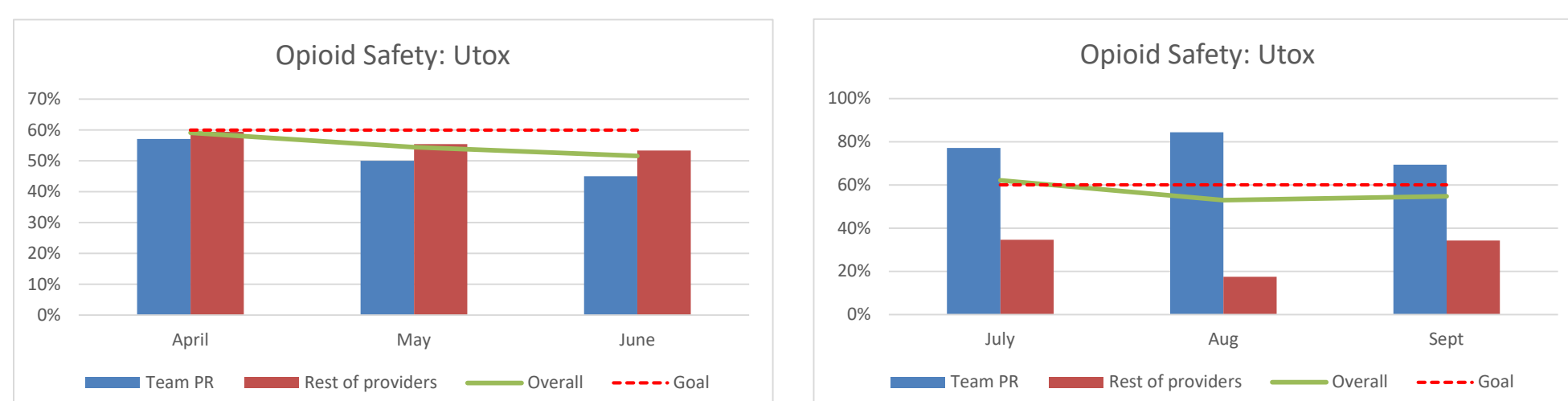
- Opioid Safety
- Hypertension
- Breast Cancer Screening

2. Team "Pink Panther" Measures

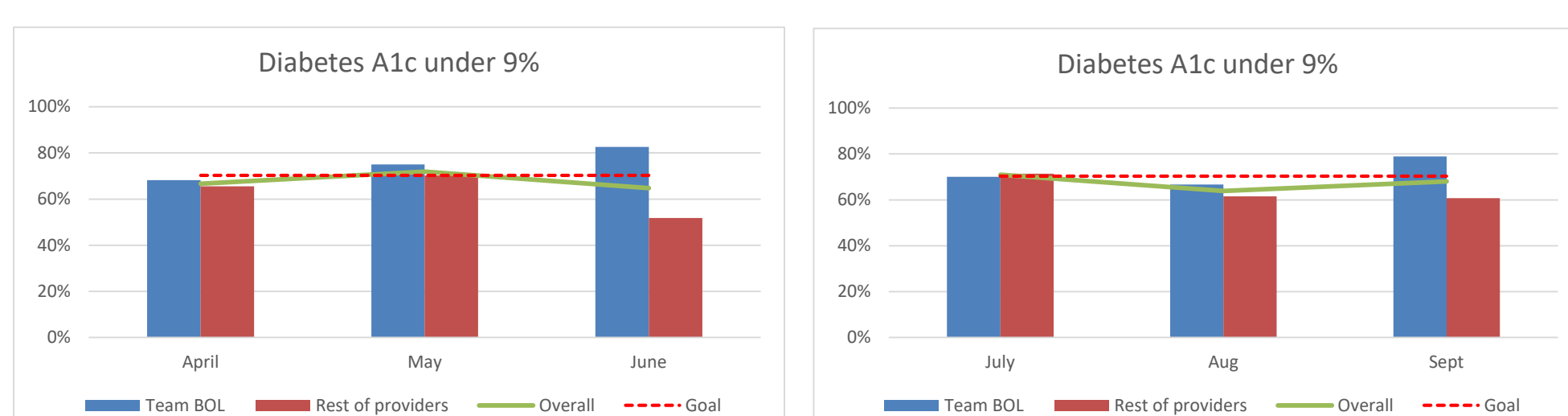
- Cervical Cancer Screening
- Diabetes HbA1c
- Colorectal Cancer Screening

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



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



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.

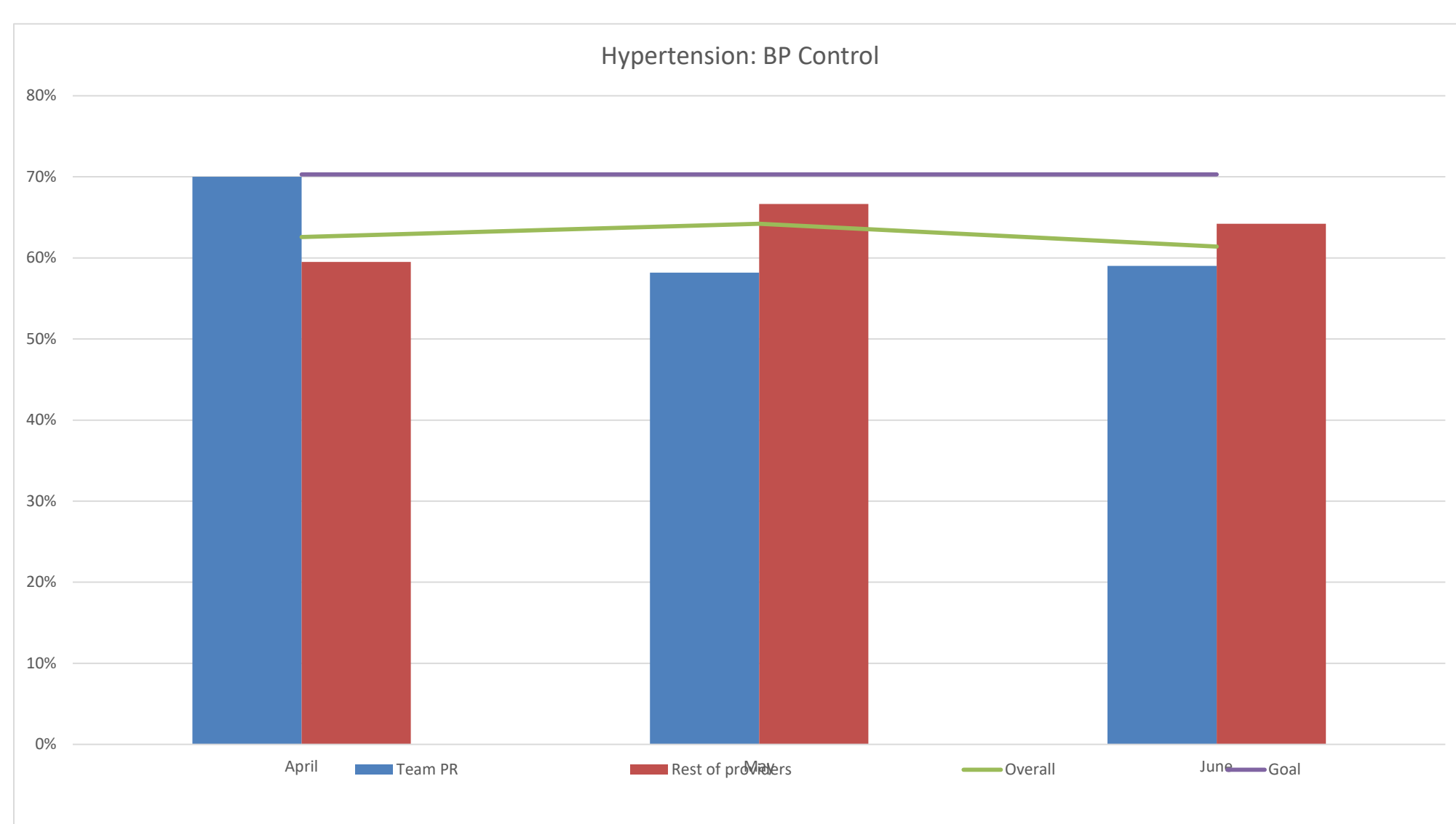
LESSONS LEARNED

- 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.

