Roadmap to
HEALTH EQUITY

Peer Learning Network

- We'll get started in just a moment.
- Please make sure you are on mute unless you are speaking.
- We will have time for questions at the end, but feel free to type a question into the chat any time.
- If you'd like to ask a question or make a comment, please use the "raise hand" function.

Roadmap to HEALTH EQUITY

Cohort 2 Capstone Presentations

September 26, 2025 | 12:00pm ET

americares | LOYOLA UNIVERSITY CHICAGO | NAFC

Disclaimer: This presentation is for educational and general informational purposes only. Nothing in this presentation should be construed as medical or legal advice/opinion. Please seek legal or other professional advice with respect to your own particular situation.


Hello!
My name is
• Your name
• Your clinic
• Location (City/State)

In this session we will…

Celebrate you!

What are we trying to accomplish?

How will we know that a change is an improvement?

What change can we make that will result in improvement?

americares

Gap Analysis Worksheet

Use this worksheet to help you identify quality improvement efforts for your practice. Discuss gaps and identify solutions that you can test with a PDSA cycle.

Preliminary Questions:

To identify areas for improvement, consider asking these questions.

Where does your clinic need to improve patient care?

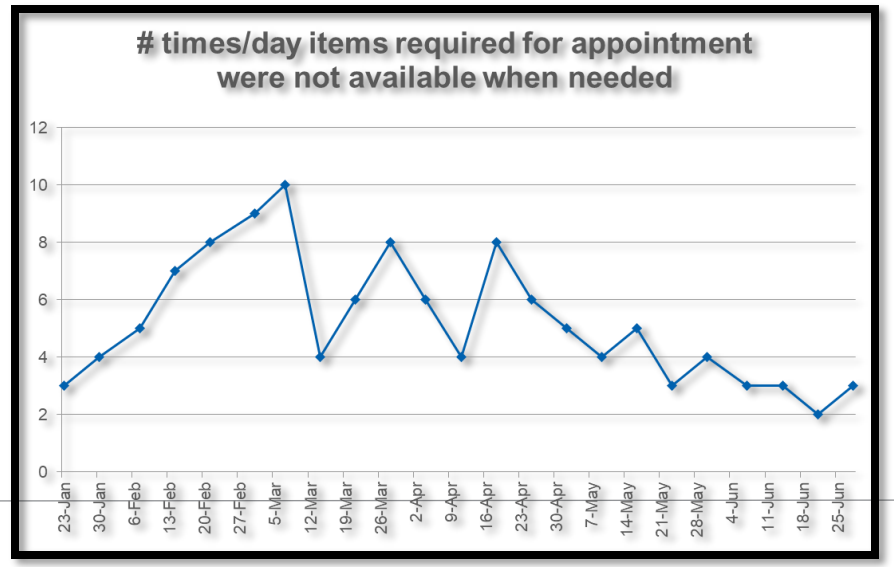
The clinic may already collect data that can reveal gaps in care processes or patient outcomes.

Where is your practice less efficient than it should be?

Staff may be able to identify bottlenecks in the workflow. Prioritize those areas that you have some control over and that the team thinks will be most impactful. Use a "go and see" approach of respectfully observing the work and then asking "why?" A team member can help identify key areas for workflow improvement within the bottleneck.

What about the day is most frustrating for your team and/or patients?

Ask patients and staff. This will generate a list from which you can prioritize areas for improvement.



Presentation Breakout Groups

Breakout Room 1 w/ Mara	Breakout Room 2 w/ Christina	Breakout Room 3 w/ Binta	Breakout Room 4 w/ Ashley
Free Clinic of Culpeper	St. Martin's Healthcare	Chesapeake Care	Charis Health Center
Community Free Clinic	Shifa Free Clinic	Neighborhood Health Clinic	Culmore Clinic
CarePoint Clinic	Beersheba Springs Medical Clinic	Univ of AZ Mobile Health Program	Urban Ministries of Wake County
Friends In Need Health Center	Palmetto Community Health Care		

8 min presentation and 2 min for questions.

Group 1

- Free Clinic of Culpeper
- Community Free Clinic
- CarePoint Clinic
- Friends In Need Health Center

Team Name:

- The Free Clinic of Culpeper

Our clinic

- The Free Clinic of Culpeper was started in 1992 by a group of concerned physicians who recognized that some patients who were uninsured and struggling financially needed an option for healthcare. Today our clinic, which operates with a staff of 7 paid employees and a few dedicated volunteers, is open 4 days a week. Uninsured individuals, who are 18 or older, live in Culpeper County and meet income guidelines are certified annually to receive free healthcare and medications- as well as free imaging and lab work through UVA Hospital. Our Clinic provides a variety of supportive services including Social Determinates of Health (SDOH) screening, Food Pharmacy and education. In 2024, we served 742 unduplicated patients, 90% of who are Spanish speaking.

Our team and Aim

Our Team aims to improve our patient's overall health and long-term outcomes by working to address SDOH, decrease barriers, provide resources, as well as high quality care and medications.

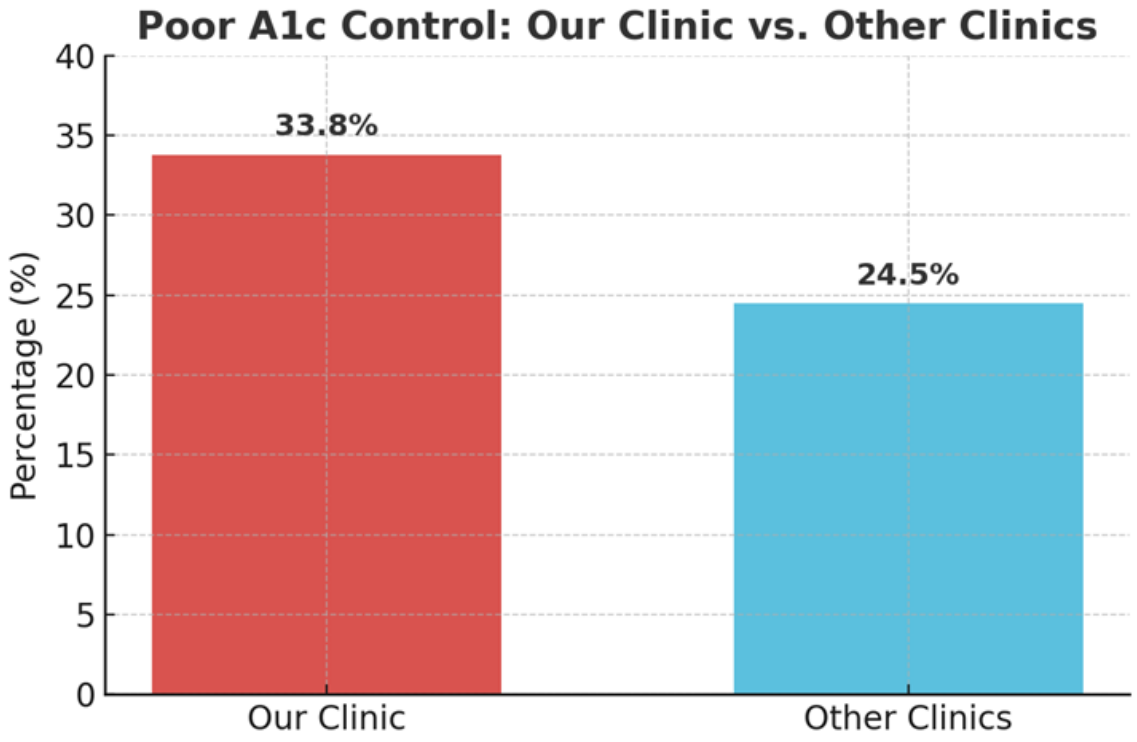
Role	Team member name
Team Lead	Tammy LaGraffe Director
Clinical Champion	Becca Buncie RN, BSN Patient Care Coordinator
Data lead	Tammy LaGraffe

Understanding the issue

- Diabetes management remains one of our most urgent priorities, with nearly one-third of our patients living with this condition.

Poor A1c control: 33.8% at our clinic vs. 24.5% at other clinics

(Americares Benchmark Report)



Changes we are testing

- The difficulty with measuring Outcomes is the tendency for slow measurable changes in A1c levels. Outcome improvement also involves the consistent compliance with medications and treatment by the patients. We chose to look at process measures to make sure we are doing everything we can to provide the best practices and care while encouraging compliance through education.

Measures:

Outcome Measures:

Identification of a cohort of 23 patients experiencing the greatest severity of illness.

Monitoring A1c levels over time to determine the impact of process measures and identify the most effective combinations.

Process Measures:

12 measures/Interventions

- **A1c monitoring**
- **Blood Glucose monitoring supplies**
- **Diabetes medications**
- **Social Determinates of Health screening (SDOH)**
- **Diabetes education with Clinic nurse**
- **Diabetes Education with UVA**
- **Fitscripts (Medical Exercise program)**
- **Endocrinolgy referral**
- **Eye exam Referral**
- **Podiatry Referral**
- **Food Pharmacy education and food**
- **Flu shot**

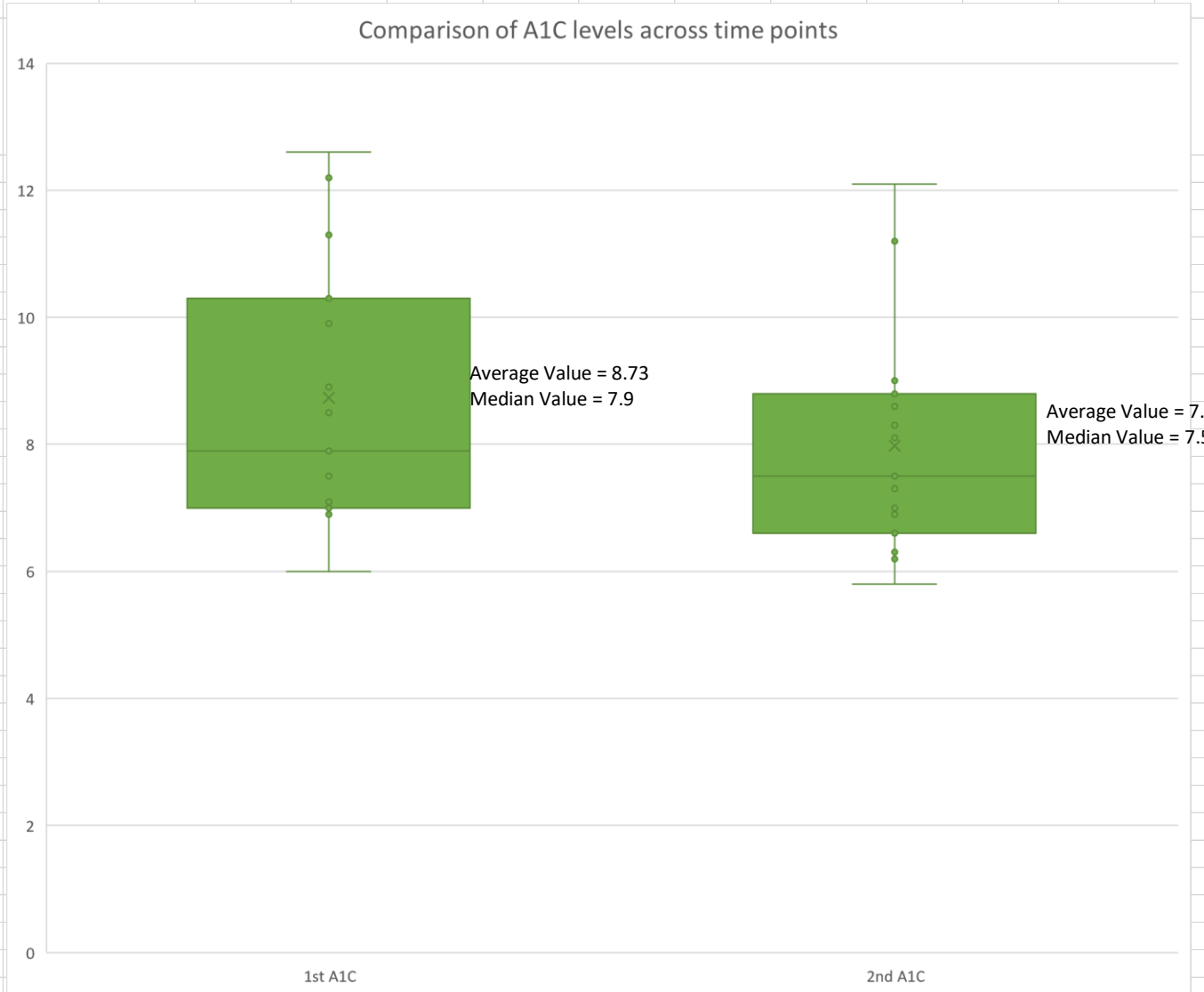
Data – Cohort of 23 patients diagnosed with Diabetes

- **What we have learned so far:**

Of the 15/23 patients who have at least 2 A1c results:

- **Improved A1c**: 9 patients (~60%)
- **Stable A1c**: 2 patients (~13%)
- **Worsened A1c**: 4 patients (~27%)
- Effective control depends on multiple factors, including medication adherence, language access, health literacy, dietary habits, and cultural considerations.
- Tracking A1c levels shows encouraging signs of improvement.
- SDOH screenings help us identify barriers and develop strategies to overcome them.

8.5

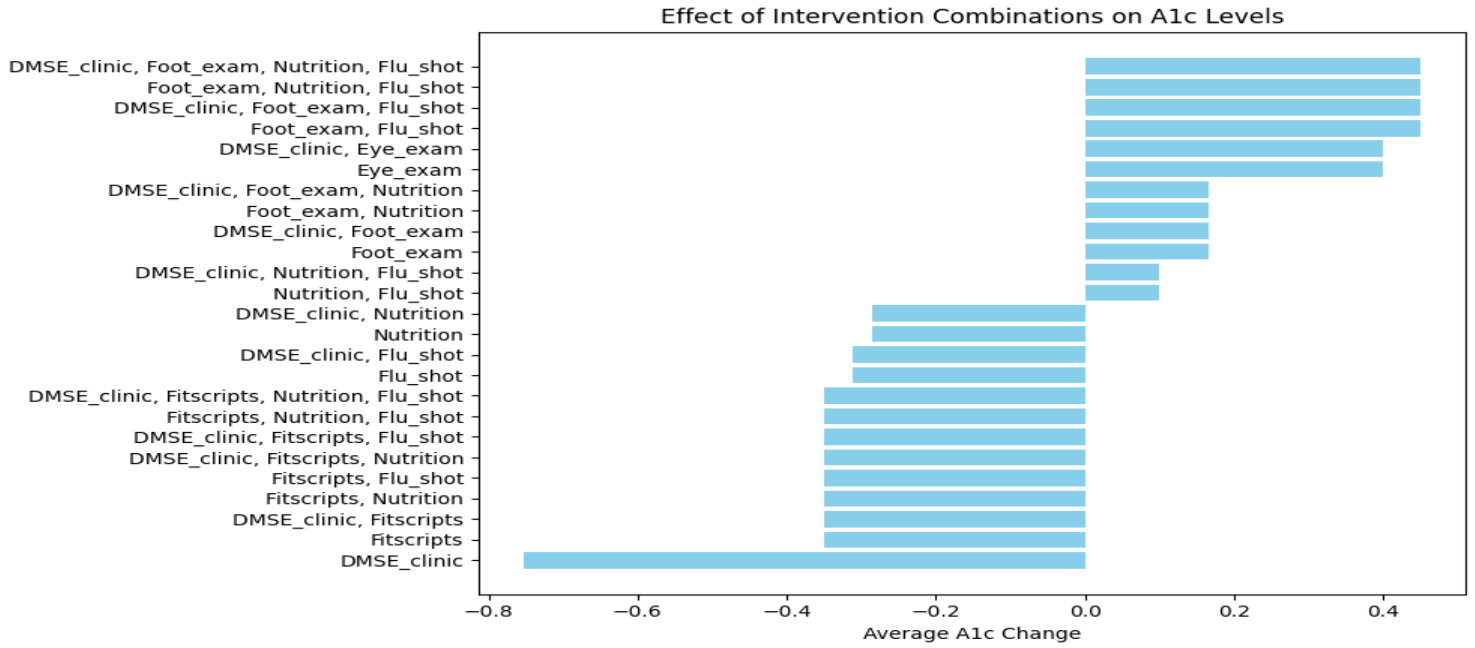

Comparison of A1C levels across time points
14
12
10
8
6
4
2
0
Average Value = 8.73
Median Value = 7.9
Average Value = 7.98
Median Value = 7.5
1st A1C
2nd A1C

Next Steps

- Continue to track A1c levels and interventions
- Analyze patient engagement
- Adjust strategies to improve care, outcomes and equity.

