KAISER PERMANENTE PHASE
PREVENTING HEART ATTACKS & STROKES EVERY DAY

CCI CENTER FOR CARE INNOVATIONS

KAISER PERMANENTE TC3
TRANSFORMING CARDIOVASCULAR CARE IN OUR COMMUNITIES

# The Never-Ending Journey Community Medical Centers 2016-2021


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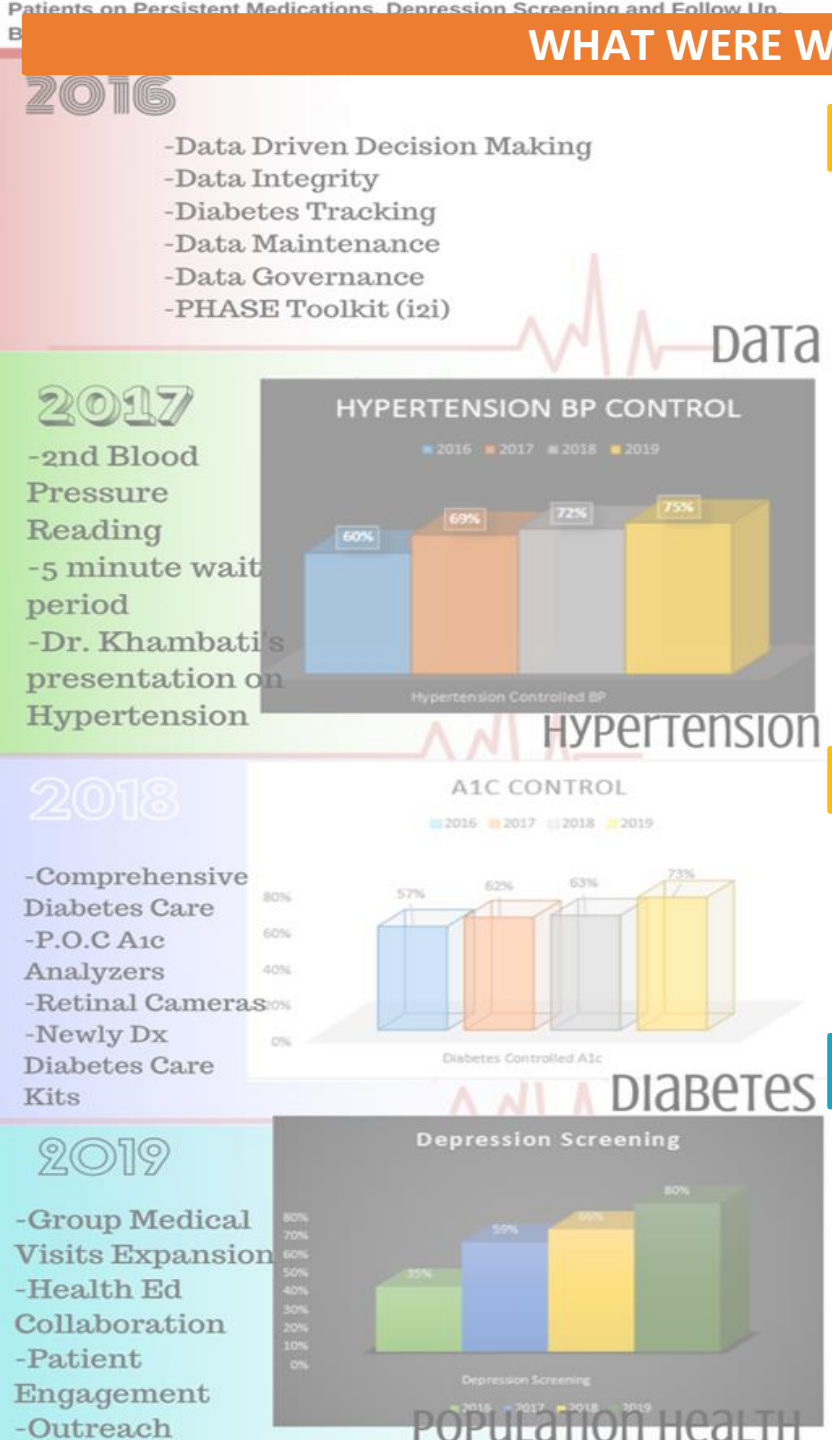
Ginger Manss, Chief Nursing Officer
Denise Armstorff, Coach


# WHAT WERE WE TRYING TO ACCOMPLISH?




## Problem Statement

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.

## Aim Statement

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.

## Health Equity Aim Statement

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.

# WHAT CHANGES DID WE MAKE THAT RESULTED IN IMPROVEMENT?

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

### Diabetes Driver Diagram

**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.

| Primary Drivers (Systems, structures, norms) | Secondary Drivers (Change Concepts) | Change Ideas |
|---|---|---|
| **Information/ data Systems** | • Panel assignment<br>• Panel data/registry to document, review care and plan visits for diabetic patients, regardless of reason for visit<br>• Systems to identify/alert staff regarding overdue preventive care needs<br>• Focus of patient visits<br>• Appointment/access management | |
| **Planned Care Delivery/ Team-Based Care** | • Clarify and assign roles, duties and tasks for planned visits (allowing for work at the top of license)<br>• Establish workflows and standardized care processes (appointment reminder calls, chart scrubbing, huddles, pre-visit planning, outreach, in-reach, etc.)<br>• Cross-train staff to perform various roles/tasks within license<br>• Identify knowledge/skill gaps and provide education/training<br>• Use of standing orders<br>• Pre-visit planning and follow-up/case management<br>• Outreach and referral processes (closing the loop to completion)<br>• Social Determinants of Health<br>• Drive Thru Clinics | |
| **Patient Engagement and Self-Management Support** | • Motivational interviewing<br>• Shared agenda-planning tool<br>• Shared goal-setting/decision-making tools<br>• Patient education classes/materials<br>• Group therapy<br>• Access to behavioral health<br>• Easy access to support patient concerns (medication, nutrition, equipment use, etc.)<br>• Telephone check-ins between visits<br>• Patient satisfaction surveys | |
| **Community Partnerships** | • Linkages with organizations to develop support programs and policies for patients<br>• Encourage participation in community education classes and support groups<br>• Raise community awareness through networking, outreach, and education.<br>• Link patients to social needs resources (State programs, local agencies, schools, faith organizations, businesses, and clubs)<br>• Closing the loop on referrals for social needs<br>• Strengthening partnerships with local agencies | |

