



PREVENTING HEART ATTACKS
& STROKES EVERY DAY



PHASING THROUGH COVID Community Health Partnership February 18, 2021

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WHAT WERE WE TRYING TO ACCOMPLISH?

Problem Statement

The purpose of this project is to develop the capacity of clinics to respond to health disparities by identifying and responding to social determinants of health. Over the next year, we are hoping to support our clinic members in these efforts by introducing and integrating health disparity data into our Community Health Partnership Health Improvement Committee (CHIC) and PHASE dashboards. As well as engaging our clinic members in testing out strategies to improve the health outcomes of patients who have poor control of their diabetes or hypertension.

Aim Statement

By March 31, 2021, CHP will improve the health of the patients we serve through our member organizations who participate in PHASE as measured by:

- Maintaining the overall % of patients with uncontrolled diabetes (Hba1c > 9) at baseline of 30% [2,462 patients impacted] (baseline-Q4 2019)

Health Equity Aim Statement

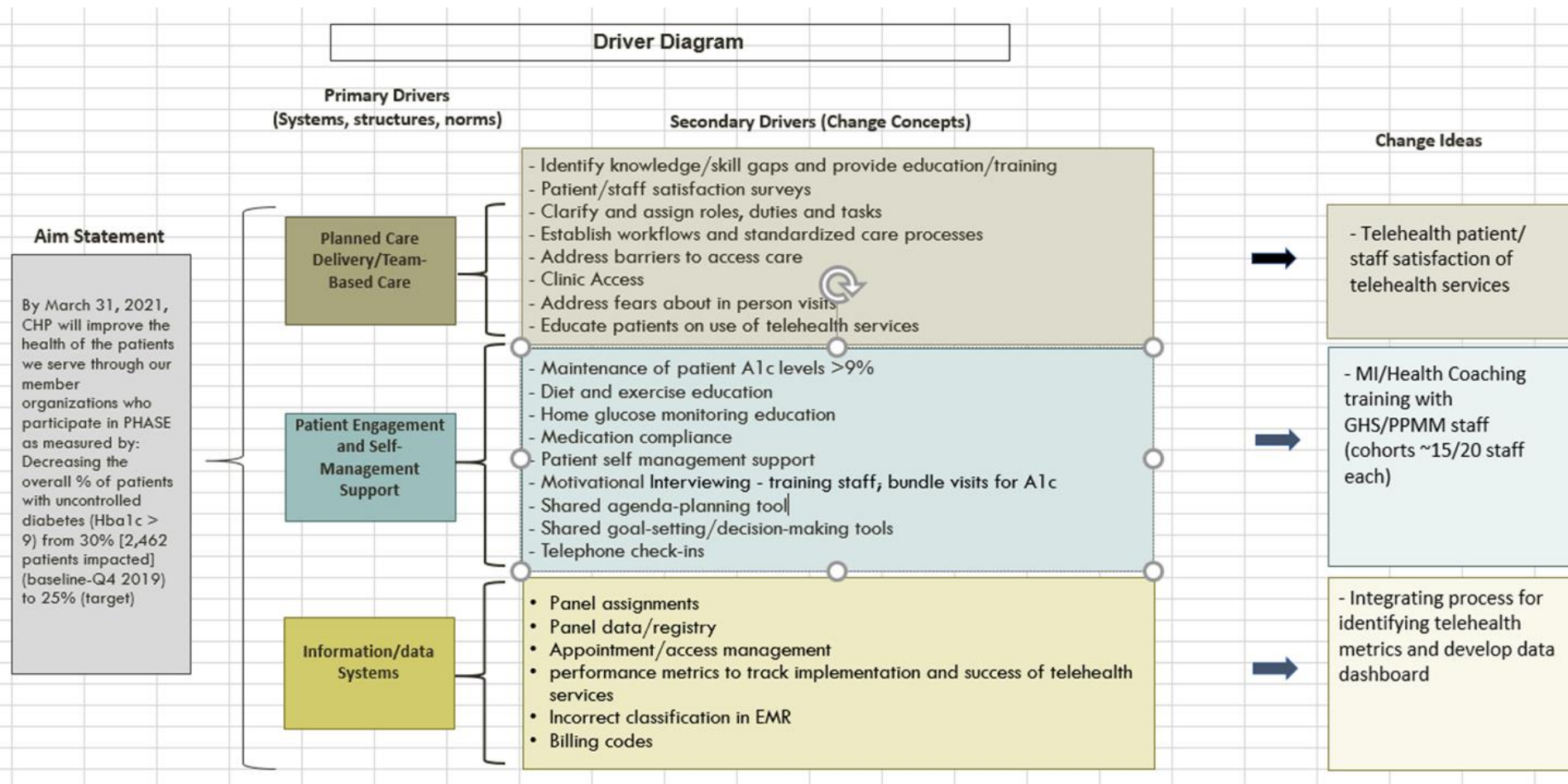
By March 31, 2021, CHP will improve the health of the patients we serve through our member organizations who participate in PHASE as measured by:

