Organizational Description

Heartland Health Centers (HHC) is a Joint Commission (JC) and Primary Care Medical Home (PCMH)-accredited Federally Qualified Health Center (FQHC). Incorporated in 2005, HHC has built a network of 15 community, school, and integrated specialty sites that serve Chicago's north side. As an urban FQHC, HHC offers community-focused, affordable and comprehensive primary, behavioral health, and dental care to 24,000 patients annually, particularly low-income individuals, the uninsured, immigrants, and refugees. HHC also works to advance innovative service models, and patient-centered best practices in community health, and is nationally recognized for integrated primary and behavioral healthcare models.

HHC is part of a national network of FQHCs that serve 27 million patients nationwide, with a mission to care for vulnerable communities regardless of ability to pay. FQHC patients often have complex health issues with more barriers to care than patients in other primary care settings including poverty, language barriers, lack of insurance and other resources, low education and low health literacy levels. This leads to prescription misuse, inability to navigate the system, more hospitalizations, and less preventive care. Indeed, 90% of HHC's patients live in poverty, 81% are a racial/ethnic minority, 33% are uninsured, sixty plus languages are spoken overall, and 33% of patients preferred a language other than English.

Heartland Health Centers (HHC) envisions a transformative model of healthcare delivery in the primary care setting. This will be achieved through the creation of an *innovation center* at one of HHC's healthcare sites located in Chicago's Albany Park community, one of the most ethnically diverse areas of the country. The heart of our vision is a system where patient needs are at the center of care and where patients are empowered to better manage their own care. Project partners, like AllianceChicago (AC), will work with the healthcare team at the innovation center to reimagine the patient/care team relationship, redesign key interfaces in its information technology platform, and test strategies to achieve the quadruple aim to enhance patient experience, improve health outcomes, reduce costs, and increase the healthcare care team's "joy in practice", a group of metrics designed to measure provider burn-out and satisfaction.

What does your organization hope to accomplish as a participant in this learning and action network?

Our project's aim is to improve the quality and long-term sustaining health of our diabetic patients. To achieve this goal, we will rapidly test ideas for change, that we will adapt, adopt, or abandon, to implement proven changes with the goal of methodically spreading it as standard practice across all of HHC's locations of care. We will look to IHI, and our fellow learners within the action network, as partners to encourage an exchange of ideas and experience and to promote creative collaboration to incorporate all known (and yet-unknown) resources including technology, community, and patients-as-partners approaches to achieve this aim. Together, we can create an environment of constant improvement to achieve the quadruple aim.

We recognize that good human-centered design plays a significant role in how people interact with the designed product. Product, in this context, can be a process that addresses prescribing

patterns and the habits of the care team, as well as, adherence to the medication management plan by the patient. Products can also be educational materials that work in tandem with a patient's preferred self-care and management routine. We want to learn from, and share with the action network, how best to practically put the patient at the center of care design for improved medication adherence. For patients, who must navigate complex needs that are often complicated by co-morbidities like hypertension that add layers to their medication treatment plan, designing a patient-centered medication optimization product is vital in supporting their efforts to maintain the best quality of life as defined and determined by the patient.

Healthcare lags far behind in incorporating technologies that are commonplace in other industries, like finance and hospitality, to improve and enhance the customer experience, interaction, and perception of the service- providing organization. Only recently, as of June 12, 2018, did the Centers for Medicaid and Medicare (CMS) reverse their ban on linking continuous glucose monitor (CGM) with smartphones as a way for patients to manage their diabetes using an existing personal device to share their data with those who can support their efforts like their providers, care givers, and family members. In this scenario, the patient's need (and expressed want) to use their smartphone was heard by CMS policymakers and initially ignored. CMS's slow decision to allow the use of smartphones to manage diabetes is only one example of a delayed patient-serving enhancement in healthcare. This missed opportunity to improve patient care serves as a reminder to listen and engage with patients by putting their priorities at the center of the choices, decisions, plans, and strategies we deploy to intersect with patients' self-identified needs, wants, and goals for their health. We want to find ways to transform our practice to fully meet the spirit of a patient-centered medical home by focusing on our diabetic patients who need a coordinated effort from the different points of interaction they encounter in managing their medications.

We would find tremendous benefit in working together with experts, coaches, and being open to coaching and learning from, and with, our colleagues. We feel that the resources we would have access to through the action network makes thinking about tackling medication optimization for our diabetic patients conceivable, doable, and achievable. In addition, we believe we can contribute to the viewpoint of the underserved and underrepresented populations we serve to complement, and enrich, the learning to ensure that patients' social determinates of health are considered when optimization processes are planned for testing in the innovation center.

Does your organization plan to focus on a sub-population, such as patients with complex needs, co-morbidities, or multiple medications? (Note that we are particularly interested in applications that focus on these populations.).