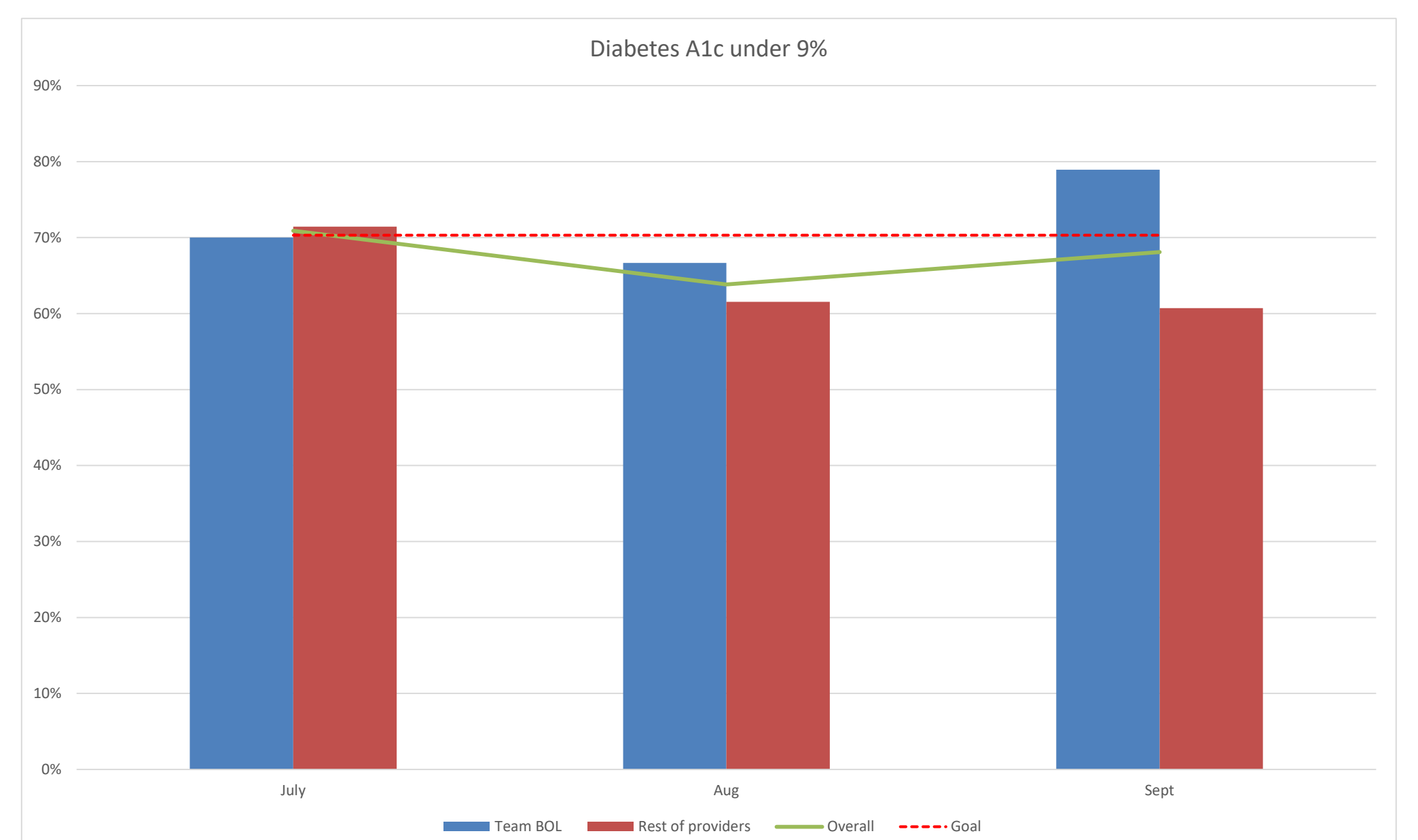
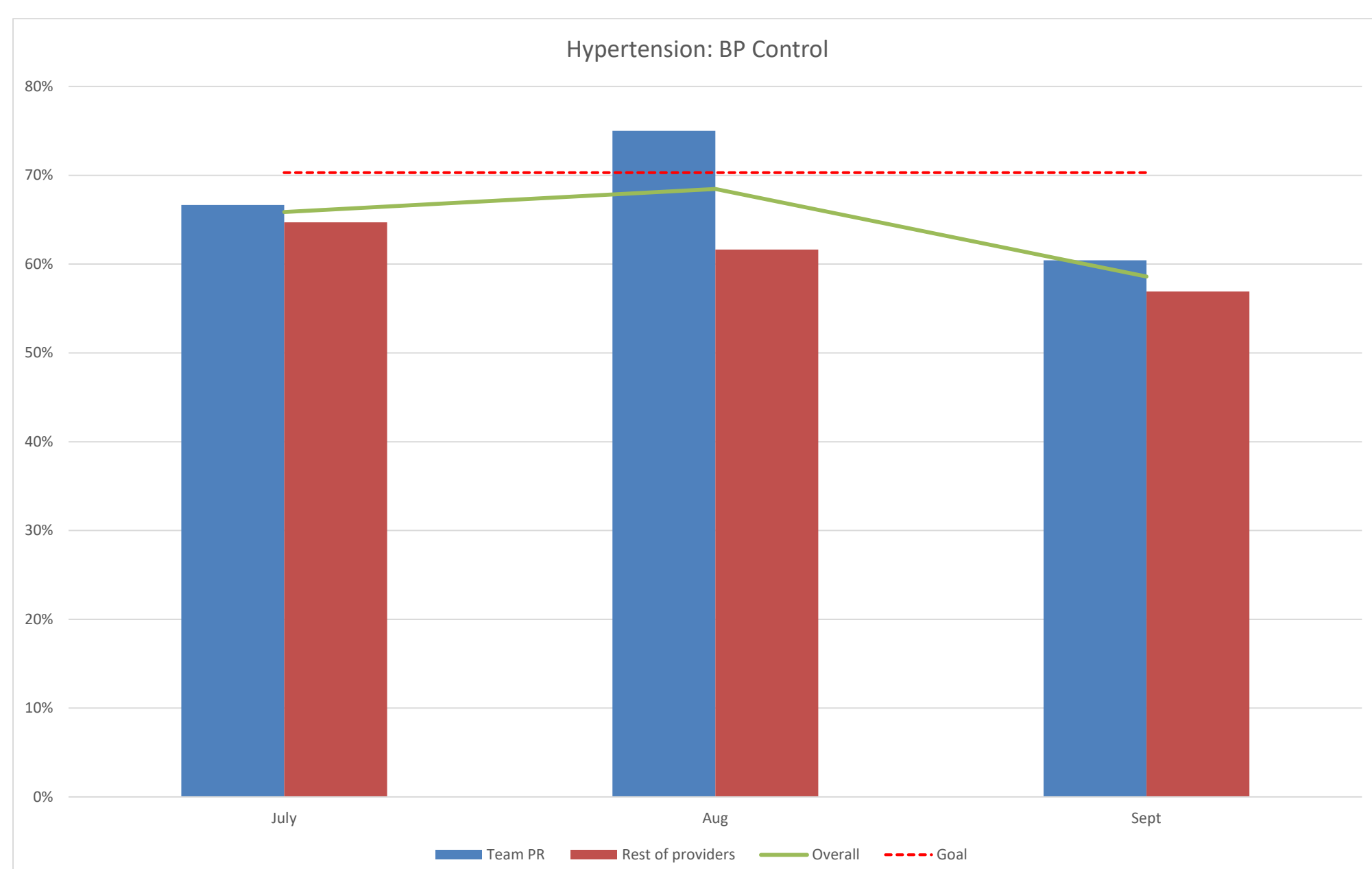
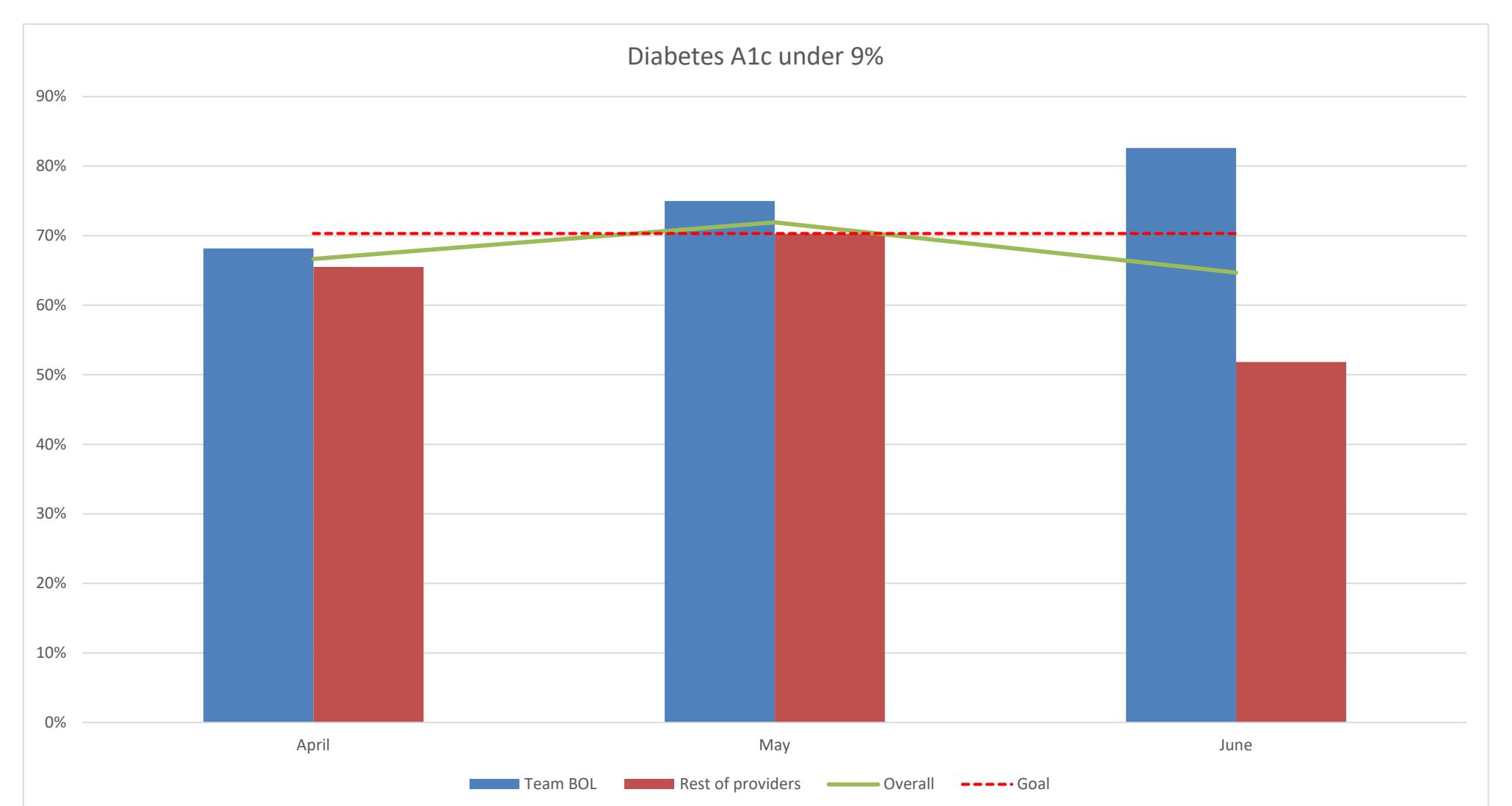