- % of participating PHASE member clinic organizations who maintain baseline for their disparity measure.

WHAT CHANGES DID WE MAKE THAT RESULTED IN IMPROVEMENT?

Our Theories for Change: How We Learned About Our Process

Organizational Driver Diagram

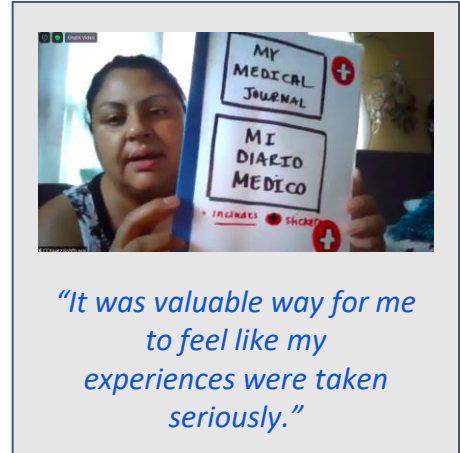


WHAT CHANGES DID WE MAKE THAT RESULTED IN IMPROVEMENT?

Process for Selecting Test Ideas

How We Engaged the Patient “Voice of the Customer”

- CHP facilitated a 7-month project engaging 9 patients with diabetes and CHC/CBO staff to better understand the non-medical referral process and experience.
- SHCSCC participated in PHASE small group sessions focused on hearing the voice of the patient to better understand health inequities.
- AACI and RFHN are interviewing patients to understand their telehealth experiences while managing their chronic disease(s).



How We Engaged Leaders, Providers, and Staff

- CHP engaged CHC staff in activities during December 2019 CHIC meeting to receive feedback on how we can support them on a variety of topics/areas
- AACI and RFHN are interviewing staff to understand their telehealth experiences while navigating patients in managing their chronic disease(s).

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?
MI training	<p>MI training with 2 pilot CHC staff cohorts</p> <ul style="list-style-type: none">● Polled CHCs on interest in MI training in virtual setting to engage PHASE patients during telehealth visits● Conducted interviews with 2 interested CHCs and created two training models based on specific needs of CHCs● Tested training model conducted in 1 session● Testing training conducted over 3 sessions● Partnered with CoachMe Health to co-deliver trainings● Cross-trained 3 additional CHP staff on MI curriculum● Total 26 CHC staff trained at 2 CHCs	Adopted
Scheduled lab appts.	<ul style="list-style-type: none">● Offered scheduled laboratory appointments to check for laboratory blood levels of A1c due to the shelter-in-place county ordinances regarding COVID-19.● Expanded scheduled laboratory appointments to include non-fasting labs, providing larger access to care.● Sent telereminder appointment reminder phone calls to patients with scheduled lab appointments.	Adopted
Drive thru testing	<ul style="list-style-type: none">● Developed workflow and tested● Tracked show rate and patient/staff experience● Variables worked through on pilot was scheduling testing during designated hours versus spread throughout the clinical day	Adopted

How Did We Know the Changes Were An Improvement?

