



PREVENTING HEART ATTACKS  
& STROKES EVERY DAY



# *Moving Toward Health Equity*

Redwood Community Health Coalition  
March 16th, 2021

REDWOOD  
HEALTH



COMMUNITY  
COALITION

*Serving Sonoma, Napa, Marin & Yolo Counties*

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## WHAT WERE WE TRYING TO ACCOMPLISH?

### How we approached PHASE this cycle

RCHC focused on gathering health center input and co-designing the grant with PHASE Champions.

- Focus areas were selected based on health center input
- AIM statements were co-designed with health centers in late 2019
- MOUs were sent to health centers for review of deliverables and expectations
- Driver diagrams were co-designed with health centers in early 2020
- RCHC hosted QI coaching calls throughout the grant to help guide health centers through their PDSA cycles

# WHAT WERE WE TRYING TO ACCOMPLISH?

## Problem Statement #1

Across RCHC health centers there exists an equity gap between patients with diabetes that are uninsured and those that have full insurance coverage. The percentage of uninsured patients with diabetes whose A1c was at goal in the measurement period January 1<sup>st</sup> 2019 to December 31<sup>st</sup> 2019, is approximately 62%. The percentage of patients insured through Partnership HealthPlan of California is approximately 71% in the same measurement period.

This inequity is problematic because it highlights the issues around lack of health insurance and resulting poor health outcomes. This is not unique to diabetes, but transcends all health conditions. By working on this now, we have the opportunity to impact other health outcomes and related measures. While health center care teams work on improving A1c control for the uninsured, they can also connect patients to onsite Enrollment Counselors. Care teams may experience better connections with patients, and build stronger relationships.

Due to the COVID-19 Pandemic and Shelter-In-Place orders across California, health centers will likely see an uptick in uninsured patients due to job losses. This will increase the denominator for this measure, and potentially increase the numerator as well.

## Aim Statement #1

#1. RCHC will improve health equity among health center patients by increasing the rate of uninsured patients with controlled diabetes (A1c of < 9%) from 62%\* to 71% by March 31st 2021.

\*Alliance Medical Center and West County Health Center data was not included in the baseline 62% or goal 71%, as these health centers are not in Relevant.

*Health centers selecting AIM #1: CommuniCare Health Centers, Marin Community Clinics, Santa Rosa Community Health*

# WHAT WERE WE TRYING TO ACCOMPLISH?

## Problem Statement #2

After health centers completed the 2019 clinic assessments, RCHC saw that the lowest scoring domain was “Patient-Team Partnership”. For this reason, RCHC selected this as a potential focus area for health centers throughout the 2020 PHASE grant. Incentivizing focus in this area, will allow health centers to dedicate staff time and prioritize this topic. From conversations with health center PHASE Champions, we’ve learned that Patient-Team Partnership is an area that health centers are beginning to include in their organizational goals.

Improving patient engagement and partnership in their care, is fundamental to ensuring patients follow medical recommendations such as eating healthier, moving more, and taking medications as prescribed. Building trusted relationships with patients takes time, so it’s vital to begin this process now. Health centers can create systems and pathways that engage patients, making it easier for them to follow recommendations and manage their health.

## Aim Statement #2

#2. RCHC will improve patient-team partnership, as defined in the 10 Building Blocks of Primary Care, by increasing the RCHC aggregate health center self-assessed score of the patient-team partnership domain by one level from 7.6 (Level B) at baseline in 2019\* to 8.6 (Level B) by the final assessment at the end of the grant period.

\*The following health centers were new to PHASE and had not completed a clinic assessment when the baseline score was established: Alexander Valley Healthcare, Marin City Health and Wellness Center, and Ritter Center. When their scores were added to the baseline score, the score dropped from 7.6 to 6.95. The goal of 8.6 will remain the same.

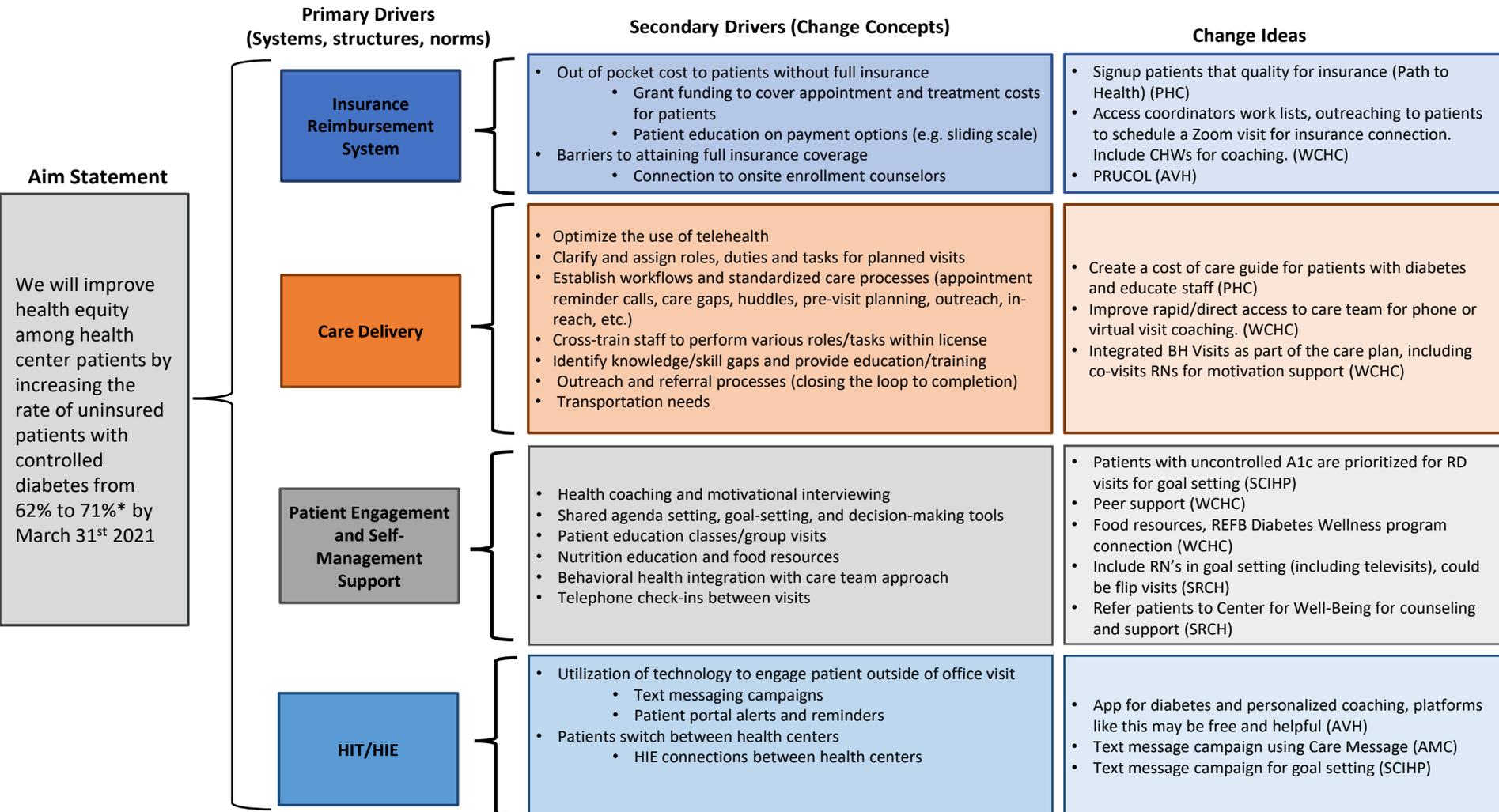
*Health centers selecting AIM #2: Coastal Health Alliance/Petaluma Health Center, West County Health Centers*