Teamlets - Data

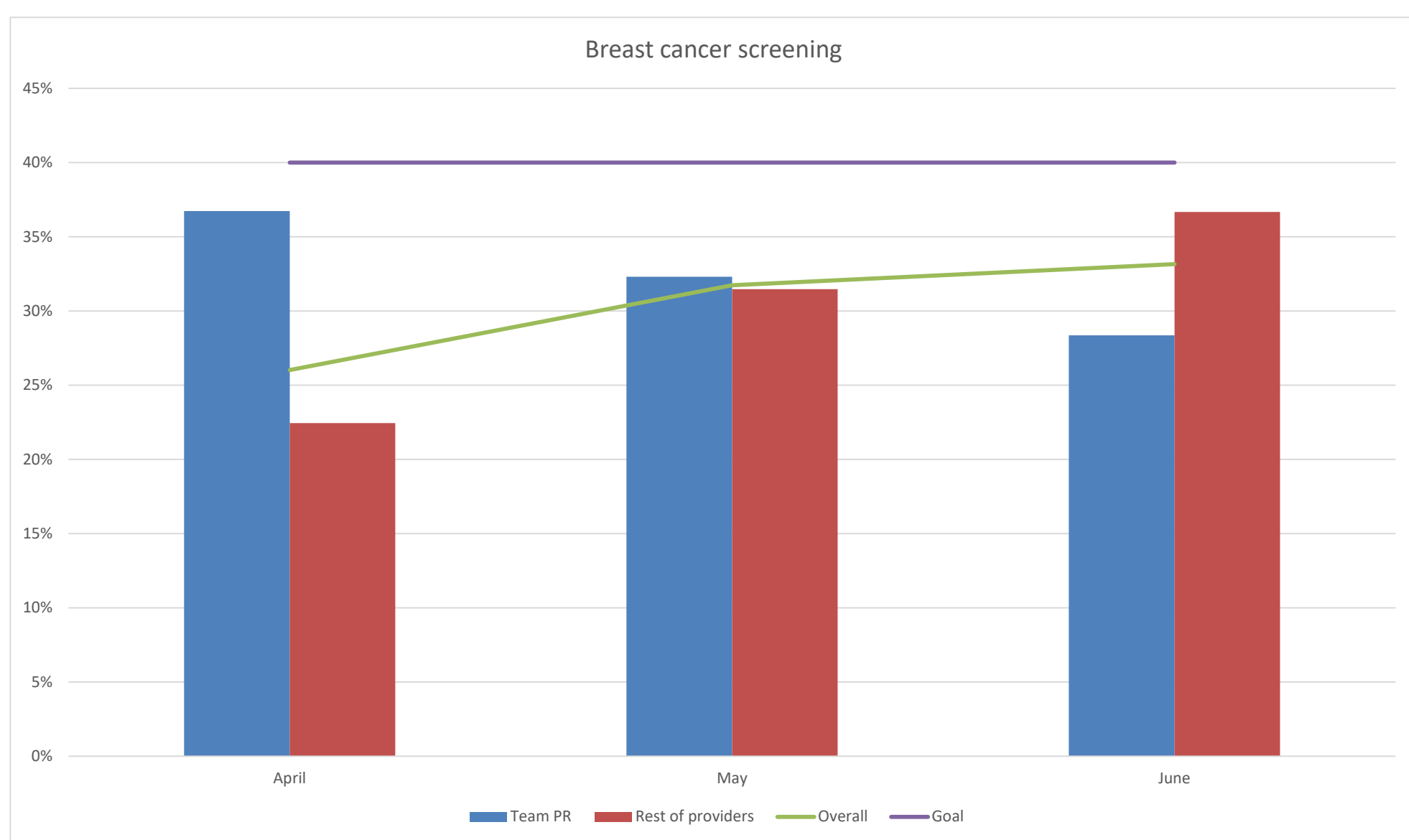
Hypertension - T1



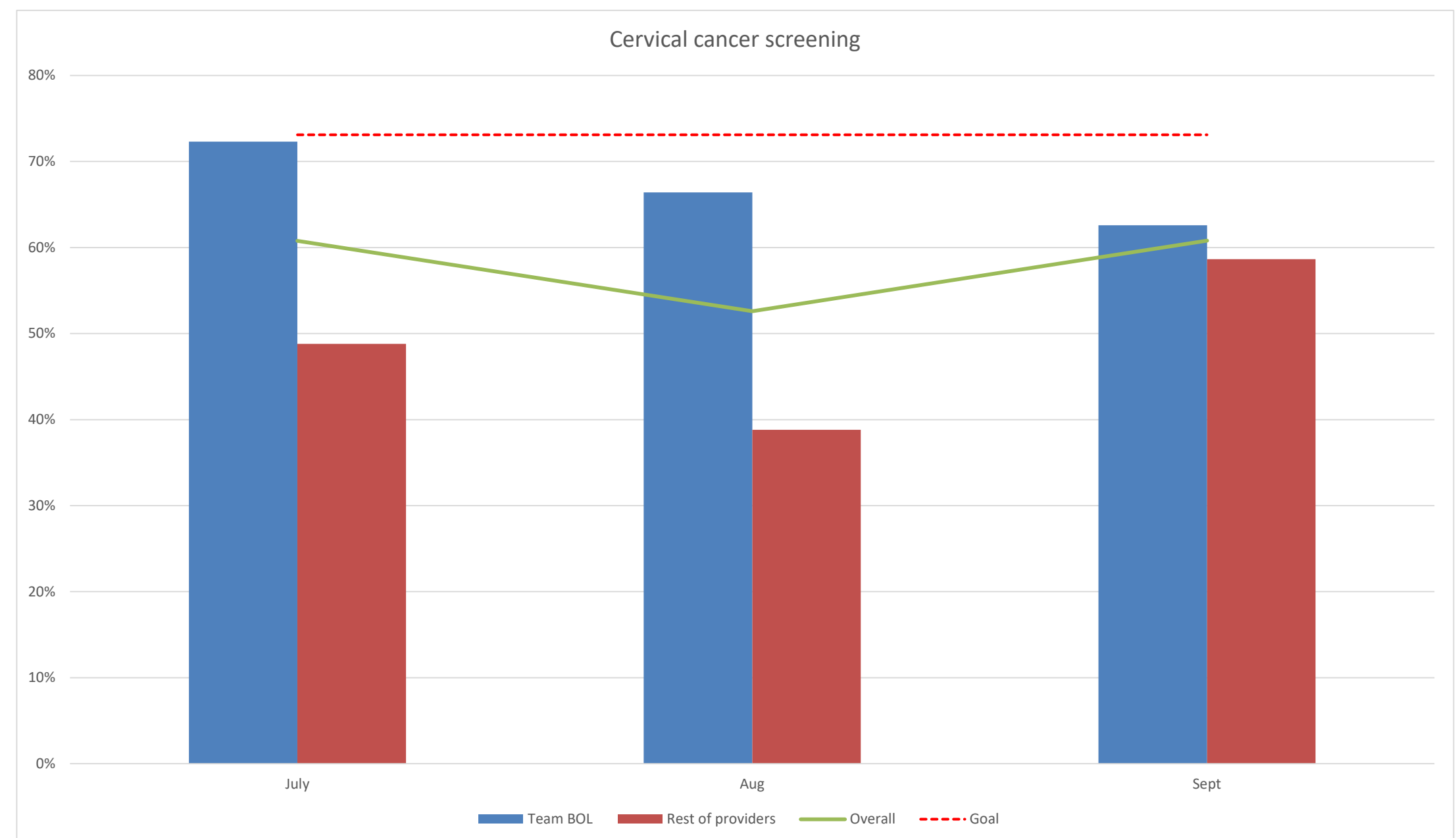