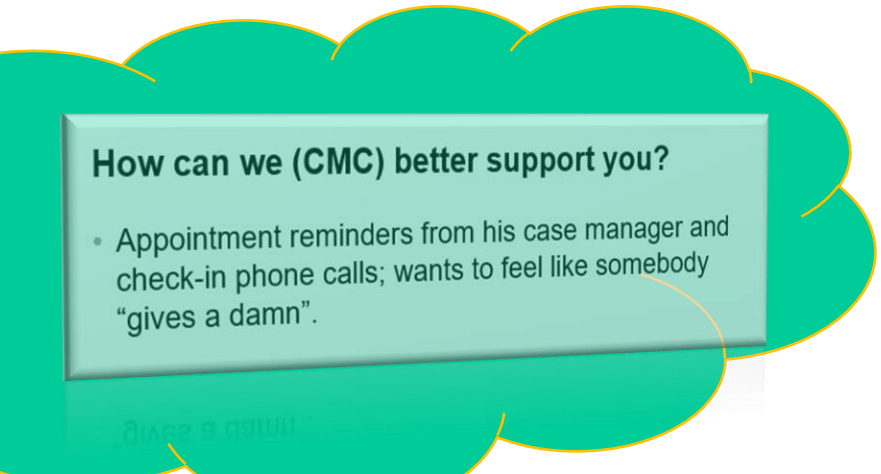
## Organizational Driver Diagram

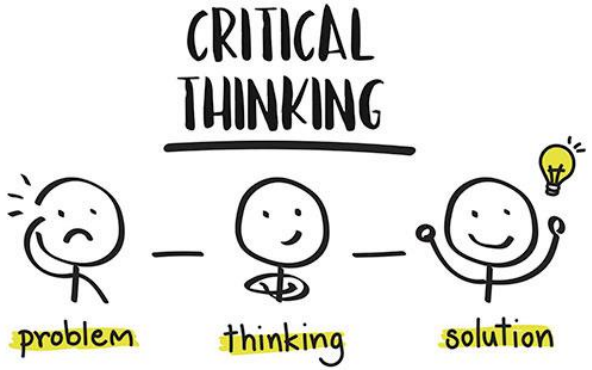
# WHAT CHANGES DID WE MAKE THAT RESULTED IN IMPROVEMENT?

## 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.*

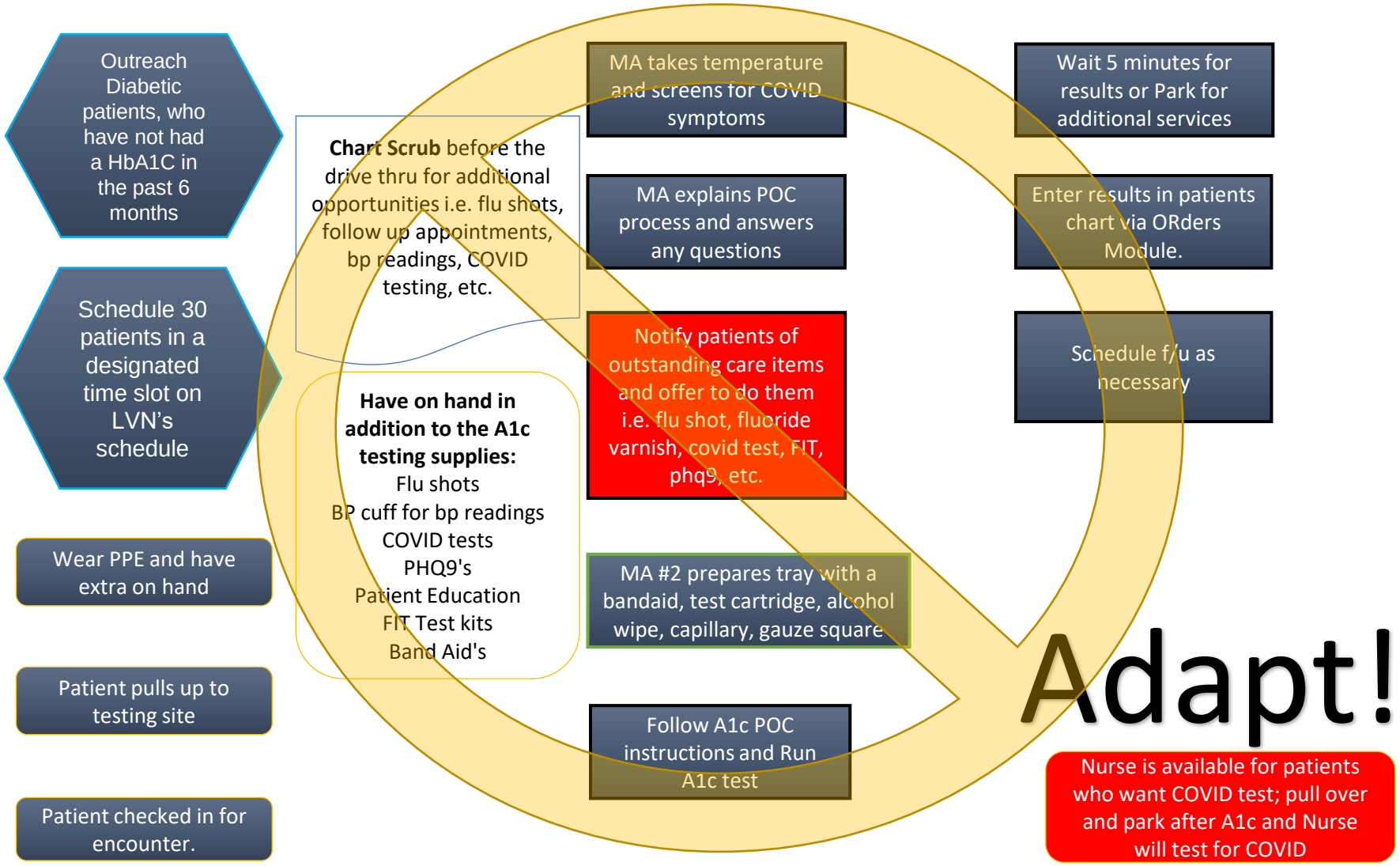
# WHAT CHANGES DID WE MAKE THAT RESULTED IN IMPROVEMENT?