Alexander Valley Healthcare, Marin City Health and Wellness Center, and Ritter Center were new to PHASE this round and were not asked to select an AIM or complete PDSA work. Instead, they were asked to test a patient-team partnership initiative and document the results.

# WHAT CHANGES DID WE MAKE THAT RESULTED IN IMPROVEMENT?

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

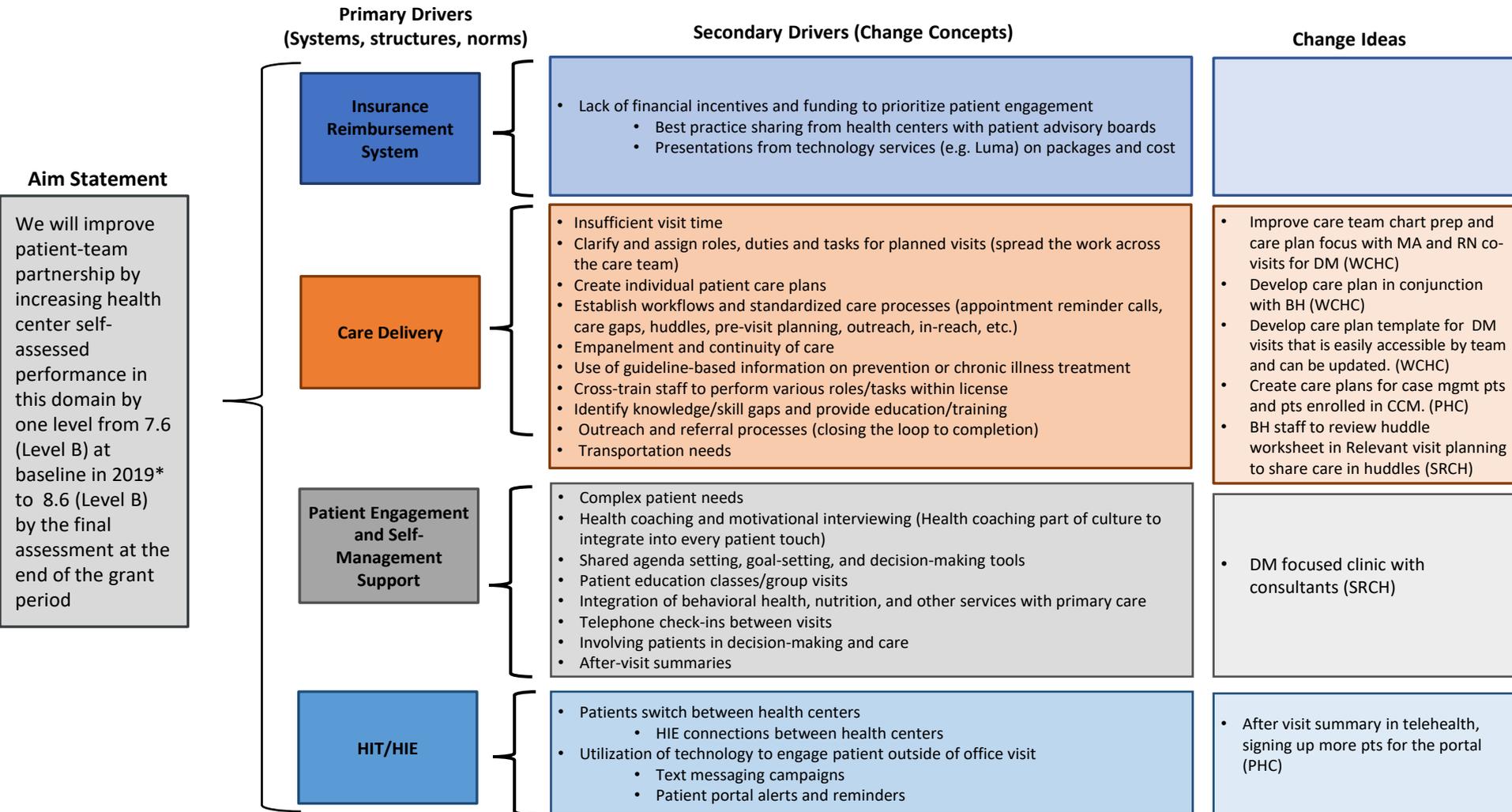
### Uninsured Patient Driver Diagram



# WHAT CHANGES DID WE MAKE THAT RESULTED IN IMPROVEMENT?

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

### Patient Team Partnership Driver Diagram



# WHAT CHANGES DID WE MAKE THAT RESULTED IN IMPROVEMENT?

## Process for Selecting Test Ideas

### How We Engaged Health Center Leaders, Providers, and Staff

RCHC engaged health centers through QI coaching and support, facilitating peer sharing, and hosting trainings and other engagement opportunities. Trainings and sharing opportunities were designed based on health center requests, and with their continued input.

