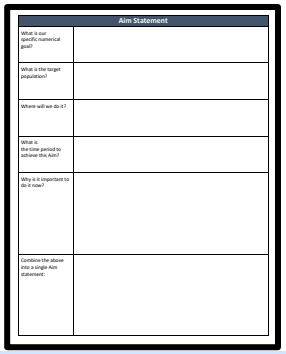
SC Communities Unite – Using Quality Improvement for Process Improvement

<table>
<tr><td colspan="4">As part of onboarding, clinic staff attend QI Boot Camp, led and facilitated by the American Cancer Society, to provide the foundation needed to work the QI process during the project.</td></tr>
<tr><td>QI Boot Camp (2- ½ days virtual training)</td><td><u>Purpose:</u> To provide an in-depth review of the quality improvement process with hands-on practice using QI tools.</td><td colspan="2"> 

 </td></tr>
<tr><td colspan="4">Monthly 1-hour Interactive TA sessions, led and facilitated by the CCPN team, are scheduled with individual clinics to provide a working QI session. Each step of the process is documented in LucidChart.</td></tr>
<tr><td>Aim Statement & QI Action Plan</td><td>Purpose: An <u>AIM statement</u> clearly defines a specific plan to improve a targeted quality improvement measure (Clinic CRCS rate) and guide your work by defining what success will look like for your clinic. The <u>QI action plan</u> provides a road map of planned efforts for the implementation of evidence-based interventions and process improvement.

Required Staff Attendance: Project lead, identified clinic lead and health system's leadership (CMO, COO, QI director)</td><td> 

We here at ECIM are focus on getting our entire clinic team to ID all Patients 50-75 and those with a family HX; to ensure screen for CRC are done at every appropriate visit. Educating all patient so that colon /rectal cancer has early detection and early treatment. ECIM goal is to increase screening by 5% (from 61% in 2020 to 66%).Hope for CURE.</td><td>Session Feedback:
>The key components that guided our team during the TA session was homing in on the purpose of the grant and the progress we wanted to see at each clinic. By talking through realistic goals, we wanted to achieve and everyone's involvement, it helped us to define our AIM statement and QI Action Plan.
>The Team did an excellent job of helping our office determine our goals for colorectal screening, what age group we wanted to target, and why that was important for our patient population. The use of the post-it notes was very helpful in piecing the AIM statement together.</td></tr>
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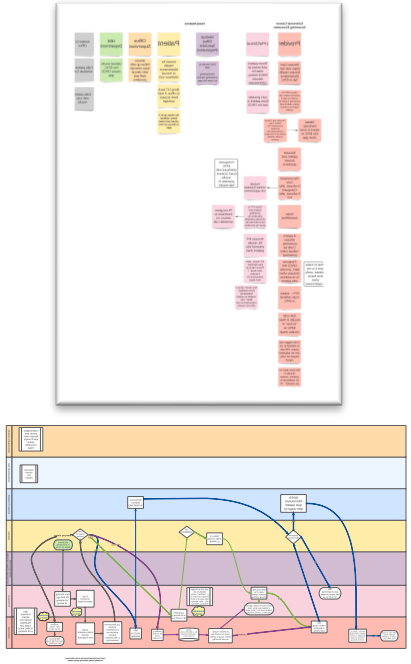
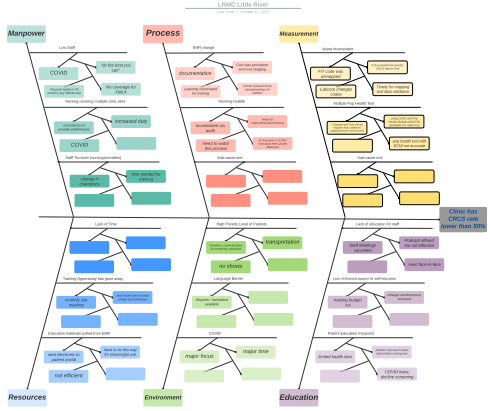
Current State Process Map	**Purpose:** Validate clinic's current state process map for CRC screening. Using a sticky note exercise in LucidChart, document a colorectal cancer screening patient encounter and identify clinic staff responsible for each step. These sticky notes will be converted into swim lanes to show process flow between clinic staff. **Required Staff Attendance:** All key staff involved in current CRC screening process. This could include but not limited to: front desk, referral specialists, CNA/MA, charge nurses, providers, lab representatives, office manager, caseworkers, QI and billing staff.		**Session Feedback:** >Having the LucidChart visual live and being built as we were on the call together was helpful. >Reviewing everyone's roles & responsibilities for CRC Screening. Also reviewing methods for identifying patients needing screening and how outreach is done.
Root Cause/Gap Analysis	**Purpose:** To determine the cause(s) of identified problem(s) that impact the CRC screening process to determine area(s)of improvement(s) at the clinic level. It can be considered root only if the final negative effect is prevented for good after the cause is removed. A fish bone diagram exercise will be facilitated in LucidChart. **Required Staff Attendance:** Staff representation from each department, including patient/Health System Board member (include staff attending clinic/health system QI meetings).		**Session Feedback:** >The TA Staff are always organized and send out meeting reminders about the focus of the TA session and key staff needed during the TA session. >It was helpful to have clinical staff and management staff in attendance to complete the fish bone diagram and identify root causes. >I feel like we just covered a lot of the clinic level issues and covid issues in this last meeting.