## Changes We Tested

### What Worked and What Didn't Work

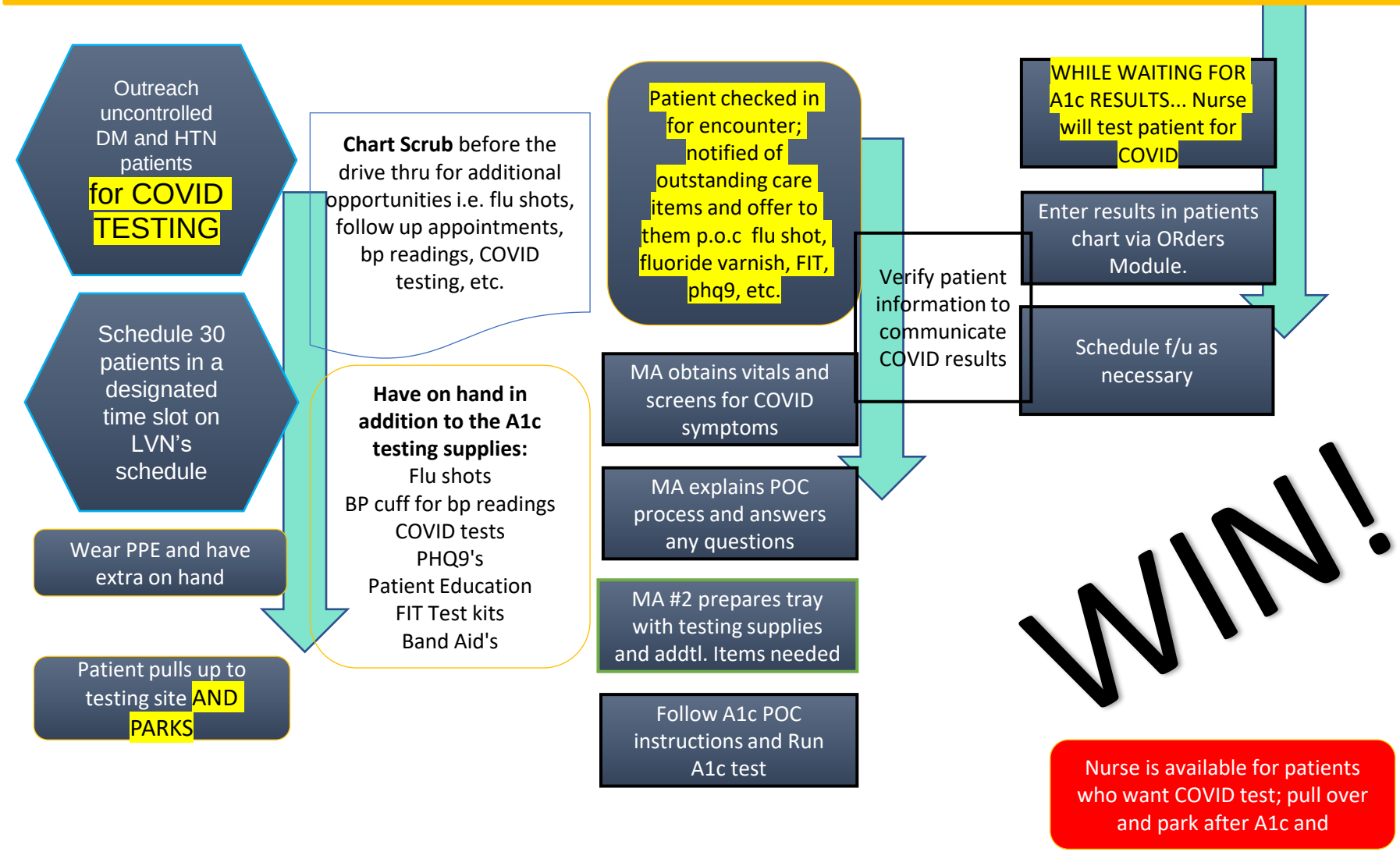
| Change Idea Tested | Summary of PDSAs | Adopted, Adapted, Abandon? |
|---|---|---|
| A1c results | Ordering labs and outreaching patients to instruct them to get their labs done prior to scheduling their next appointment. | Abandoned. |
| Point of Care A1c Use | All patients with diabetes get a P.O.C A1c result at time of visit (sites with P.O.C machine) | Adapt! |
| Drive Thru | • Outreaching uncontrolled diabetic patients for a drive thru style appointment to obtain their A1c results<br>• Outreaching patients with Diabetes/Hypertension for drive thru COVID testing and getting BP and A1c using value added time during the appointment.<br>• More notes! Tie into slide 3 | Adapt!<br>*See slide 6 and Slide 7* |

# Process Flow Map – 1ST CYCLE



# WHAT CHANGES DID WE MAKE THAT RESULTED IN IMPROVEMENT?

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



# How Did We Know the Changes Were An Improvement?

## What We Measured

### Measures Set

| Measure Type/Name | Description/ Specifications | Baseline % 4/1/2019 – 3/31/2020 | Target % |
|---|---|---|---|
| **Outcome (Directly related to the aim):** | | | |
| Health Plan Measure | Increase in the number of visits per member per year for patients with diabetes and/or hypertension | 3.75 medical visits per year for patients with HTN | 5 visits per year |
| Health Plan Measure | Decrease the number of patients with diabetes who have not had an A1c in the last year. | 16% | 12% |
| **Process (Steps to achieve the aim):** | | | |
| Internal | Registering patients with a race/ethnicity on file | 52% | 100% |
| | | | |
| **Balancing (Unintended impact/consequence):** | | | |
| Utilization | Decrease in the amount of no shows | 19% | 12% |
| | provement in Patient isfaction scores | 75% | 85% |

COMMUNITY Medical Centers

# Diabetes Management Dashboard

**Last Update:**
1/14/2021 8:00:20 AM
**User:**
Albahar, Anuit

Patient List

Reset Filters

Patients Last Seen
Last 2 years

Center
(All)

Primary Care Provider
(All)

PCP Specialty
(All)

Rendering Provider
(All)

Rendering Specialty
(All)

HbA1c Control Status
(All)

Latest HbA1c Completed
(All)

Enc. Payer
(All)

Payer Member
(All)

Ethnicity
(All)

Race
(All)

