SBNC
SANTA BARBARA NEIGHBORHOOD CLINICS
Your Health Home

Santa Barbara Neighborhood Clinics

PHLN Year 2 Project Aim

Seeing 10% of the current assigned patients on the capitation list that we have not already seen (350).

Improvement in patient health outcomes, providing culturally informed nutrition literacy, and removing financial barriers to obtaining healthy foods.

Measures for Success

- Improvement or decline in clinical outcomes for diabetic patients, specifically:
  - Hemoglobin A1C, Blood Pressure
  - PHQ9, Foot Examination, Retinal Screening, and Microalbumin Testing (annually)

Measures for Success

1. By November 1, 2019, the number of known diabetics with a recorded HgbA1c during the past year will increase from 70 to 75 percent. Determine how much is patient non-compliance and how much to care team oversight or error.

2. By April 1, 2019, key staff will have explored the feasibility of offering care team and/or patient incentives for performance on defined issues related to diabetic care; by June 1, 2019, incentives will be in place if approved.

3. By November 1, 2019, number of referrals made by behavioral health specialists and dental clinic staff for known diabetic patients to at least one needed diabetic service as defined by the diabetic care plan will increase from zero to 15 percent of total referrals made for the reporting year. Referral will be defined to include HgbA1c testing and recording.

4. **By December 31, 2019, SBNC would have seen an additional 350 patients assigned on the Medi-Cal Managed Care Capitation list that have not been previously seen at SBNC. Those at risk of Diabetes or diagnosed at visit would become a Managed Care Panel Participant for the Care Management Teams led by the Registered Nurses.**

Changes

Tested Changes

- Auditing and training of data entry
- Follow-up appointments made for Diabetic patients with controlled condition
- Involved the Call Center Manager in contacting patients on Capitation List to bring them into the clinic for their Initial Health Assessment

Implemented Changes

- Include gaps in care in daily patient huddle reports
- Recruited/hired an RN for the Panel/Case Managers
- Fully Cross-Trained RNs to review Capitation Lists, contact patients, schedule appointments, f/u with patients who were referred to specialties
- Created a task checklist for recording HbA1cs into EMR

Using Data for Improvement

- The Data that we collected included patient HbA1C levels to calculate overall percentage of patients with controlled diabetes.
- Using this data we realized that not all the data was being captured resulting in a higher skewed rate of uncontrolled diabetic patients.
- We conducted staff training and education, included an MA on the Quality Improvement Committee and created a new tracking spreadsheet to increase accountability.

Chronic Disease Management		
	Target	Actual
Asthma Treatment	> 77.70%	95.00%
Blood Pressure Control		
Hypertensive Patients <140/90	>64%	60.61%
Diabetes Control		
Diabetes Patients with HbA1 <=9%	>=68.9	72.78%

SBNC PDSA (Plan Do Study Act) In House HbA1c

2019 Q1

	ESNC	ESNC %	GNC	GNC %	ICC	ICC %	IVNC	IVNC %	WSNC	WSNC %
Total # of In House HbA1c	**314**		**221**		**25**		**113**		**264**	
Total # Not In EHR	28	9%	24	11%	1	4%	17	15%	14	5%
Total # W/Different Results in NG	0	0%	0	0%	0	0%	0	0%	0	0%

2019 Q2

	ESNC	ESNC %	GNC	GNC %	ICC	ICC %	IVNC	IVNC %	WSNC	WSNC %
Total # of In House HbA1c	**300**		**169**		**15**		**100**		**251**	
Total # Not In EHR	29	10%	17	10%	2	13%	7	7%	7	3%
Total # W/Different Results in NG	5	2%	8	5%	0	0%	1	1%	1	0%

2019 Q3

	ESNC	ESNC %	GNC	GNC %	ICC	ICC %	IVNC	IVNC %	WSNC	WSNC %
Total # of In House HbA1c	**297**		**180**		**21**		**76**		**315**	
Total # Not In EHR	27	9%	21	12%	4	19%	12	16%	6	2%
Total # W/Different Results in NG	2	1%	9	5%	0	0%	0	0%	3	1%

2019 Q4

	ESNC	ESNC %	GNC	GNC %	ICC	ICC %	IVNC	IVNC %	WSNC	WSNC %
Total # of In House HbA1c										
Total # Not In EHR		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Total # W/Different Results in NG		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!