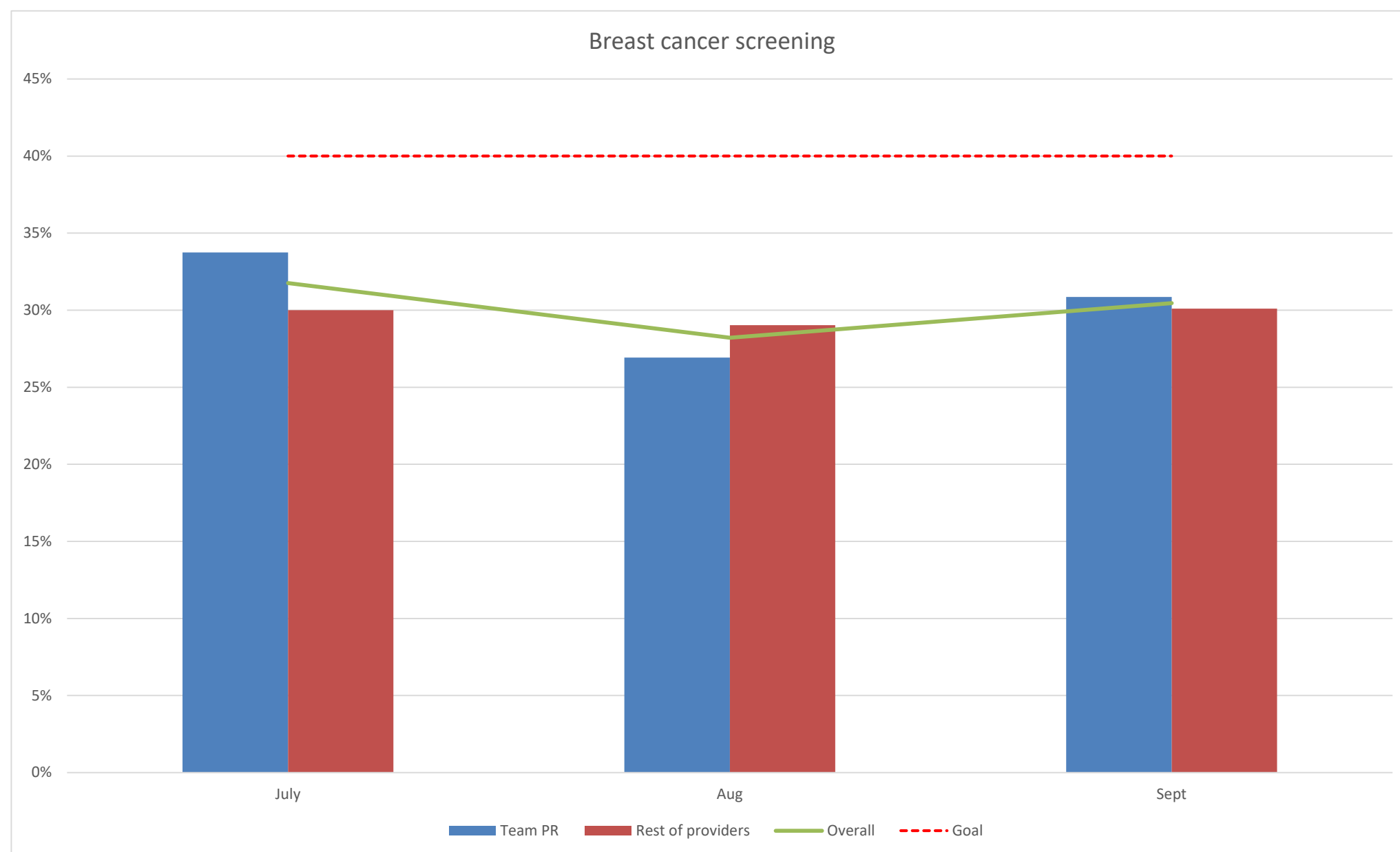
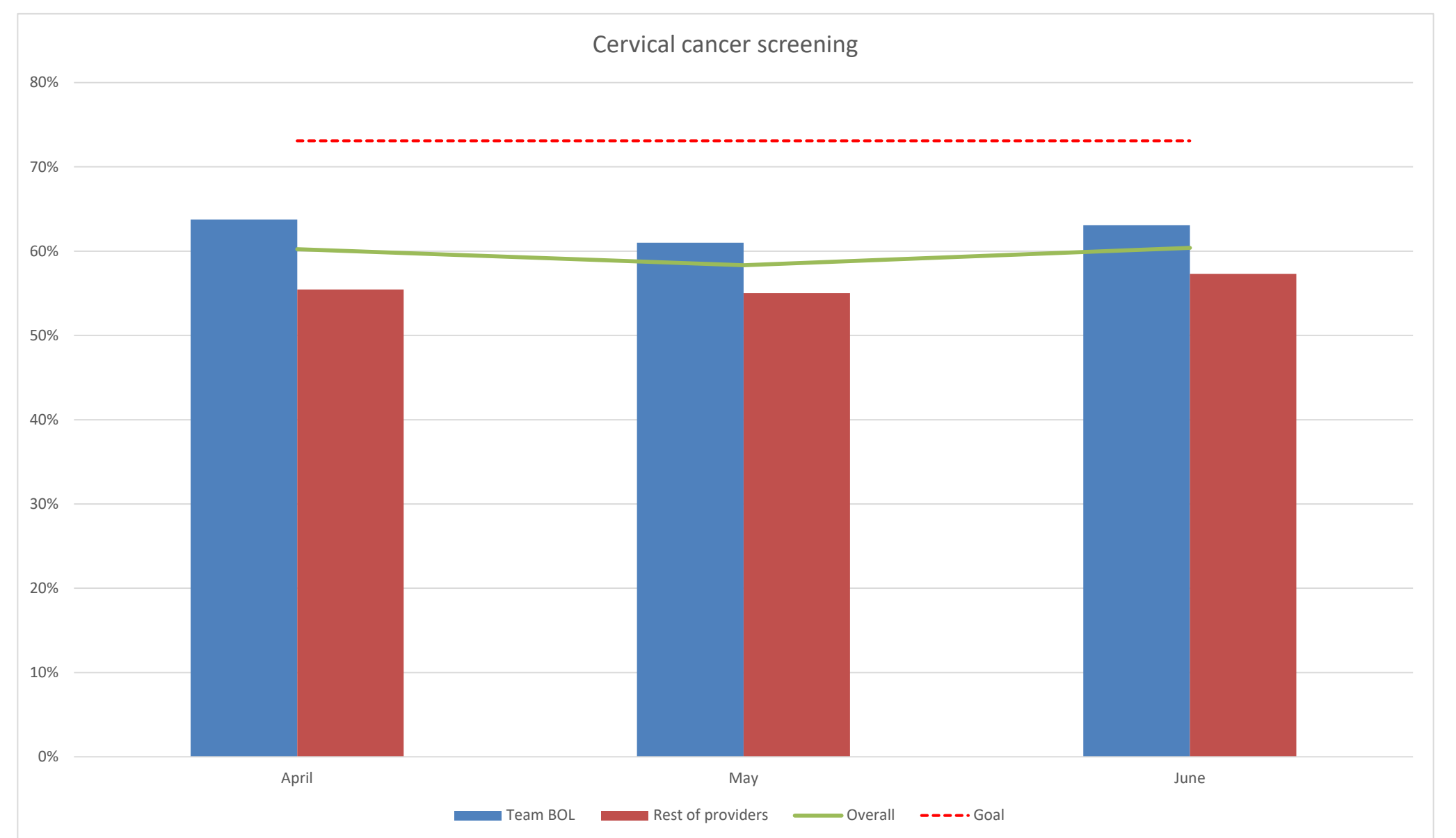
Diabetes: HbA1c < 9% - T2