#### QI Coaching & Support:

- Co-designed driver diagrams with health centers during a PHASE Champion meeting
  - Health centers provided edits to the “secondary drivers” created the “change ideas”
- Provided PDSA support and QI coaching during regular health center check-ins
- Published numerous [QI Chat Room podcast](#) episodes related to PHASE work

#### Peer Sharing:

- Hosted quarterly PHASE Champion meetings to share program updates and facilitate roundtable sharing between health centers
- Hosted three health center virtual quality tours and shared recordings
- Interviewed Kaiser Permanente Santa Rosa about their PHASE program, and shared recording

#### Trainings & Other Opportunities :

- Hosted UCSF pharmacy student who provided health centers academic detailing on statin therapy
- Provided SMBP machine expense reimbursement to health centers for uninsured patients
- Offered two UCSF Advanced Management of Diabetes trainings for health center providers

# WHAT CHANGES DID WE MAKE THAT RESULTED IN IMPROVEMENT?

## Process for Selecting Test Ideas

### How We Engaged the Patient “Voice of the Customer”

The following health centers interviewed patients over the phone regarding their healthcare experience: Marin City Health and Wellness Center, Ritter Center, and West County Health Center.

Key themes that emerged from West County’s interviews:

- Patients were experiencing feelings of **isolation, loneliness, and boredom**.
- Patients **blamed** their lack of self control (i.e. overeating) for their poor health and **struggled** to think of a time they were feeling healthy.
- Patients were **reluctant or unable to find community**.
- Patients **felt disempowered** in themselves to make changes.

As a result of the interviews, the health center is considering offering non-medical, non-health Zoom classes, groups, for social connection.

# WHAT CHANGES DID WE MAKE THAT RESULTED IN IMPROVEMENT?

## Changes We Tested

### What Worked and What Didn't Work

#### Summary of PDSA Work

RCHC created driver diagrams for our AIM statements. Health centers selected one of the AIM statements, and helped populate “change ideas” during a PHASE Champion meeting.

RCHC provided health centers a PDSA worksheet and tracker. We met virtually with each health center at least once throughout the year to review their PDSA work and provide QI coaching as needed.

#### PDSA Highlights:

- Student pharmacist blood pressure clinic over WebEx
- CareMessage for collecting blood sugar readings and assessing patient confidence to make healthy choices
- Referral to Center for Well-Being for BP control

# WHAT CHANGES DID WE MAKE THAT RESULTED IN IMPROVEMENT?

## Changes We Tested

### What Worked and What Didn't Work

#### Alliance Medical Center PDSA Work

**AIM Statement:** Alliance Medical Center will decrease the percentage of adult patients with type 1 or 2 diabetes whose most recent HbA1C is greater than 9% from 38.03% to 35% by December 31, 2021.

**PDSA Being Tested:** 25 Week CareMessage Diabetes Program for adult patients with type 1 or 2 diabetes with recent A1C greater than 9% to determine which of these patients is not confident in making healthy choices to help lower their blood sugar level.

#### **Results & Key Learnings:**

Most of the patients enrolled in the program see the importance of managing their blood sugar and most of them are willing to make healthy choices to help manage their blood sugar level. Most of the patients are also willing to change their eating habits to help lower their blood sugar level.

#### Adapt

- We will continue with the CareMessage Diabetes Program since the patients will answer different questions pertaining to managing their diabetes. This will help us know which of these patients are ready to embark on this journey of helping manage their diabetes. We will also reach out to patients who opted out of the program and get the reasons for opting out. Our health coaches have already started offering ZOOM group classes for the patients who replied that they are not confident in making healthy choices to help manage their blood sugar levels.
- This approach helps our health coaches to know what medication these patients are taking for their diabetes which helps them to better educate the patients well. The health coaches can easily make outreach calls to patients not taking any medication for their diabetes and offer them some education about the importance of taking medication for diabetes.
- We will continue to ask these patients if they are short of diabetes medication and narrow the search down to our diabetic uninsured patients and have our medical assistants make outreach calls to these patients and schedule them for appointments.

# WHAT CHANGES DID WE MAKE THAT RESULTED IN IMPROVEMENT?

## Changes We Tested

### What Worked and What Didn't Work

#### Marin Community Clinics PDSA Work

**AIM Statement:** In order to prevent poor outcomes for our patients with diabetes in an equitable way, we aim to increase the percentage of uninsured patients with diabetes mellitus at Marin Community Clinics with an A1C<9% from 61% on September 1, 2020 to 70% by 6/1/2021.

**PDSA Being Tested:** Whether interactive text messaging is an effective way for uninsured patients with diabetes to report blood sugar control.

**Results & Key Learnings:**

Patients were more receptive and responsive than expected to the concept of sending in blood sugars by text. Learnings were that some patients sent in all their blood sugars and many added additional info to the return text, indicating that a little more information about how to text in their numbers may be helpful. More clear instructions about how to send back the BS data by text were successful in further cycles of testing.

**Adapt**

- We tested the interactive text messaging on a larger group of patients, however had a lower response among this larger group. In light of the possible interference from the holiday (responses were requested on 12/24), we will plan to send another round of texts to this same group in early 2021 to see if we receive more useful responses. We plan to wait for the Luma platform to be in place before continuing this PDSA.