Lessons learned

- A combination of interventions has shown some improvements.
- As is usually the case, these improvements show dependence on the relationship to the patient's engagement in treatment, medication compliance and ability to follow through, which is also strongly affected by SDOH.



The Community Free Clinic

Concord, NC

Located 26 miles northeast of Charlotte

Our clinic

- 1061 patients in HealthNet Cabarrus, for which our clinic is the “hub”
  - Of these, 678 are seen in our facility.
  - 76% of all patients in our system are non-English speaking.
  - Primary health concerns include diabetes, hypertension, and increasingly behavioral health.

Our team and Aim

Role	Team member name
Team Lead	Penny Aronson
Clinical Champion	Karen Chow RN BSN
Data lead	Gaby Bussiere

- Our project was to examine what we could do to better outcomes for our patients with diabetes.
- *Diabetes treatment outcomes have been a long- term focus for our clinic, and previously we have had in-depth data analysis by a PharmD (a volunteer).*

In discussion with our providers, we found our patients have difficulty following through with self-management

Understanding the issue

Anecdotally, as well as through a review of patient records, we found that we do well with maintaining a consistent follow up schedule of office visits, A1C and A/C ratio rechecks, foot exams, and retinal exams (photos).

What was lacking was motivation and mutual goal setting to encourage our patients to maintain or improve their health through diet, exercise, and other modalities.

Changes we are testing

- We have used Lifestyle Medicine for over 5 years. The grant ended and the nutritionist we shared with another agency was reassigned just as we started this project. The in-depth teaching was not available starting in mid-April. Our MedServe fellows currently provide health coaching as we work to reevaluate our needs.
- Our patient demographic shifted in those same 5 years. We saw a need to adjust our educational materials to include other cultures, as well as provide interpreters to assist with education sessions.

Your measures

Outcome Measure

- *Decreased A1C levels (overall goal <7, initial goal of <9)*
- *Stable annual diabetic eye exams*
- *No diabetic foot ulcers or amputations*

Process Measures

-Percentage patients referred for health coaching (includes diet, exercise, coping skills)

-Percentage patients who attend at least one session

-Percentage of patients who provide food and exercise logs showing progress on self-determined goals for food choices and increased activity

Next Steps

- Nutrition intern from UNC-C working with our two MedServe fellows on a cookbook focusing on foods our patients normally enjoy at home but presented in a more healthful manner.
- Community partners providing small group sessions for yoga, mindfulness, generalized discussions on increasing activity at home with demonstrations.
- Reexamine our food pharmacy distributions and whether they should be linked to class attendance.
- We have always had diabetes management as a top concern for our patients. Continue to research ways to increase patient buy-in to take better care of themselves and thus have fewer comorbidities.

Lessons learned

- It is difficult to re-think how you have been managing a disease process and provide the tools for patient success while being mindful of cultural influences, language barriers, and a patient's personal biases. Managing all of that in a low-income population with limited resources is even more challenging.
- Documenting the information on each patient in a way that allows for relatively easy, clean reporting can provide its own challenges.
- Have more frequent check-in sessions among project staff so everyone is prepared to carry the load if someone is unable work as planned.

CarePoint Clinic

- Fall City, WA

Our clinic

- CarePoint Clinic is a small, rural clinic serving patients in the Snoqualmie Valley- located about 30 miles east of Seattle
- We have recently added a mobile clinic which has given us the freedom to host clinics directly to the residents of the small towns of our community
- The last few years have seen incredible growth in our appointments: 150 appts in 2023, 480 appts in 2024 and already 475 for 2025
- Our data collection and quality improvement areas have fallen behind with this rapid growth so we are taking one focus at a time to slowly implement large scale change

Our team and Aim

Depression Screening Follow Up

We would like to have at least 50% documented follow up for any PHQ4 out of range. We will increase our chart reviews and staff screening procedures to maintain our projected 100% screening compliance and add extra steps for documented follow up recommendations. We will achieve at least 50% documented follow up by December 31, 2025.

Role	Team member name
Team Lead	Misty Messer, Executive Director
Clinical Champion:	Andrea Pitman, Clinic Manager
Data lead	Misty Messer

Understanding the issue

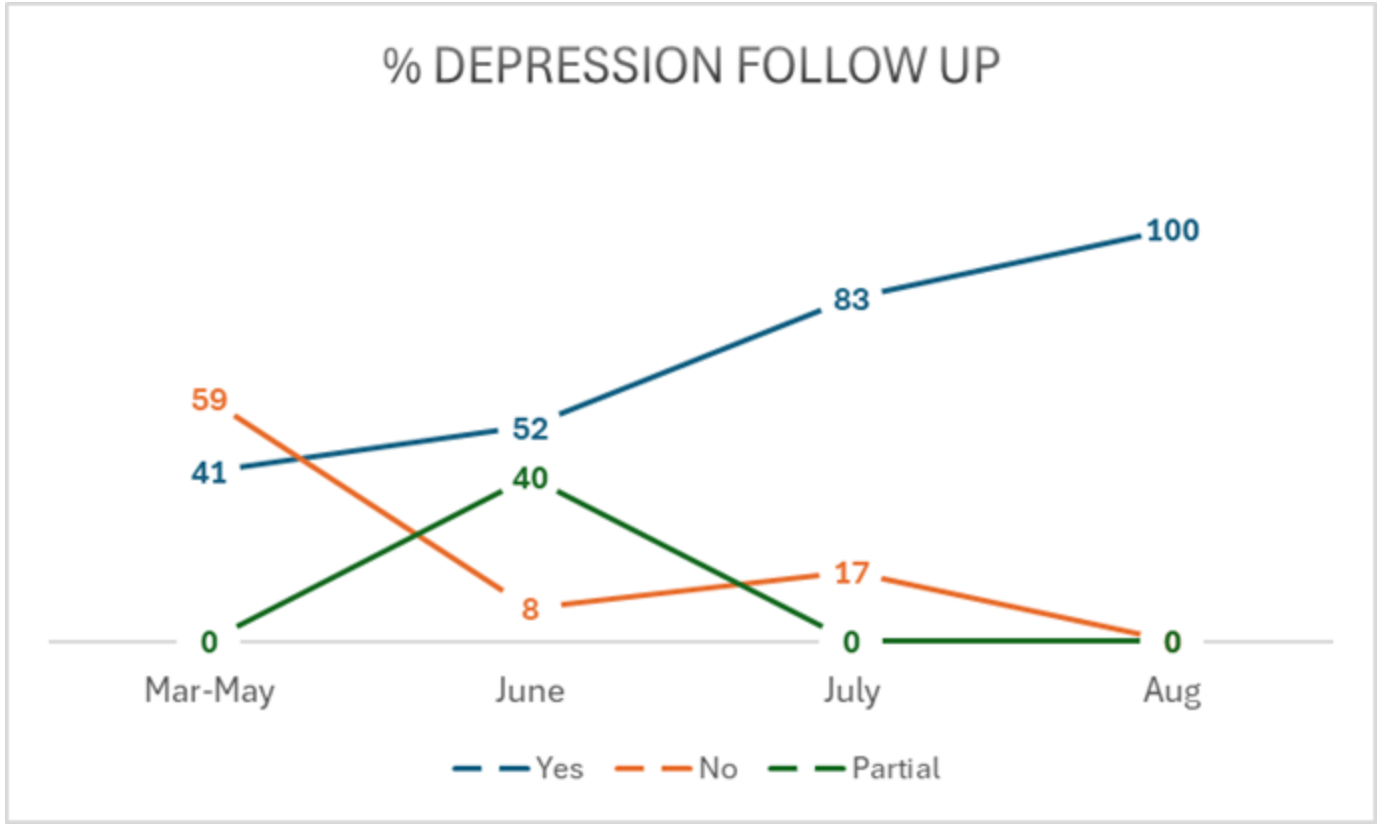
- Our clinic runs entirely on volunteer medical providers and nurses. We have found that the lack of consistency and continuity in medical staff leads to gaps in the screening process. There was a wide range of compliance and comprehensive charting
- Our goal was to start small in coaching and training our volunteers
- We currently do depression screening at every single appointment so now we just needed to add the next level of charting and follow up
- One other issue we have found is the lack of funding and staffing to support the data collection requirements of our increased appointment totals

Changes we are testing

- Data collection on a monthly basis
- Training of medical staff to improve charting
- Utilizing our regular weekly staff to provide that consistent training to every volunteer
- Closer monitoring to determine if more changes are needed

Data

- We pulled data from before we started the project (Mar-May) and then monthly through the process
- We tracked “Yes” meaning there was follow up charting; “No” meaning there was none; and “Partial” meant there was incomplete charting or not up to the standard we hoped



Next Steps

- Our next steps will be to maintain the new standard we have established and continue to increase training and consistency with new volunteers
- We would like to also start tracking our follow through with charted advice or steps. Currently we do not have a process to ensure those who need additional support are able to access that support.
- Our staff will continue to focus on our depression screening and follow up because we know how important mental health follow up can be for overall health
- Our long term goal will be to apply the PDSA to other areas in our clinic that need additional data quality improvement

Lessons learned

- Our biggest and most important lesson is that changes do not have to be huge or all at once
- It is okay to start small (just like our clinic!) and work toward proficiency in each small change before adding or moving to another change
- Our team was more receptive to the changes than we thought- sometimes we assume our volunteers will not adapt to changes because they are not here every week or this is just their side job…but they surprised us with their willingness and excitement to improve our clinic in small ways


FRIENDS
IN NEED
HEALTH CENTER

- Opened in 1995 in the Greater Kingsport area of Northeast Tennessee
- Serves **eight counties** in Northeast Tennessee and **three counties** in Southwest Virginia

FRIENDS IN NEED TEAM & AIM

Team Aim: Develop and implement streamlined workflows to train clinical staff on consistent data collection during encounters for comorbidities, such as BMI, blood pressure, and PHQ-9, ensuring accurate and standardized reporting to improve patient outcomes.

SERVICES

- Primary Medical Care
- Dental Care
- Pharmaceutical Assistance

2024 TOTAL PATIENTS

ENCOUNTERS
5,952
+ 1,400 FROM 2023

MEDICAL
2,262
+ 600 FROM 2023

TELE-MED
978
+ 600 FROM 2023

DENTAL
3,690
+ 1,100 FROM 2023

2025 GOALS

ENCOUNTERS

7,700

MEDICAL

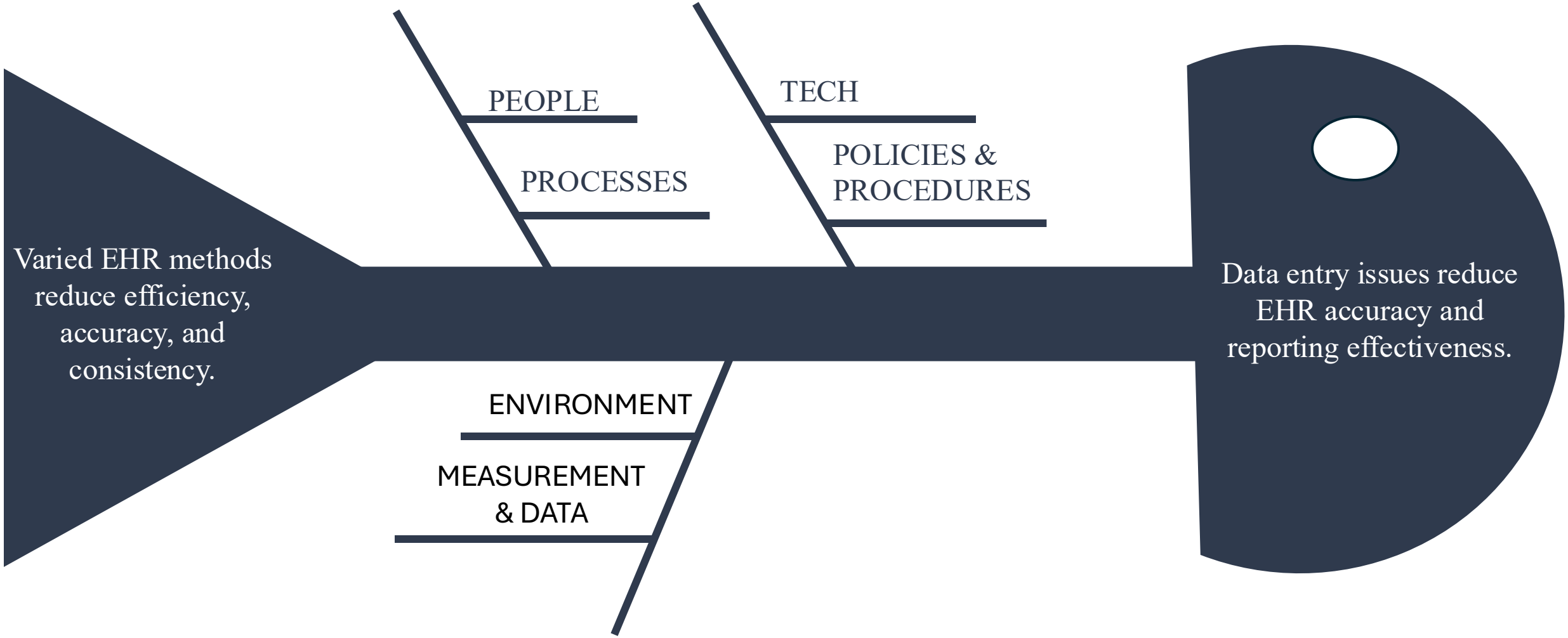
2,450

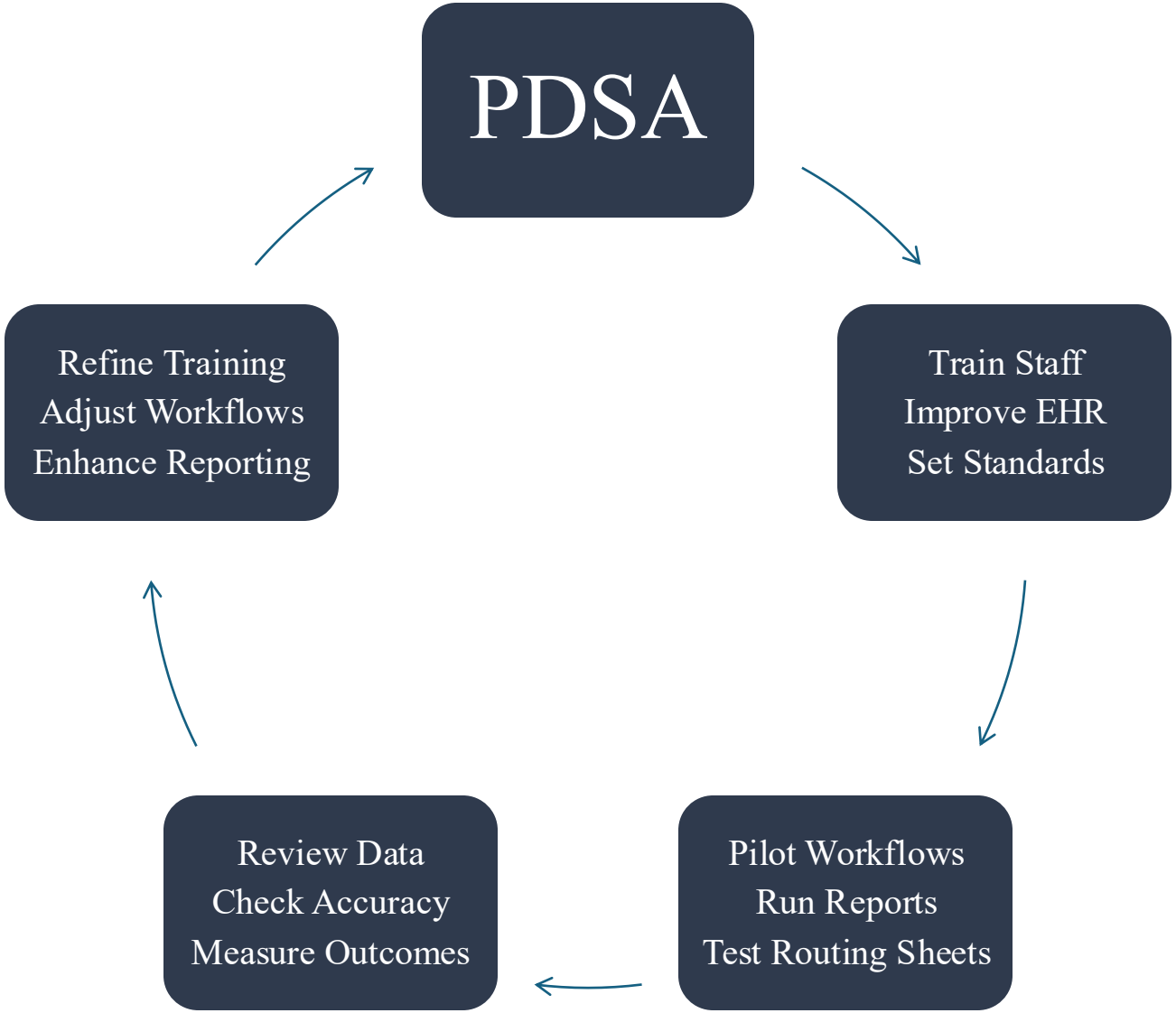
TELE-MED

1,050

DENTAL

4,200


Varied EHR methods reduce efficiency, accuracy, and consistency.
PEOPLE
PROCESSES
TECH
POLICIES & PROCEDURES
ENVIRONMENT
MEASUREMENT & DATA
Data entry issues reduce EHR accuracy and reporting effectiveness.