What We Measured (Community Health Partnership)

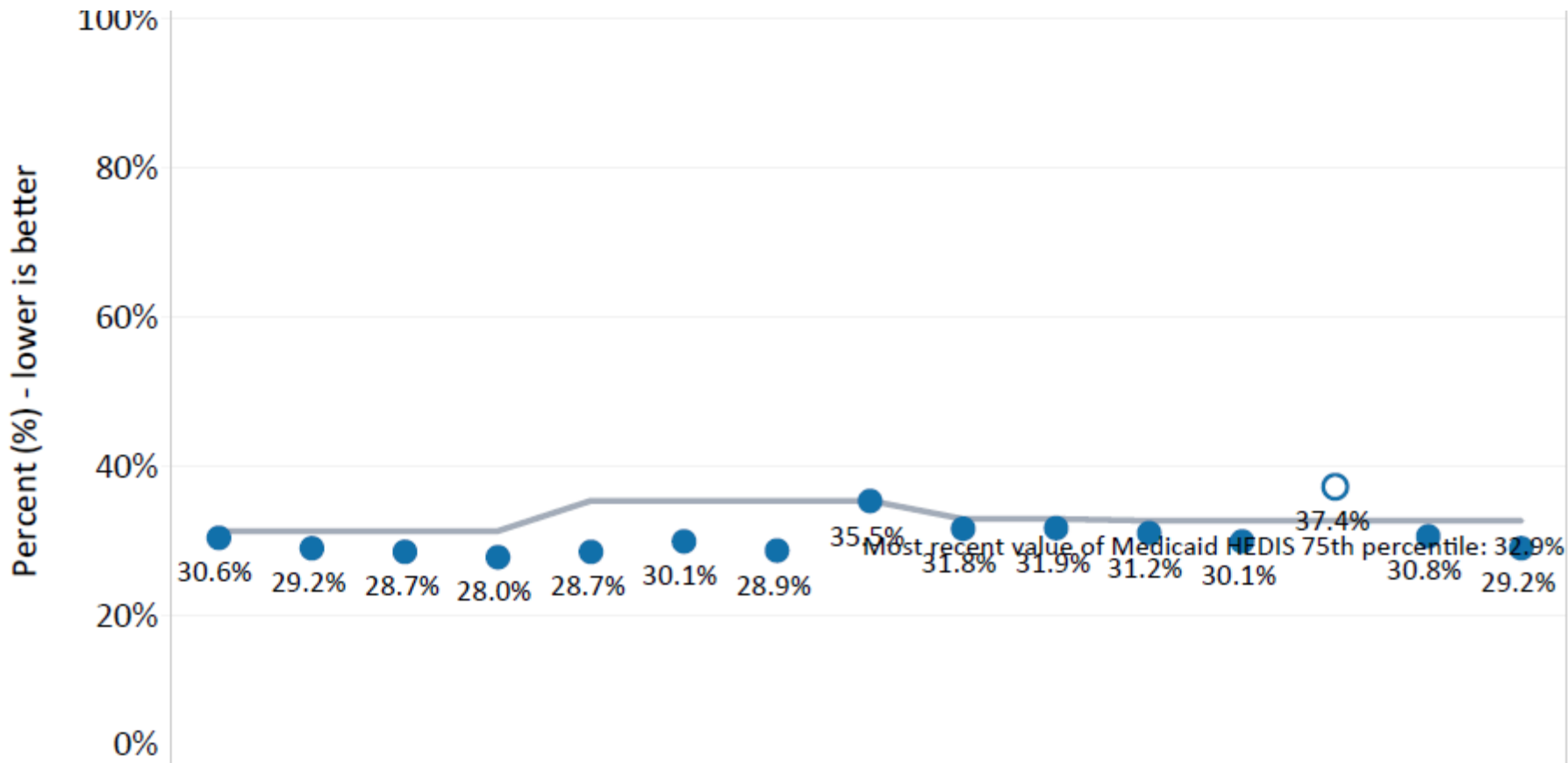
Measures Set

Measure Type/Name	Description/ Specifications	Baseline %	Target %
Outcome (Directly related to the aim):			
A1c poor control	Percentage of patients with uncontrolled diabetes (A1c)	30%	30%
Process (Steps to achieve outcome):			
Staff trained	Number of staff trained in motivational interviewing/health coaching	NA	40
Increased confidence	% of staff who rate their confidence level regarding Ask-Tell-Ask at 4 or above	NA	75%
Balancing (Unintended impact/consequence):			
Uncontrolled Hypertension	Percentage of patients with diabetes with uncontrolled hypertension (blood pressure)	31%	31%

How Did We Know the Changes Were An Improvement?