# WHAT CHANGES DID WE MAKE THAT RESULTED IN IMPROVEMENT?

## Changes We Tested

### What Worked and What Didn't Work

#### Petaluma Health Center PDSA Work

**AIM Statement:** Improve the Patient-Team partnership for patients with hypertension by increasing the number of patients who are able to monitor their blood pressure at home and have it recorded in the electronic health record from 0 to 500 patients by Dec 31<sup>st</sup>, 2020.

**PDSA Being Tested:** Offer a pharmacist-led BP clinic over Webex to capture BP readings for patients with hypertension and help bring BP under control if elevated.

**Results & Key Learnings:**

Some patients had difficulty navigating Webex and did not have their BP cuff with them. Throughout the PDSA cycles, the scheduling and number of patients seen increased.

**Adapt**

- We will try to spread the word about the correct way to schedule and educate patients about Webex.
- We will remind patients that this is a virtual visit and to have their BP monitor with them.
- We will centralize the appointment confirmation process to explain Webex.
- This virtual clinic will continue in 2021.

# WHAT CHANGES DID WE MAKE THAT RESULTED IN IMPROVEMENT?

## Changes We Tested

### What Worked and What Didn't Work

#### Santa Rosa Community Health PDSA Work

**AIM Statement:** Develop a system that will improve access to SMBP kits for uninsured patients by December 31, 2020.

**PDSA Being Tested:** Patient referrals to the Center for Well-Being's (CWB) Blood Pressure Program.

#### **Results & Key Learnings:**

The patients who declined the referrals to CWB wanted to go home and try the BP Monitor Kit out for themselves. The care team thought patients weren't incentivized to go to the CWB since they were already given a home BP Monitor Kit as part of the visit that day. The referral process wasn't tested with uninsured patients who don't qualify for a free BP Monitor Kit.

#### Abandon

- The first approach was abandoned since the lead provider was mainly seeing Partnership patients that were getting BP Monitor Kits during the visit already. The patients that were already receiving a BP Monitor Kit through Partnership weren't particularly motivated to get referred to the Center for Well-Being. This doesn't seem to be the best way to reach uninsured patients who need a BP Monitor Kit.

#### Adapt

- The lead provider continued to refer some patients to the Center for Well-Being. New Care Coordinators are starting at the health center and will be enrolling a panel of patients (many uninsured) that have diagnoses of HTN and DM. They will be working in collaboration with the Center for Well-Being and their BP Program (Carium Project) to coach and case manage patients, helping them achieve their health goals. The Care Coordinators will have access to BP Monitor Kits that they can distribute for free to uninsured patients. We think this direct outreach from the Care Coordinators (with and without referrals from providers) will be a better way to improve access to SMBP Kits for uninsured patients.
- We could also try texting uninsured patients with HTN and offering the free BP Monitor Kit.

# WHAT CHANGES DID WE MAKE THAT RESULTED IN IMPROVEMENT?

## Changes We Tested

### What Worked and What Didn't Work

#### West County Health Center PDSA Work

**AIM Statement:** We will increase the percentage of uninsured patients not at goal with a PHASE Care Plan complete from 32% to 40% by 12/31/2020 (subpopulation of total PHASE population).

**PDSA Being Tested:** Patient interviews of multiple different demographics: Spanish Speakers, working adults, younger age group.

#### **Results & Key Learnings:**

It was difficult to translate the process to someone completely outside of the project. The team is working from home and do not have access to call out using the clinic's phone line. The team was hesitant to leave a voice mail (requesting a call back) with a personal cell phone number, however didn't want to block their number either, afraid that no one would answer a blocked call. The team found the majority of patients were busy and unreachable during business hours.

#### Abandon

- Having a Spanish speaking Medical Assistant, outside of the project team, conduct the interviews.

#### Adapt

- The team will go into the office and make calls from the organization's phone line.
- The team will trial a voice message text for younger patients, allowing the patient to respond on their own time and still maintain the integrity of the back-and-forth dialog. This provides time flexibility. West county needs to investigate with its IT department how to call out on a personal cell phone using a WCHC caller ID.

# How Did We Know the Changes Were An Improvement?

## What We Measured

### Measures Set

Measure Type/Name	Description/ Specifications	Baseline %	Target %
<b>Outcome (Directly related to the aim):</b>			
Hemoglobin A1c Control (< 9%)	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c (HbA1c) less than or equal to 9.0 percent during the measurement period.	62%	71%
Health center self-assessed performance in "Patient-Team Partnership" domain	Sum of PHASE health centers self-assessed scores in "patient-team partnership" domain divided by 10 (number of participating health centers)	6.95	8.6
<b>Process (Steps to achieve outcome):</b>			
Uninsured Comprehensive Diabetes Care (HbA1c Testing)	Percentage of uninsured patients 18-75 years of age with diabetes who had a primary care visit and hemoglobin A1c (HbA1c) test during the last 12 months.	93%	90%
Patients enabled in patient portal	Percentage of patients with a primary care visit during the month who have an enabled patient portal status	36%	38%

# How Did We Know the Changes Were An Improvement?

## What We Measured

### Measures Set

Measure Type/Name	Description/ Specifications	Baseline %	Target %
<b>Balancing (Unintended impact/consequence):</b>			
Uninsured nephropathy screening or evidence of nephropathy	Percentage of uninsured patients 18-75 years of age who had a diagnosis of diabetes with a recent nephropathy screening test or evidence of nephropathy	86%	84%
Total telehealth visits out of total primary care visits	Percentage of telehealth visits during the month out of all primary care visits	0%	40%

# How Did We Know the Changes Were An Improvement?

## Results: Run Charts

### Outcome

Uninsured Hemoglobin A1c Control (< 9%)  
(data is rolling year)