SBNC UDSX Calendar Year 2019 Q2

	Recommended SBNC Goal 2019	State % 2017	National % 2017	National % 2018	SBNC All 2018	SBNC ALL 2019 Q1	SBNC ALL 2019 Q2	Q1	Q2	Q1	Q2	Q1	Q2
HbA1c Poor Control (>9%) All DM pts. with NO HbA1c	30%	34%	33%	33%	26%	24%	24%	40%	22%	38%	31%	N/A	N/A

Strategies for Success

PROMPT: What strategies or tools have helped you mitigate challenges and manage your changes? *Examples may be using PDSAs to engage staff and get buy-in; allocating one hour per week of protected time to focus on your project; using visual displays of data to show progress and celebrate early wins.*

1. Used a PDSA cycle to identify source of missing data
2. Dedicated employee to correcting data entry issue to improve controlled numbers
3. Provided ongoing updates in controlled patient numbers
4. Included MA on Quality Improvement Committee of the Board of Directors

Key Tools & Resources

PROMPT: What 1-3 tools/resources have been integral to your project? *Examples could include workflows, patient questionnaires, a registry, job descriptions, brochures/pamphlets, etc.* Please email CCI copies of shareable resources so that we can print copies and post to the PHLN program website.

New Log Sheet for tracking HbA1c entry

PDSA (Plan, Do, Study, Act) Cycle

Huddle Reports

New Log Sheet for Tracking HbA1c entry

DCA Vantage Analyzer Log Sheet A1c

Document all patient and quality Control Results on this sheet

Date	Acct#	DOB	Patient/Control Name	A1C Test Results	Clinician	Cartridge Lot # and Expiration	Your Initials	Entered Into NextGen?

***Note-Quality Control (QC) is required when the following conditions occur:**

- QC must be performed if the instrument is turned off/on or moved to another location
- Always run QC after you have swiped a calibration card
- Each new **Lot Number** or new shipment requires two controls (normal and abnormal refer to the quick instruction or the operator'

JANUARY

DCA Vantage Analyzer Log Sheet A1c

Document all patient and quality Control Results on this sheet 2019

Date	Acct#	DOB	Patient/Control Name	A1C Test Results	Clinician	Cartridge Lot # and Expiration	Your Initials	Entered Into NextGen?
1/2/18	28474	10/15/40		8.7	DH	0952 11/20	GV	✓
1/2/18	17572	7/15/51		5.9	DH	0952 11/20	CR	✓
1/2/19	47655	5/31/82		14.0	NS	0952 11/20	CB	✓
1/2/19	61940	10/30/66		6.4	AMO	0952 11/20	CG	✓
1/3/19	34176	2/20/57		13.2	DH	0952 11/20	GV	✓
1/3/19	1301	12/21/62		6.8	NS	0952 11/20	CB	
1/4/19	1660	02-21-83		5.2	AV	0952 11/20	[illegible]	✓
1/4/19	25845	10-a-47		5.8	DA	0952 11/20	[illegible]	✓
1/4/19	42833	4-20-75		7.0	VA	0952 11/20	[illegible]	✓
1/4/19	16850	6/12/75		12.1	VA	0952 11/20	BS	—
1/4/19	30367	3/14/28		8.4	VA	0952 11/20	CG	✓
1/4/19	20247	3/04/53		8.3	VA	0952 11/20	CR	✓
1.9.18	28616			7.4	NS	0952 11/20	CB	
1/7/18	12199	2/10/74		8.6	DH	0952 11/20	CR	✓
1/7/18	30140	3/7/48		6.3	NS	0952 11/20	BS	—
1/7/18	51990	2/6/47		7.6	NS	0952 11/20	BS	—
1/7/19	1243	2/1/54		7.1	DH	0952 11/20	CG	✓
1/7/19	17015	6/8/49		6.1	NS	0952 11/20	CB	✓
1/8/19	14918	12/17/65		7.9	VA	0952 11/20	CR	✓
1/8/19	51352	11/14/61		6.1	VA	0952 11/20	CR	✓
1.9.19	5104	11.16.71		5.8	NS	0952 11/20	CB	✓
1.9.19	33320	10/4/31		10.0	DH	0952 11/20	GV	✓
1/9/19	10962	6/11/40		5.7	DH	0952 11/20	GV	
1/9/19	29644	12/31/55			DH	0952 11/20	CR	✓
1/9/19	39686	7/29/46		7.1	NS	0952 11/20	BS	—
1/9/19	49847	6/23/60		6.4	NS	0952 11/20	CB	✓
1/10/19	21426	10/6/54		8.5	DH	0952 11/20	GV	—