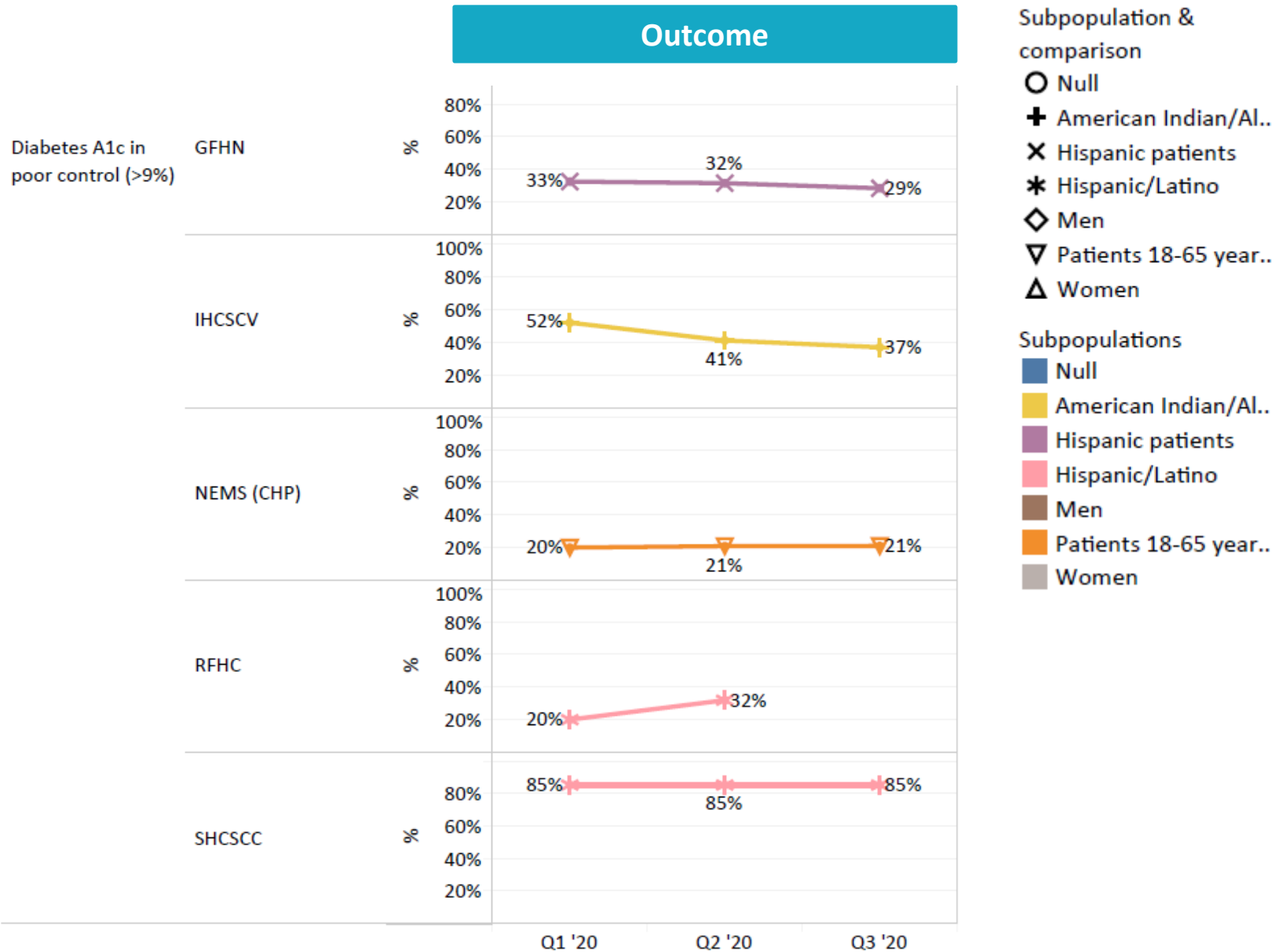
Results: Run Charts

Outcome



How Did We Know the Changes Were An Improvement?

Results: Run Charts



How Did We Know the Changes Were An Improvement?

Results: Run Charts

Process

	TOTAL RESPONDENTS	# WHO FELT CONFIDENT ABOUT PRACTICING THEIR SKILLS	% WHO FELT CONFIDENT ABOUT PRACTICING THEIR SKILLS
GFHN	8	8	100%
PPMM	8	6	75%

How Did We Know the Changes Were An Improvement?

What We Measured (North East Medical Services)

Measures Set

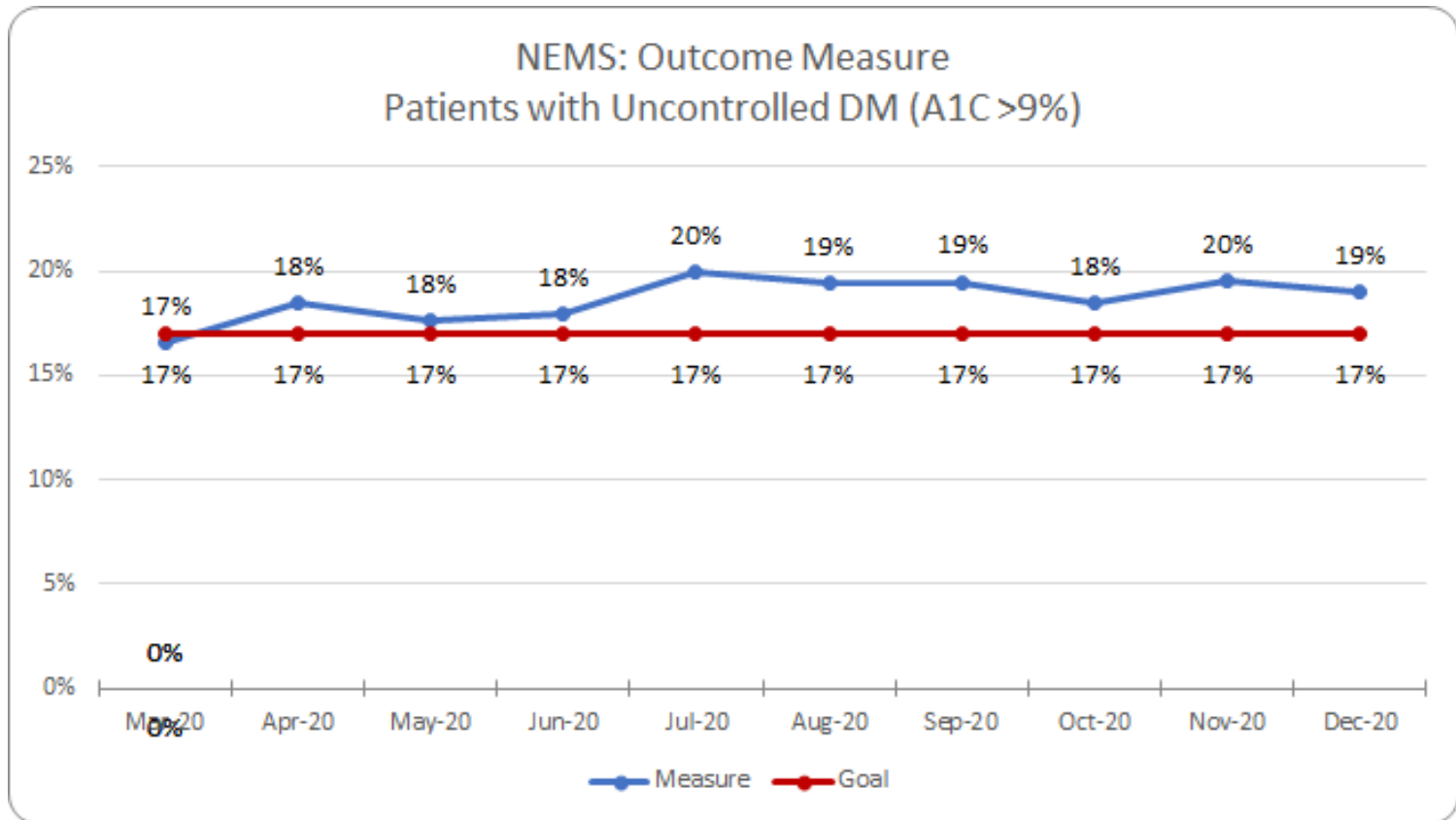
Measure Type/Name	Description/ Specifications	Baseline %	Target %
Outcome (Directly related to the aim):			
A1c poor control	Percentage of patients with uncontrolled diabetes (A1c)	17%	17%
Process (Steps to achieve outcome):			
Nephropathy	patients (A1c >9%) with completed nephropathy monitoring	59%	59%
A1c Testing	Patients (A1c >9%) with A1c tests conducted within the last 12 months	35%	35%
Balancing (Unintended impact/consequence):			
Statin therapy	Percentage of patients who were prescribed or were on statin therapy	91%	91%