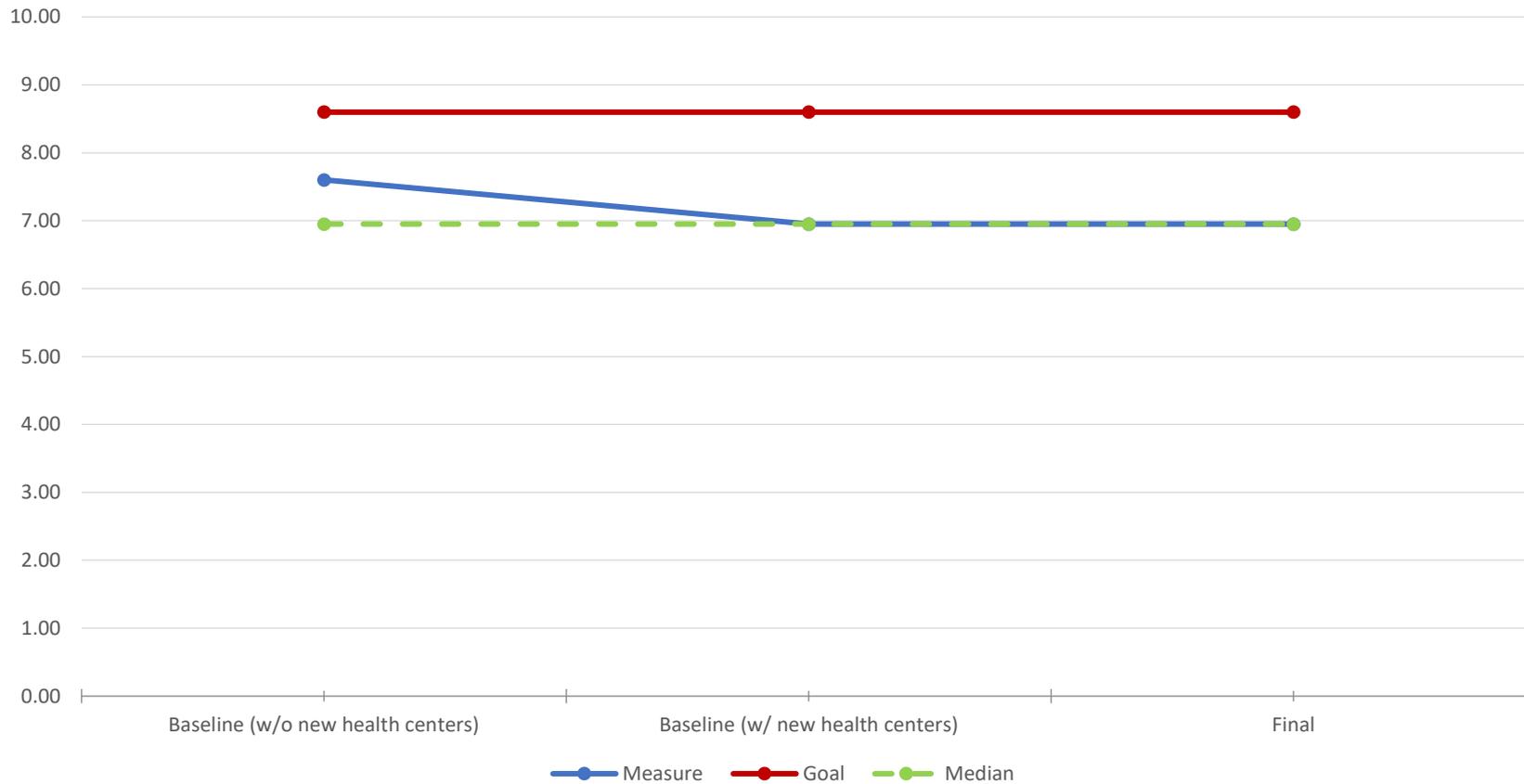
\*Data includes AMC and WCHC

# How Did We Know the Changes Were An Improvement?

## Results: Run Charts

### Outcome

#### Patient-Team Partnership Performance



\*Baseline data includes AMC and WCHC  
Final data includes only AMC, AVH, MCC, RC, SRCH

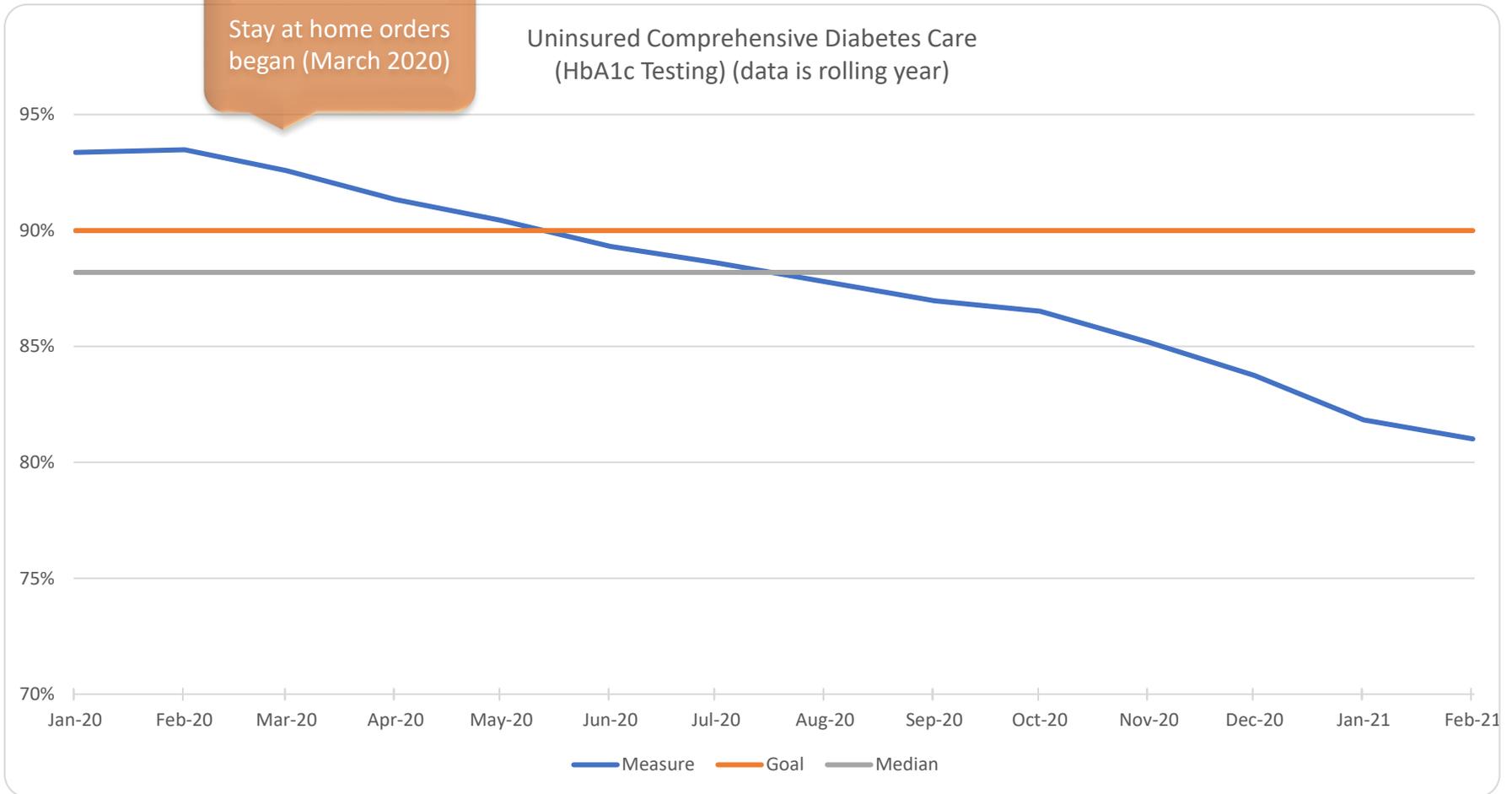
# How Did We Know the Changes Were An Improvement?