*Note-Quality Control (QC) is required when the following conditions occur:

- QC must be performed if the instrument is turned off/on or moved to another location
- Always run QC after you have swiped a calibration card
- Each new Lot Number or new shipment requires two controls (normal and abnormal refer to the quick instruction or the operator'

PDSA (Plan, Do, Study, Act) Cycle

Project Lead	Leslie Kearney	Title	Director of Quality
Team	QI Committee	Change	Increase % of A1c Data Entry
Date Range	2018 01 – 2018 12	Cycle #	#1
		Key Words	In House HbA1c Documentation

BACKGROUND:

SBNC's UDS clinical measure of HbA1c levels >9% are higher than the National average and the California average. This measure of all A1c's >9% include any DM patient seen in the reporting year that does not have a recorded HbA1c in NextGen EHR. During HEDIS chart audits, it was noted that 4 patients had HbA1c results mentioned in the patient's Master IM, but not entered into the Standing Orders module in the patient's chart. SBNC's QI Committee agreed that we need to conduct a PDSA to determine how widespread the issue is.

SBNC's baseline data for 2017 = 31.06%

UDS Reporting Considerations:

- HbA1c <8%
- HbA1c >9% or No Test During the Reporting Year

PLAN:

Aim/Objective Statement for this cycle:

SBNC would like to know the number of In House HbA1c results that have been verbally given to providers, but not entered into the patient's EHR. SBNC would also like to note the difference in data by facility to determine where additional training needs to take place and also to determine if a shared best practice from one site to another will affect the data.

Specific questions to address in this cycle:

1. What is each site's flow process for In House HbA1c running and data entry?
2. What are the barriers to utilizing SBNC's Standing Order for Diabetic patients?
3. What are the barriers to real time data entry of all In House HbA1c results?

Predictions/Hypotheses:

We feel there will be a significant % of In House labs not found in EHR.

Plan for change/test/intervention

Who: Medical Assistants/Lab Assistants
What: Number of A1c In House labs entered into NextGen
When: Calendar Year 2018
Where: ESNC, GNC, ICC_Medical, IVNC, WSNC
How: Manually mining all A1c In House results in EHR

Director of Quality will request each facility scan In House HbA1c logs for Q1 2018, and subsequent Quarterly logs to her. Dir. of Quality will look up each result on all logs to determine the number of tests not entered into EHR.
Each site's % of In House labs not entered into EHR will be reported to QI. All Clinic Managers will be informed of results, additional training will be given where needed, process flow will be reviewed, and all missing In House HbA1c's will be entered into EHR.

Measures
The percent of HbA1c In House tests that are resulted into NextGen EHR, and the percent of results that are on the logs, but do not match what is entered into NextGen EHR.

Plan for data collection
Each Quarter, all sites will submit HbA1c logs to the Director of Quality, who will then look up all patients listed on the logs to assess whether or not the result was entered into the patient's EHR, and if entered, was the result the same as the result listed on the log sheets.

DO:
In House A1c lab logs were scanned to the Director of Quality (Leslie Kearney) for review. Leslie, a part time assistant (Carl Bruce), and a volunteer (Ilene Gutierrez), looked up each and every A1c listed on all site's In House lab logs. Each patient with a missing A1c in EHR was highlighted with one color highlighter, and each patient with a result in EHR that differed from what was written on the log, was highlighted and the differing result written on the same line.

STUDY:
After review of all calculated data, every site had missing A1c result %s ranging from 0% to 24% in Q1, Q2, and Q3. Percentages with differing results ranged from 0% to 6%.

SBNC PDSA (Plan Do Study Act) In House HbA1c

2018 Q1

	ESNC	ESNC %	GNC	GNC %	ICC	ICC %	IVNC	IVNC %	WSNC	WSNC %
Total # of In House HbA1c	**341**		**134**		**6**		**105**		**260**	
Total # Not In EHR	17	5%	22	16%	1	17%	25	24%	14	5%
Total # W/Different Results in NG	13	4%	4	3%	0	0%	3	3%	1	0%

2018 Q2

	ESNC	ESNC %	GNC	GNC %	ICC	ICC %	IVNC	IVNC %	WSNC	WSNC %
Total # of In House HbA1c	**306**		**204**		**7**		**92**		**287**	
Total # Not In EHR	22	7%	21	10%	0	0%	16	17%	22	8%
Total # W/Different Results in NG	9	3%	8	4%	0	0%	5	5%	10	3%