How Did We Know the Changes Were An Improvement?

Results: Run Charts

Outcome

[NOTE: Include Run Charts for Global Aim and Health Equity Aim]



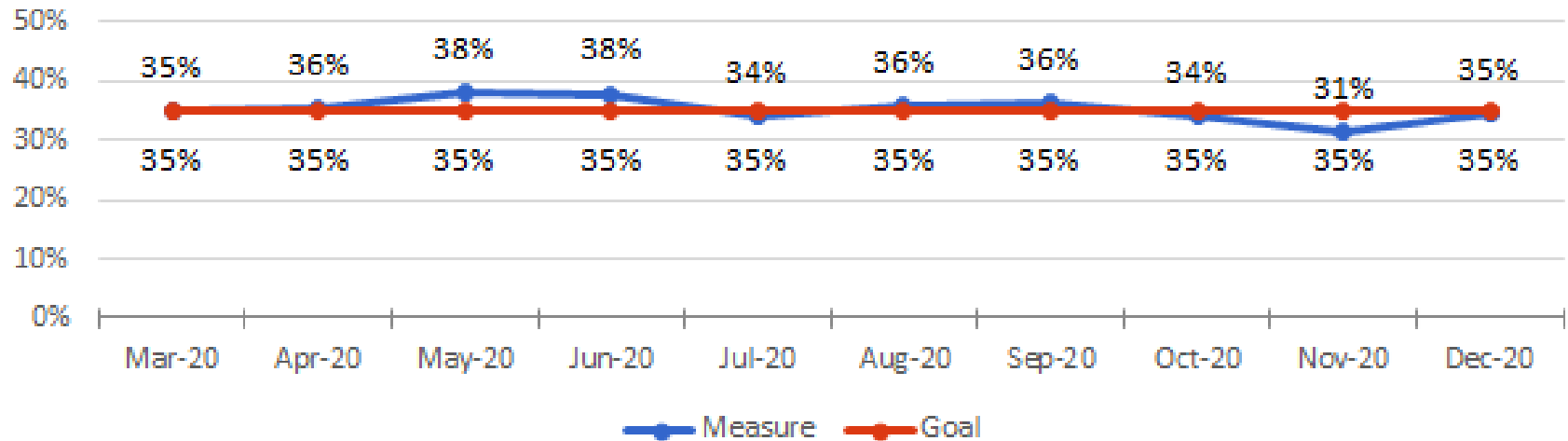
How Did We Know the Changes Were An Improvement?