PDSA
Train Staff
Improve EHR
Set Standards
Pilot Workflows
Run Reports
Test Routing Sheets
Review Data
Check Accuracy
Measure Outcomes
Refine Training
Adjust Workflows
Enhance Reporting

CONTINUED IMPROVEMENT AREAS

Continue addressing deficiencies by improving workflows to enhance employee reporting in the EHRs.

We customize EHR fields to capture key clinical data, enabling quicker and more accurate reporting and improving overall effectiveness.

Continue training on clinic documentation policies and procedures, and regularly evaluate workflows to identify and address areas for improvement.

Perform routine data downloads while assessing EHR reporting enhancements for accuracy, efficiency, and alignment with clinic needs.

Evaluate data to confirm it promotes consistent care delivery and measurable health improvements for patients.

Group 2

- St. Martin's Healthcare
- Shifa Free Clinic
- Beersheba Springs Medical Clinic
- Palmetto Community Health Care

St Martin’s Healthcare

St Martin’s Healthcare is in rural Garrett, Indiana.

Our Clinic

St Martin’s Healthcare provides quality medical, dental, vision, behavioral health, advocacy services, and medication assistance to bridge the gap in healthcare for uninsured and under-insured residents of DeKalb, Noble, Steuben, and LaGrange counties.

St Martin's Healthcare and Aim

- What was the Aim of your project?

We aim to see the A1c results of new patients decrease to 9 or less. New patients usually come into the clinic undiagnosed or without access to healthcare and medications. New patient A1c levels are usually double digits. The goal is to create this process and begin to see results by May 2025. We will begin to assess outcomes by September 2025.

Role	Team member name
Team Lead	Destiney Douglas
Clinical Champion	Michelle Haynes
Data lead	Destiney Douglas, Grace Denny, Sharon Brososky

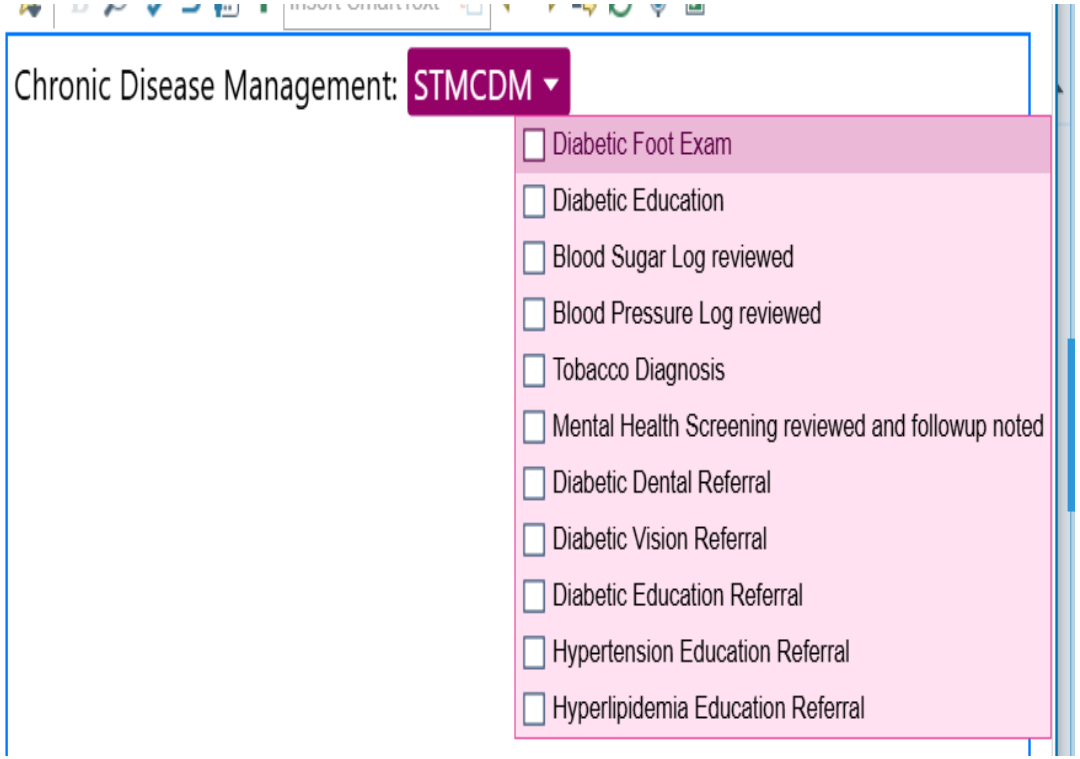
Understanding the issue

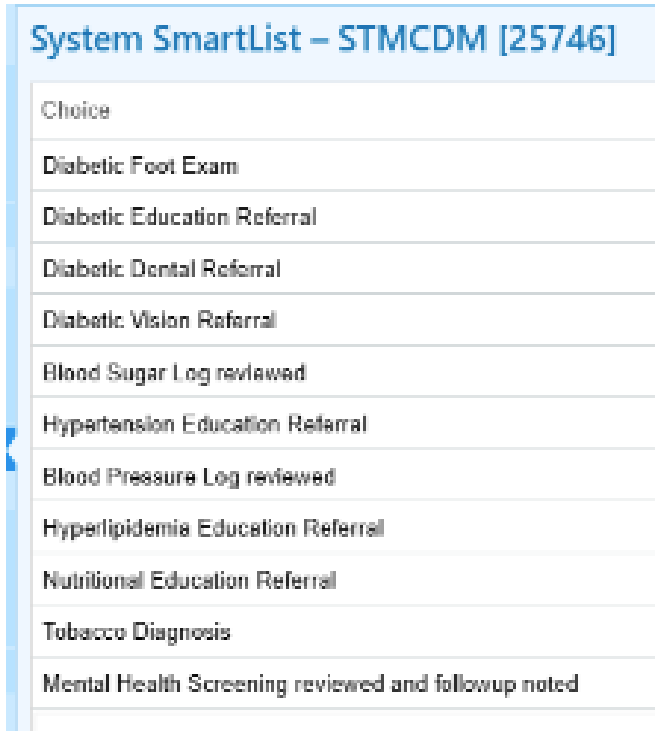
- We strive to improve support for our diabetic patients with our diabetic chronic disease management program. Our focus for this project is to improve our diabetic chronic disease management program by introducing quality improvement.
- As a result of COVID-19, we changed our diabetic education from group sessions to one – on – one. We got away from overseeing diabetic education.
- We are providing education for our new staff and volunteers to educate them about diabetic patient requirements.
- The time and manpower it takes to track the diabetic chronic disease program
- Referrals were not being entered, and patients were leaving without scheduling their diabetic education; foot checks were being missed, and dental and vision appointments were needed to improve the health of diabetic patients.

Changes we are testing

- We introduced a smart list to assist in reminding the providers to enter referrals for the diabetic chronic disease management program. Such as diabetic education, foot exams, dental, and vision referrals, and reviewing patients' blood sugar logs.
- We had one provider use the smart list for a day.
- We found that the list needed updating, but it was user-friendly and much appreciated.
- We also had to have our Epic team make some changes, so I was able to view the smart list and notes from the providers to audit charts.

Smart Lists





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Measures

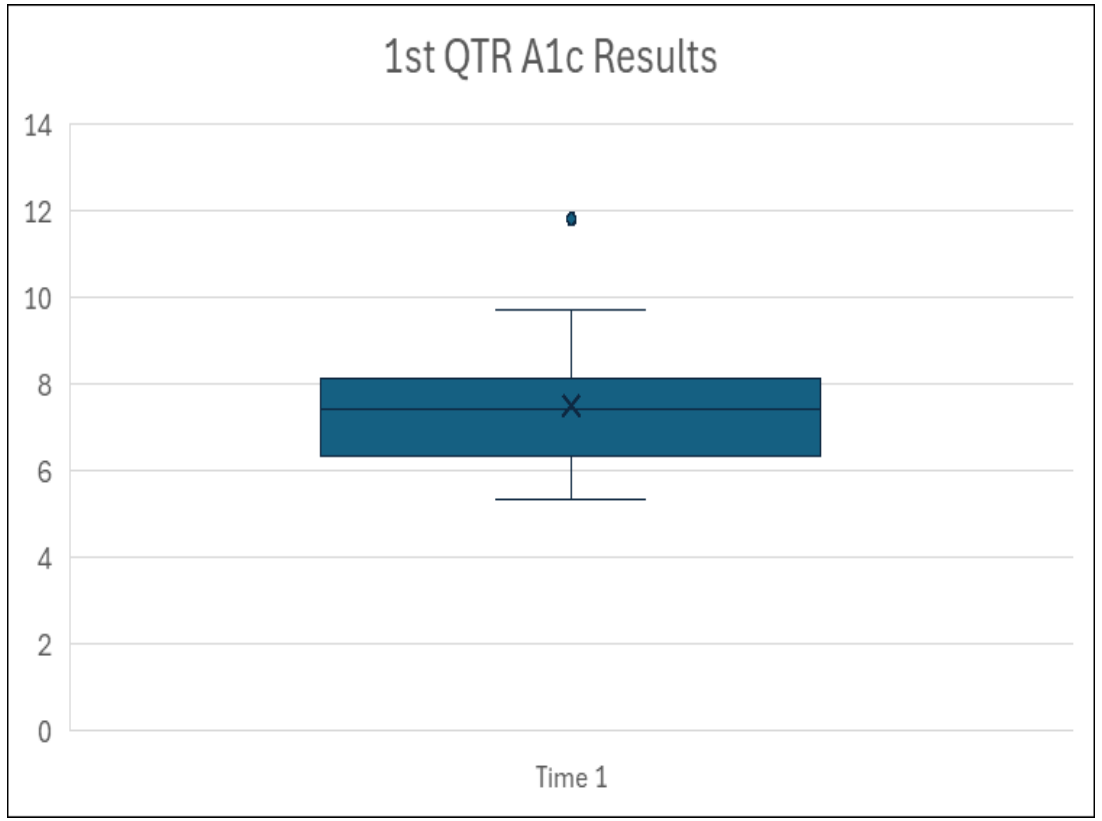
The process measures we used included a baseline of the patient's last A1c result, and then we began to track all A1c results obtained for the patient. We perform an A1c lab on each diabetic patient every three months.

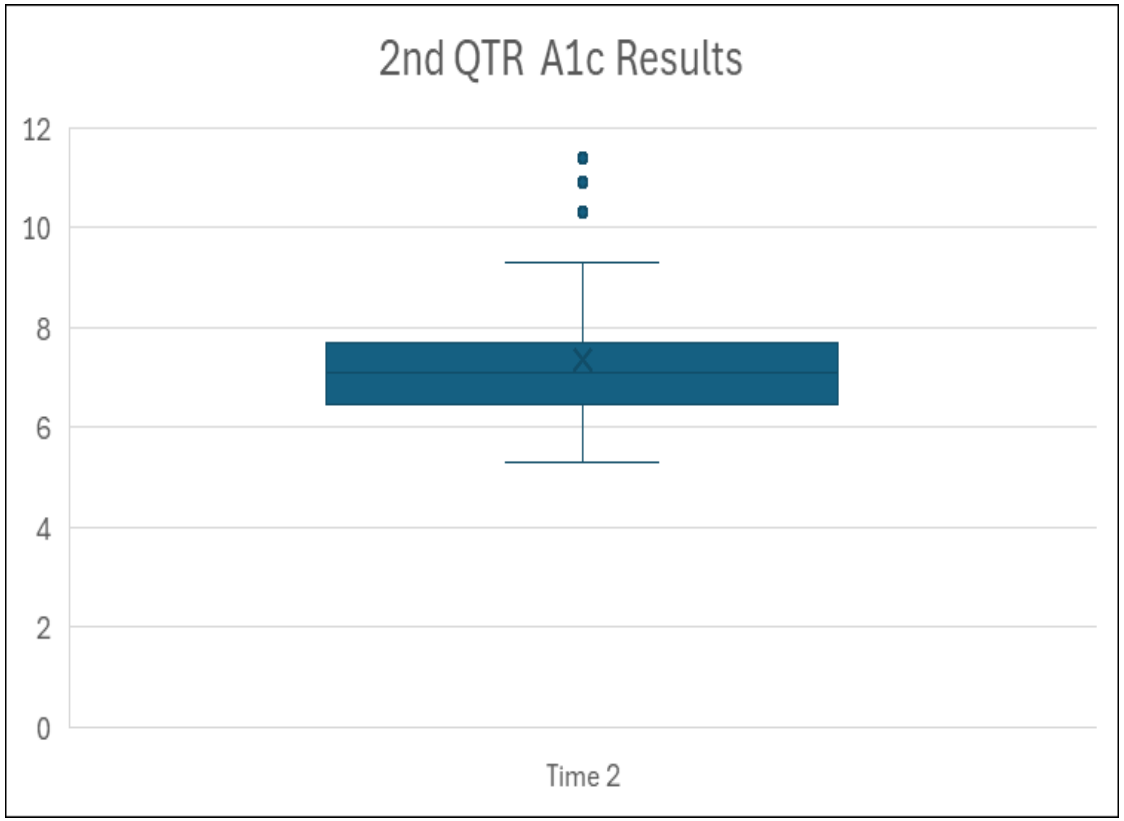
We used the A1c results and created a box and whisker chart to visualize the patient's progress.

This showed that within the blue box, fifty percent of our patients lowered their A1c results. They were 8 and above and then dropped their A1c results between 6 and 8.

The whisker lines above and below the blue box show our entire patient population. Their A1c results dropped between 5 and 9.

A1c Results for 1st & 2nd Quarter





Next Steps

Our next steps to continue this work are to continue tracking the data, such as patient A1C results, patient compliance with reports, and process improvements. We will also continue to work with patients to ensure they are compliant in completing their diabetic education, vision appointments, dental appointments, and foot checks. We will continue to spend more time with patients who are not improving and require additional education.

We are excited to take what we learned from this quality improvement project to improve patient care in other areas, such as PSA screenings, colonoscopy screenings, and women's health screenings.

Lessons learned

We learned how to improve our diabetic chronic disease management program by tracking patient A1C results, patient compliance, process improvements, and reporting.

We learned how to introduce and use quality improvement to improve our patients' care.

We also learned how to take the data collected and use it to tell our patient's story.

