The Never-Ending Journey
Community Medical Centers
2016-2021

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Ginger Manss, Chief Nursing Officer
Denise Armstorff, Coach
COVID produced a lot of barriers. But it also challenged us to be creative in how we “see” our patients. 2020 was filled with endless opportunities for PDSA cycles but it also focused on Reinventing healthcare delivery by embracing technology and accelerated the implementation of telehealth and transitioning from in-person visits to telephone and virtual/video visits overnight. Patients with Diabetes and Hypertension are at an increased risk of contracting and succumbing to COVID so finding a way to monitor them remotely was our primary objective.

Community Medical Centers will decrease the number of patients with uncontrolled diabetes who have an A1c greater than 9% from 38% to 30% by March 2021.

Community Medical Centers will decrease the number of African American patients with uncontrolled diabetes who have an A1c greater than 9% from 24% to 21% by March 2021.
Aim Statement

We will improve the health of our diabetic patients by decreasing the % of patients with uncontrolled diabetes (HbA1c > 9%) from 38% to 30% by March 2021.

Diabetes Driver Diagram

Primary Drivers
(Systems, structures, norms)

Information/data Systems

Secondary Drivers (Change Concepts)

- Panel assignment
- Panel data/registry to document, review care and plan visits for diabetic patients, regardless of reason for visit
- Systems to identify/alert staff regarding overdue preventive care needs
- Focus of patient visits
- Appointment/access management

- Clarify and assign roles, duties and tasks for planned visits (allowing for work at the top of license)
- Establish workflows and standardized care processes (appointment reminder calls, chart scrubbing, huddles, pre-visit planning, outreach, in-reach, etc.)
- Cross-train staff to perform various roles/tasks within license
- Identify knowledge/skill gaps and provide education/training
- Use of standing orders
- Pre-visit planning and follow-up/case management
- Outreach and referral processes (closing the loop to completion)
- Social Determinants of Health
- Drive Thru Clinics

- Motivational interviewing
- Shared agenda-planning tool
- Shared goal-setting/decision-making tools
- Patient education classes/materials
- Group therapy
- Access to behavioral health
- Easy access to support patient concerns (medication, nutrition, equipment use, etc.)
- Telephone check-ins between visits
- Patient satisfaction surveys

- Linkages with organizations to develop support programs and policies for patients
- Encourage participation in community education classes and support groups
- Raise community awareness through networking, outreach, and education.
- Link patients to social needs resources (State programs, local agencies, schools, faith organizations, businesses, and clubs)
- Closing the loop on referrals for social needs
- Strengthening partnerships with local agencies

Organizational Driver Diagram
What changes did we make that resulted in improvement?

Process for Selecting Test Ideas

How We Engaged the Patient “Voice of the Customer”

To facilitate input/feedback from our most marginalized population, the homeless, we took a direct and personal approach. Staff who spent the entire year screening for COVID symptoms at the homeless shelter, asked some of our homeless men what about their health was most important to them and what we can do help guide them toward self management and developing self efficacy.

How We Engaged Leaders, Providers, and Staff

The Chief Executive Officer and Chief Nursing Officer challenged us to “think out-of-the-box.” Our unique ideas led to discussion(s) with other Executives, who became partners in brainstorming. It became quickly evident that outcomes were going to be affected due to the pandemic, so quick thinking and brainstorming and rapid testing became more crucial than ever before. How Maggie and Vacaville staff were incorporated into the process.
<table>
<thead>
<tr>
<th>Change Idea Tested</th>
<th>Summary of PDSAs</th>
<th>Adopted, Adapted, Abandon?</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1c results</td>
<td>Ordering labs and outreaching patients to instruct them to get their labs done prior to scheduling their next appointment.</td>
<td>Abandoned.</td>
</tr>
<tr>
<td>Point of Care A1c Use</td>
<td>All patients with diabetes get a P.O.C A1c result at time of visit (sites with P.O.C machine)</td>
<td>Adapt!</td>
</tr>
</tbody>
</table>
| Drive Thru         | • Outreaching uncontrolled diabetic patients for a drive thru style appointment to obtain their A1c results  
                     • Outreaching patients with Diabetes/Hypertension for drive thru COVID testing and getting BP and A1c using value added time during the appointment.  
                     • More notes! Tie into slide 3 | Adapt! See slide 6 and Slide 7 |
Outreach Diabetic patients, who have not had a HbA1C in the past 6 months

Schedule 30 patients in a designated time slot on LVN's schedule

Wear PPE and have extra on hand

Patient pulls up to testing site

Patient checked in for encounter.