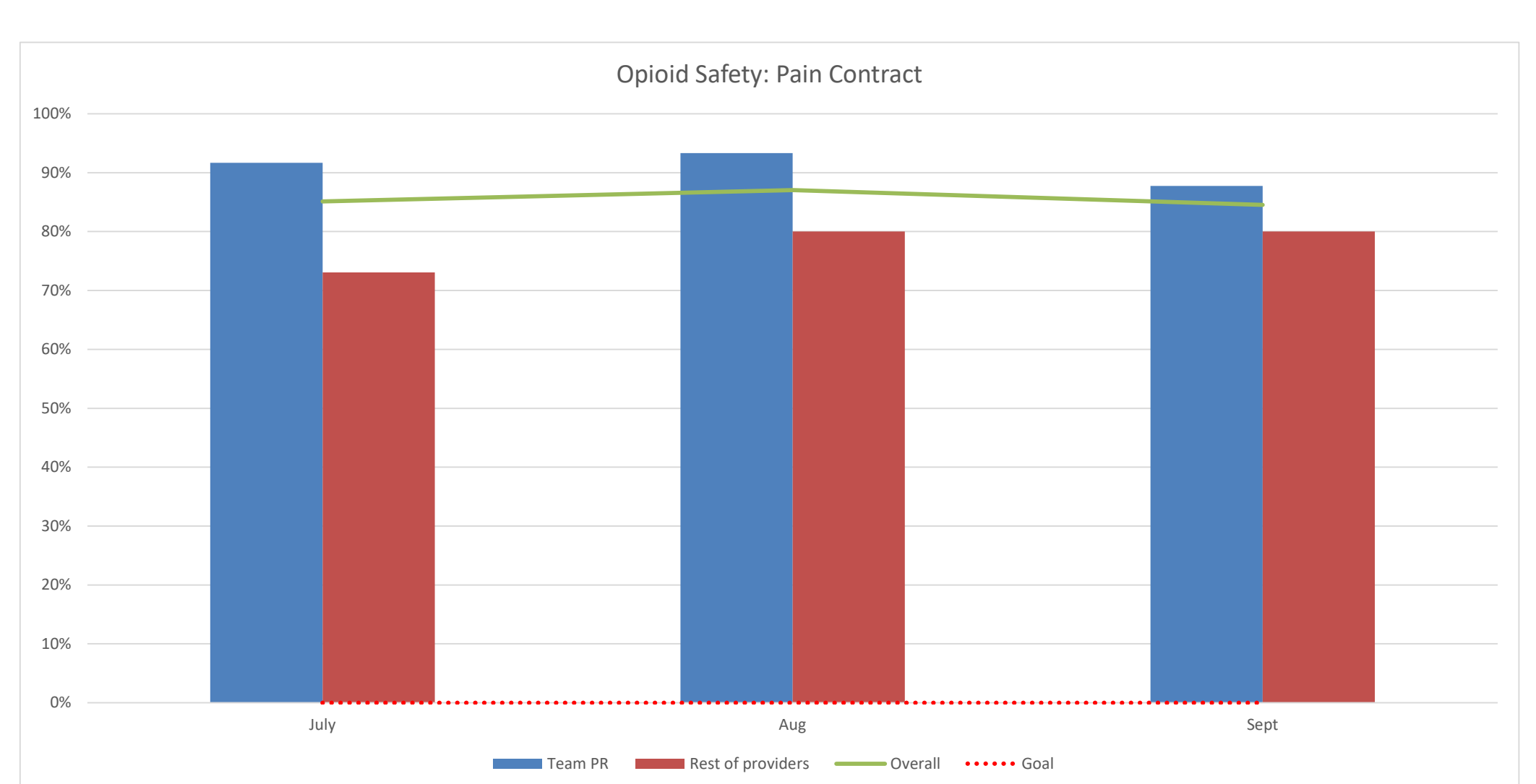
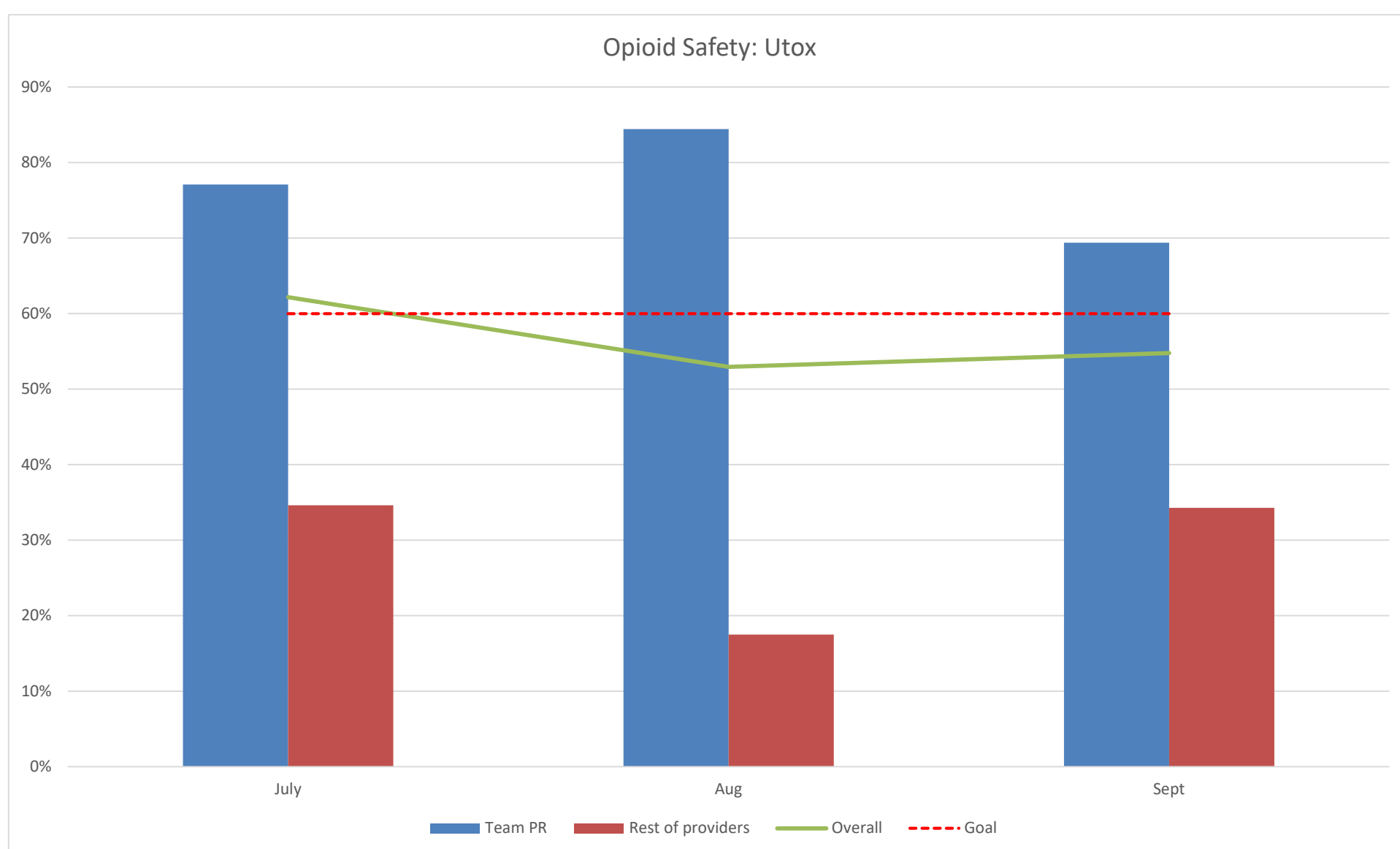