2018 Q3

	ESNC	ESNC %	GNC	GNC %	ICC	ICC %	IVNC	IVNC %	WSNC	WSNC %
Total # of In House HbA1c	**281**		**187**		**18**		**92**		**261**	
Total # Not In EHR	30	11%	26	14%	0	0%	18	20%	39	15%
Total # W/Different Results in NG	6	2%	10	5%	1	6%	4	4%	2	1%

UDS DM HbA1c Poor Control:
Q1 2018 = 39.83%
Q2 2018 = 32.57%
Q3 2018 = 29.25%

ACT:

Data are presented to QI Committee members at the end of each quarter. Discussions have taken place as to what is prohibiting staff from entering the data. The following flow issues were defined:

Each site's physical layout is different and presents unique challenges and some common barriers.

Medical Assistants were not always empowered by clinicians to follow established Standing Orders, often told not to perform the A1c unless the visit was specifically a DM Follow Up visit. This barrier was overcome by continued education of staff and providers as to the importance of test collection at the time of visit, regardless of the reason for the visit.

Currently, Huddle reports and Standing orders are now being utilized regularly. In addition to the cultural challenge, All SBNC site's physical layout is challenging for MAs who are collecting the result. The lab has two computers, but both are often being utilized by the Lab Assistants. The MA then verbally informs the clinician of the result and is not able or does not remember to enter the data into the patient's EHR.

Each site's MAs could possibly benefit by having a tablet or lap top available to them in each lab, expediting efficient data entry in real time, no longer relying on written results or verbal results to clinicians.

It was noted that each site was using a different Log Sheet. Only one site had the correct log sheet that included 4 PHI items, MRN, DOB, Rendering Provider, and Patient Name. One site was not listing MRNs, only the patient's name, DOS and provider seeing the patient.

Next Steps:

1. Re-design Log Sheet (See Attached) to include a column titled "In NextGen" and disseminate to all sites, confirming use.
2. Discuss with Admin team the ability to purchase additional lap tops/tablets for In House lab data entry in real time by the MA, which will eliminate the need to hand a clinician a written result or communicate a verbal result.
3. Relay all data to all clinic managers and assistant managers to evaluate which of their MAs may benefit by additional training.
4. Continue data collection through Q4 2018 for final review.

SBNC PDSA (Plan Do Study Act) In House HbA1c

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Total # W/Different Results in NG	6	2%	10	5%	1	6%	4	4%	2	1%

2018 Q4

	ESNC	ESNC %	GNC	GNC %	ICC	ICC %	IVNC	IVNC %	WSNC	WSNC %
Total # of In House HbA1c	**320**		**236**		**5**		**44**		**267**	
Total # Not In EHR	7	2%	20	8%	2	40%	10	23%	6	2%
Total # W/Different Results in NG	17	5%	23	10%	0	0%	0	0%	2	1%

SBNC PDSA (Plan Do Study Act) In House HbA1c

2019 Q1

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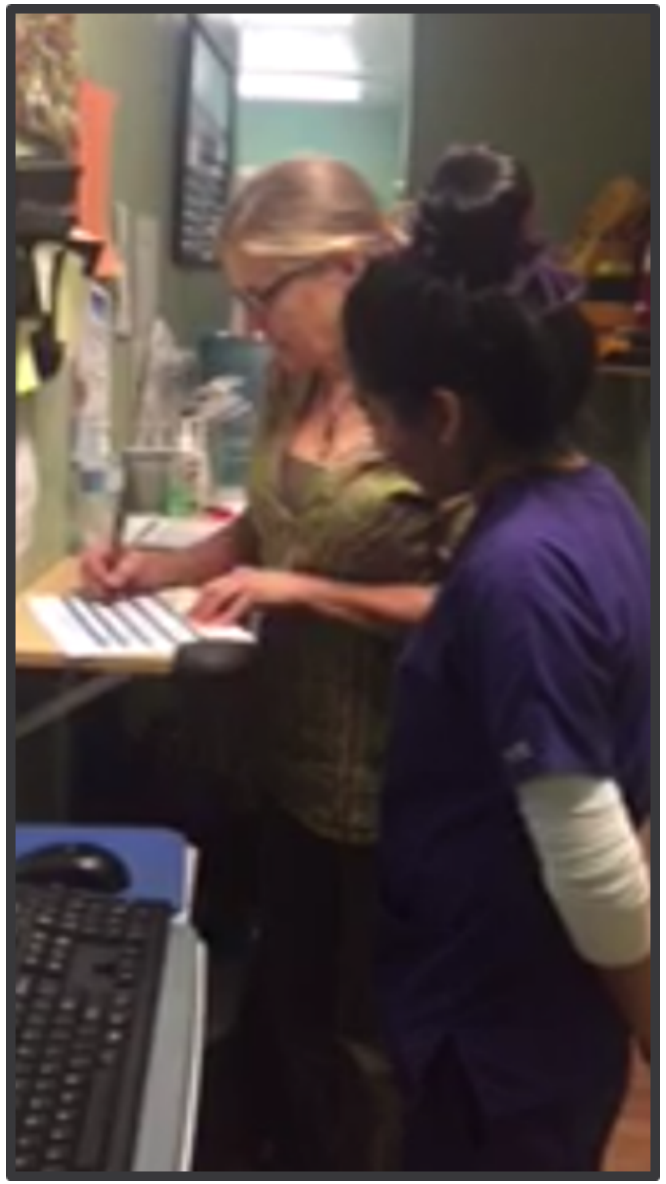
2019 Q4

