Learning Session #2
“Strategies to Building Better Practice and Community Teams and Effectively Engage Patients So They Can Live Well with Diabetes and Hypertension”
March 17, 2016
8:30AM – 3PM
Maple Hill Farm, Hallowell

Welcome our Participating Practices:

- Ellsworth Internal Medicine
- Lincoln Medical Partners Family Medicine – Damariscotta
- York County Community Action – Nasonn Health Care
- York Family Practice

Welcome to our Project Partners:

- **Maine Quality Counts**: Project Leadership, QI coaching, PCMH expertise
- **Maine Centers for Disease Control & Prevention (ME CDC)**: Grantee and Partner
- **Partnerships for Health**: Evaluation Partner
- **QC Health Improvement Partnership Leadership (QCHIP) Group and Community Partners**: Operational guidance, advice and direction

CDIC Project Team:

**Project Staff:**
- Lisa Letourneau, MD, MPH
- Amy Belisle, MD, Interim Director
- Megan Stiles, Project Manager
- Deb Gilbert, Administrative Coordinator
- QI Specialists:
  - Sue Butts-Dion
  - Kim Gardner
  - Amanda Banister
  - Chelsea Edwards
- Kellie Slate Vitcavage, Consumer and Community Engagement Program Manager

**Peer Consultants:**
- Dr. Peter Emery
- Dr. John Devlin
- Rhonda Selvin, NP
- Michele Mitchell

**Evaluation Team-Partnerships for Health:**
- Holly Richards
- Nathan Morse
- Ashley Lauze

**Today’s Agenda:**

- Understand roles and responsibilities for team based care and how they can be applied to the chronic disease model.
- Collaborate with community partners and other participating teams to identify new approaches to working with patients so they can live well with diabetes and high blood pressure.
- Share progress in the learning collaborative and review data for quality improvement.
- Understand the principles of health literacy and how it applies to engaging patients in self-management.
The Importance of Focusing on Chronic Disease Improvement:

- 33% of people in Maine have hypertension, 39% have high cholesterol, and 23% of all deaths in Maine are attributed to heart disease
- 11% of Mainers have pre-diabetes/diabetes, putting them at 2-4 times greater risk for heart disease
- Chronic Disease is the number one cause of death, accounting for 32% of mortalities in Maine in 2010.
- Despite their hard work, primary care practices face many challenges in helping their patients meet treatment goals for diabetes and heart disease
- New studies suggest we need to have even better blood pressure control

What does better health look like for your patients and your community?

How can we work together to improve health in our communities?

- **Work Together**: Learn from each other in the project to improve systems and test changes and use a team based approach to care
- **Improve Quality Metrics**: Understand national metrics and goals around diabetes and hypertension care including metrics with CMS PQRS reporting, medical home and ACOs
- **Engage Consumers, Patients and Community Partners**: Enhance how we are including them as partners in our improvement work and focus on shared decision making
- **Optimize Existing Work**: Build on the work of the PCMH/Health Homes, Behavioral Health Homes, Community Care Teams, Care Coordination, healthcare organizations and community organizations

High Level Aim & Goals:

**2015 Aim Statement**: By June 2016:
- improve the care of patients with hypertension by up to 10% in order to reach an overarching goal of >75% of patients having adequate control of their blood pressure (<140/90) (NQF 18)
- and reduce by up to 10% the percentage of patients with DM (type 1 & type 2) whose most recent HbA1c level during the measurement year was greater than 9.0% (poor control) or was missing a result, or if an HbA1c test was not done in order to reach an overarching goal of <15%. (NQF 59)

What Matters Most when Leading and Sustaining QI Efforts?

- Leadership Matters
- Teams Matter
- Data Matter
- Relationships Matters
- Patient and Family Stories Matter
- Fun Matters
Teams Matter:

- Team-based care: teamwork and attitude are critical to quality improvement
- Work to include the tools from Team STEPPS training in your work
- Make sure you include everyone from the front office staff, nurses, medical assistants, providers, billers/coders, etc.
- Use everyone to their highest ability
- Develop better ways to communicate: you cannot build a team or change behavior by email edicts
- Develop clear goals, workflows, and training to guide the work
- Decide how you will spread your work to everyone involved in health care delivery at your office
- Look at quality improvement support available to your practices
- Think about building interprofessional and interdisciplinary teams

Team STEPPS® Core Teamwork Skills

- Leadership
- Communication
- Situation Monitoring
- Mutual Support
- Skills

Rules

1. Runners are not allowed to build and builders are not allowed to run.
2. Unused materials that are not replaced to their spot at the front or back of the room will detract one block from the overall height of the tower.
3. Only the leader can view the algorithm. The leader may not view the tower as it is being built.
4. All materials are located at the front and back of the room. Runners may only take 5 items from the table at a time.