## Results: Run Charts

### Process

Stay at home orders began (March 2020)

Uninsured Comprehensive Diabetes Care (HbA1c Testing) (data is rolling year)

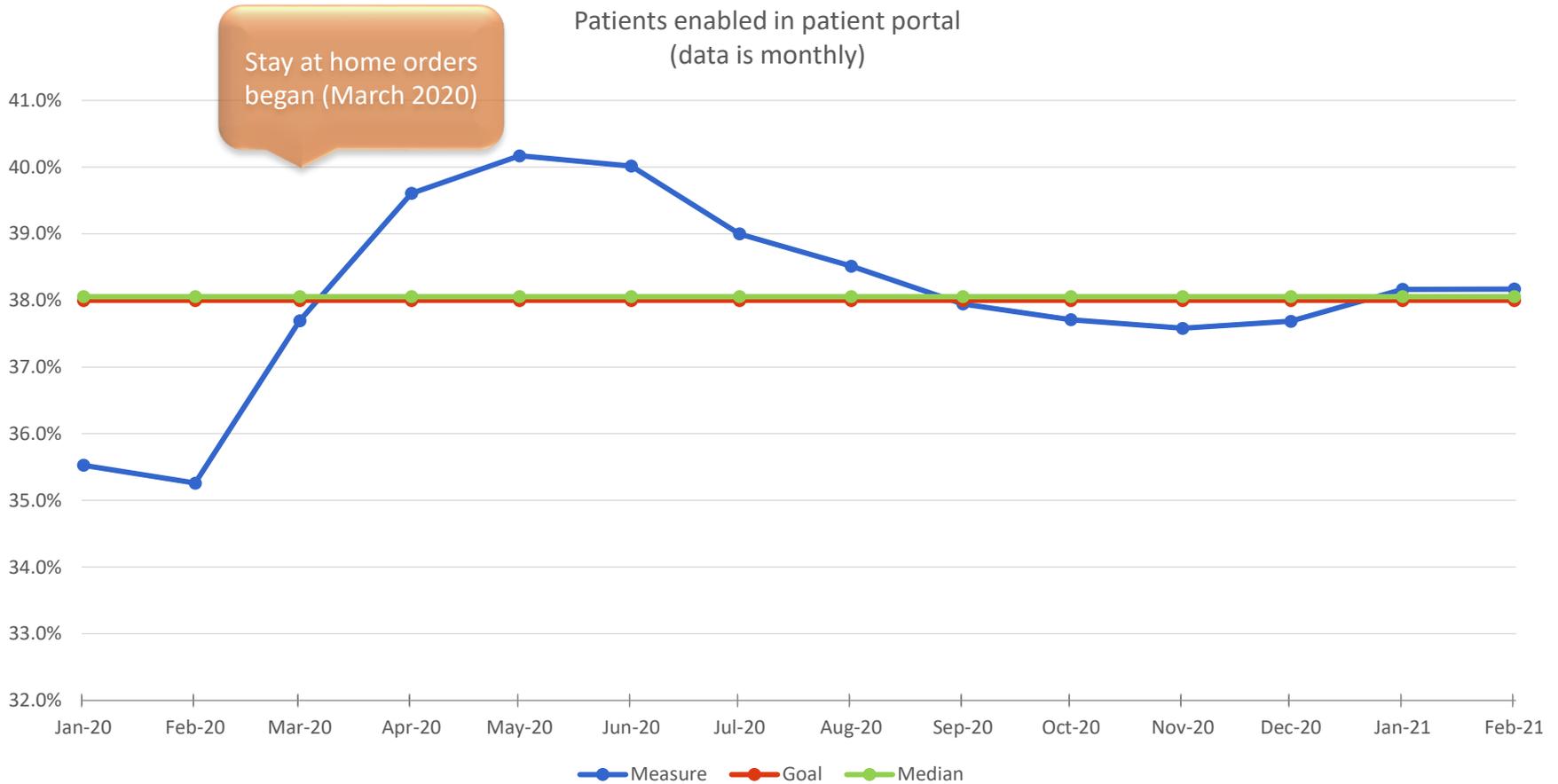


\*Data does not include AMC and WCHC

# How Did We Know the Changes Were An Improvement?

## Results: Run Charts

### Process

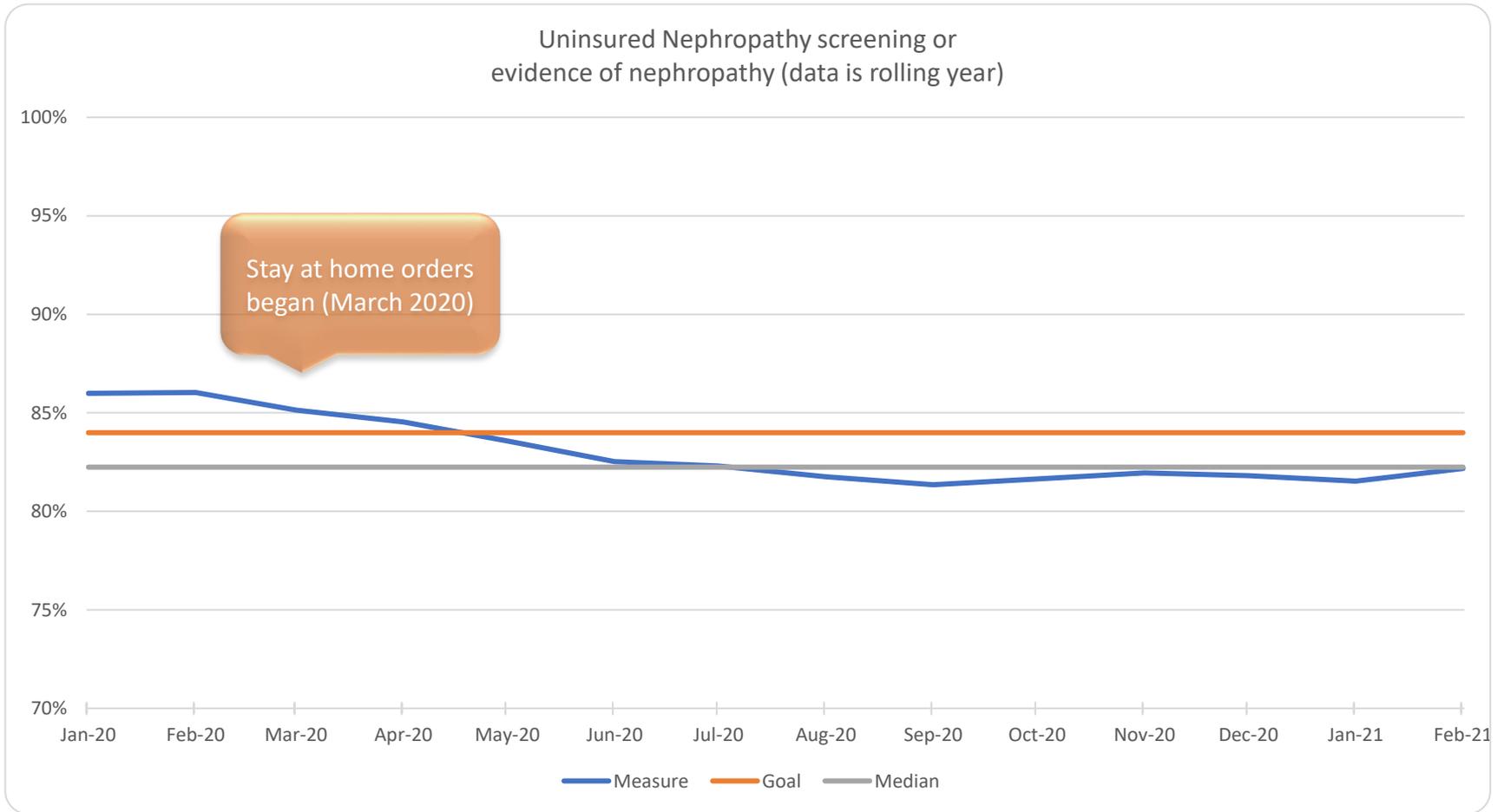


\*Data does not include AMC and WCHC

# How Did We Know the Changes Were An Improvement?

## Results: Run Charts

### Balancing

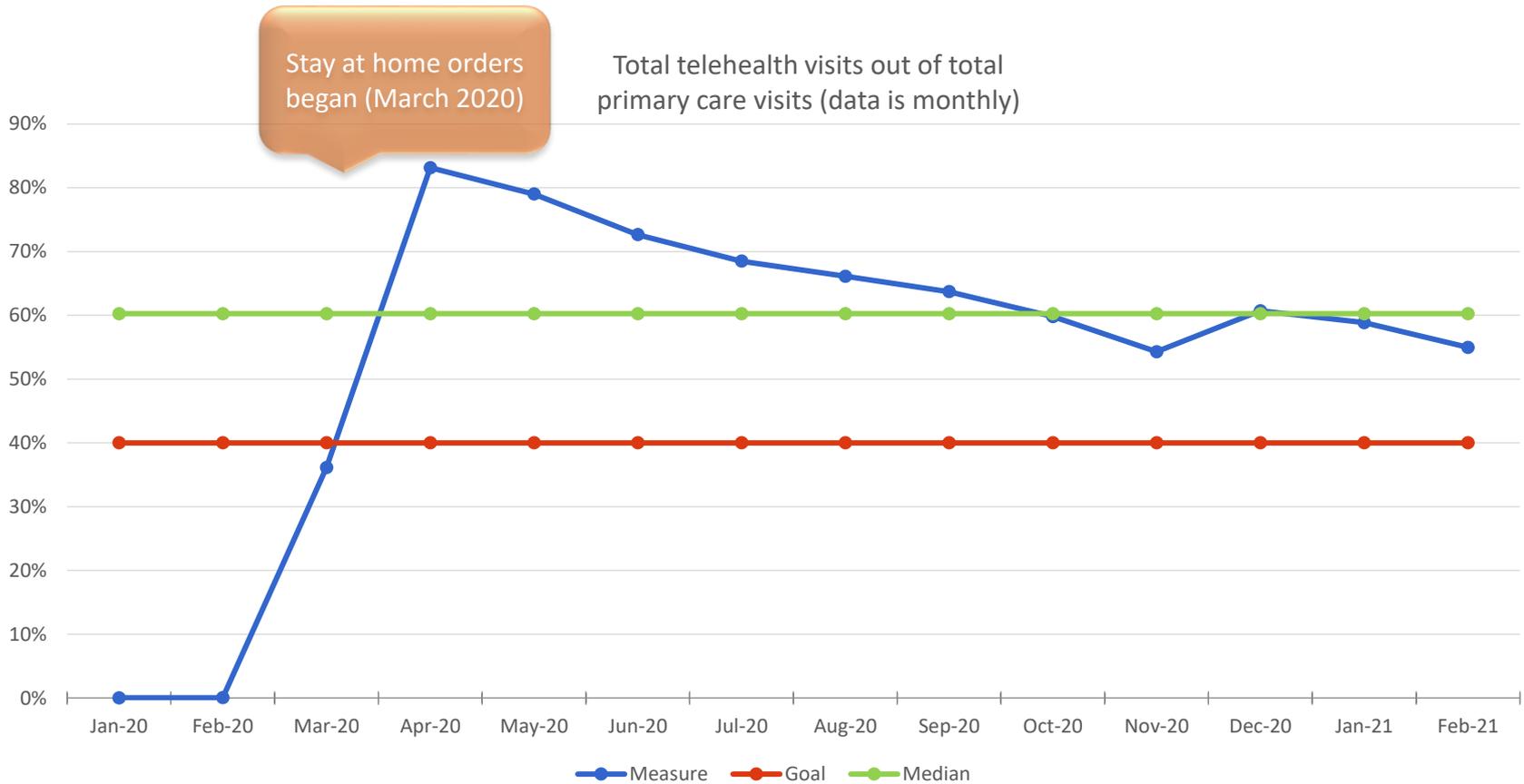


\*Data does not include AMC and WCHC

# How Did We Know the Changes Were An Improvement?

## Results: Run Charts

### Balancing



\*Data does not include AMC and WCHC.  
Data includes dental office visits and teledentistry.

# How Did We Know the Changes Were An Improvement?

## Here's What We Learned

### Bright Spots/Accomplishments

#### Bright Spots:

- Despite the pandemic, we were able to execute our PHASE workplan
- RCHC's PHASE team and health center PHASE teams were nimble and adaptable to everchanging situations
- RCHC convened telehealth workgroups and sessions for health centers to learn and share best practices

#### Accomplishments:

- Interviewed Kaiser Permanente Santa Rosa about their PHASE program
- Hosted three health center virtual quality tours
- Hosted quarterly PHASE Champion meetings
- Reported quarterly data
- Supported health center completion of baseline and final clinic assessments
- Hosted UCSF pharmacy student who provided health centers academic detailing on statin therapy
- Provided PDSA support and QI coaching during regular health center check-ins
- Published numerous QI Chat Room podcast episodes related to PHASE work
- Provided SMBP machine expense reimbursement to health centers for uninsured patients