Homeless Status

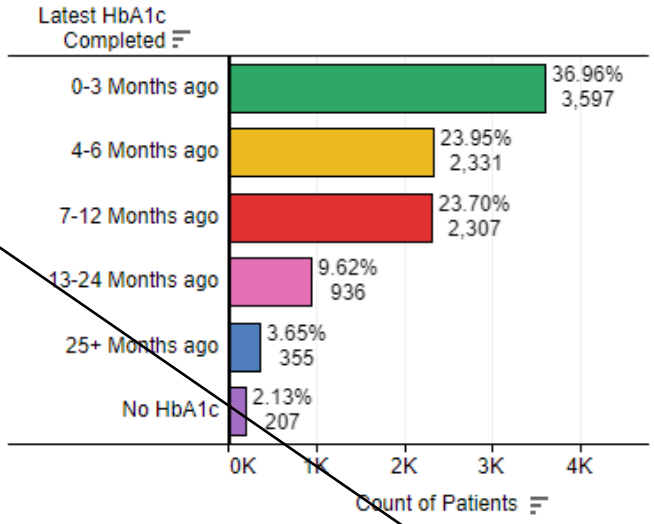
# of Diabetic Patients
9,733

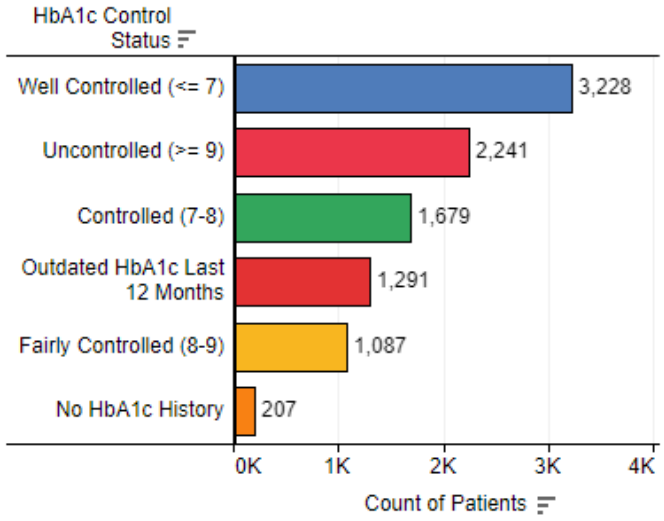
% of Patients HbA1c >= 9
39.4%

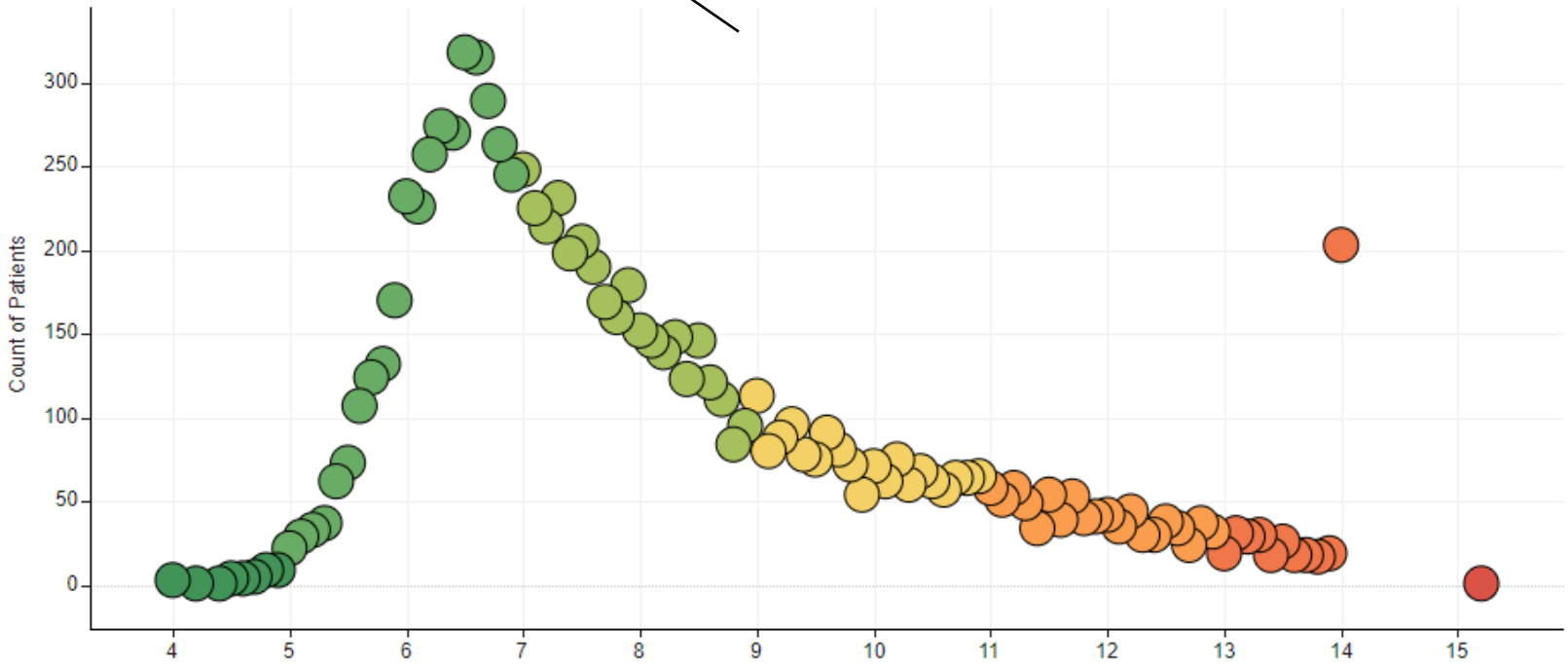
% of Patients HbA1c < 9
60.6%

% of Patients HbA1c < 8
49.1%

% of Patients HbA1c < 7
30.9%



COMMUNITY Medical Centers

# Diabetes Management Dashboard

**Last Update:**
1/14/2021 8:00:20 AM
**User:**
Albahar, Anuit

Patient List

Reset Filters

Patients Last Seen
Previous year

Center
(All)

Primary Care Provider
(All)

PCP Specialty
(All)

Rendering Provider
(All)

Rendering Specialty
(All)

HbA1c Control Status
(All)

Latest HbA1c Completed
(All)

Enc. Payer
(All)

Payer Member
(All)

Ethnicity
(All)

Race
(All)