We are halfway through the collaborative: What are your plans for the home stretch?

Raffle and Prizes
1. Tell Us About Your Plans for the Home Stretch - Complete your paper and enter to win ($10 iTunes Gift Card)
2. Nominate one person in your practice for the 10th Player Award - Who is the Sparkplug for Getting Your Office Going? Who has gone above and beyond? ($10 iTunes Gift Card)
3. Suggest a Theme Song for Today’s Meeting ($10 iTunes Gift Card)
4. Additional Raffle Prizes at the end of the day - must be present to win!
Principles of Team-Based Care:
Expanding the Team to Improve the Quality of Life for Patients Living with Diabetes and Hypertension

Dora Anne Mills, MD, MPH, FAAP
Vice President for Clinical Affairs UNE
Center for Health Innovation
dmills2@une.edu
207-221-4621

Participants will be able to:

- List the reasons for adopting effective team-based care strategies
- Describe the principles of effective team-based care
- Identify resources for primary care practices to improve team-based care

210,000 – 440,000
80%

A Team of Experts is not An Expert Team

“It is clear that HOW care is delivered is as important as WHAT care is delivered”. IOM 2001

Health Care Reform Necessitates Interprofessional Team-Based Practice

- Payment reform – value based payment
- Integrated care – primary care, behavioral health, and/or oral health

Vision for 21st Century Health Care Professionals

IOM Core Competencies for Health Care Professionals:
- Provide patient-centered care
- Work in interdisciplinary teams
- Employ evidence-based practice
- Apply quality improvement
- Utilize informatics

US CDC’s 3 Buckets of Prevention:
Clinical Care
- Innovative patient-centered care
Community-Wide Health
- Focused on Preventive care

http://www.ncbi.nlm.nih.gov/books/NBK221510/
Key Winnable Battles for Public Health

- Tobacco
- Nutrition, Physical Activity, Obesity and Food Safety
- Healthcare-Associated Infections
- Motor Vehicle Injuries
- Teen Pregnancy
- HIV

State Innovation Model (SIM)

- In Maine:
  - Community Care Teams
  - Patient-Centered Medical Homes, Health Homes, Behavioral Homes
  - ACOs with value-based payment
  - Community Health Workers

Paul R. LePage, Governor  Mary C. Mayhew, Commissioner

- Access and continuity
- Planned care for chronic conditions and preventive care
- Risk stratified care management
- Patients and caregiver engagement
- Coordination of care across the medical neighborhood

- Million Hearts
- Risk Stratified Care
- Population Health Management
- Shared Decision Making
- Individual Risk Modification Planning
- Team-Based Care
- Quality and Clinical Data Reporting
Participants will be able to:

• List the reasons for adopting effective team-based care strategies
• Describe the principles of effective team-based care
• Identify resources for primary care practices to improve team-based care

Interprofessional Collaborative Practice (IPCP)

“When multiple health workers from different professional backgrounds work together with patients, families, caregivers, and communities to deliver the highest quality of care” (WHO, 2010)

4 Interprofessional Competencies

• Values/Ethics
• Roles/Responsibilities
• Communication
• Teamwork

2011 by associations of schools of nursing, MD, DO, pharmacy, dental, & public health (AACN, AAMC, AKOM, ACE, ADEA, and ASEP) http://www.aacn.nche.edu/education-resources/ipreport.pdf

Does It Work?

So far, yes. 7 studies indicate positive outcomes in diabetes care, medical errors, OR care, patient satisfaction, behavioral health care.


Implementing IP Practice tools such as TeamSTEPPS works to reduce errors and improve outcomes and care

http://www.teamsteppsportal.org/evidence-base

Participants will be able to:

• List the reasons for adopting effective team-based care strategies
• Describe the principles of effective team-based care
• Identify resources for primary care practices to improve team-based care

What can you do to build tools for interprofessional practice?