Chart Scrub before the drive thru for additional opportunities i.e. flu shots, follow up appointments, bp readings, COVID testing, etc.

Have on hand in addition to the A1c testing supplies:
- Flu shots
- BP cuff for bp readings
- COVID tests
- PHQ9’s
- Patient Education
- FIT Test kits
- Band Aid’s

MA takes temperature and screens for COVID symptoms

MA explains POC process and answers any questions

Notify patients of outstanding care items and offer to do them i.e. flu shot, fluoride varnish, covid test, FIT, phq9, etc.

Enter results in patients chart via ORders Module.

Wait 5 minutes for results or Park for additional services

Schedule f/u as necessary

Follow A1c POC instructions and Run A1c test

Adapt!

Nurse is available for patients who want COVID test; pull over and park after A1c and Nurse will test for COVID
**WHAT CHANGES DID WE MAKE THAT RESULTED IN IMPROVEMENT?**

**Our Theories for Change: How We Learned About Our Process**

**Outreach uncontrolled DM and HTN patients for COVID TESTING**

**Schedule 30 patients in a designated time slot on LVN’s schedule**

**Wear PPE and have extra on hand**

**Patient pulls up to testing site AND PARKS**

**Chart Scrub** before the drive thru for additional opportunities i.e. flu shots, follow up appointments, bp readings, COVID testing, etc.

**Have on hand in addition to the A1c testing supplies:**
- Flu shots
- BP cuff for bp readings
- COVID tests
- PHQ9’s
- Patient Education
- FIT Test kits
- Band Aid’s

**Patient checked in for encounter; notified of outstanding care items and offer to them p.o.c flu shot, fluoride varnish, FIT, phq9, etc.**

**MA obtains vitals and screens for COVID symptoms**

**MA explains POC process and answers any questions**

**MA #2 prepares tray with testing supplies and addtl. Items needed**

**Follow A1c POC instructions and Run A1c test**

**While waiting for A1c RESULTS... Nurse will test patient for COVID**

**Enter results in patients chart via ORders Module.**

**Schedule f/u as necessary**

**Verify patient information to communicate COVID results**

**Nurse is available for patients who want COVID test; pull over and park after A1c and**

**WIN!**
# How Did We Know the Changes Were An Improvement?

## What We Measured

<table>
<thead>
<tr>
<th>Measure Type/Name</th>
<th>Description/Specifications</th>
<th>Baseline % 4/1/2019 – 3/31/2020</th>
<th>Target %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome (Directly related to the aim):</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Health Plan Measure</td>
<td>Increase in the number of visits per member per year for patients with diabetes and/or hypertension</td>
<td>3.75 medical visits per year for patients with HTN</td>
<td>5 visits per year</td>
</tr>
<tr>
<td>Health Plan Measure</td>
<td>Decrease the number of patients with diabetes who have not had an A1c in the last year.</td>
<td>16%</td>
<td>12%</td>
</tr>
<tr>
<td><strong>Process (Steps to achieve the aim):</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal</td>
<td>Registering patients with a race/ethnicity on file</td>
<td>52%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Balancing (Unintended impact/consequence):</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Utilization</td>
<td>Decrease in the amount of no shows</td>
<td>19%</td>
<td>12%</td>
</tr>
<tr>
<td></td>
<td>Improvement in Patient satisfaction scores</td>
<td>75%</td>
<td>85%</td>
</tr>
</tbody>
</table>
How Did We Know the Changes Were An Improvement?

Results: Run Charts

Outcome

- % of Patients HbA1c ≥ 9: 39.3%
- % of Patients HbA1c < 8: 60.7%
- % of Patients HbA1c < 7: 49.2%
- % of Patients HbA1c < 7: 31.0%

Diabetes Management Dashboard

Patient List

Last Update: 1/14/2021 8:00:20 AM
User: Albahar, Anuit
How Did We Know the Changes Were An Improvement?

Results: Run Charts

Disparities at a Glance

June 2020
How Did We Know the Changes Were An Improvement?

Results: Run Charts

Disparities at a Glance
How Did We Know the Changes Were An Improvement?

Results: Run Charts

Process

CMC saw a record number of patients at the beginning of the pandemic.