For this project, we plan to focus on our diabetic patients at our Albany Park location. We have a high prevalence of diabetes at this site and a great need to utilize resources well. Additionally, diabetes frequently co-exists with other diseases such as hypertension and hyperlipidemia (among others), and the treatment of diabetes routinely requires multiple medications for control of glucose, cholesterol, and blood pressure.

We ask a lot of our diabetic patients—that they track their sugars and their blood pressure, take multiple medications often at least twice daily, change their eating habits, and that they exercise more. These demands a lot on a patient's lifestyle and often requires a change in habits, sometimes all at once. We believe that we consistently underestimate the difficulty patients experience to "comply" with their treatment plans, not to mention our patients who also suffer from depression, food insecurity, unemployment, or other psycho-social issues that can complicate the picture. We also believe that our participation in the Medication Optimization in Primary Care shared learning and action network will allow the HHC team to develop robust approaches to test diverse innovative change ideas for medication optimization: implementing patient-centered approaches to address medication safety and appropriateness, adherence, access, and communication of benefit risk. Ensuring we focus on all aspects of the patient's journey from initiation of treatment (or decisions to forego treatment), to follow-up, to ongoing review and support of their medication treatment plan, and coordination of care will allow our team to best address the needs of patients with complex needs, co-morbidities, or multiple medications.

The name of the medical or administrative leader who this team will be able to rely on to remove whatever obstacles may arise or to obtain necessary resources during the learning and action network?
Laurie Carrier, MD, Chief Medical Officer

Please list the names and titles of the three people most likely to participate in the learning and action network.
Gloria Mejia, CPhT, Manager, Community Health Center [Heartland Health Center, Albany Park]
Jeff Panzer, MD, MS – Medical Director, Quality & Innovation [Heartland Health Center, Albany Park]
Jin Nam, RN, MS – Director of Practice Transformation [AllianceChicago]

Describe the QI experience of the team members. In a brief paragraph, describe a recent improvement project undertaken by the team member(s), including the project design, measurement strategy, and any results.
Gloria Mejia, CPht, is currently completing her bachelor's degree in Health Care Administration. She is certified through the Pharmacy Technician Certification Board and has a basic certificate in quality and safety from the IHI open school. Gloria has worked as a pharmacy technician in inpatient and outpatient settings for over a decade.

Jeff Panzer, MD, is a practicing Family Physician and has a master's degree in healthcare quality and patient safety, has completed the IHI open school modules, and has attended three IHI conferences including the Innovation Manager Training Program. Jeff also served as Medical Director of Quality Improvement at Oak Street Health where he led several improvement initiatives.

Jin Nam, RN, MS, has extensive quality management experience, using the DMAIC (an acronym for Define, Measure, Analyze, Improve and Control) model for improvement at an academic medical center's surgical services department between 2004-2014. Some of her projects included: an implant inventory management project [outcome: a budget-neutral $2 million stagnant-to-needed inventory exchange over 6 months]; a pilot staffing and scheduling model to align with operational needs [outcome: 64% reduction in staff overtime and a $56K immediate savings on unnecessary overtime]; a redesigned nursing orientation plan [outcome: training time reduced by 50%]; a pilot of standardized instruments and supplies used by surgeons for procedures [outcome: a supply cost reduction of $100K and expanded time for case preparation by teams was reduced by 67% while processing cost was reduced by $24K annually, This project was implemented and spread across multiple teams]. In her current role at AllianceChicago, she works with multiple Chicago health centers, including Heartland Health Centers, to support their QI work using the IHI quality toolkit and a PDSA approach as the standard method of testing improvement ideas. She is currently completing her Graduate Certificate program in Innovation and Implementation Science [completion date August 2018] at Indiana University Purdue University Indianapolis (IUPUI) and received a scholarship from the National Association of Community Health Centers (NACHC) for a one-year access to the IHI Open School.

Jeff and Gloria also worked together at Iora Health, a private ambulatory care company, on medical record request process improvement where they improved the “release of information form” and the process for requesting, receiving, and reconciling the prior medical records into the current chart. For these projects, they created a project charter using the model for improvement and conducted PDSA cycles. Another project at Iora Health addressed lab ordering process improvement with the goal of reducing variability amongst users (health coaches and providers) in the process and the team was able to get to >90% consistency in the process across the clinic after 2 months and several PDSA cycles.

In addition, Gloria, Jeff, and Jin are currently working on a visit intake process improvement project where the intent is to minimize waste, and maximize value-added activities, when medical assistants are rooming patients at the start of an office visit. The team is using the IHI Quality Toolkit for this project and has seen dramatic improvements to date.

Thank you very much for considering our application. Please contact us should you require any additional information about Heartland Health Center or AllianceChicago.