• Values/Ethics
• Roles/Responsibilities
• Communication
• Teamwork
TeamSTEPPS

U.S. DHHS AHRQ curriculum for health professionals that teach team skills

Curriculum and materials are free or low cost: http://teamstepps.ahrq.gov/

Primary Care Module
http://www.ahrq.gov/professionals/education/curriculum-tools/teamstepps/primarycare/

Teamwork & the Primary Care Team
• The Primary Care Team has all these obstacles to effective care:

Leadership

Leadership is a process of motivating people to work together collaboratively to accomplish tasks

Characteristics of effective leadership:
– Role modeling and shaping teamwork through open sharing of information
– Constructive and timely feedback
– Facilitation of briefs, huddles, debriefs, and conflict resolution

Leadership Strategies
• Briefs – planning
• Huddles – problem solving
• Debriefs – process improvement

Leaders are responsible to assemble the team and facilitate team events
But remember...
Anyone can request a brief, huddle, or debrief

Briefs

Planning
– Form the team
– Designate team roles and responsibilities
– Establish climate and goals
– Engage team in short- and long-term planning
### Briefing Checklist

<table>
<thead>
<tr>
<th>TOPIC</th>
<th>✓</th>
<th>✓</th>
<th>✓</th>
<th>✓</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who is on your team today?</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All members understand</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>and agree upon goals?</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Roles and responsibilities</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>understood?</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff availability?</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workload?</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Available resources?</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Review of the day’s patients?</td>
<td>✓</td>
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</tr>
</tbody>
</table>

### Huddle

**Problem Solving**
- Hold ad hoc, “touch-base” meetings to regain situation awareness
- Discuss critical issues and emerging events
- Anticipate outcomes and likely contingencies
- Assign resources
- Express concerns

### Debrief

**Process Improvement**
- Brief, informal information exchange and feedback sessions
- Occur after an event or shift
- Designed to improve teamwork skills
- Designed to improve outcomes
  - An accurate reconstruction of key events
  - Analysis of what worked or did not work and why
  - What should be done differently next time
- Recognize good team contributions or catches

### Debrief Checklist

<table>
<thead>
<tr>
<th>TOPIC</th>
<th>✓</th>
<th>✓</th>
<th>✓</th>
<th>✓</th>
<th>✓</th>
<th>✓</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication clear?</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Situation awareness maintained?</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Workload distribution?</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did we ask for or offer assistance?</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Were errors made or avoided?</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>What went well, what should change, what can improve?</td>
<td>✓</td>
<td></td>
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</tr>
</tbody>
</table>

### One-Page TeamSTEPPS Core Tools

- Briefs, Debriefings, Huddles
- SBAR
- Call-out
- Check – back
- Situation Monitoring
- STEP

Pick a tool every month and work on it as a team!
Barriers to Team Effectiveness

**BARRIERS**
- Inconsistency in Team Membership
- Lack of Time
- Lack of Information Sharing
- Hierarchy
- Defensiveness
- Conventional Thinking
- Complicity
- Varying Communication Styles
- Conflict
- Lack of Coordination and Followup With Co-Workers
- Distractions
- Fatigue
- Workload
- Misinterpretation of Cues
- Lack of Role Clarity

**TOOLS and STRATEGIES**
- Brief
- Huddle
- Debrief
- STEP
- Cross-Monitoring
- Feedback
- Advocacy and Assertion
- Two-Challenge Rule
- CUS
- DESC Script
- Collaboration
- SBAR
- Check-Back
- Handoff

**OUTCOMES**
- Shared Mental Model
- Adaptability
- Team Orientation
- Mutual Trust
- Team Performance
- Patient Safety!!

St. Louis University (SLU) Online TeamSTEPPS Module: The Essentials

33 interactive slides
Can be done by individuals or as a group


Other Resources: IHI Open School

Online Courses on Patient Safety, including teamwork and communication
- [http://www.ihi.org/education/ihiopenschool/courses/Pages/default.aspx](http://www.ihi.org/education/ihiopenschool/courses/Pages/default.aspx)

Building an Integrated Team That Works

U.S. DHHS SAMHSA HRSA


CREATING AN ECOMAP OF YOUR COMMUNITY RESOURCES:
WHO AND WHAT MAKES UP THE TEAM IN YOUR COMMUNITY

**THANK YOU!**
How does your community approach improving the quality of life for patients living with diabetes and high blood pressure?