	ESNC	ESNC %	GNC	GNC %	ICC	ICC %	IVNC	IVNC %	WSNC	WSNC %
Total # of In House HbA1c										
Total # Not In EHR		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!
Total # W/Different Results in NG		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!		#DIV/0!

Huddle Reports

Care Team Huddle Report

- Provides real-time data intelligence on the patients that are coming in today or tomorrow.
- Offers an easy to view, color-coded list of patients with appointments
- Includes key clinical indicators and historical data to help you plan your day.
- Your care team can review the list and easily identify patients that need services or may require additional time and resources.



i2iTracks Care Team Huddle
Appointments Scheduled for Tomorrow

Time	Provider	Resource	Type	Patient	Age	Sex	Language	Race	PCP	Acuity
8:30 AM		WS Med Assistant	Mil Familias Lab New Pt.							
	Reason: ID-Mil-0071-00075 **History (12 Mo.):** No Shows: 1 Canceled: 1 Visits: 0 ER: 0 Admits: 0 **Last Visit DR:** **Outstanding Referrals:** 0									
	Last BMI: **Weight Change (6 Mo.):** **Last BP:** **Last PHQ:**									
	Smoker: **Framingham Risk Factor:**									
	Due: Immunization: Flu (i2i), Immunization: HPV, Immunization: Tdap, Immunization: Tetanus (i2i), Procedure / Referral: DAST, Procedure / Referral: PHQ-9									
8:30 AM	Willis, Sharon FNP	Willis, Sharon NP WS	DM Follow Up			M	English	White	Ellis, Melissa PA-C	1.43
D B	**Reason:** check in @ 815 am **History (12 Mo.):** No Shows: 3 Canceled: 1 Visits: 6 ER: 0 Admits: 0 **Last Visit DR:** Willis, Sharon FNP **Outstanding Referrals:** 2									
	Last BMI: 22.85 (4/30/18) **Weight Change (6 Mo.):** -2.25 lbs. **Last BP:** 116/76 (4/30/18) **Last PHQ:** 14 (5/17/16)									
	Last Colon Cancer Screening: **Smoker:** No **Last 3 A1c:** 10.1 (4/30/18) 11.7 (3/26/18) 11.9 (2/8/18) **Last 3 BP:** 116/76 (4/30/18) 118/82 (3/26/18) 107/70 (2/8/18)									
	Last 2 LDL: 107 (2/8/18), 109 (4/5/17)									
	Due: Immunization: Hepatitis B, Immunization: Pneumovax (i2i), Procedure / Referral: Colorectal Cancer Screening, Procedure / Referral: DM Retinopathy Screening, Procedure / Referral: Ophthalmology Visit (i2i)									
8:30 AM	Lawton, Susan MD	Lawton, Susan MD	Depo			F	English	Other	Silva, Virginia PA-C	0.95
	Reason: ck in 8:15am Depo - upt due per las master notes 13 weeks due 5/9 to 5/23 last DEPO:2/21/2018 **History (12 Mo.):** No Shows: 2 Canceled: 0 Visits: 6 ER: 0 Admits: 0 **Last Visit DR:** Willis, Sharon FNP **Outstanding Referrals:** 3									