Results: Run Charts

Process

[NOTE: Include at least 2 process measure run charts]

Poor controlled diabetes patients (A1c >9%) with A1c tests conducted within the last 12 months

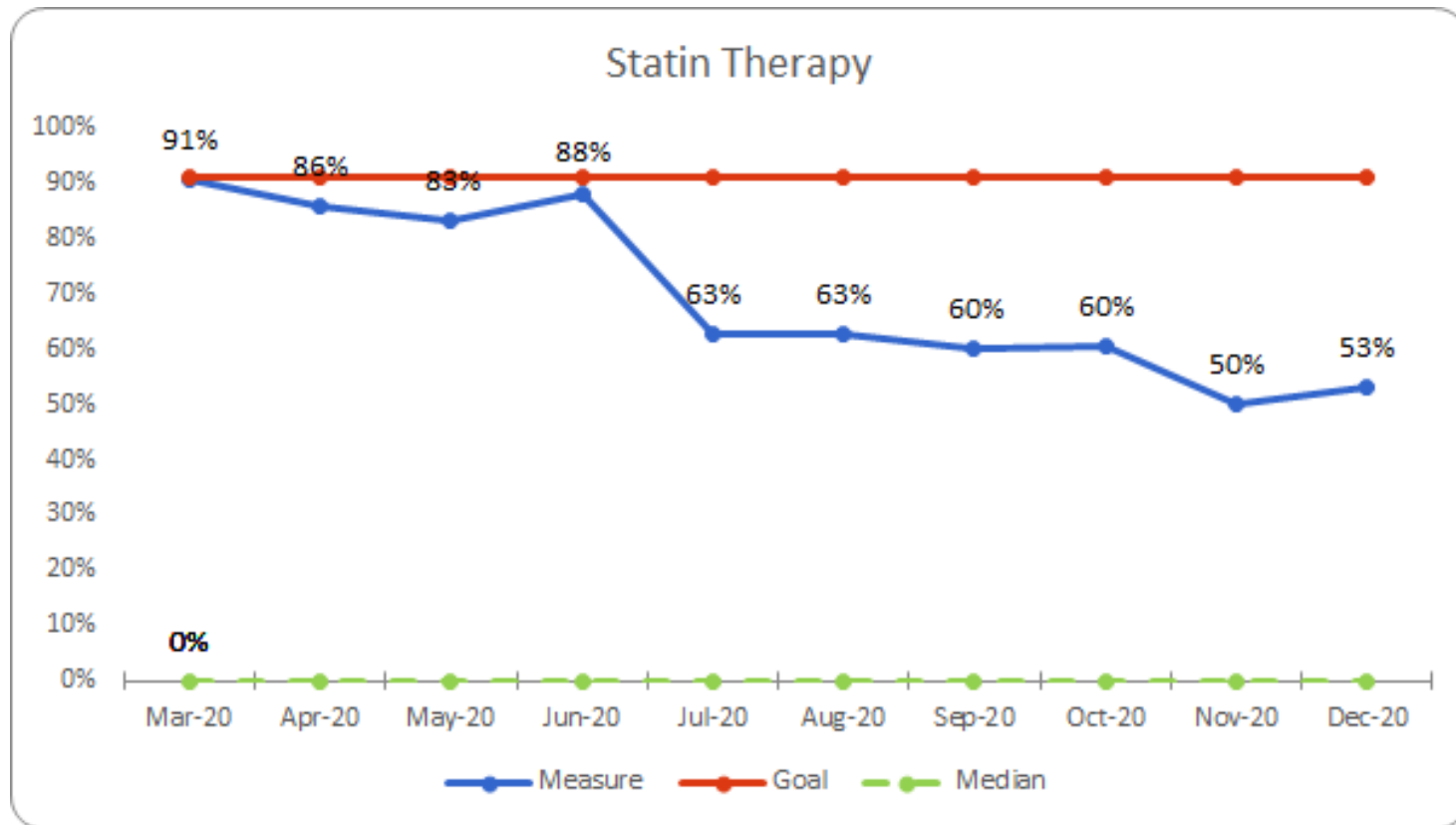


How Did We Know the Changes Were An Improvement?