Homeless Status

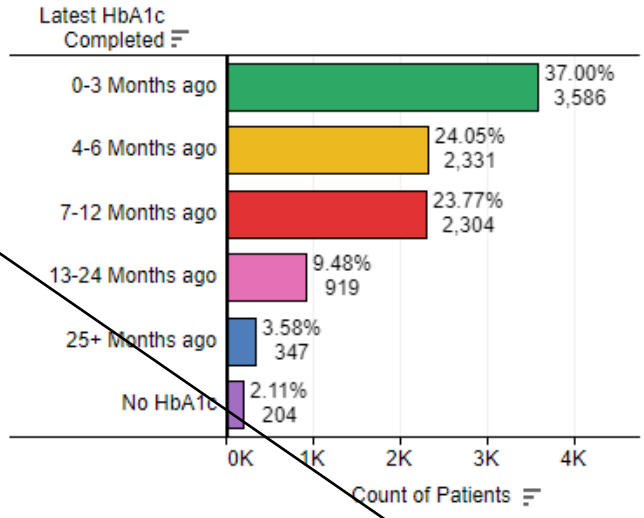
# of Diabetic Patients
9,691

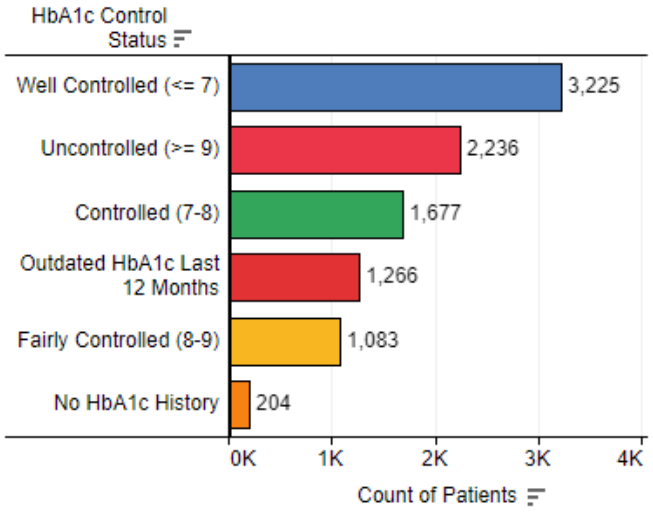
% of Patients HbA1c >= 9
39.3%

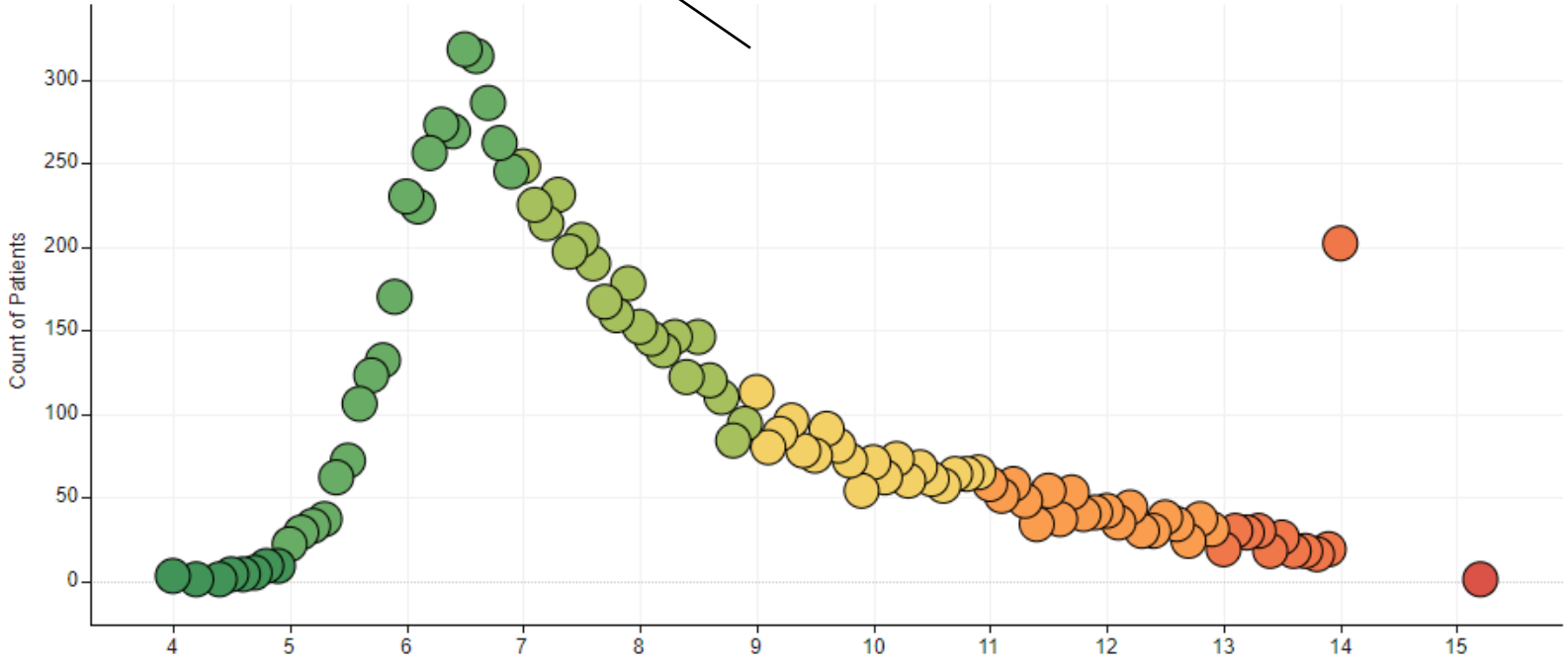
% of Patients HbA1c < 9
60.7%

% of Patients HbA1c < 8
49.2%

% of Patients HbA1c < 7
31.0%



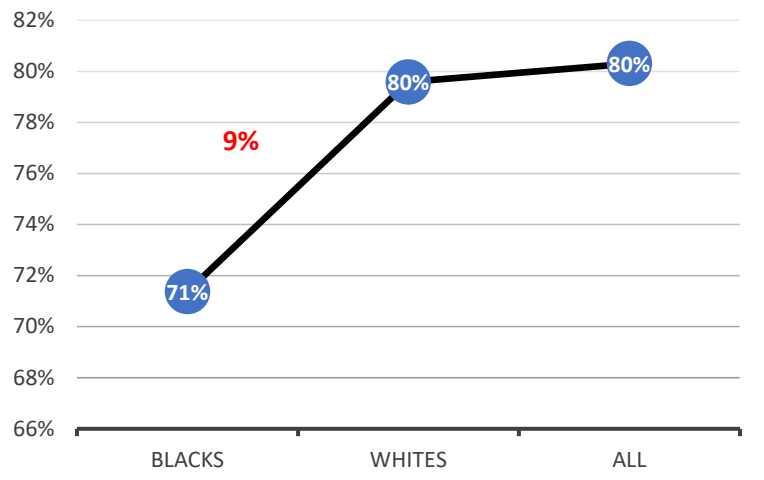
# How Did We Know the Changes Were An Improvement?