	Last BMI: 23.08 (2/21/18) **Weight Change (6 Mo.):** **Last BP:** 106/68 (2/21/18) **Last PHQ:** 6 (3/6/17)									
	Last Pap: 8/25/2017 **LMP:** **Smoker:** No **Framingham Risk Factor:** 0.05%									
	Due: Immunization: Flu (i2i), Immunization: HPV, Procedure / Referral: DAST, Procedure / Referral: PHA, Procedure / Referral: PHQ-9									
8:30 AM	Shoemaker, Lynn PA	Shoemaker, Lynn PA WS	GYN Visit				Spanish; Castilian	White	Shoemaker, Lynn PA	1.9
D	**Reason:** Patient requesting Diflucan check ir @ 815 am **History (12 Mo.):** No Shows: 0 Canceled: 2 Visits: 9 ER: 0 Admits: 0 **Last Visit DR:** Shoemaker, Lynn PA **Outstanding Referrals:** 1									
	Last BMI: 36.6 (4/25/18) **Weight Change (6 Mo.):** 4 lbs. **Last BP:** 112/75 (4/25/18) **Last PHQ:** 1 (12/20/17)									
	Last Pap: 10/2/2017 **LMP:** **Last Mammo:** 9/27/2017 **Last Colon Cancer Screening:** 12/2/2013 Colonoscopy **Smoker:** No **Last 3 A1c:** 11.6 (4/25/18) 10.1 (1/24/18) 11.2 (12/20/17)									
	Last 3 BP: 112/75 (4/25/18) 110/76 (1/24/18) 120/78 (12/20/17) **Last 2 LDL:** 107 (12/13/17), 114 (6/3/17)									
	Due: Immunization: Flu (i2i), Immunization: Hepatitis B, Procedure / Referral: DM Retinopathy Screening, Procedure / Referral: Ophthalmology Visit (i2i), Procedure / Referral: Screening Mammogram									
8:45 AM		WS Med Assistant	Bloodwork				Spanish; Castilian	White	Wiggins, Kendra MD	1.9
D B	**Reason:** check in @ 8:30am recheck CBC **History (12 Mo.):** No Shows: 0 Canceled: 1 Visits: 8 ER: 0 Admits: 0 **Last Visit DR:** Gaona, Veronica LCSW **Outstanding Referrals:** 4									
	Last BMI: 25.28 (4/24/18) **Weight Change (6 Mo.):** 0.25 lbs. **Last BP:** 130/76 (4/24/18) **Last PHQ:** 13 (4/16/18)									
	Last Colon Cancer Screening: 11/24/2015 FIT **Smoker:** No **Last 3 A1c:** 7.8 (4/16/18) 8.1 (8/29/17) 7 (2/16/17) **Last 3 BP:** 130/76 (4/24/18) 102/68 (4/16/18) 130/87 (9/7/17)									
	Last 2 LDL: 115 (4/16/18), 102 (10/22/16)									
	Due: Immunization: Flu (i2i), Immunization: Hepatitis B, Procedure / Referral: Colorectal Cancer Screening, Procedure / Referral: DM Retinopathy Screening, Procedure / Referral: Mammogram (i2i), Procedure / Referral: Ophthalmology Visit (i2i), Procedure / Referral: PHA, Procedure / Referral: Screening Mammogram									

Santa Barbara Neighborhood Clinics
PCMH Factor 2D3 Meetings with Care Team Huddle Report
Isla Vista Neighborhood Clinic
Example 1