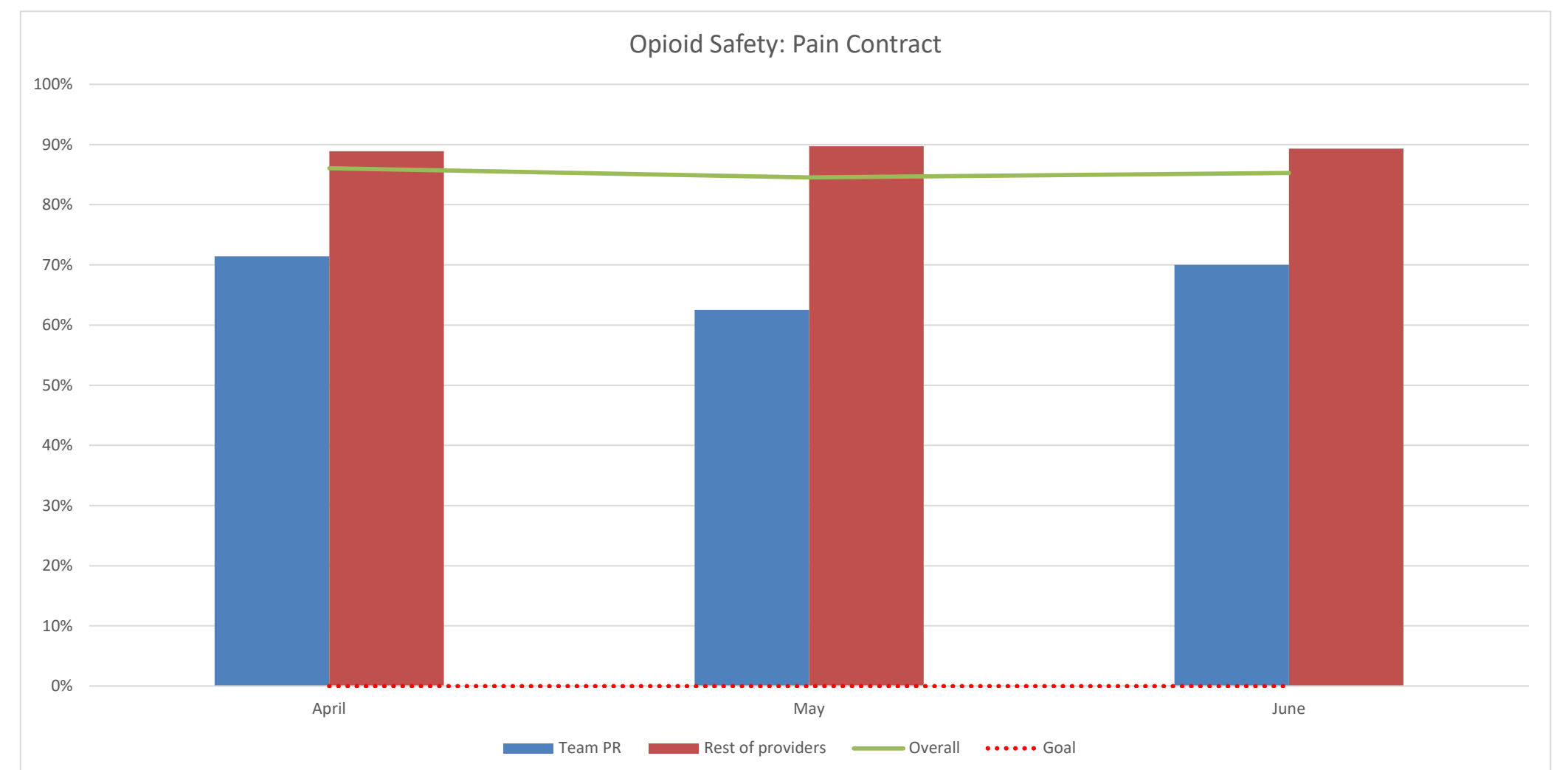
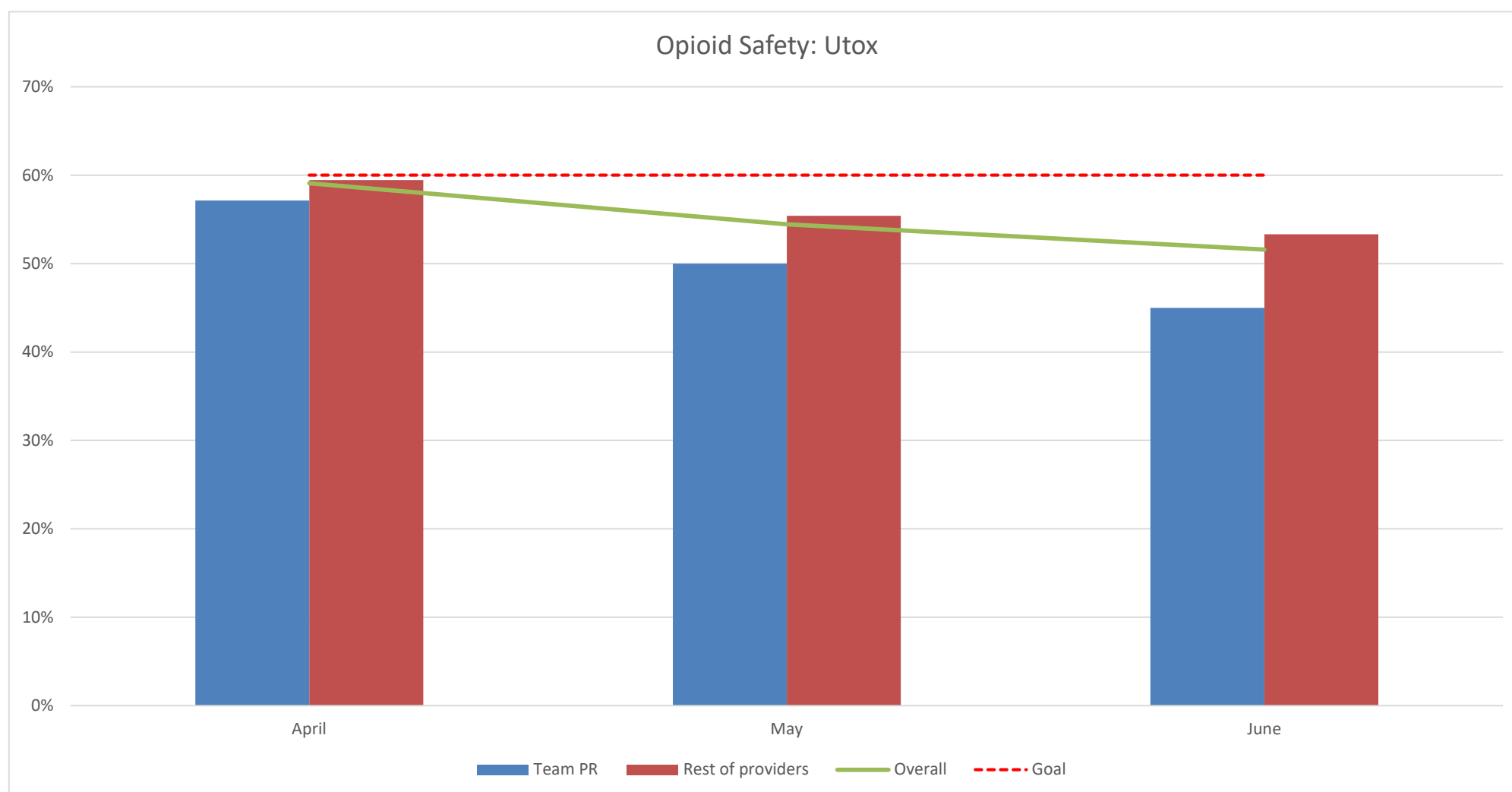
Breast Cancer Screen – T1