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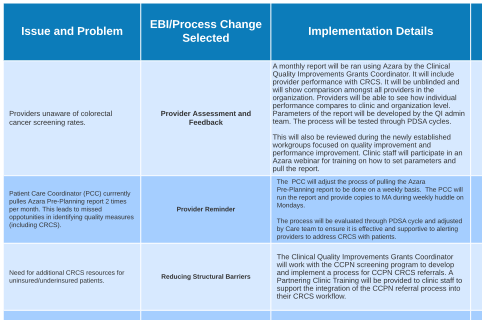
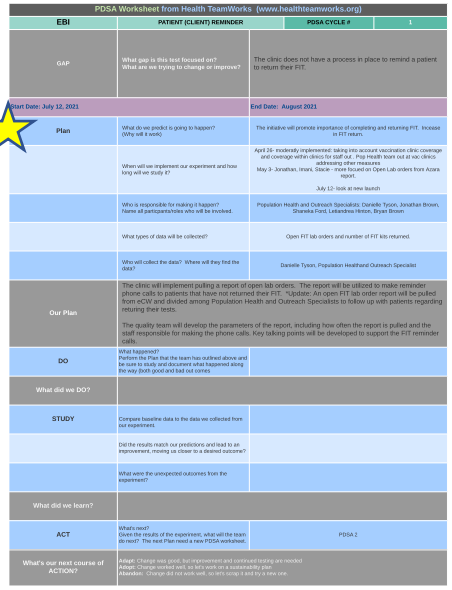
<table>
<tr>
<td>EBI Selection</td>
<td>Purpose: Improve performance and increase efficiency of clinic CRC screening process through implementation of evidence-based interventions.

Required Staff Attendance: All key staff involved in the clinic CRC screening process. This could include but not limited to front desk, referral specialists, CNA/MA, charge nurses, providers, lab representatives, office managers, caseworkers, QI and billing staff.</td>
<td>Eastover Family Practice
Lisa Scott | October 12, 2022
 
<table>
<tr><th>Issue and Problem</th><th>EBI/Process Change Selected</th><th>Implementation Details</th></tr>
<tr><td>Providers unaware of colorectal cancer screening rates.</td><td>Provider Assessment and Feedback</td><td>A monthly report will be ran using Azara by the Clinical Quality Improvements Grants Coordinator. It will include provider performance with CRCS. It will be unblinded and will show comparison amongst all providers in the organization. Providers will be able to see how individual performance compares to clinic and organization level. Parameters of the report will be developed by the QI admin team. The process will be tested through PDSA cycles.

This will also be reviewed during the newly established workgroups focused on quality improvement and performance improvement. Clinic staff will participate in an Azara webinar for training on how to set parameters and pull the report.</td></tr>
<tr><td>Patient Care Coordinator (PCC) currently pulles Azara Pre-Planning report 2 times per month. This leads to missed opportunities in identifying quality measures (including CRCS).</td><td>Provider Reminder</td><td>The PCC will adjust the process of pulling the Azara Pre-Planning report to be done on a weekly basis. The PCC will run the report and provide copies to MA during weekly huddle on Mondays.

The process will be evaluated through PDSA cycle and adjusted by Care team to ensure it is effective and supportive to alerting providers to address CRCS with patients.</td></tr>
<tr><td>Need for additional CRCS resources for uninsured/underinsured patients.</td><td>Reducing Structural Barriers</td><td>The Clinical Quality Improvements Grants Coordinator will work with the CCPN screening program to develop and implement a process for CCPN CRCS referrals. A Partnering Clinic Training will be provided to clinic staff to support the integration of the CCPN referral process into their CRCS workflow.</td></tr>
</table></td>
<td>Session Feedback: What key components drive your team for success?
Having the support of the CCPN team, knowing what reporting is available to us currently, and having great participation by our team members.</td>
</tr>
<tr>
<td colspan="4">Approved CIPS triggers clinics implementation of EBIs using PDSA cycles. Additionally, monthly CRCS rates are reviewed and validated by clinics to allow data to drive decisions. The following 4 Interactive TA sessions focus on PDSA cycles for each selected EBI. Monthly, the PDSA worksheets are reviewed and updated. In addition, the evaluation (CARE) team reviews the documents and provides feedback to guide discussion during the next TA session.</td>
</tr>
<tr>
<td>PDSA Cycle #1</td>
<td>Purpose: To test the impact of the evidence-based interventions being implemented on the clinic's CRC screening rate. The "plan" step will be built out in the PDSA worksheet in LucidChart.