ICNA Relief
SHIFA CLINIC, SC

ROADMAP FOR HEALTH EQUITY

DRIVING QUALITY IMPROVEMENT PROJECT

COLON CANCER QI

Presented By:

MARLENE LOVO

WWW.SHIFACLINICS.COM

Shifa Clinic

Healing with love

HEALTH SERVICES

Multispeciality No cost health care with over **4000 medical visits**

No cost In house pharmacy with vaccines
Over $1 M worth of medications dispensed

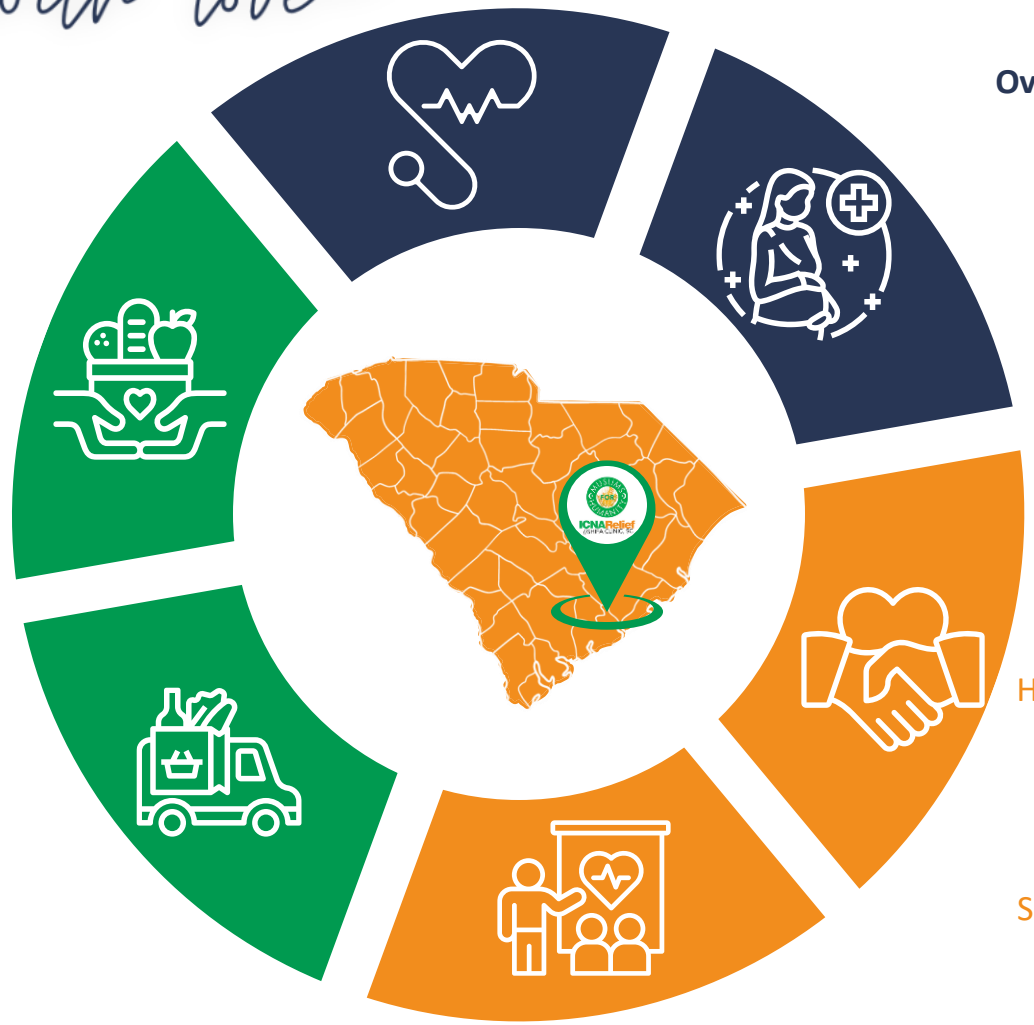
No cost labs
over $535K worth of labs provided

HUNGER PREVENTION

On site food pantry that sees over **800-900 families** every month

Partnership with Amazon that delivers groceries to **100 households** lacking transportation every month

Partnership Title one Schools for child hunger prevention bags **100 children** per month



OUTREACH

Community Health Fairs that connect thousands of people with health resources and fresh food

Health Education classes that teach people ways to prevent diabetes through nutrition and lifestyle change

Seasonal events like Back to School, Turkey Giveaways and Holiday Distributions

OUR TEAM

MARLENE LOVO	DR RESHMA KHAN	LUPE BARRAGAN-MOSER
Team Lead	Clinical Champion & Medical Director	Data lead

AIM

Raise our colon cancer baseline screening rate from 10% to 50% by December 2025

Key Barriers to Success

01 Team Cohesion

Lack of coordination and alignment within the care team.

02 Patient Education

Gaps in delivering clear, accessible education to patients.

04 Volunteer/student training

Insufficient preparation and guidance for volunteers and students.

03 Provider Motivation

Limited engagement and motivation among providers.

BASE LINE PROCESS MAP

1

Patient Visit

Patient arrives at clinic.

2

Eligibility check

Provider determines if patient is due/eligible for colon cancer screening.

3

Case entry

Student places case with Office Manager for referral.

4

Referral

Office Manager sends referral to CCPN and logs it in an Excel spreadsheet.

5

Patient navigation

CCPN Patient Navigator contacts patient to complete screening.

6

Results and charting

Office manger uploads the results and places notification for provider to sign results and follow up.

CHALLENGES WITH BASELINE PROCESS

Eligibility Gaps

Providers were not consistently screening patients for colon cancer eligibility and strict criteria for CCPN

- **Impact:** Patients due for screening were often missed.

Overburdened Referral System

Only one referral partner (CCPN) was handling referrals for the entire state.

- **Impact**: Significant delays in processing referrals and patient navigation.

Language Barriers

Patient communication and navigation faced breakdowns due to English-only materials.

- **Impact** Miscommunication and lower patient follow-through.

Office Manager Constraints

Referral entry and tracking (Excel spreadsheet) were handled by the Office Manager, who was juggling multiple tasks.

- **Impact** Inconsistent effort, missed follow-up, and limited accountability.

Excel Tracking

Referrals were logged manually in an Excel spreadsheet.

- **Impact**: Difficult to maintain, error-prone, and not suitable for real-time tracking.

Cost Barriers for Non-Eligible Patients

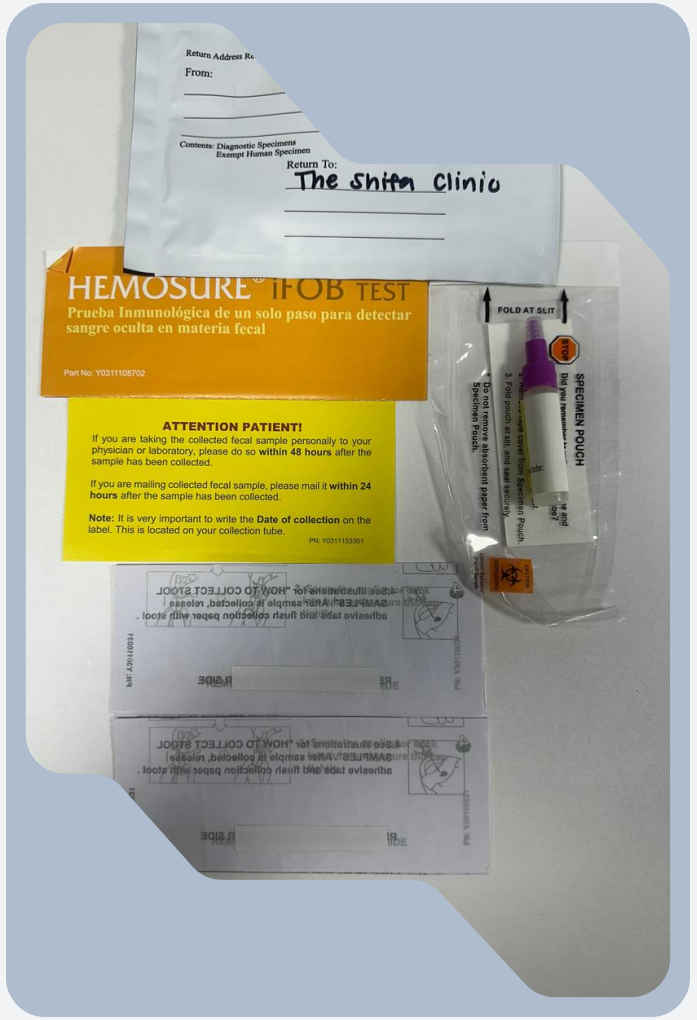
Patients who did not qualify for CCPN coverage had no affordable alternative.

- Impact: Screenings were delayed or not completed due to out-of-pocket costs.

PDSA 1 : Assign a Physician Assistant student for chart review prior to appointment

Plan/Do Aim: Improve eligibility screening & kit distribution

- Assign an online PA student to assist with reviewing charts and/or referral criteria to determine patient eligibility
- Train the PA student on eligibility criteria and how to use Kintone.
- Assign the student a manageable patient list to review and teach the student how to get eligible patient list
- Student flags eligible patients and writes their names on the Kintone
- Track and document any issues or feedback from the patient.
- Intern volunteer to read the flag and provide the kit in house from Roper Saint Francis



Key Observations

Problem

- The flags were not read by intake and volunteer
- Student providers not recieving the kits to give out to the patient
- Lost oppurtunity to provide screening

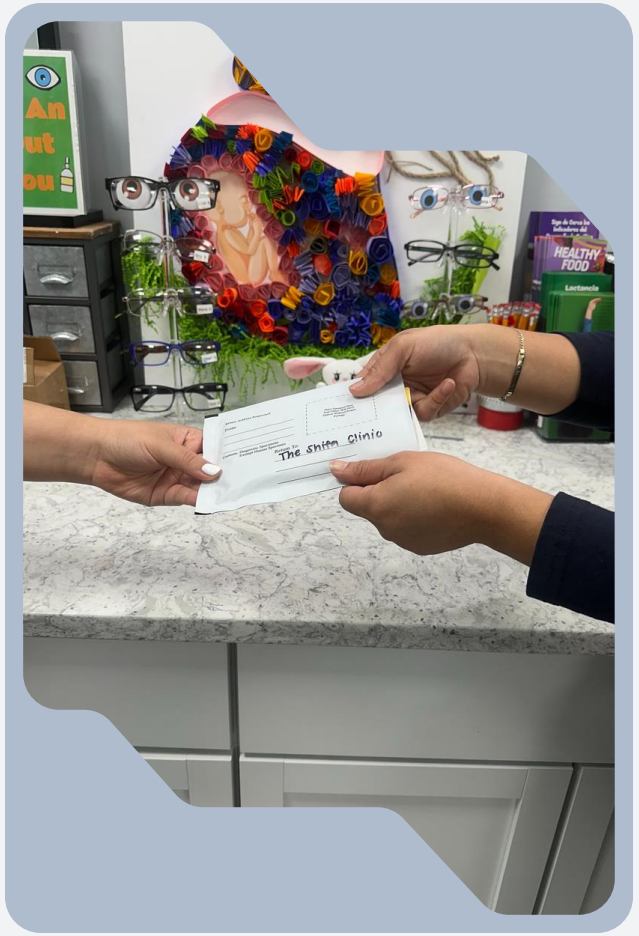
PDSA 2 : Took the intern out and replaced by pharmacy dispensing

Change: Pharmacy Manager dispensed FIT kits directly to provider/student

- Removed reliance on interns/volunteers
- Pharmacy Manager, bilingual in English and Spanish, developed bilingual educational materials
- Provided culturally and linguistically appropriate education to patients on kit use

Key Observations

- Improved distribution of kits
- Stronger patient understanding due to bilingual education
- **Problem**: Kits not being returned by patients



PDSA 3 : Drop Box afer hours

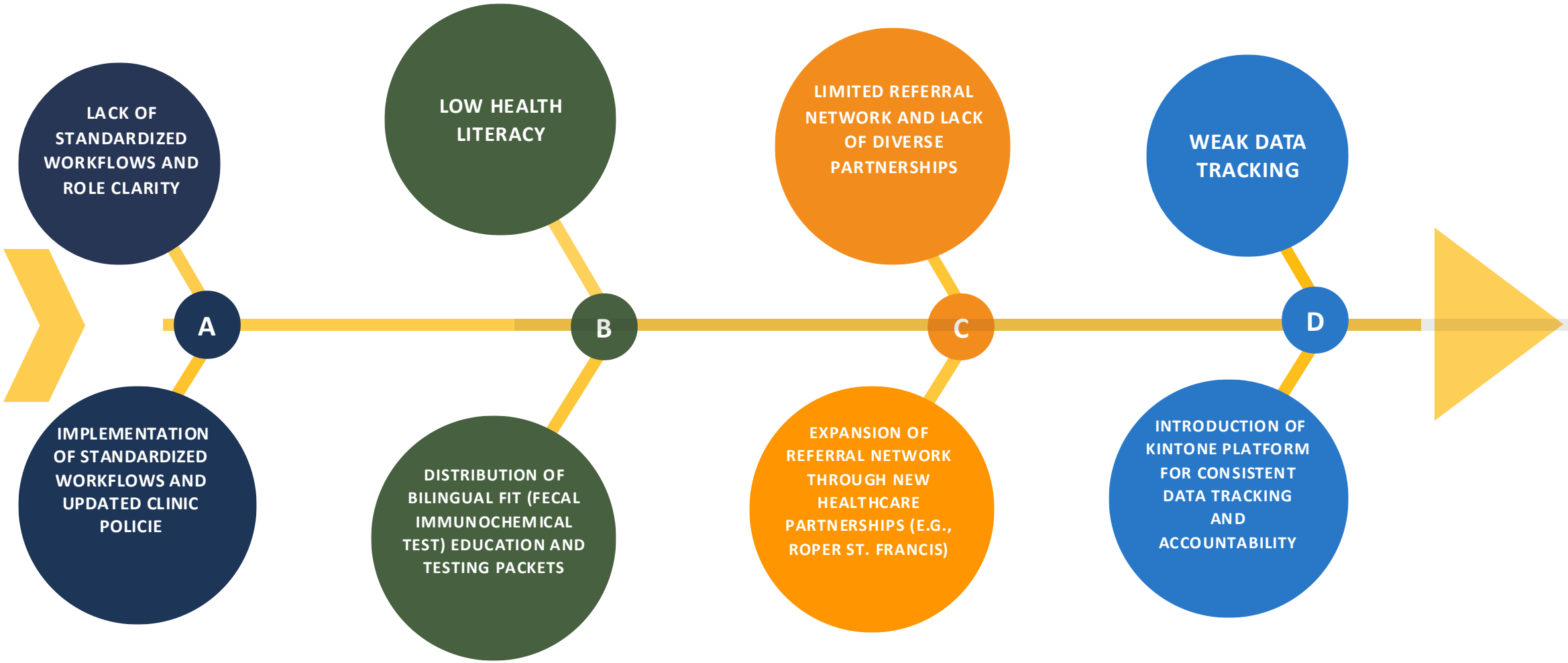
Change: Lockbox installed for after-hours kit return

Allowed patients to drop off completed kits at their convenience

Key Observations

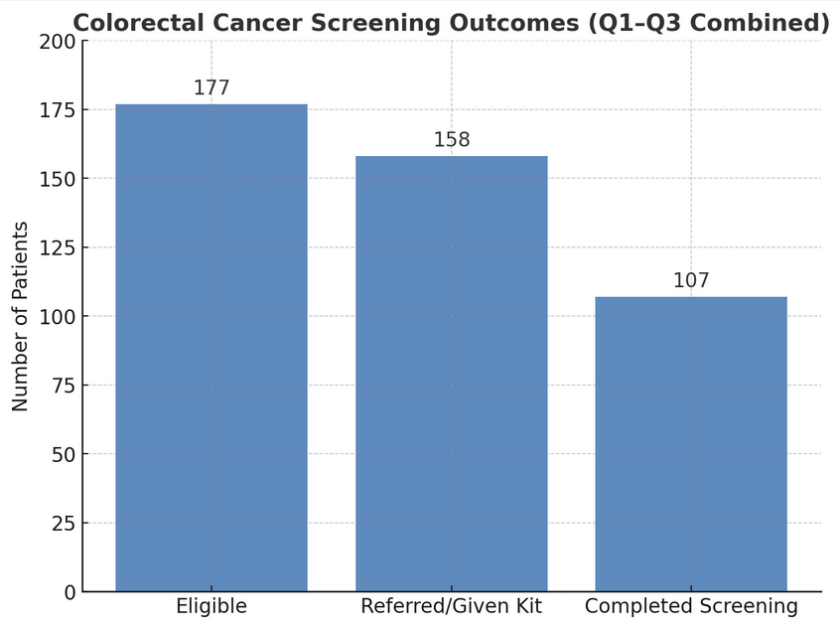
- Lockbox was underutilized; most patients did not return kits through it
- Still available as a resource for those who choose to use it
- Ongoing challenge: Ensuring timely return of completed kits

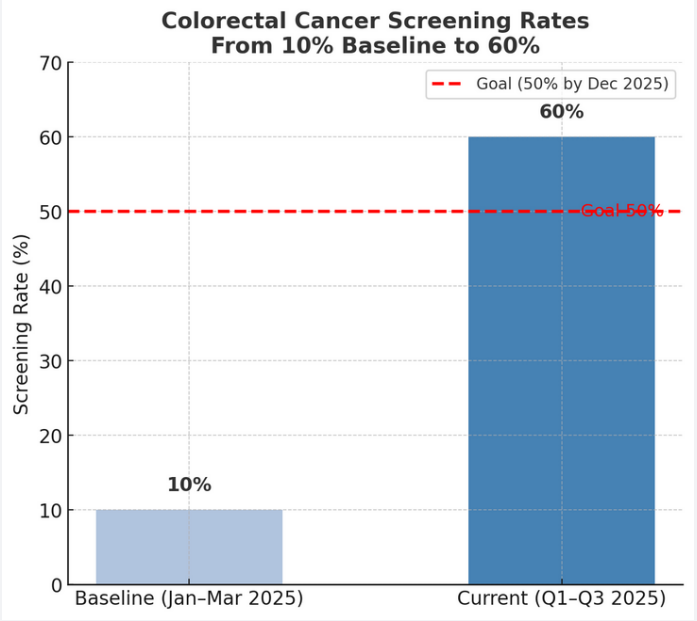
CLOSING THE GAPS: CHALLENGES AND RESPONSES



Outcome and Measures

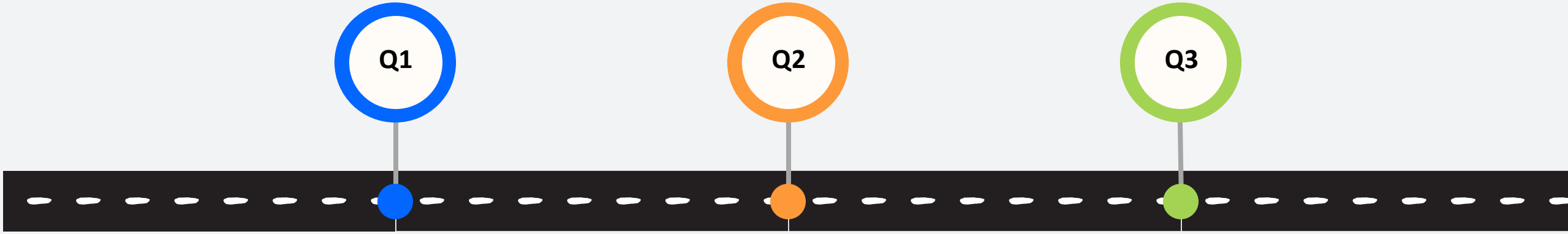
Quarter	Number of Patients seen between a	# patients eligible for CC screening
Q1 Jan-March	**117**	**79**
Q2 April- June	**108**	**66**
Q3 July to present	**43**	**32**





Ahead of Goal — From 10% to 60%

Results and Interpretation



Strong Start

- All eligible patients were referred or given kits, showing excellent provider/student engagement.
- However, only two-thirds (68%) completed the screening, pointing to return barriers.