- By the end of the project, we hope to work with you to develop workflows around diabetes and hypertension within your organization and your community.
- How do you currently interface with others regarding diabetes and hypertension?
- Think about how this relates to the work of the Patient Centered Medical Home
- Understand the “eco-map” of a family and the many groups that they work with in a community and how this relates to screening and services

What does the medical and community neighborhood look like for patients and families in your area?

How can we look at community resources for a family: Eco-Map

- An eco-map is a graphic representation that shows all of the systems at play in an individual’s life. Eco-maps are used in individual and family counseling within the social work and nursing profession. They are often a way of portraying Systems Theory in a simplistic way that both the social worker and the client can look at during the session.


Relational Coordination

- Relationships shape the communication through which coordination occurs
- Relational coordination is the “communicating and relating for the purpose of task integration”

Relational Coordination Survey Questions

<table>
<thead>
<tr>
<th>RC dimensions</th>
<th>Survey Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Frequent Communication</td>
<td>How frequently do people in each of these groups communicate with you about patients living with diabetes and hypertension?</td>
</tr>
<tr>
<td>2. Timely Communication</td>
<td>How timely is their communication with you?</td>
</tr>
<tr>
<td>3. Accurate Communication</td>
<td>How accurate is their communication with you?</td>
</tr>
<tr>
<td>4. Problem Solving Communication</td>
<td>When there is a problem, do people in these groups blame others or try to solve the problem?</td>
</tr>
<tr>
<td>5. Shared Goals</td>
<td>Do people in these groups share your goals?</td>
</tr>
<tr>
<td>6. Shared Knowledge</td>
<td>Do people in these groups know about the work you do around diabetes and hypertension?</td>
</tr>
<tr>
<td>7. Mutual Respect</td>
<td>Do people in these groups respect the work you do around diabetes and hypertension?</td>
</tr>
</tbody>
</table>

Jody Hoffer Gittell, Professor, Brandeis University, Director, Relational Coordination Research Collaborative, http://rcrc.brandeis.edu/survey/RC%20Survey.html
Community Eco-Map Instructions

Using your eco-maps as a guide, create a community eco-map on how to best support the patient and family presented in the case study in a manner that is responsive, respectful of the patients and family’s goals and ensures that feedback loops are closed.

Be prepared to share in the larger group in 30 minutes.

Eco Mapping Symbols

= A Strong Relationship
= A Weak/Vulnerable Relationship
= A Stressful/Adverse Relationship
= Flow of Resources

What tools are you using to Start Conversations with Patients, Consumers and Communities:

• How Do We Get the Care We Need to Lead Healthier Lives
  – Ten Steps for Improving Blood Pressure (NH)
  – Million Hearts®
  – AMA Prevent Diabetes STAT
  – Everyone With Diabetes Counts (EDC)

• And Reduce Unnecessary Care
  – Choosing Wisely®
    • Do I really need this test or procedure?
    • What are the risks?
    • Are there simpler, safer options?
    • What happens if I don’t do anything?
    • How much does it cost?

How is the Collaborate Tool Going?

• Survey patients electronically upon check out

Ten Steps for Improving Blood Pressure Control & HTN Self Management Resources

Diabetes Wallet Cards
Community Linkages to Support Prevention, Self-Management & Control of DM & HTN

Resources to build partnerships between primary and preventive care with public health and the community to support a system of community care coordination.

Collecting, Displaying and Analyzing Data for Improvement: What it Takes

Sue Butts-Dion, Improvement Advisor
11:15 AM

Data Collection Simulation: Block Stacking

• Roles
  • 1 time keeper/reader
  • 1 chief stacker
  • 1 stacker assistant
  • 1 start/stop technician
  • 1 recorder
  • 1 team leader
  • 1 QA expert/facilitator (can combine with team lead if necessary)
  • Observer(s)

Block Stacking Instructions

• Stack and unstack (re-nest) the blocks without making errors. Errors occur when blocks fall down.
• If the blocks fall down while stacking up, you must continue to stack them and then re-nest them—do not stop the clock.
• Decide what data to collect (everyone should collect elapsed time, # falls, and any other data of interest).
• Design a data collection form on a piece of flip chart paper.
• Pilot 3 stackings and then make any necessary revisions to the plan/form.
• Run process (stack blocks) 9 additional times.
• Note: Assistant stackers must be ready to stand in and assist if the stacker needs relief.