## Results: Run Charts

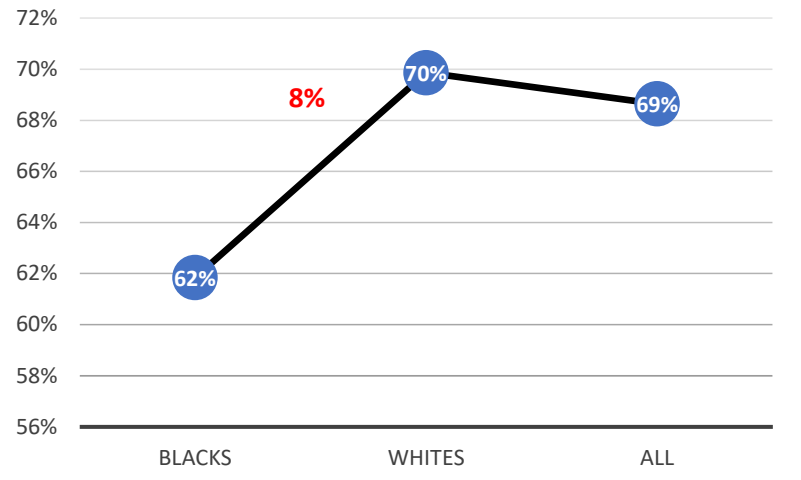
Outcome

Disparities at a Glance

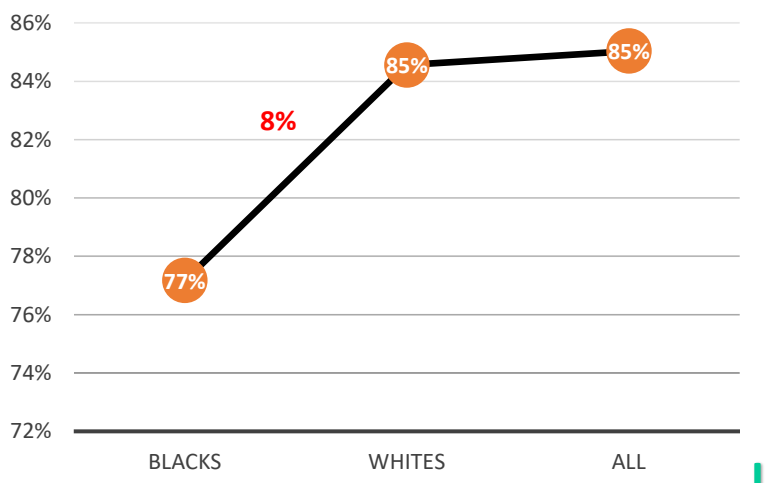
### ACEs & ARBs



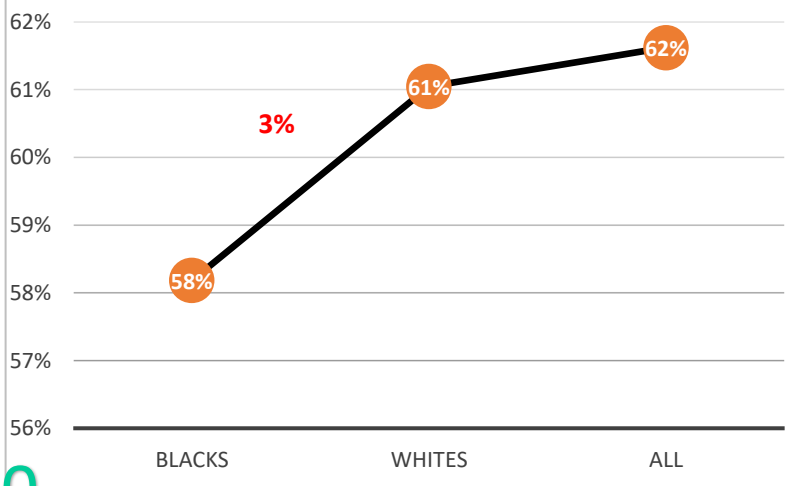

### Controlling High BP




### A1c Testing




### A1c Control

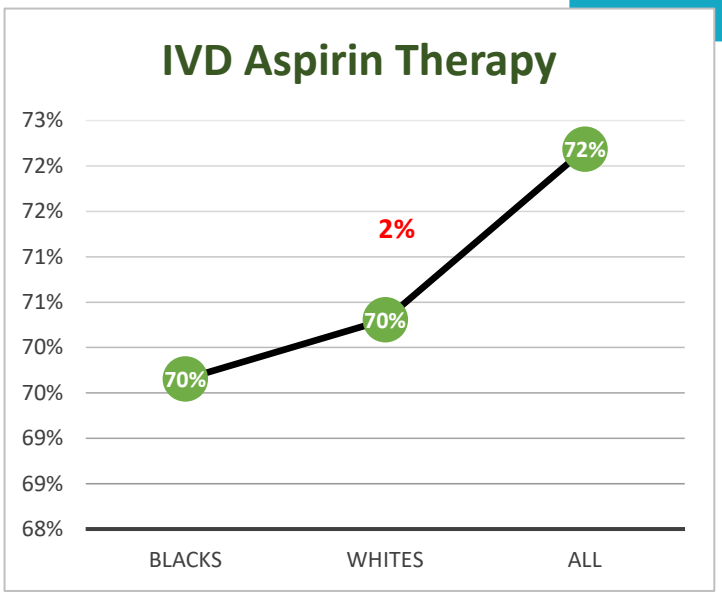


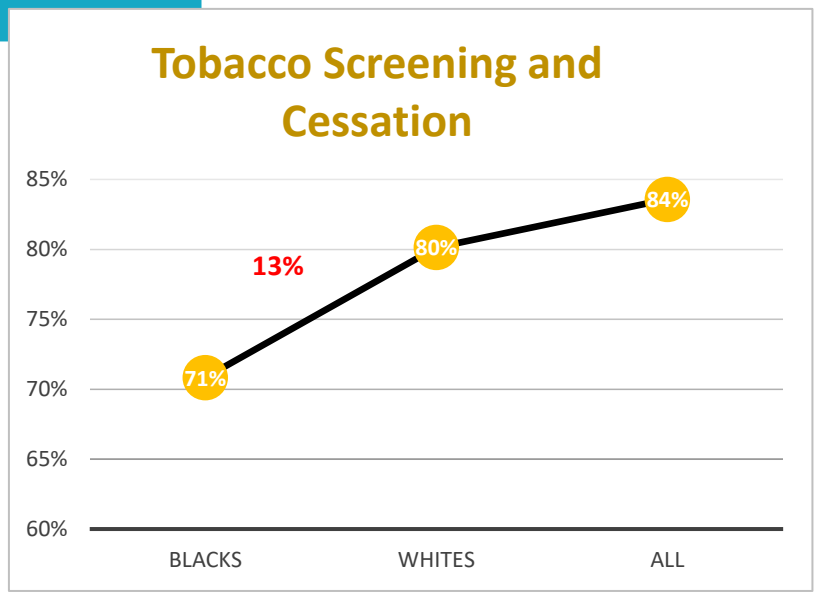

June 2020

# How Did We Know the Changes Were An Improvement?

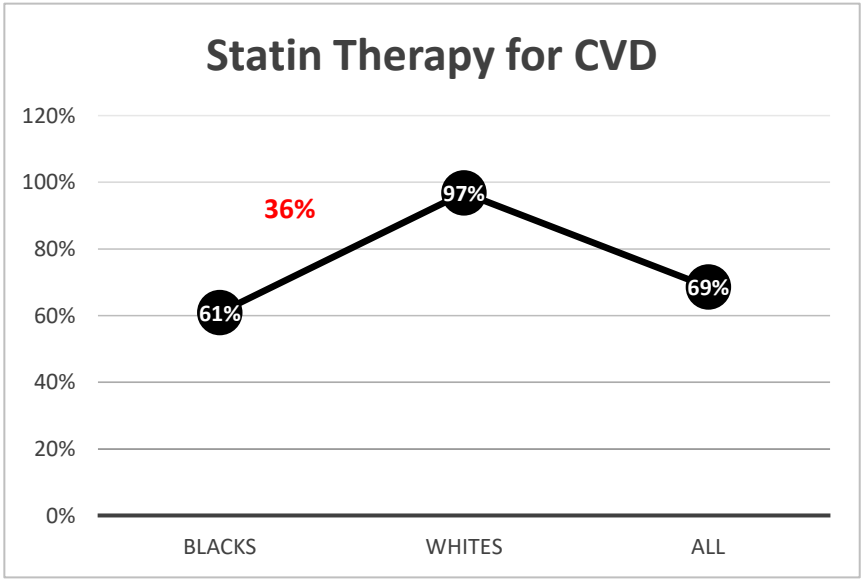
## Results: Run Charts

**Outcome**




# Disparities at a Glance

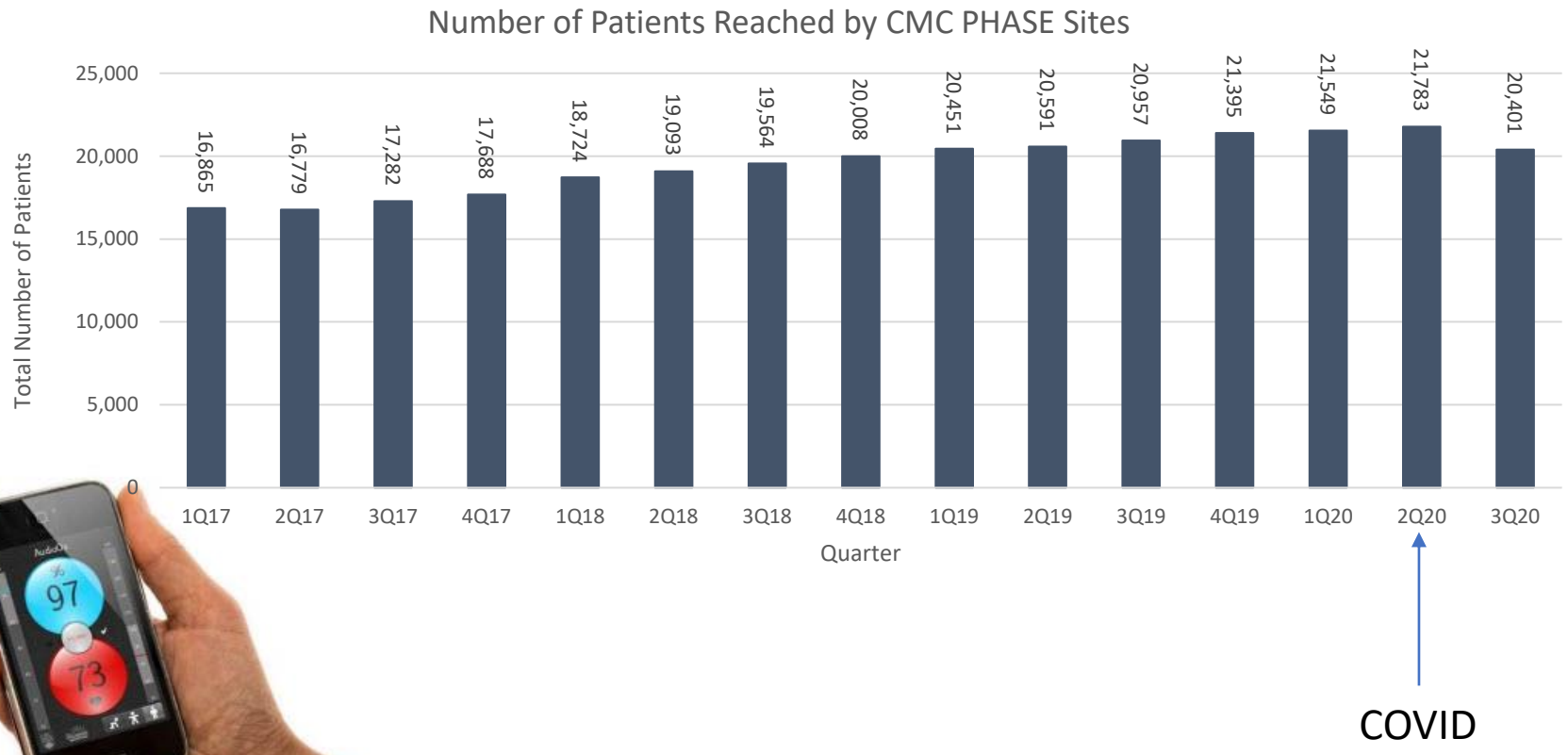