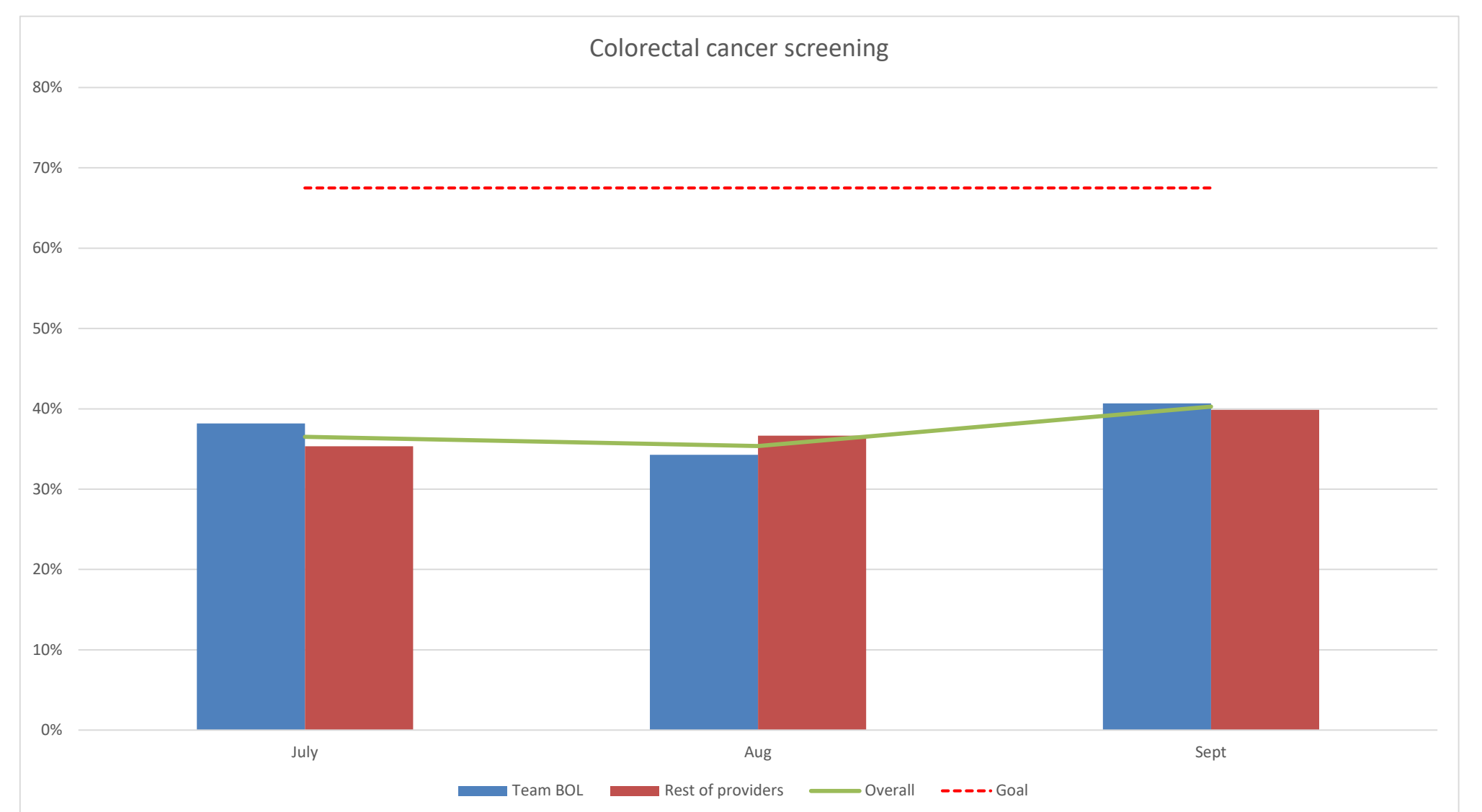
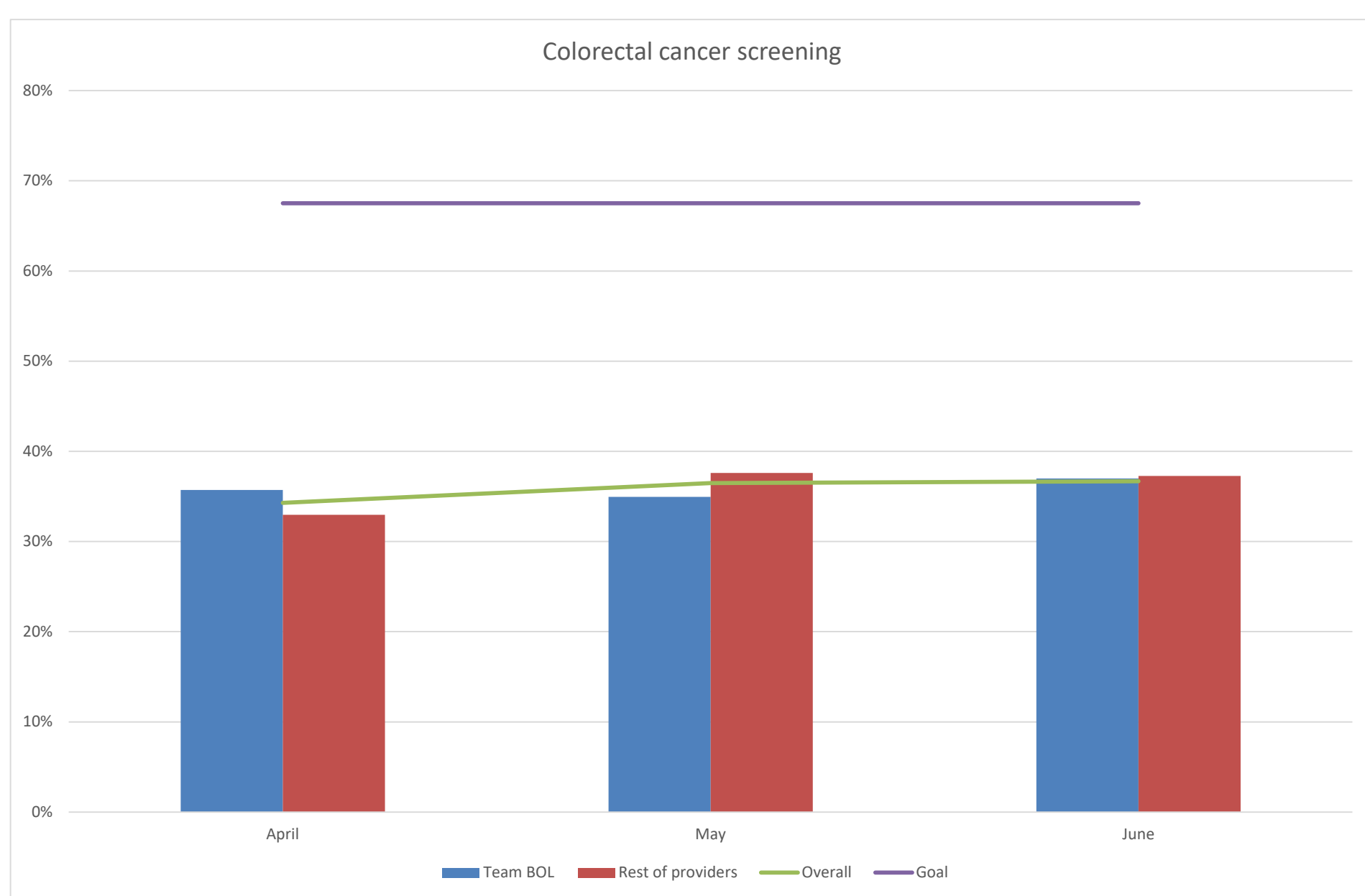
Cervical Cancer Screen – T2