Debrief

• What did you learn about data collection that you might bump into in real life?

“It sounded an excellent plan, no doubt, and very neatly and simply arranged. The only difficulty was, she had not the smallest idea how to set about it.”
Lewis Carroll, of Alice in Alice in Wonderland
“Data” – just a bunch of numbers!

In order to effectively use data, you MUST:
- Display appropriately
- Understand variation

Plot data over time: “Tracking a few key measures over time is the single most powerful tool an improvement team can use.”
Source: IHI

CDIC 2 Data

The Headlines Scream
- Great News!

Tennessee highway fatalities drop for third straight year

Reality

In the Improvement world, we are trying to introduce special cause (change) and then make it common cause (sustainable) over time – a new process.
The purpose of this test is to identify a shift in the process. A run containing 6 or more consecutive data points all above or all below the median indicates a non-random pattern in your data which should be investigated. This non-random pattern may be a signal of improvement or of process degradation.

(Astronomical Point(s)

An astronomical point is one that is obviously and blatantly much higher or lower than all the other points on the chart. On a run chart this rule is not determined statistically but rather by judgment or consensus. (The IHI extranet definition)

RUN CHART TOOL:

Three (3) simple rules that indicate if something is not typical random variation. Only one rule needs to be present.

Rule 1
Rule 2
Rule 3

% patients with HTN Documented Barriers or Facilitators to Health (Note: This data is made up—not CDIC2.)

CDIC 2 Data (Note: This IS CDIC 2 data—not yet enough data points to see shifts or trends but can begin to see some activity.)

% Patients with Diabetes w/Previst Planning Documented

% Patients with HTN w/Previst Planning Documented

Actually a couple of shifts!!!!
So what?

1. Most of the time in improvement we are trying to introduce non-random variation into the system towards the direction of goodness. And then making it stable (random) at a new level or with less spread.

2. It is also very helpful to understand variation (the voice of the system) as it helps better inform our action and interaction with our system.

Variation exists

**Common Cause**
- Common cause variations are problems built right into the system, such as defects, errors, mistakes, waste and rework. In a stable system, common cause variation will be predictable within certain limits.
- Common cause variation is produced by the aggregate of the variation in all the variables (random)

**Special Cause**
- Special cause variations represent a unique event that is outside the system, such as a natural disaster, or an unexpected strike by public transportation workers
- Special cause is produced by a non-typical variable. (non-random)

Knowledge: Improvement Action
1. Random variation: Change the system
2. Non-random variation: Investigate (Become curious!)

---

Special Cause:
- Investigate
- Find out what is different
- Seek to eradicate (bad) or exploit (good) the cause

Common Cause:
- Take action on the system or process
Variation: Improvement Strategies

- Inappropriate reaction to variation can lead to many negative consequences
  - Wasted efforts
  - Attention diverted from real issue
  - Variation increases (tampering)
  - Loss of confidence
  - Frustration

Thank you!

Attention
Work
Care

Jessica Begley, MPH
MaineHealth Community Education Program

Engaging Patients:
Understanding the Importance of Health Literacy when Communicating with Patients
Jessica Begley, MPH
MaineHealth Community Education Program

What is Health Literacy?

The ability for adults to:

- Read
- Write
- Compute
- Understand/evaluate
- Communicate
- Use

Health Numeracy

- The ability for adults to use math skills are critical to managing personal and population health
  - Taking medicine correctly
  - Reading food labels
  - Using medical devices
  - Understanding test results
  - Making informed decisions (risk)
  - Managing bills and insurance
  - And ??

After this presentation you will be able to…

- List at least 4 out of 6 components of health literacy.
- Provide 2 examples of how health literacy impacts healthcare and health behavior.
- List 2 evidence-based methods to address limited health literacy.
- Use the health literacy checklist to evaluate documents.
A paragraph to illustrate…

“You voluntarily consent to participate in this research investigation. You may refuse to participate in this investigation or withdraw your consent and discontinue participation in this study without penalty and without affecting your future care or your ability to receive alternative medical treatment at the University.” - Paasche-Otlow, Taylor, & Brancati, 2005

What are the health literacy levels for adults?

Poll

What percentage of Americans have proficient health literacy?