i2i

Appointments Scheduled for Today

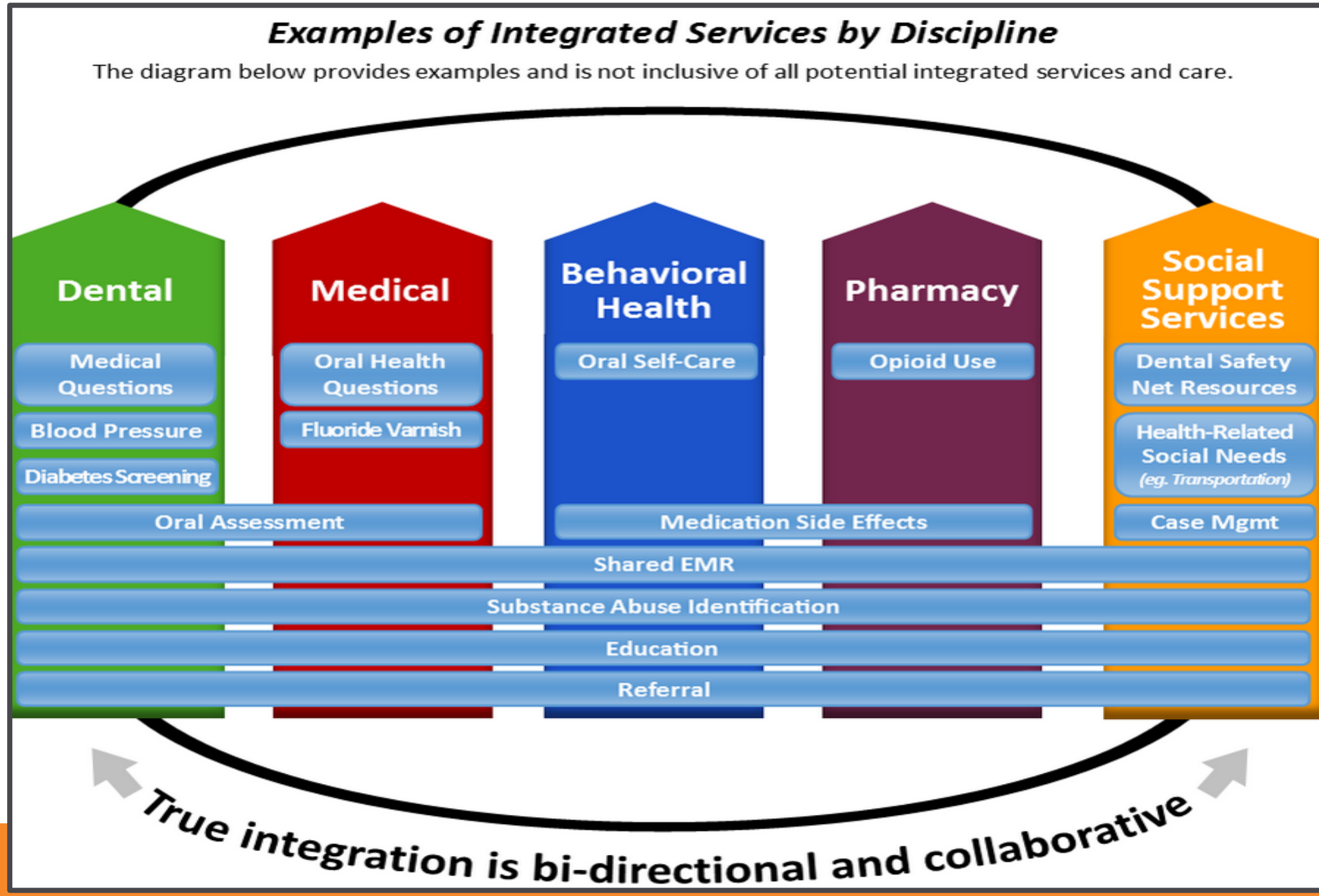
Virginia 1/4/17

Time	Provider	Resource	Type	Patient	Age	Sex	Language	Race	PCP	Acuity
12:00 PM	Silva, Virginia PA	Silva, Virginia PA-C	Same Day	[redacted]	Yrs	F	English	Asian	DeVaney, Ana Sofia PA-C	1.9
	Reason: chk 1145 wants new bc **History (12 Mo.):** No Shows: 0 Canceled: 0 Visits: 3 ER: 0 Admits: 0 **Last Visit DR:** DeVaney, Ana Sofia PA-C **Outstanding Referrals:** 0									
	Last BMI: 25.19 (9/12/16) **Weight Change (6 Mo.):** **Last BP:** 112/72 (9/12/16) **Last PHQ:** 3 (6/22/16)									
	Smoker: No **Framingham Risk Factor:** 0.72%									
	Due: Immunization: Flu (i2i), Immunization: Tetanus (i2i), Procedure / Referral: DAST, Procedure / Referral: Pap (i2i)									
12:15 PM	Silva, Virginia PA	Silva, Virginia PA-C	Follow Up	[redacted]	42 Yrs	M	English	White	Silva, Virginia PA	1.43
	Reason: ck in at 12pm Ultrasound **History (12 Mo.):** No Shows: 4 Canceled: 1 Visits: 1 ER: 0 Admits: 0 **Last Visit DR:** Silva, Virginia PA **Outstanding Referrals:** 8									
	Last BMI: 28.85 (12/15/16) **Weight Change (6 Mo.):** **Last BP:** 121/77 (12/15/16) **Last PHQ:** 13 (5/21/15)									
	Smoker: Yes **Framingham Risk Factor:**									
	Due: Immunization: Flu (i2i), Immunization: Tetanus (i2i), Procedure / Referral: DAST, Procedure / Referral: PHA									
12:45 PM	Silva, Virginia PA	Silva, Virginia PA-C	Office Visit	[redacted]	24 Yrs	F	English	Asian	Silva, Virginia PA	0.85
	Reason: cough pt ck in at 1230 **History (12 Mo.):** No Shows: 0 Canceled: 1 Visits: 6 ER: 0 [illegible]a, Virginia PA **Outstanding Referrals:** 2									
	Last BMI: 36.22 (12/28/16) **Weight Change (6 Mo.):** 6 lbs. **Last BP:** 144/89 (12/28/16) **Last** [illegible]									
	Last Pap: 12/28/2016 **LMP:** 12/18/2016 **Smoker:** No **Framingham Risk Factor:** **Last 3 BP:** [illegible]3/16) 133/80 (8/30/16) **Last 2 LDL:**									
	Due: Immunization: Flu (i2i), Immunization: Tetanus (i2i)									
	Protocols: Pre-DM									
1:15 PM	Silva, Virginia PA	Silva, Virginia PA-C	STD Exam	[redacted]	20 Yrs	M	English	White	Goetz de Gaona, Meg NP	
	Reason: check in @ 1pm woudl like to get the HIV RNA test **History (12 Mo.):** No Shows: 0 Canceled: 0 Visits: 3 ER: 0 Admits: 0 **Last Visit DR:** Silva, Virginia PA **Outstanding Referrals:** 0									
	Last BMI: 22.43 (11/16/16) **Weight Change (6 Mo.):** **Last BP:** 129/80 (11/16/16) **Last PHQ:**									