Improvement in Completion Rate

- Fewer patients were referred (76% of eligible), possibly due to workflow changes and reduced reliance on volunteers.
- Yet, completion rates improved to 88% of those referred, suggesting pharmacy manager-led distribution with bilingual education increased patient understanding and follow-through.

Decline in Completion

- While referral rates increased (91% of eligible), completion dropped to 31%.
- This shows that access to return options (lockbox) did not sufficiently motivate patients to return kits.
- Indicates a need for reminder systems, navigation support, or incentive strategies.

KEY TAKEAWAYS AND NEXT STEPS

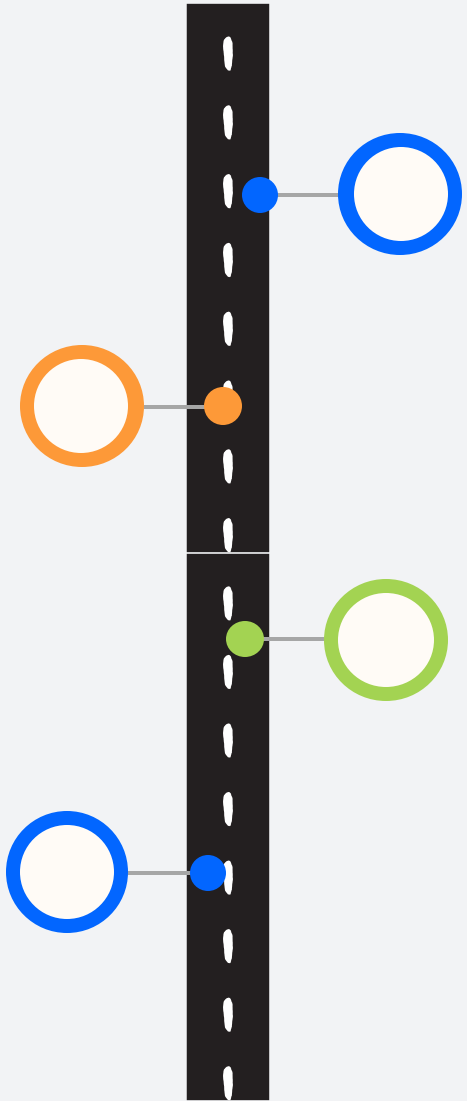
KEY TAKEAWAYS

Eligibility identification was consistent

but sustained completion remains the primary challenge.

Process redesign improved education and distribution (Q2

but did not fully address return barriers (Q3).



Next steps

•Introduce patient FIT completion incentives

Consider patient reminders (text/phone follow-up), incentives, or provider-driven reinforcement at subsequent visits.

•Establish a quarterly workflow review

•Use real-time Kintone tracking data and patient feedback to identify bottlenecks and drive improvements in the FIT screening process.

LESSONS LEARNED

01

Preventive care requires structure

oWithout a clear and standardized workflow, eligible patients can easily be missed.

Data drives improvement

Using tools like Kintone allowed us to track patient outcomes, flag follow-up needs, and guide decision-making.

02

03

Language accessibility is clinical care

Providing bilingual instructions and patient education directly impacted screening completion and patient engagement.

Quality improvement is integral to care

PDSA cycles helped us test small changes that led to measurable improvements in screening rates

04

05

Partnerships strengthen impact

Engaging providers, staff, and students in shared responsibility ensures continuity, sustainability, and broader reach of preventive care efforts.

Patients are at the center of success

Despite the positive changes from this QI project, success ultimately depends on patients' willingness and ability to participate in their care.

06

ICNARelief
SHIFA CLINIC, SC

THANK YOU

FOR YOUR ATTENTION

September 2025

Shifa.sc@icnarelief.org

www.shifaclinics.com

Beersheba Springs Medical Clinic

- 19592 TN-56
  Beersheba Springs, TN 37305

Our Clinic at a Glance

- We are a nonprofit rural medical clinic dedicated to providing accessible, quality healthcare to individuals and families in our community– especially those who are uninsured, underinsured, or medically underserved.

Our team and Aim

By December 31st, 2025 our clinic will implement routine and regular depression screenings for 80% of eligible patients during their visits to establish a baseline for mental health and reduce the risk of a missed diagnosis.

Role	Team member name
Team Lead	LaKisha Dickinson
Clinical Champion	Katelynn Nolan
Data lead	Emma Nolan

S.A.D- Stay Another Day

Understanding the issue

Current State

- Depression screenings not consistently completed for all patients.

Desired State

- Routine, standardized depression screenings for every patient at baseline and follow-up when appropriate.

Gap Causes

* No standardized workflow or policy

*Limited staff training/awareness

*Time constraints during visits

*Lack of EHR prompts/reminders

Tools Used to Analyze Issue

* Chart review of patient records

*Staff interviews/surveys

system

Change Strategies

* Implement PHQ-9 as standard screening tool

*Add prompts for screening

*Provide staff education on importance of depression screening

*Establish compliance tracking and reporting

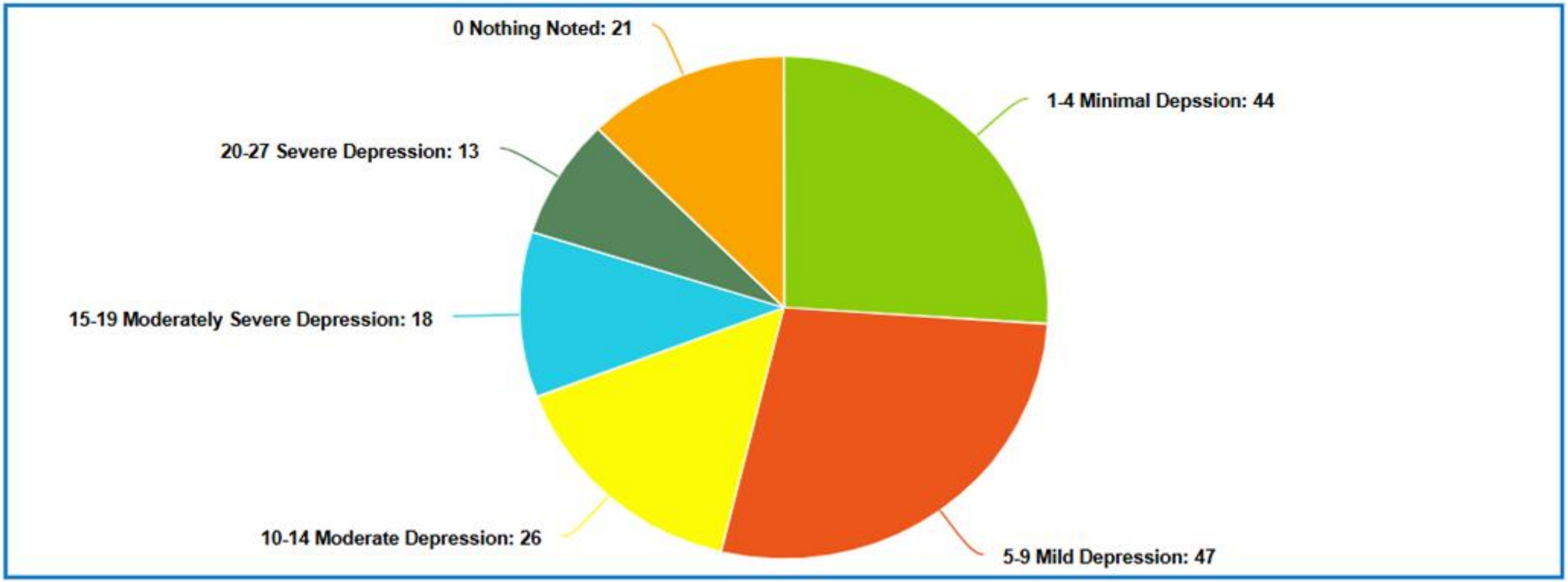
Outcome Measure

80% of all patients seen from May 1st- December 31st have a PHQ9 in their chart and the provider has reviewed it.

Data

- 169 PHQ9 forms documented with a total of 176 non duplicated visits. This is an amazing 96.02% success rate.
- Please see next slide for a breakdown of the reports

Patient Responses



Next Steps

- Continue to offer all of our patients the PHQ9 form on a yearly basis. Most of our patients are returning patients so we see them monthly, we found them doing the form every visit to be redundant.
- Continue to partner with the Grundy County Health Department to send patients there is they are needing further treatment than we offer.
- Continue to keep depression/anxiety medication on hand in the clinic for the patients that we can see and treat in house.

Lessons learned

- To include all patients when handing out documents to allow a true understanding and to not let the patients feel singled out.
- Allow time for the staff to process the change. Change is hard and it doesn't happen overnight.
- Completing the PHQ9 with every visit is redundant and the patients feel yearly would be sufficient.
- The biggest lesson I learned from this is that mental health care is slim to none. Even once we found a patient may need more care they can not afford it and therefore to begin then abruptly stop a medication could be more harmful to them.

Palmetto Community Health Care

- 410 Oakland Avenue Rock Hill, South Carolina

SOUTH CAROLINA FREE CLINIC ASSOCIATION

Care When It Counts

NAFC 2024 STANDARDS GOLD

Our clinic

- Free clinic providing primary care to low-income, uninsured residents of York and Lancaster County, South Carolina.
- Established in 2008 as Palmetto Volunteers in Medicine, later known as York County Free Clinic.
- Rebranded in 2022 to Palmetto Community Health Care (PCHC) when our service area expanded to include Lancaster County.

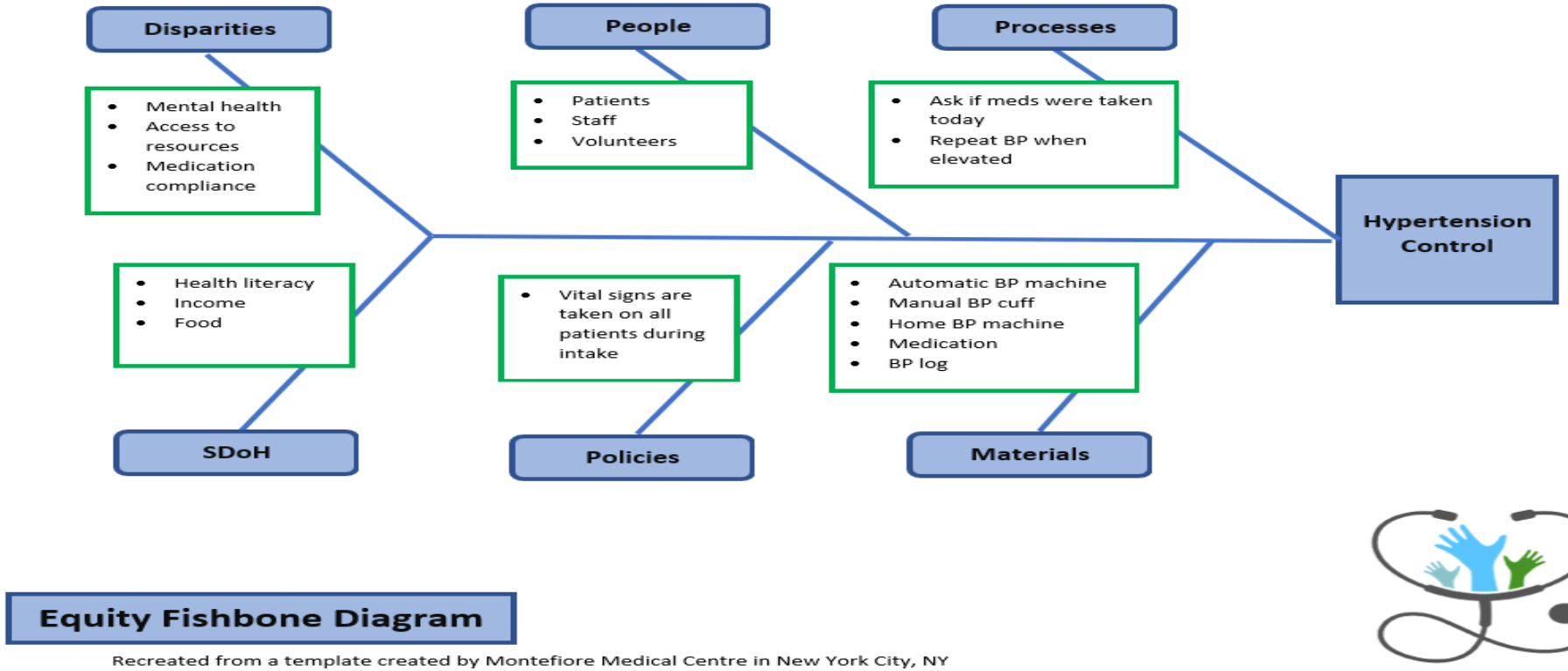
Our team and Aim

- **Project Aim**
  - *Among patients with an existing hypertension diagnosis, there will be a 15% increase of those at target blood pressure <140/90 in the next 6 months.*

Role	Team member name
Team Lead	LaTiffany Morrison, Executive Director
Clinical Champion	Ayesha Massey, FNP
Data lead	Ayesha Massey, FNP

Understanding the issue

- Gaps identified include healthcare literacy, medication compliance, adequate resources.



Changes we are testing

- **(P)** Pre appointment phone call to discuss med compliance, home BP checks and reminder about low salt diet.
- **(D)** inconsistent pre-appointment calls and data collection.
- **(S)** 23 of 42 hypertensive patients at target BP (54.7%).
- **(A)** complete another PDSA with modifications, review status again by 9/5/2025

- **(P2)** Review intake process and BP measurement technique to ensure accuracy.
- **(D2)** 2 patients had BP log for review, 7 took meds before appointment, 6 above target got a BP recheck.
- **(S2)** 13 of 26 hypertensive patients at target BP (50%).
- **(A2)** complete another PDSA with modifications, review status again by 1/6/2026

Your measures

Outcome Measure

- *BP reading at visit*

Process Measures

- *Pre-appointment phone call by staff or volunteer*
- *BP recheck when above target*
- *Asking if meds were taken before visit*
- *Is BP log available for review*

Data

- July – 42 patients with hypertension seen. Baseline of 18/37 (48.6%) at target. 23/42 (54.7%) were at target this month, 5 were new patients. 6 established patients had an improvement in BP compared to last visit.

- August – 26 patients with hypertension seen. Baseline 17/25 (68%) at target. 13/26 (50%) were at target this month, 1 new patient. 3 established patients had an improvement in BP compared to last visit.

Next Steps

- **What is next for this project?**
  - Create a fishbone 2.0 to determine what other processes we can modify to improve the % of patients at target BP.
  - Explore ways to get home BP monitors for patients so that they are equipped to take a more active part in managing hypertension.

- **How will you ensure the work continues?**
  - Make data review an agenda item for staff/volunteer meetings to allow ongoing discussion. Invite staff/volunteer and patient input in the PDSA process as we develop ways to improve the quality of care we offer and the overall health of the patients that we serve.