# How Did We Know the Changes Were An Improvement?

## Results: Run Charts

### Process

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



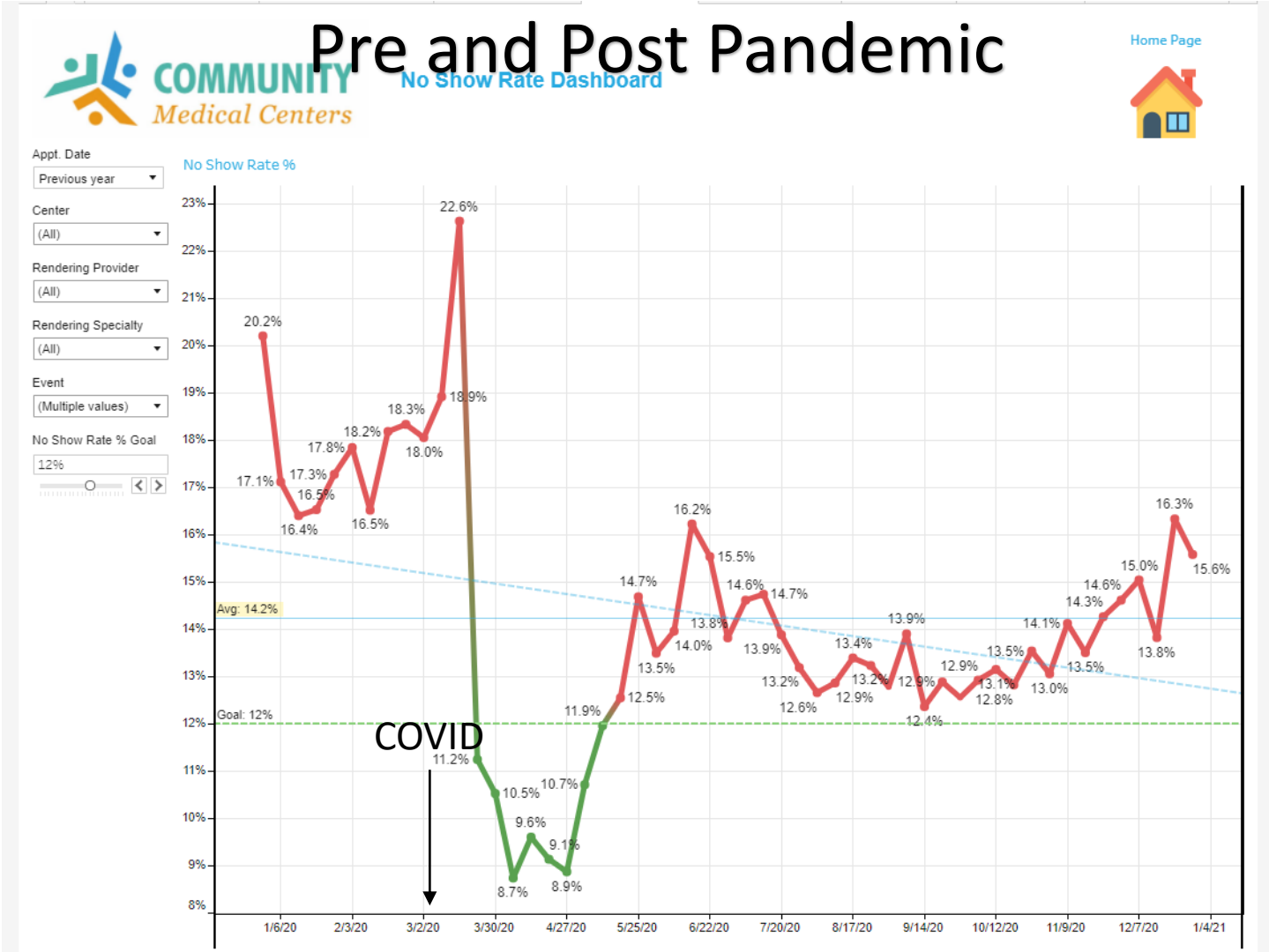

# How Did We Know the Changes Were An Improvement?

## Results: Run Charts

**Balancing**

# No Show Rate 2020

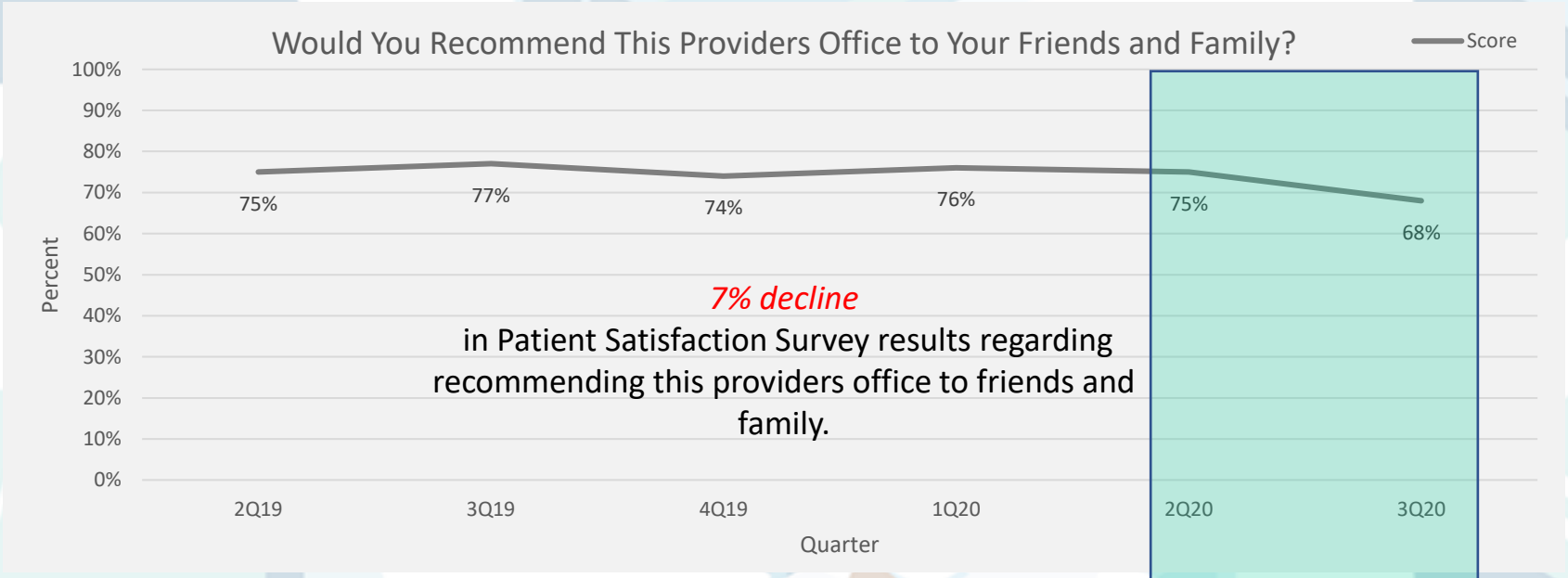
## Pre and Post Pandemic



# How Did We Know the Changes Were An Improvement?

## Results: Run Charts

### Balancing



# 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


### Overall Challenges

| Challenge | How We Overcame/Resolution |
|---|---|
| Limited lab services, no A1c results | Purchased Point of Care A1c analyzers for sites with limited to no lab access to obtain current A1c results for patients. |
| No in person visits, no BP readings | Video/Virtual visits. If provider can see the cuff and instruct patient on obtaining BP reading, this is an official reading. |
| Depression Screenings | Conduct depression screening over the phone prior to telehealth appointment with provider |
| Staffing shortages | Remote work schedules |
| | |

# 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.