Results: Run Charts

Balancing

[NOTE: Include at least one balancing measure]



How Did We Know the Changes Were An Improvement?

Here's What We Learned

Bright Spots/Accomplishments

- All of our CHC members were able to identify and start reporting health disparity data
 - Most are able to stratify by race, ethnicity, language, gener, insured/uninsured
 - CHP's Data Committee a approved disparity data exploration
 - COVID pandemic highlighted the need to address health equity, particularly for patients with chronic conditions, by using data to identify gaps in care by specific health disparities
- The clinic transformations that our clinic members have undergone to support their patients and community through COVID, especially in ensuring they can continue to provide care to their PHASE population
 - Monitored patients with hypertension using home blood pressure monitoring device
 - Development of hypertension self-management standing order policy
 - Development of health coach bundled visit to address gaps in care & reestablish care for diabetic patients
 - Piloting of drive-up A1c testing for diabetic patients
- Clinic staff are very resilient and can step up in a time of crisis
 - Flexibility and the ability to pivot to the needs of our clinic members is key for maintaining engagement (i.e., focus on telehealth & MI, donations of PPE and remote monitoring devices)

"I am so excited about potentially bringing more drive-thru services and increasing access for our patients! So far, I feel that things have gone pretty smooth. I think that having more machines to do more tests simultaneously for the families/couples that we have seen driving together would be nice). I think that it is sufficient to have 2 HSS's assigned to A1c testing and 1 HSS to manage regularly scheduled PC visits, at least while we have more phone visits than in-person visits scheduled. That has prevented the clinic flow from being disrupted."

~ Quote from PPMM staff regarding PDSA on HbA1c Drive-up Testing

How Did We Know the Changes Were An Improvement?

Here's What We Learned

The Challenge of the COVID-19 Pandemic

- Greater integration of health coaching and motivational interviewing into clinic workflows for engaging PHASE patients into care during the pandemic
- Staff shortage: due to layoffs, needing to choose between caring for family at home or working, exposure, travel and quarantine; moving staff around and taking on new roles
- Shift in priority to address COVID: pause on QI activities; reduced capacity for collecting data on a consistent basis
- Decrease in patient visits: due to sheltering in place and fear/concerns

Overall Challenges

Challenge	How We Overcame/Resolution
Technical issues related to handling a lot of tests outside - cross contamination, etc.	Expand team care roles/functions In-house A1c machine Look for best practices
Gaps in data	Collect new baseline QI work with health plan to address gaps in care for MediCal patients
Patients will continue to be hesitant to come into the clinic or lab	Patient education Drive thru testing Look for best practices

What's Next for PHASE/TC3?

Here's How We Will Continue the Work

SPREAD

1. Expansion of telehealth strategies focused on chronic care management
 - Integration of telehealth metric on consortium dashboard
 - Sharing of best practices during consortium QI convenings
1. Offer motivational interviewing (MI) training to all clinic members
2. Continue to explore collection and use of data by specific disparities

SUSTAINABILITY

1. MI curriculum built into our “Training Institute” with options to offer virtually, in-person, a one time training, or as a series. CHP staff certified trainers.
2. Expanding health disparity to preventative services, specifically looking at breast cancer and cervical cancer screening.
3. We will add a telehealth metric related to patients with chronic conditions to consortium dashboard.

THE DESIRED FUTURE

1. To use data to its fullest capacity to reduce disparities
2. Conduct assessment focusing on demographic subgroup to understand how we can reduce disparities from the perspective and health experience of the patients
3. Continue to collect data to track if new strategies are effective
4. Engage 1-2 CHCs interest in collecting and using disparity data (work on above 3)
5. Expand the way se use telehealth metric ...