A. 10%
B. 12%
C. 20%
D. 22%

NAAL Health Literacy Results

Most people struggle with:
Education, language, culture, access to resources, and age are all factors that affect a person’s health literacy skills.

- Older adults (65+)
- Racial and ethnic minorities
- People with less than a high school degree or GED
- People with low income levels
- Non-native speakers of English
- People with compromised health status

How many of you see patients with these characteristics?

Impact of Limited Health Literacy

- Poor understanding of basic medical terms
- Poorer understanding of their chronic conditions
- Low literacy is linked to:
  - Decreased use of preventive health screenings
  - Increase in self-reported poor health status
  - Increased healthcare dollars
  - Increased preventable hospitalizations and ED use
  - Poorer compliance with medications
  - Poorer health outcomes

Health Literacy Affects Everyone

Even people who read well and are comfortable using numbers can face health literacy issues when they…

- Aren’t familiar with medical terms or how their bodies work.
- Have to interpret statistics and evaluate risks and benefits that affect their health and safety.
- Are diagnosed with a serious illness and are scared and confused.
- Have health conditions that require complicated self-care.

How Can You Tell if a Patient has Limited Health Literacy?

- You can’t tell by looking.
- Signs that may indicate include:
  - Incomplete forms
  - Many missed appointments
  - Not following medication regimens
  - Unable to name or explain medications
  - Lack of follow through for labs, imaging or referrals
  - Defer reading until at home

What does limited health literacy look and feel like?
So, what can you do?

- Use evidence-based approaches to improve patient understanding, satisfaction, and adherence:
  - Stick to “need to know” & “need to do”—eliminate “nice to know”
  - Use teach back & show back—For verbal patient education
  - Demonstrate, draw pictures, call out important information
  - Use plain language—For all forms of communication - print, verbal, electronic, & other media

MaineHealth Guidelines

www.mainehealth.org/cep

Plain Language Interactive Checklist

Examples
- 24 Hour Urine Collection
- Constipation Regimen
- Breastfeeding and Medicines

A paragraph to illustrate…Revised

“You don’t have to be in this research study. You can agree to be in the study now and change your mind later. Your decision will not affect your normal care. Your doctor’s attitude toward you will not change.”

- Paasche-Orlof, Taylor, & Brancati, 2003
Next Steps

Take a stab at it!

Jessica Begley, MPH
MaineHealth Community Education Program
beglej@mainehealth.org
207-396-7413

What is one thing you would like to incorporate from this session?

1. Refer patients with diabetes and hypertension to community programs?
2. Use the Hypertension and Diabetes Wallet Cards?
3. Incorporate a few Health Literacy tips into patient materials?
4. Champion a group to plan FREE community Blood Pressure Clinics?

Save the Dates!

- Blood Pressure Trainings:
  • Ellsworth FP: March 8th and April 12th 7-10 am
  • Nason Health Care: March 17th 1-4 pm
  • York Family Practice: April 6th 7-10 am
- Submit monthly chart review and PDSA: April 15th
- Final webinar: April 21st from 12-1 pm, "Hiding in Plain Site (Patients with High BP): Hilary K. Wall, MPH, Senior Health Scientist, CDC Division for Heart Disease and Stroke Prevention.
- Final Learning Session: June 16th from 8:30 – 1:00 at Maple Hill Farm in Hallowell

Raffle and Prizes

1. Home Stretch Award ($10 iTunes Gift Card)
2. 10th Player Award: Sparkplug Award for Getting Your Office Going ($10 iTunes Gift Card)
3. Theme Song for Today's Meeting ($10 iTunes Gift Card)
4. Additional Raffle Prizes - must be present to win!

CME Certificates:

- CME disclosure: The speakers today do not have any relevant financial relationships with the manufacturer(s) of any commercial product(s) and/or provider of commercial services discussed in this CME activity. Some QC staff do have funding for another project, The Chronic Pain Collaborative 2 Project which is funded by a grant by the Pfizer Foundation’s Independent Grants for Learning and Change (IL&C).
- CME will be available for participants
- We do not have separate nursing CEUs - but you can get a CME certificate.
- A CME evaluation survey will sent after the learning session via email.
- Please complete the survey via Survey Monkey within 1 week
- A CME certificate will be emailed within 1 month of completion of the survey.
Chronic Disease Improvement Collaborative 2 (CDIC)

We welcome your comments and questions!

CDIC website: www.mainequalitycounts.org/CDIC

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