- Offered two UCSF Advanced Management of Diabetes trainings for health center providers

# How Did We Know the Changes Were An Improvement?

## Here's What We Learned

### The Challenge of the COVID-19 Pandemic

The COVID-19 pandemic has challenged everyone in unique ways. For health centers it required them to switch operations to function remotely practically overnight. In addition to getting many staff members setup remotely, they quickly had to figure out how to implement telehealth visits (including workflows, billing, etc.) for all patients.

### Overall Challenges

Challenge	How We Overcame/Resolution
Remote work and telehealth	Work with IT departments to get staff setup remotely. Collaborate as a coalition to share best practices for implementing telehealth on a wide scale.
Declining staff wellness and availability	Providing opportunities for staff to socially connect (virtual dance parties), support personal COVID-19 challenges (e.g. family infection), allow flexible hours/workflows to accommodate new childcare needs.
Quality measures dropping	Switching from trying to improve measure performance, to trying to maintain pre-COVID rates. This is ongoing work.

# What's Next for PHASE/TC3?

## Here's How We Will Continue the Work

### SPREAD

RCHC will spread the implementation of virtual care, providing health centers support and resources related to telehealth. RCHC will spread the use of PDSA work in grant deliverables, as this was a successful way to incentivize health centers to conduct and document their QI work. Learnings from PHASE PDSA work will be spread throughout the RCHC network.