Lessons learned

- **What have your learned as part of this journey so far?**

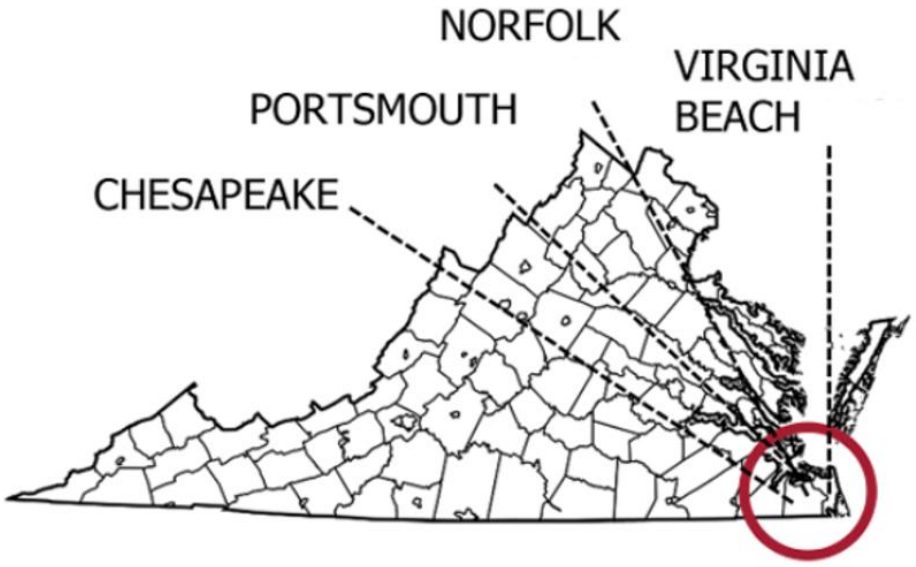
  - Quality improvement is not an instant success but takes time and consistent effort to test and implement.
  - It is more important to look at the data, recognize gaps in quality and explore ways to improve than focusing on the sole outcome measure.
  - Awareness of social determinants of health and other external factors that impact the data. We are limited as a free clinic on assisting with external factors, but there is an opportunity for us to collaborate with other community partners to explore ways to create positive outcomes together.

Group 3

- Chesapeake Care
- Neighborhood Health Clinic
- Univ of AZ Mobile Health Program

Chesapeake Care Clinic

- Located in Chesapeake, VA
- Serving Hampton Roads, VA



Our clinic

- 829 unduplicated patients in 2024
  - 540 medical/specialty patients
  - 420 dental patient
  - 347 pharmacy patients
- 79% of patients have at least one chronic disease
- 7,834 visits
- 450 volunteers (5.21 FTE)
- 18 staff (16 clinical, 2 admin)

Our team

To improve blood pressure control to 140/90 for 60% of hypertensive patients by December 31, 2025.

Role	Team member name
Team Lead	Dourina Petersen
Clinical Champion	Rachel Munthali
Data lead	Ismael Gil

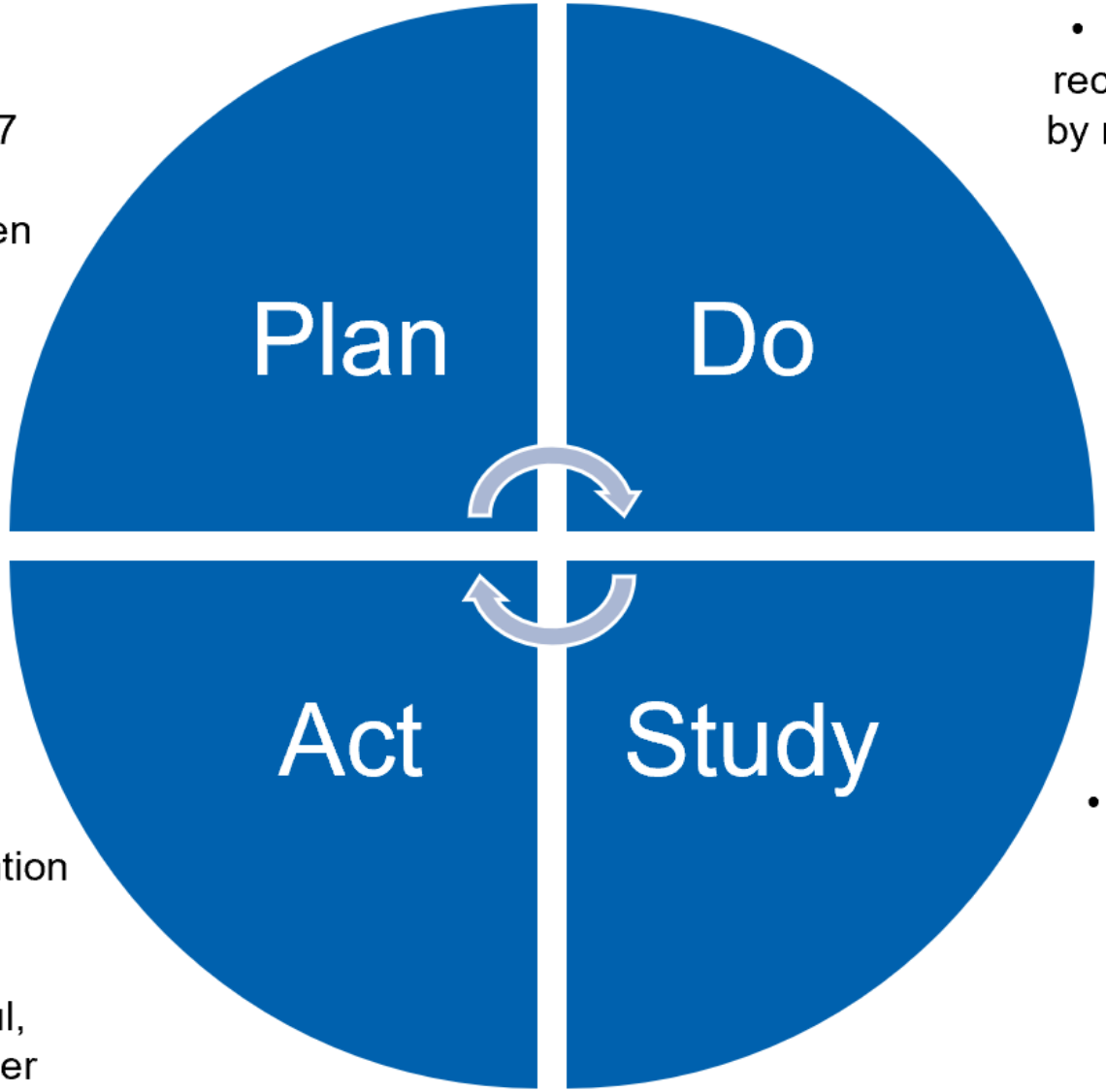
OLD DOMINION UNIVERSITY | NORFOLK STATE UNIVERSITY

Joint School of Public Health

Changes we are testing

Objective: to ensure accurate blood pressure measurement

- Repeat blood pressure it initial reading 7 140/90 (5 minute between readings)



- Data collected & rechecks performed by medical assistant
- If successful, adopt intervention into standard practice
- If unsuccessful, implement other strategies
- Analyze data to determine if interval had desired effect

Your measures

Outcome Measure

What is the outcome measure(s) you are tracking?

Blood Pressure Control

Process Measures

What processes measures are you tracking?

- Adherence to blood pressure measurement protocols by nurses and medical assistants
- Scheduling of follow-up appts

BLOOD PRESSURE CONTROL

Total Patients Counted: 196
Chesapeake Care Clinic
Benchmark: 24,769 patients from 80 clinics

BY SEX

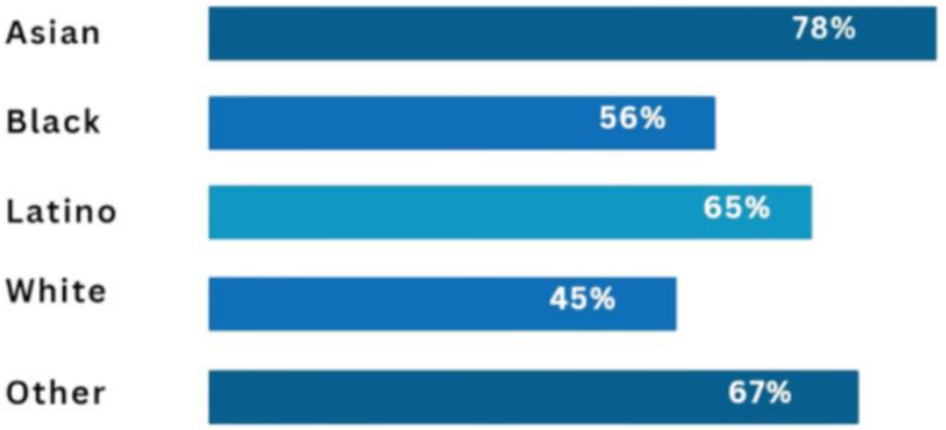
55% Male

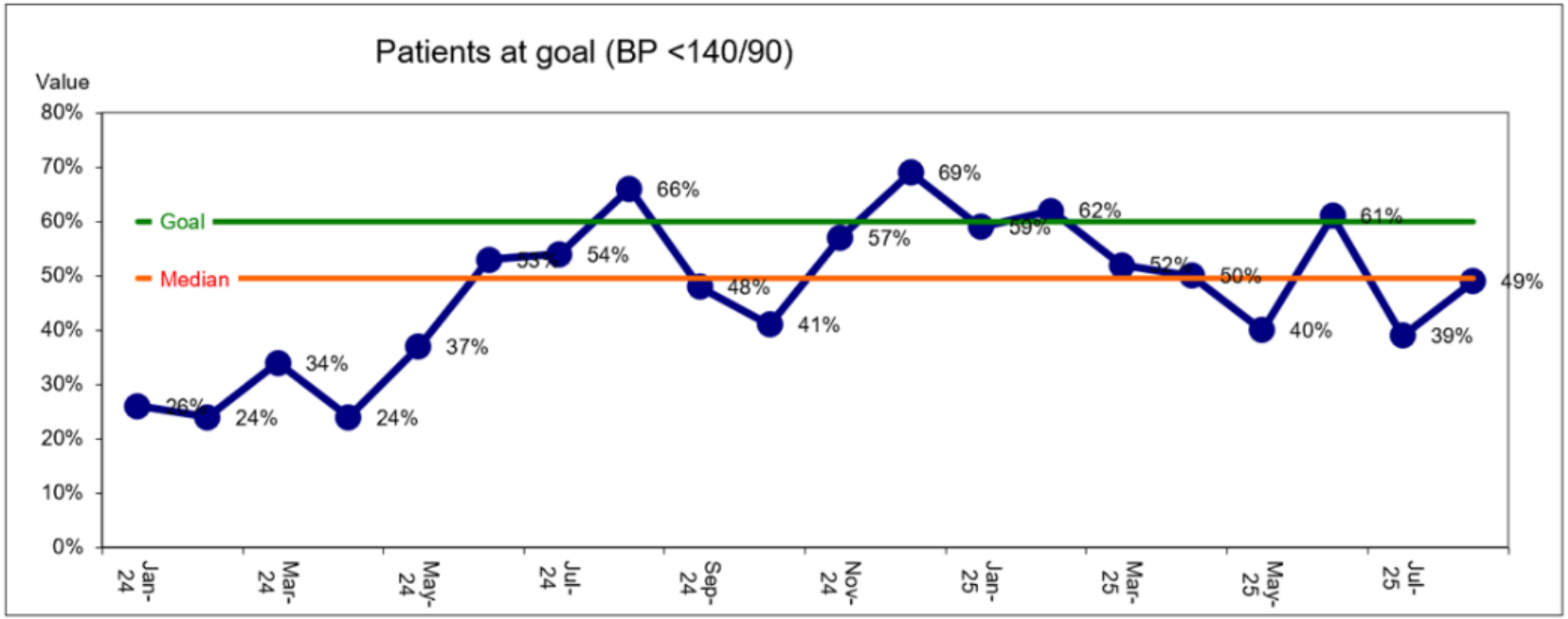
59% Female

BY ETHNICITY

TOTAL PATIENTS CONTROLLED

BY RACE




Patients at goal (BP <140/90)
Value
80%
70%
60%
50%
40%
30%
20%
10%
0%
Goal
Median
26%
24%
34%
24%
37%
53%
54%
66%
48%
41%
57%
69%
59%
62%
52%
50%
40%
61%
39%
49%
Jan-24
Mar-24
May-24
Jul-24
Sep-24
Nov-24
Jan-25
Mar-25
May-25
Jul-25

Lessons learned

- What have your learned as part of this journey so far?
  - Patient education needs to be simple and culturally relevant
  - Medication Adherence is a persistent challenge
  - Regular tracking of outcomes, missed appointments, and medication refill rates so we can quickly respond

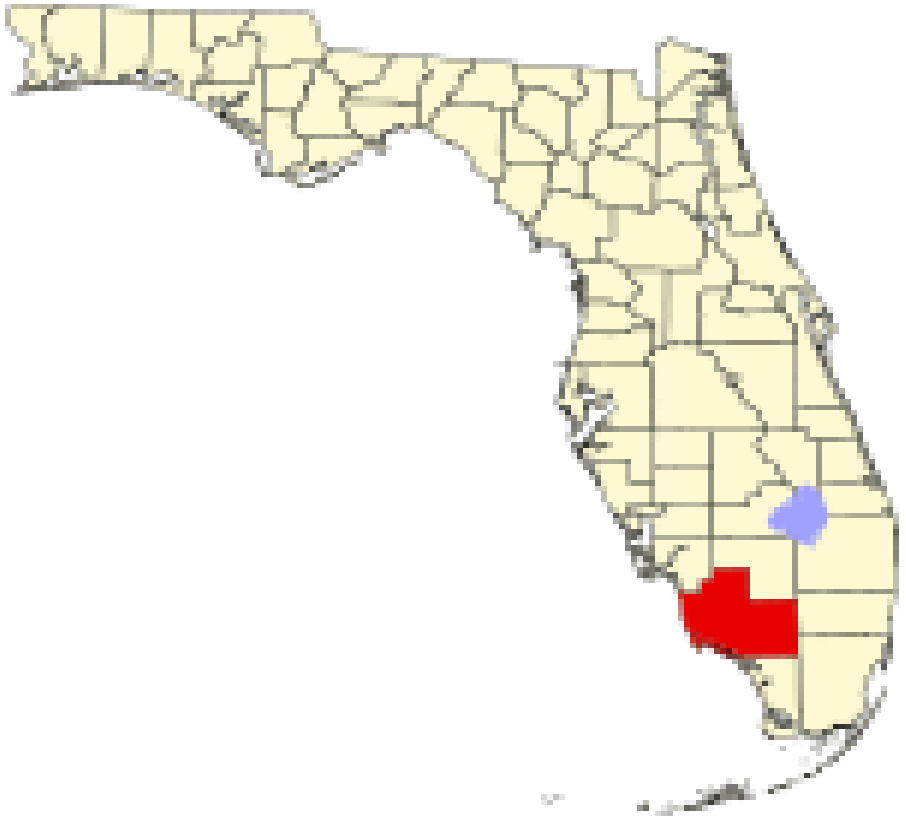
Next Steps

- What is next for this project?
- How will you ensure the work continues?

    - Continue to monitor blood pressure control and use PDSA cycle to test small changes
    - Begin tracking another quality measure
    - Use data to demonstrate value

Neighborhood Health Clinic

- Naples Florida



Our clinic

The highest quality, comprehensive care delivered at the Clinic depends upon the loyal VOLUNTEER physicians, dentists, nurses and non-medical staff to care for our patients.

With our ever-growing community, the demand for quality healthcare for low-income, working but uninsured Collier County adults increases.

Our team and Aim

- What was the Aim of your project?

PROJECT AIM IS ***to screen 100% of patients for depression as well as create a follow up plan for those at risk.***

Role	Team member name
Team Lead	Traci Rollins
Clinical Champion	Marza Cruz
Data lead	Cheryl Chapman

Understanding the issue

Background:
Routine yearly depression screenings are a critical part of providing comprehensive, preventive healthcare. According to national guidelines (e.g., USPSTF), adults should be screened for depression when adequate systems are in place for diagnosis, treatment, and follow-up. Our clinic adopted these guidelines, aiming for 100% compliance in eligible patient visits.

Identified Issue:
Recent audits reveal that depression screening compliance shows 59 %, falling short of our internal benchmark of 90%. This gap suggests inconsistent implementation of the screening protocol.

Changes we are testing

- Blue Dots
- Electronic Sticky Notes
- Adding PHQ2 to Intake Forms
- Adding PHQ2 to Encounter Forms
- Creating Depression Screen Report for monitoring
- Follow up referral monitoring
- Quality RN for review
- ROADMAPS for yearly benchmark

Your measures

Outcome Measure

What is the outcome measure(s) you are tracking?