<table>
<thead>
<tr>
<th>Quarter</th>
<th>Number of Patients Reached by CMC PHASE Sites</th>
</tr>
</thead>
<tbody>
<tr>
<td>1Q17</td>
<td>16,895</td>
</tr>
<tr>
<td>2Q17</td>
<td>16,779</td>
</tr>
<tr>
<td>3Q17</td>
<td>17,282</td>
</tr>
<tr>
<td>4Q17</td>
<td>17,688</td>
</tr>
<tr>
<td>1Q18</td>
<td>18,724</td>
</tr>
<tr>
<td>2Q18</td>
<td>19,093</td>
</tr>
<tr>
<td>3Q18</td>
<td>19,581</td>
</tr>
<tr>
<td>4Q18</td>
<td>20,068</td>
</tr>
<tr>
<td>1Q19</td>
<td>20,451</td>
</tr>
<tr>
<td>2Q19</td>
<td>20,591</td>
</tr>
<tr>
<td>3Q19</td>
<td>20,957</td>
</tr>
<tr>
<td>4Q19</td>
<td>21,395</td>
</tr>
<tr>
<td>1Q20</td>
<td>21,549</td>
</tr>
<tr>
<td>2Q20</td>
<td>21,783</td>
</tr>
<tr>
<td>3Q20</td>
<td>20,401</td>
</tr>
</tbody>
</table>

COVID
How Did We Know the Changes Were An Improvement?

Results: Run Charts

Balancing

No Show Rate 2020
Pre and Post Pandemic

COVID
How Did We Know the Changes Were An Improvement?

Results: Run Charts

Balancing

Would You Recommend This Providers Office to Your Friends and Family?

<table>
<thead>
<tr>
<th>Percent</th>
<th>2Q19</th>
<th>3Q19</th>
<th>4Q19</th>
<th>1Q20</th>
<th>2Q20</th>
<th>3Q20</th>
</tr>
</thead>
<tbody>
<tr>
<td>75%</td>
<td>77%</td>
<td>74%</td>
<td>76%</td>
<td>75%</td>
<td>68%</td>
<td></td>
</tr>
</tbody>
</table>

7% decline in Patient Satisfaction Survey results regarding recommending this providers office to friends and family.
How Did We Know the Changes Were An Improvement?

Here’s What We Learned

Bright Spots/Accomplishments

What stands out most about the work of PHASE/TC3 2019-2020?
The freedom to try things that otherwise seemed outlandish.

What surprised you?
Adaptability

What did you learn about the process of change?
It’s Never-ending.

What are you most proud of?
All we’ve accomplished with PHASE since 2016.

What did you learn about your team?
They are resilient.
# How Did We Know the Changes Were An Improvement?

## Here’s What We Learned

### The Challenge of the COVID-19 Pandemic

![Image](https://via.placeholder.com/150)

The whole country would be tested by midnight if Chick-fil-A was running the drive thru testing centers. 😻

### Overall Challenges

<table>
<thead>
<tr>
<th>Challenge</th>
<th>How We Overcame/Resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited lab services, no A1c results</td>
<td>Purchased Point of Care A1c analyzers for sites with limited to no lab access to obtain current A1c results for patients.</td>
</tr>
<tr>
<td>No in person visits, no BP readings</td>
<td>Video/Virtual visits. If provider can see the cuff and instruct patient on obtaining BP reading, this is an official reading.</td>
</tr>
<tr>
<td>Depression Screenings</td>
<td>Conduct depression screening over the phone prior to telehealth appointment with provider</td>
</tr>
<tr>
<td>Staffing shortages</td>
<td>Remote work schedules</td>
</tr>
</tbody>
</table>
What’s Next for PHASE/TC3?

Here’s How We Will Continue the Work

New Aim Statement and Focus Areas for Change

- What new aim will you set globally to improve the health of the PHASE/TC3 population?
  Race data on ALL patients
- What new aim will you set for your health equity focus?
  Race data on ALL patients
- What specifically might you focus on (think about primary drivers)
  Analyzing outcomes based on Race to direct the appropriate care to the appropriate population
- What change ideas will you test (think about secondary drivers)?
  Patient Registration workflow to include collecting sensitive information like race and gender for all

SPREAD

We learned from the Drive Thru PDSA that patients want what patients want. If we can identify those “wants” and couple them with services they need, both Provider and patient will consider the visit a success. Managing their diabetes/hypertension was not a want, but patients were motivated to come to their appointment when they were getting tested for COVID for free without ever leaving their vehicle.

SUSTAINABILITY

We need to advocate for Point of Care A1c readings be measure compliant, reimbursable and incentivized the same way COVID advocated for the acceptance of Self Monitored Blood Pressure Readings.