Required Staff Attendance: All key staff involved in the CRC screening process. This could include but not limited to front desk, referral specialists, CNA/MA, charge nurses, providers, lab representatives, office manager caseworkers, QI and billing staff.</td>
<td>Fetter-Charleston
Lisa Scott | October 12, 2022
 
<table>
<tr><td colspan="3">PDSA Worksheet from Health TeamWorks (www.healthteamworks.org)</td></tr>
<tr><td>EBI</td><td>PATIENT (CLIENT) REMINDER</td><td>PDSA CYCLE # 1</td></tr>
<tr><td>GAP</td><td>What gap is this test focused on?
What are we trying to change or improve?</td><td>The clinic does not have a process in place to remind a patient to return their FIT.</td></tr>
<tr><td colspan="2">Start Date: July 12, 2021</td><td>End Date: August 2021</td></tr>
<tr><td>Plan</td><td>What do we predict is going to happen? (Why will it work)</td><td>The initiative will promote importance of completing and returning FIT. Incease in FIT return.</td></tr>
<tr><td></td><td>When will we implement our experiment and how long will we study it?</td><td>April 26- moderatly implemented: taking into account vaccination clinic coverage and coverage within clinics for staff out . Pop Health team out at vac clinics addressing other measures
May 3- Jonathan, Imani, Stacie - more focused on Open Lab orders from Azara report.

July 12- look at new launch</td></tr>
<tr><td></td><td>Who is responsible for making it happen? Name all participants/roles who will be involved.</td><td>Population Health and Outreach Specialists: Danielle Tyson, Jonathan Brown, Shaneka Ford, Lekendrea Hinton, Bryan Brown</td></tr>
<tr><td></td><td>What types of data will be collected?</td><td>Open FIT lab orders and number of FIT kits returned.</td></tr>
<tr><td></td><td>Who will collect the data? Where will they find the data?</td><td>Danielle Tyson, Population Healthand Outreach Specialist</td></tr>
<tr><td>Our Plan</td><td colspan="2">The clinic will implement pulling a report of open lab orders. The report will be utilized to make reminder phone calls to patients that have not returned their FIT. *Update: An open FIT lab order report will be pulled from eCW and divided among Population Health and Outreach Specialists to follow up with patients regarding returing their tests.

The quality team will develop the parameters of the report, including how often the report is pulled and the staff responsible for making the phone calls. Key talking points will be developed to support the FIT reminder calls.</td></tr>
<tr><td>DO</td><td>What happened?
Perform the Plan that the team has outlined above and be sure to study and document what happened along the way (both good and bad out comes</td><td></td></tr>
<tr><td>What did we DO?</td><td colspan="2"></td></tr>
<tr><td>STUDY</td><td>Compare baseline data to the data we collected from our experiment.</td><td></td></tr>
<tr><td></td><td>Did the results match our predictions and lead to an improvement, moving us closer to a desired outcome?</td><td></td></tr>
<tr><td></td><td>What were the unexpected outcomes from the experiment?</td><td></td></tr>
<tr><td>What did we learn?</td><td colspan="2"></td></tr>
<tr><td>ACT</td><td>What's next?
Given the results of the experiment, what will the team do next? The next Plan need a new PDSA worksheet.</td><td>PDSA 2</td></tr>
<tr><td>What's our next course of ACTION?</td><td colspan="2">Adopt: Change was good, but improvement and continued testing are needed
Adopt: Change worked well, so let's work on a sustainability plan
Abandon: Change did not work well, so let's scrap it and try a new one.</td></tr>
</table>
https://www.healthteamworks.org/sites/default/files/resource/PDSA%20Worksheet_2.pdf</td>
<td>Session Feedback: What key components drive your team for success?
>Additional staff were trained on the "Provider/Nurse Reminders" to increase usage of the PVP and CDSS gap in care alerts so that CRC screening can be discussed and offered. Some small increases in screening were noted at the sites doing PDSAs.
>Organizing what and who will be done as part of the PLAN of the PDSA</td>
</tr>
</table>