- ❑ *# of annual depression screens completed in Calander year*
- ❑ *# of scores over 5 with a follow up plan documented*

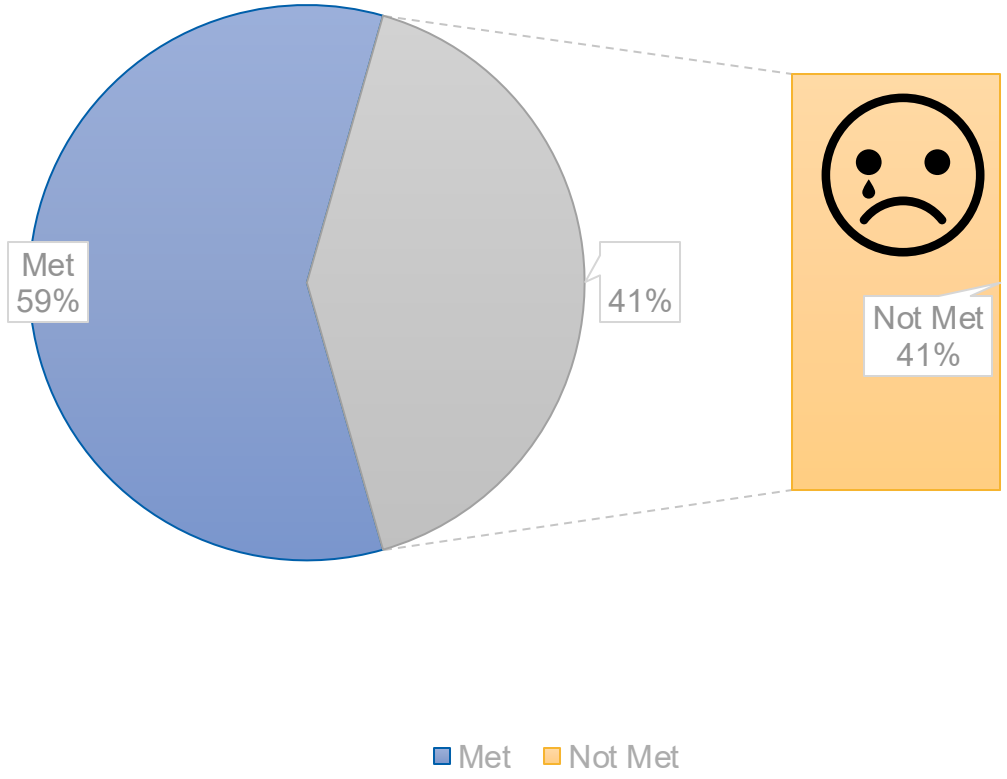
Process Measures

What processes measures are you tracking?

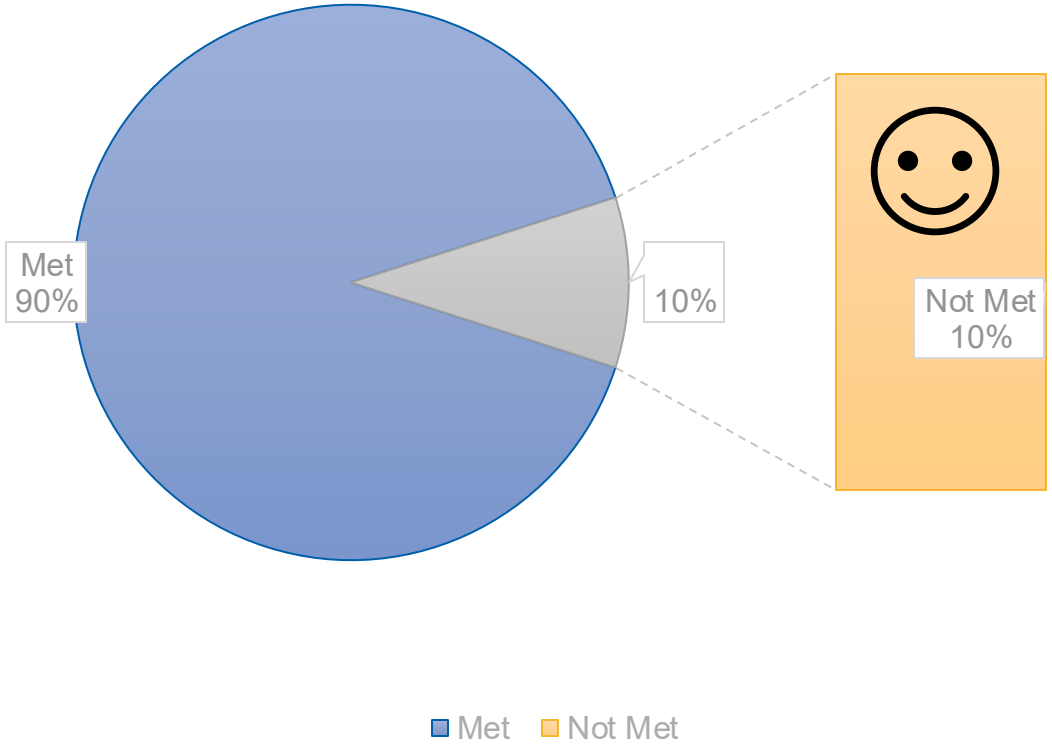
- ❑ *Encounter forms flagged with blue dot*
- ❑ *Follow up actions taken (order, medications, consults)*

Results

2024 Annual Depression Screen N=646

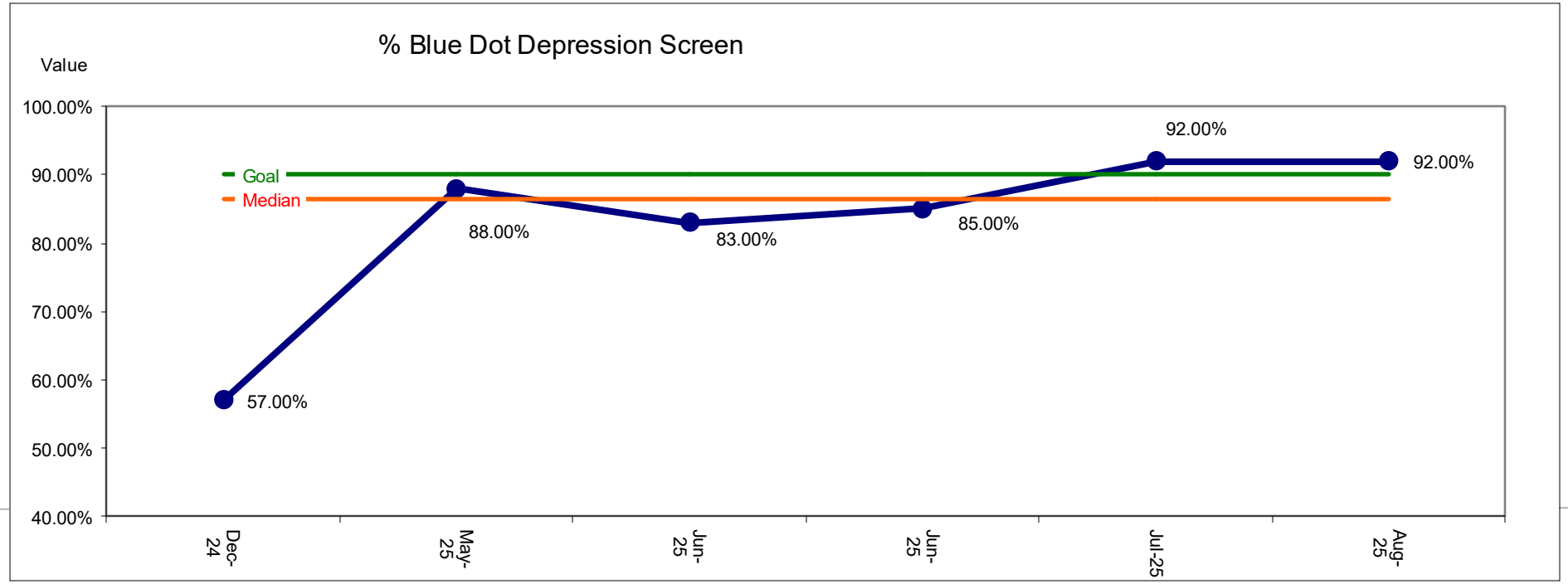


2025 (Jan-Aug) Annual Depression Screen N=566

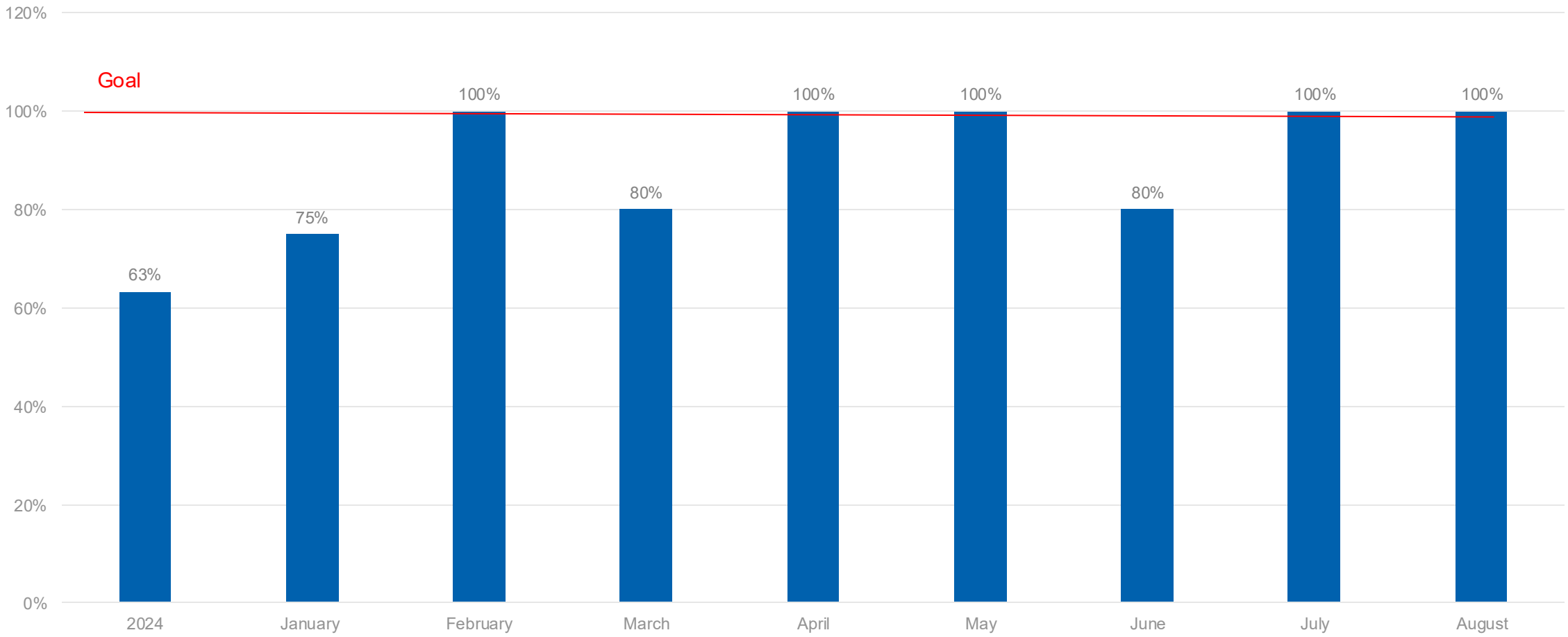


Next Steps

- ❑ Continue with Blue Dot Flagging
- ❑ Continue with Case Management of Depression Screen monitoring
- ❑ How will you ensure the work continues?
  - Regular Report review to identify follow up progress



% with a score of >= 5 and follow up plan



Lessons learned

- What have your learned as part of this journey so far?

1. Constant, clear and simple **Communication** is key
2. Importance of Pivoting
3. Understanding Cultural Barriers
4. What gets measured gets managed and what gets ***measured & managed*** will improve

COLLEGE OF MEDICINE TUCSON
Family & Community Medicine

Diabetes QI

Alicia Dinsmore, Program Manager
University of Arizona Mobile Health Program

University of Arizona Mobile Health Program

Services

- Primary Care for all ages
- Prenatal Care
- Family Medicine Doctors + Residents
- Mobile Program
- Southern, AZ

Our Team & Aim

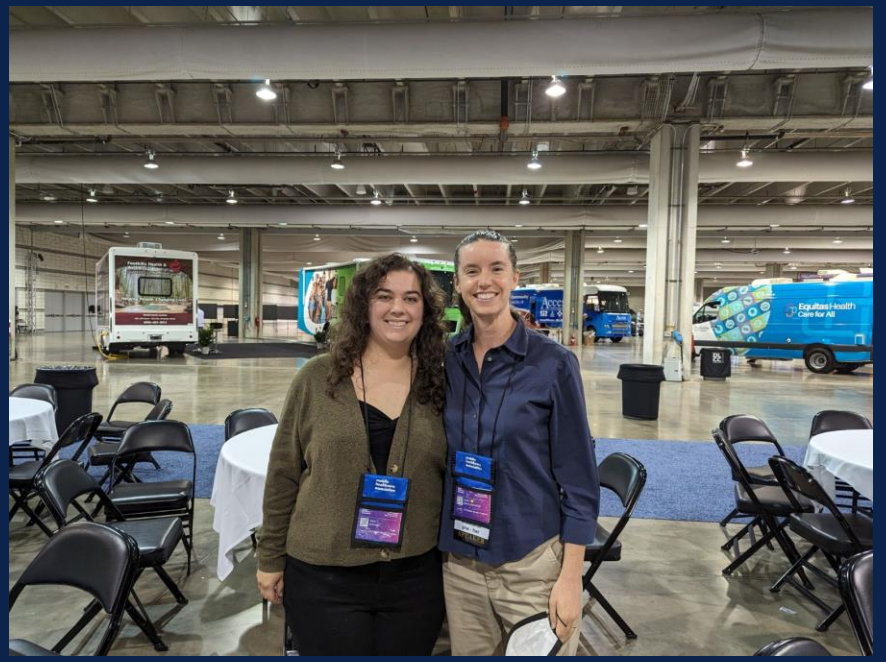
AIM:

Increase annual HbA1c control rates to **70% or higher** for MHP patients with diabetes by 2027.

Team Lead: Alicia Dinsmore

Clinical Champion: Nicole Person-Rennell

Data Lead: Alicia Dinsmore



Understanding the Issue

- Low HbA1c Control Rates (range between 29-45%)
- Limited Continuity of Care for 14% of patients
    - Lack consistent follow-up protocols
    - Patient factors that limit follow-up
- Inconsistent Referral Documentation
    - Lack of structured EMR workflow to prompt consistent documentation of referrals and labs
    - No centralized dashboard to identify patients with missing labs or uncontrolled diabetes
- Limited Patient Education Access
    - No funding for CHW, limited integration with other community programs

Changes We Are Doing

Interventions

- **EMR Template Integration**
- Follow-up Protocol
- Referrals to Community Diabetes Programs

PLAN: Design EMR Template

DO: Integrate into clinics

STUDY: Template usage rates, referral rates

ACT: Identify gaps in care

Our Measures

- Outcome Measure
  - HbA1c Control Rates
- Process Measure
  - Use of EMR Template
    - Chronic, stable. Uncontrolled, last A1C_
    - Meds_
    - Ophtho
    - Foot exam
    - UAC
    - A1C
    - PPSV

Data

Metrics	Pre (July)	Post (August)
EMR template usage rate	N/A	71% (5/7)
Labs completed	67% (4/6)	29% (2/7)
Meds	83% (5/6)	100% (7/7)
Ophtho	17% (1/6)	29% (2/7)
Foot exam	33% (2/6)	43% (3/7)
UAC	17% (0/6)	0% (0/7)
A1C Control	50% (3/6)	43% (3/7)
PPSV	N/A	N/A

NEXT STEPS

- Continue gathering data - 6 months
- Implement Follow-Up Protocol - March 2026
- Implement Referrals to Community Programs - September 2026

COLLEGE OF MEDICINE TUCSON

Family & Community Medicine

The UA Department of Family and Community Medicine is one of the top-ranking family medicine programs in the country. The department is known for outstanding pre- and post-doctoral education, groundbreaking research and innovative community outreach programs designed to improve the health of individuals, families and communities in the region and beyond. The department places strong emphasis on research in the fields of tobacco cessation, substance abuse, obesity, cancer survivorship, behavioral health and disabilities.

Group 4

- Charis Health Center
- Culmore Clinic
- Urban Ministries of Wake County

CHARIS
HEALTH CENTER

Mount Juliet, Tennessee

Capstone Project Presented By: Dr. Courtney Johnson

Our Clinic

Charis Health Center is located in Mount Juliet, Tennessee and provides affordable primary healthcare to the uninsured throughout Middle Tennessee.

Charis operates with a small staff and cadre of dedicated volunteers out of two clinic locations and a mobile health unit.