	Smoker: No **Framingham Risk Factor:**									
	Due: Immunization: Flu (i2i), Immunization: Tetanus (i2i), Procedure / Referral: DAST, Procedure / Referral: PHQ-9									
1:30 PM	Silva, Virginia PA	Silva, Virginia PA-C	Nexplanon Removal/Insertion	[redacted]	21 Yrs	F	English	White		0.95
	Reason: ck in at 1pm verification of income **History (12 Mo.):** No Shows: 1 Canceled: 0 Visits: 0 ER: 0 Admits: 0 **Last Visit DR:** **Outstanding Referrals:** 0									
	Last BMI: 23.11 (1/23/14) **Weight Change (6 Mo.):** **Last BP:** 114/67 (1/23/14) **Last PHQ:**									
	Smoker: No **Framingham Risk Factor:**									
	Due: Immunization: Flu (i2i), Immunization: Tetanus (i2i), Procedure / Referral: DAST, Procedure / Referral: PHQ-9									
2:00 PM	Silva, Virginia PA	Silva, Virginia PA-C	PHA Adult	[redacted]	23 Yrs	M	English	White		
	Reason: Bring Immunization records on the day of your appointment. ch in 1:30 (angie's former pt) **History (12** [illegible] anceled: 2 Visits: 1 ER: 0 Admits: 0 **Last Visit DR:** Baldwin, Polly MD **Outstanding Referrals:** 0									
	Last BMI: 35.16 (1/30/16) **Weight Change (6 Mo.):** **Last BP:** 127/84 (1/30/16) **Last PHQ:** 23 (1/30/16)									
	Smoker: No **Framingham Risk Factor:**									
	Due: Immunization: Flu (i2i), Immunization: Tetanus (i2i), Procedure / Referral: DAST, Procedure / Referral: PHA									

Shows screenings that the patient is due for

Outstanding Referrals

Integration Model



Next Steps

Spreading

- Implement a similar workflow currently used at our Westside Neighborhood Clinic to all the other clinics to ensure daily recordings of HbA1c
- Further diversify the QI Committee to include at least one representative from each staff position at the clinic

Sustaining

- Ongoing reeducation and training of new staff
- Continued audits of process
- Continue to address identified barriers
- Train Dental Assistants to perform HbA1c testing (integration)

Current Challenges or Barriers

PROMPT: What are the top one or two challenges you're currently encountering that fellow PHLN-ers can help you with? *Is there a specific question, curiosity or frustration you would like to brainstorm with the people listening to/reading your storyboard presentation?*

1. Turnover: having to reeducate new staff

2. Availability of workstations: MAs cannot enter data in the EMR in a timely manner