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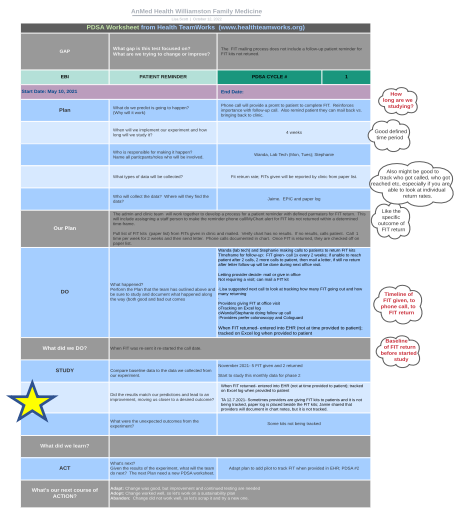
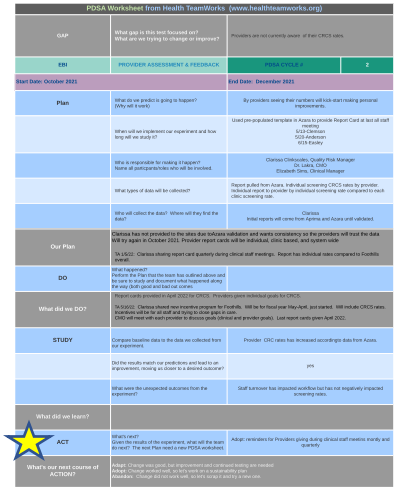
PDSA Cycle #2	**Purpose:** To test the impact of the evidence-based interventions being implemented on the clinic's CRC screening rate. Discuss and verify documentation on the "study" step of PDSA cycles. **Required Staff Attendance:** All key staff involved in the CRC screening process. This could include but not limited to front desk, referral specialists, CNA/MA, charge nurses, providers, lab representatives, office manager caseworkers, QI and billing staff.		**Session Feedback: What key components drive your team for success?** Reviewing and documenting measurable progress during the TA session.
PDSA Cycle- Status Outcomes/Review Analysis	**Purpose:** To test the impact of the evidence-based interventions being implemented on the clinic's CRC screening rate. Review PDSA cycle for selected EBIs. Discuss "act" of PDSA cycles. Determine if adjustments need to be made and move into next PDSA cycle. **Required Staff Attendance:** All key staff involved in the CRC screening process. This could include but not limited to front desk, referral specialists, CNA/MA, charge nurses, providers, lab representatives, office manager caseworkers, QI and billing staff.		**Session Feedback: What key components drive your team for success?** >Talked through report data (number of patients to contact) and what will be feasible given our current staffing and plan. Had to make some adjustments to our current thinking and pace or rate at which we can contact patients. It's good to do math! >Additional data will be pulled and reviewed to support the implementation of the EBIs

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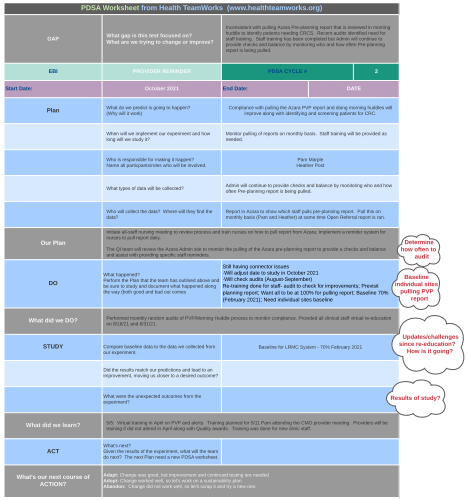
PDSA Cycle Status/Transition to Phase 2	**Purpose:** To test the impact of the EBIs being implemented on the clinic's CRCS rate. Discuss PDSA cycles and status of EBI implementation. Review data needs to evaluate EBI implementation. **Required Staff Attendance:** All key staff involved in the CRC screening process. This could include but not limited to front desk, referral specialists, CNA/MA, charge nurses, providers, lab representatives, office manager caseworkers, QI and billing staff.		**Session Feedback: What key components drive your team for success?** >Meeting and discussions concerning our PDSA. >TEAMWORK
In addition to the clinics attending monthly Interactive TA sessions facilitated by CCPN, clinics participate in a monthly learning collaborative (LC) facilitated by ACS. The LC brings all project partners together for peer to peer sharing on successes/challenges as well as share best practices focused on the project. As clinics transition from the initial year of the project, they move to quarterly TA sessions to allow for additional time to "work the process" and review data over time. BA deeper data dive is done with clinics to guide the potential for additional process adjustments/enhancements. These date points include: • Stool-based testing (FIT/Cologuard) return rate • Stool-based testing+ (FIT/Cologuard) to colonoscopy completion rate • Colonoscopy completion rate			