### SUSTAINABILITY

RCHC will sustain the PHASE Dropbox, Quality Culture Series meetings, documentation of promising practices, and recording QI Chat Room podcast episodes. These efforts have proved to be successful. RCHC will continue to support health center SMBP programs, food access programs and referral processes, clinical trainings, quality measures and more. RCHC will sustain our health equity initiatives as part of our Health Equity workgroup, track progress on quality measures through our QI Peer Network meetings, and continue our food security and nutrition work started through our February 2021 Food Champion roundtable.

### THE DESIRED FUTURE

- Aim Statement: To increase the rate of blood pressure and A1c control among health center patients to pre-Covid levels by March 31st, 2022 through bringing patients back into care.
- Problem Statement: The Covid-19 pandemic has caused all quality measures to drop across health centers. This is due to stay-at-home orders, patient fears of coming into clinic, and lack of virtual health connection due to low tech literacy among patients or living in a tech desert. Patients are also experiencing increased in food insecurity, chronic stress, and a decrease in physical activity levels. Health centers ultimately succeeded in converting in-person care to virtual, however this was an enormous lift and requires ongoing support. Health centers are now focused on the vaccine rollout, which is the current top priority.
- Key learnings from 2020:
  - Ask health centers what support and resources they need, then listen and provide that support and those resources.
  - Be flexible and open to changing to meet the needs of health centers.
- RCHC needs leadership to continue supporting the prioritization of this work to achieve the desired future, including dedicated staff time to work on cardiovascular and health equity initiatives.