Opioid Safety – T1



Colorectal Cancer Screening T2





Patient Journey Maps

PATIENT JOURNEY MAP – HYPERTENSION

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

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 | <p>Patients are engaged. Thinking of food as medicine</p> <p>Focus on upstream things that can be improved – be relentless</p> <p>Provide culturally sensitive recommendations – i.e. smaller portions rather than eliminating foods</p> | MA makes Follow-up appointment | <ol style="list-style-type: none"> 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 |
|---|---|---|--|--|
| <p>Patient asks for/demands refill without appointment</p> <p>Calls for appointment when medication is exhausted</p> <p>Provider not available when appointment is needed stressing front desk and patient</p> <p>Frustrated, Sense of helplessness</p> <p>Angry because they cannot be seen when they want</p> <p>Tries to gain control through subterfuge</p> | <p>Anxiety about process, feels judged</p> <p>Triplicates are lost</p> <p>Upset because we are behind and become angry if we are late</p> <p>Does not want pictures and does not want to fill out forms</p> <p>Crappy</p> <p>Sidetracked with psych issues/conversations</p> | <p>Just want to talk to provider</p> <p>Want a different medication, to try something else</p> <p>Do not understand why they need their BP and pulse taken</p> <p>Want stronger meds</p> <p>Depressed, chronic pain, feel like being held hostage</p> <p>Anxious about taper</p> <p>Don't know what different medications are for</p> <p>When forwarded to a nurse on telephone and nurse reminds them about agreement, they say they have not read the agreement</p> <p>Offended when asked for urine sample, Don't remember signing an agreement</p> <p>Say they did not agree to a utox and did not read the agreement</p> | <p>Blast you with their symptoms and pain</p> <p>Angry and scared</p> <p>Don't admit they are there for pain meds</p> <p>Resigned to tapering</p> <p>Incredulous, cannot believe that we are taking away a dose that works</p> <p>Think we assume they are a drug addict</p> | <p>Don't check out, grab prescription and run out the door</p> |
| <p>CHALLENGES – "TUGGLE"</p> | <ul style="list-style-type: none"> <input type="checkbox"/> "Tuggle" - Visit is stressful and difficult, need accuracy on prescriptions, careful review, easy to make mistakes. <input type="checkbox"/> Education – Patients do not understand the medications, the purpose, why step down is needed, why BP/Pulse is needed, what will happen next <input type="checkbox"/> Patients are on best behavior with provider but not with rest of staff making visit stressful for staff <input type="checkbox"/> 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 |
|--|--|--|--|--|---|
| <p>Patients need to be reminded to bring their list of meds to the appointment</p> | <p>Population of patients over 70 years old are the patients who may not have a contract</p> <p>Polypharm and Multiple complicated conditions</p> <p>Pain med may be small part of the visit</p> <p>Utox alert</p> <p>MA checks to see if patient is due for Medication agreement and Utox</p> | <p>Patients need help getting into the clinic if they are older and mobility impaired</p> <p>This is a community with many mobility impaired patients</p> <p>Geriatric patients need help. It is time consuming</p> <p>Patients generally think/say we are kind and gracious</p> | <p>Patient asks why the utox is needed.</p> <p>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</p> <p>Patients comply with the utox screen because they need the meds</p> <p>Can the MA give the Medication Agreement to the patient to review</p> <p>Patients ask the MA how to use medications and if they can use them together, will this work with that, etc.</p> | <p>It is hard to give attention to the contract because so many other things are going on -- Visit focus is not the contract</p> <p>sleep disorder and depression are common issues</p> <p>Focus on CURES and Utox and sometimes overlook agreement</p> <p>Agreement does not seem as important for patients who are not abusing the system i.e. Don't lose meds or ask for refills</p> <p>Concerned about "false positives" put in their record</p> | <p>Patient has to wait at the end of the visit</p> <p>MA makes next appointment for patient and gives them prescription</p> <p>This is in place and working. Patients have not complained</p> |
| <p>CHALLENGES –</p> | <ol style="list-style-type: none"> 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 | | | | |
| <p>Activities --</p> | <ol style="list-style-type: none"> 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 |
|--|---|---|--|---|-----------|---|
| <p>Could be any appointment with female patient, usually not for acute appointments though</p> | <p>MA and Provider review the medical record and alerts and decide if a mammogram is due</p> <p>Overdue Mammogram could be added to chief complaints</p> | <p>Screening for mammogram</p> <p>Could Front Desk help screen for mammogram so that paperwork if needed could be completed before the visit?</p> | <p>Discussion with patient when mammogram is due.</p> <p>Patients feel hesitant</p> <p>MA asks if patient wants a mammogram. If the answer is yes, it is ordered</p> <p>If yes, MA reviews insurance.</p> <p>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</p> <p>If yes and patient has insurance, the MA orders the mammogram</p> | <p>Have discussion with patient when mammogram is due</p> <p>Uninsured patients are more willing to have mammogram</p> <p>If patient agrees, they fill out the form in room</p> <p>Paperwork is lengthy</p> <p>Need someone who speaks Spanish to help patient navigate the next steps. Silvana?, Jasmin?</p> | | <p>Barriers</p> <p>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.</p> <p>Paperwork needed for uninsured</p> <p>Patient feels lost in the big facility that does mammograms</p> <p>Challenges</p> <p>Orders written and not fulfilled by pts</p> |
| <p>Actions</p> | <ol style="list-style-type: none"> 1. Alert – Customize it so that it 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 |
|---|--|---|---|---|--|--|
| <p>Appointment for WWE includes PAP but PAP can be offered at other visits if due.</p> <p>Are patients due for a PAP reached by Recall program? Yes,</p> <p>Can FD become aware of WWE rqmts and check in with provider if one is needed?</p> <p>Can everyone become aware of screening requirements and always consider how to encourage women to have PAP when due?</p> | <p>Alerts reviewed</p> <p>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?</p> <p>Can we make sure to schedule a follow-up appointment for the PAP if it is due and cannot fit into the current appointment</p> | <p>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.</p> | <p>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</p> <p>Can we alert the entire team to be aware of a PAP that is due and include it in discussion with patient?</p>  | <p>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.</p> <p>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?</p> <p>When exam is needed for another reason, provider should check status of PAP so both could be done at the current visit.</p> | <p>Can PAP visit be scheduled at check out if needed?</p> <p>Any time a woman is in for a visit, make sure entire team thinks about screening and steps to take if due.</p> <p>Can PAP Alert be included in the pt. summary:</p> <p>Can we develop pamphlet:</p> | <p>Are the alerts effective? Do patients call?</p> <p>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.</p> <p>Appt. mismatch – Can we improve this so that the appt. reason is real reason for visit.</p> <p>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</p> |