Our Team and Aim

- Tracking Improvement of HA1C via POC Lab
- Reducing No Show Rates

Role	Team member name
Team Lead	Dr. Courtney Johnson
Clinical Champion	Angelina Cortez, RN
Data lead	Dr. Courtney Johnson

Understanding the Issue

Tracking Improvement of HbA1c via POC Lab

Gap Analysis Findings:

- Current average turnaround time for HbA1c results is 1–2 weeks when sent to an external lab.
- Lack of real-time data delays provider decisions and follow-up care.
- Limited staff training on POC device use has created inconsistency in utilization.
- No standardized workflow for documenting results in the EMR at the time of the visit.

Reducing No-Show Rates

Gap Analysis Findings:

- No-show rate averaged 28% over the previous quarter.
- Reminder calls are inconsistently performed; some patients do not receive any reminders.
- No process exists to identify and follow up with high-risk patients with repeated no-shows.
- Appointment scheduling does not account for patient transportation barriers or language needs.

Changes Being Tested

Tracking Improvement of HbA1c via POC Lab

- Implement point-of-care (POC) HbA1c testing during patient intake for all diabetic patients.
- Train clinical staff on correct use and maintenance of the POC HbA1c device.
- Standardize workflow: assign responsibility, place supplies at intake stations, and build steps into visit checklists.
- Enter POC HbA1c results directly into the EMR during the patient's visit.

Reducing No-Show Rates

- Implement a structured reminder system (calls, texts, and/or emails) 48 hours before appointments.
- Assign a designated staff member daily to complete and track patient reminders.
- Flag patients with repeated no-shows in the EMR for targeted follow-up and barrier assessment.
- Offer same-day or next-day appointment slots to reduce scheduling barriers.
- Screen for transportation, language, and scheduling barriers during appointment scheduling and provide resources (interpreters, transportation assistance, flexible times).

Our Measures

Tracking Improvement of HbA1c via POC Lab

Outcome Measures:

- **% of diabetic patients with a documented HbA1c result within the past 6 months.**

(Goal: Increase the % of diabetic patients receiving timely HbA1c monitoring)

UPCOMING: **% of diabetic patients with reduced HbA1c level patients over time.**

Reducing No-Show Rates

Outcome Measure:

- **Monthly no-show rate for scheduled patient appointments.**

(Goal: Decrease overall no-show rate by at least 10% from baseline)

Tracking Improvement of HbA1c via POC Lab

Process Measures:

- **% of eligible diabetic patients who receive a POC HbA1c test at their visit.**
- **% of POC HbA1c results entered into the EMR during the same visit.**
- **# of staff trained and competency-validated on use of POC HbA1c devices.**

(These help confirm whether the new POC workflow is being used and sustained.)

Reducing No-Show Rates

Process Measures:

- **% of scheduled patients who receive a reminder (call, text, or email) 48 hours before their appointment.**
- **% of flagged "frequent no-show" patients who receive targeted outreach prior to their next scheduled visit.**
- **# of patients offered same-day/next-day appointments each week.**
- **% of appointments where staff document transportation or language needs during scheduling.**

(These measures track how consistently our no-show reduction strategies are being applied.)

Data

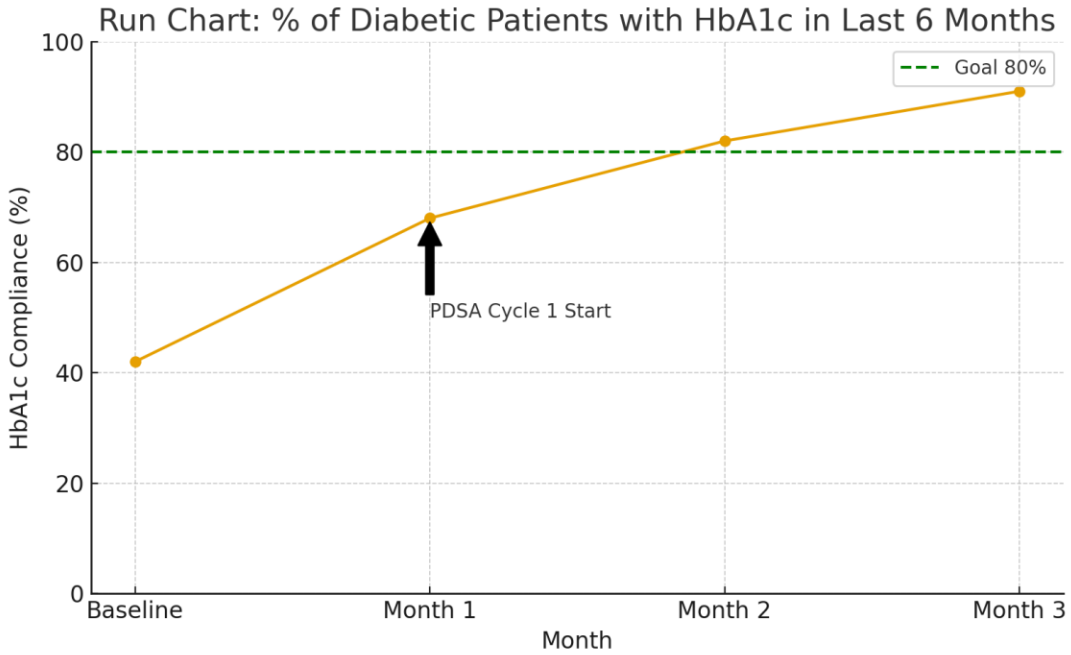
Tracking Improvement of HbA1c

Most Recent Data

Baseline (Pre-intervention): 42% of diabetic patients had a documented HbA1c in the past 6 months

- Month 1 after implementation: 68%
- Month 2: 82%
- Month 3: 91%

UPCOMING: **% of diabetic patients with reduced HbA1c level patients over time.**

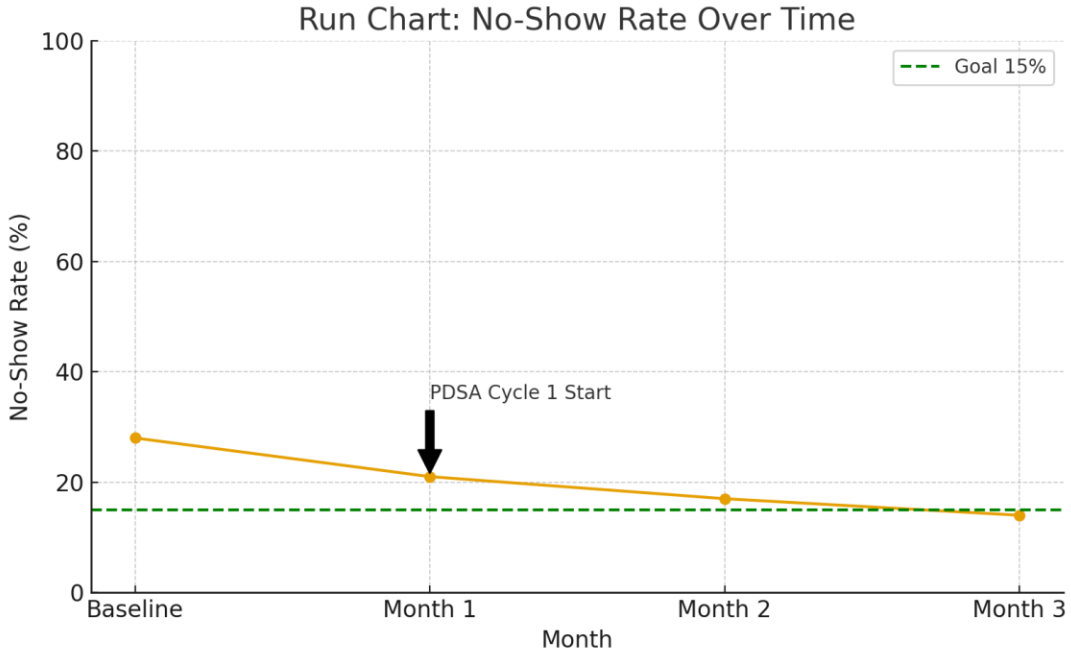


Reducing No-Show Rates

Most Recent Data

Baseline (Pre-intervention): 28% no-show rate

- Month 1 after reminders implemented: 21%
- Month 2: 17%
- Month 3: 14%



Next Steps

Tracking Improvement of HbA1c Next Steps

- Continue monitoring monthly compliance rates and trend lines.
- Incorporate real-time alerts in the EMR so staff can see which patients are due.
- Begin reviewing patient outcomes (% of diabetic patients with reduced HbA1c level patients over time) to measure clinical impact, not just process completion.

Sustainment Plan

- Include POC HbA1c workflow in new staff onboarding and annual competencies.
- Review HbA1c compliance data quarterly at quality meetings and share with the team to maintain visibility and engagement.

Reducing No-Show Rates Next Steps

- Continue reminders and begin segmenting patients with chronic no-show history for more intensive outreach (e.g., social needs screening).
- Explore offering increased telehealth options for patients with transportation or work barriers.

Sustainment Plan

- Make the reminder system part of daily front-desk workflow with a clear assignment.
- Track and review no-show rates monthly and report at staff meetings.
- Recognize and celebrate staff successes when no-show rates drop to reinforce behavior.
- Periodically re-train staff on best practices for scheduling and patient engagement.

Lessons Learned

HbA1c via POC Lab

- Real-time testing improves care decisions.
- Standardized workflows ensure consistency.
- Staff training & engagement drive success.

Reducing No-Show Rates

- Reminder systems significantly reduce no-shows.
- Patient barriers (transportation, language, work) require tailored solutions.
- Data tracking keeps the team focused & motivated.

Overall

- Small tests of change (PDSA) build momentum.
- Celebrate quick wins to engage staff.
- Sustainability requires ownership & integration into daily workflow.

ROADMAP PROJECT
Culmore Clinic QA team

- 6165 Leesburg Pike,
- Falls Church, VA 22044

Our clinic

- Culmore Clinic is a 501(3c) non-profit healthcare organization.
- The clinic serves the healthcare needs of an immigrant population most of which are Spanish speaking. It is primarily volunteer supported.
- 3 years ago there were less than 400 patients and the clinic only offered primary care services and behavioral health. Over the 3 years, the clinic's focus has been on growth and establishing other services.
- The clinic has been successful and currently has over 1,000 patients.
- A variety of other services including vision care, GI, nephrology, neurology, cardiology, clinical trials, diabetes workshops, nutrition as well as other specialty services have been added.
- The clinical focus has turned to quality improvement. This opportunity with roadmap has paved the way to begin our QI process to ensure patients are receiving the highest patient centered quality care.
- This is the first QI project done at the clinic.

Our Team and Aim

- What was the Aim of your project?

By December 31, 2025, we will improve diabetes management by decreasing the percentage of patients with type 2 diabetes who have a documented hemoglobin A1c (HbA1c) value of greater than 7.0% from 59% to 54%.

We will achieve this through enhanced care coordination, patient education, and consistent follow-up using a team-based approach.

Role	Team member name
Team Lead	Maria Obeid
Clinical Champion	Maria Obeid
Data lead	Cathleen Scully

Understanding the issue

- Difficulties with follow up due to SODH, including lack of transportation, work schedules, lack of childcare, etc.
- Lack of adherence to treatment plan due to cost of medications and the above mentioned SODH
- Barriers to exercise
- Inability to afford or access healthy options such as fresh fruits vegetables and lean proteins.
- Inconsistent follow up appointments
- Different provider across different appointments

Changes we are testing

- **Plan:** Identify patients with A1c (HbA1c)>7.0% before their upcoming appointment. Care coordinators or medical assistants will flag them for provider review.
- **Do:** Call these patients in advance to remind them to bring blood sugar logs and questions and ensure A1c (HbA1c)lab testing has been completed ahead of the visit.
- **Study:** Track the number of flagged patients who have receive timely A1c (HbA1c) labs.
- **Act:** Expand the pre-visit planning process to more patients or adjust based on feasibility.

Your measures

Outcome Measure

Approximately 5% improvement in A1c (HbA1c) *levels for type 2 diabetics with a* A1c (HbA1c) *levels >7 in 2025.*

Process Measures

- *Quarterly review of diabetic patients seen in 3 months and whether a follow up appointment was scheduled with the same provider. If not, the patient will be contacted to come in for the lab draw and a follow up appointment.*
- *Re-educate providers and clinical staff on the new process.*

Quarterly A1c (HbA1c) Data

Quarter 1 -2025

- 137 patients diagnosed with Type 2 DM
- 57 had a A1c (HbA1c) completed (41%)
- 31 >7% (54%)

Quarter 2- 2025

- 137 patients diagnosed with Type 2 DM
- 59 patients had a A1c (HbA1c) completed (43%)
- 37 patients had a A1c (HbA1c) value >7% (62%)
- 25 patients had a A1c (HbA1c) test completed in both Q1 and Q2
- 48% no change
- 28% worse by 1-4%
- 24% improved by 1-2%

=100%

Next Steps

- Continue the project until results are seen using the PDSA cycle.
- Adjust as needed and slowly add to our evaluation efforts to continue to provide quality care specific to the population with type 2 diabetes.
- We hope to parallel a similar QI process for hypertension, depression screening, cancer screening including cervical and colorectal.
- Re-establish our QI committee by engaging staff and volunteers that have expressed interest. The committee will be approved by the board of directors and quarterly meetings will be conducted. This will keep the clinic focused and on task.

Lessons learned

- QI takes time and effort that needs to be considered when planning any QI projects.
- Keep it small, trying to implement too many changes can become overwhelming and is not effective.
- Utilize students and volunteers when planning any QI projects and involve them from the start.
- Ensure support and buy-in from your team members and volunteers.

Urban Ministries of Wake County

- Raleigh, North Carolina
- 3 services programs:
  - Hunger and Nutrition Program
    - Food pantry
  - Healthcare Program
    - Free & charitable clinic, Open Door Clinic
  - Housing Program
    - Shelter for adult single women, Helen Wright Center
- Volunteer Services program
  - Volunteer opportunities
  - Unpaid Internships

urban ministries
OF WAKE COUNTY
COMPASSION. DIGNITY. CARE.

Open Door Clinic

- Provide primary care and specialty care to 1200 uninsured adults.
  - Dermatology, ENT, GYN, Podiatry, Cardiology, Nephrology
- Licensed onsite pharmacy.
- Onsite food pantry – coordinate food box distributions during appointments
- 17 Clinic staff, ~7-12 volunteers daily, ~20 interns per semester
- 7000 annual appointments
- 37000 monthly prescriptions filled last year.

Our team and Aim

- Create a FIT test tracking system to ensure responsible use of resources and improve colorectal cancer screening completion.

Role	Team member name
Team Lead	Diana Castillo, Clinic Director
Clinical Champion	Dr. Elizabeth Campbell, Medical Director
Data lead	Junho Yu, Clinic Coordinator

Understanding the issue

- We learned that:
  - We didn’t have a standardized protocol of distribution, receipt
  - Inconsistent messaging to patients regarding timeframe of returning test
  - Multiple tests distributed to patients
  - No follow ups to non-returned tests (due to no tracking!)
  - Not enough education, tests provided being left behind in exam rooms.
- As a free clinic that relies on volunteers for the day-to-day operations, inconsistency tends to happen often.

Changes we are testing

- Started with only 1 staff provider, 1 staff medical assistant.
- Updated process:
  - Dispenser: Provider > volunteer
    - Retraining of intake volunteers
  - Timeframe: 2 weeks
  - Recorded note in Pt. Chart

Data (if you have data to share)

- From 8/1/2025 – 9/24/25:
  - We currently have 38 patients that have NOT returned their FIT tests ☹
  - No recorded to follow ups on those 38 patients. ☹
  - Unable to find report to run through Athena, estimated by medical assistants, that we've received ~25-30 returned tests within this time period.
  - That would make our return rate 44%.
- This gives us a baseline that we can work from!
  - If unable to find report, will ask medical assistants to start manually keeping track of returned tests.
  - Assign new task of following up with patients that have not returned tests to specific staff member

Next Steps

- What is next for this project?
  - Update new Standard Operating Procedure
  - Staff training on new process
  - Volunteer training on new process
  - Reminders (staff & volunteers) on SOP – can be quarterly or semi-annually

- How will you ensure the work continues?
  - Clinic leadership and management – keeping this as a success metric.
  - Once it's built in – SOP, materials, training, - it will stay.

Lessons learned

- What have your learned as part of this journey so far?
  - PDSA are VERY informative and it's the best way to capture data that can help you make you informed decision.
  - As a leader, you need to MAKE time for your team to have the opportunities to reevaluate their current processes, to make suggestions, conduct their own PDSAs and make updates.
  - Require staff to not only suggest a process improvement, provide these resources to help them.
  - Encourage a growth mindset within your team

Next Steps

- Final Assessments
  - Due October 10th
- Satisfaction Survey
  - Due September 30th

Payments will be processed as soon as all requirements are met.


THANK YOU!