Quality Improvement: Going Back to Basics and Inventing the Future in the Era of COVID-19

Doron Schneider

The work of Elijah P. Mays, Jr., described in an article in this issue (1), connects the past, present, and future of quality improvement (QI). The author begins with a question: what is the rate of screening for vitamin B12 for people with type 2 diabetes who are prescribed metformin in my clinic? An initial chart review reveals a rate of 68%—low enough for the clinic to decide to do something about it. The gap between the current and ideal states was sufficiently large that energies were devoted to creating change.

The structural and process changes introduced in Dr. Mays' clinic take us back to the Chronic Care Model, as introduced by Dr. Ed Wagner years ago (2). Dr. Wagner's model (Figure 1) puts the clinic in the context of the community, with all its resources that clinic staff ideally should be aware of and connect patients to. In the clinic itself are four levers that, when pulled, allow for productive interactions between patients and their care team. First is "self-management," through which patients are provided the tools, education, and skills they need to proactively and effectively care for their condition. "Decision support" is the lever that ensures that clinic staff and health care professionals use evidence-based guidelines and algorithms that are patient centered and context specific and that facilitate optimal decision-making based on the clinical scenario. Ideally, these tools are seamlessly integrated into the electronic medical record and office workflow. Next is "delivery system redesign," through which all staff operate at the highest level of their licenses and the process of care is coordinated and proactively planned, with resultant high levels of patient-clinician communication and evidence-based laboratory testing and prescription of medications. The final lever is "information systems," where computer systems and EMRs facilitate the clinical team's provision of high-quality care and serve as more than a static, one-way storage repository of information.

In his Quality Improvement Success Story, Mays describes an effort that began as a project to satisfy a graduate degree requirement. However, the story he tells includes so much more. We see a clinic that is learning its way forward and changing in response to internal forces and external realities. Specifically, the article describes efforts by the clinic's nurse practitioner and physician assistant students to perform pre-visit planning with regard to vitamin B12 screening. This activity was thoughtfully linked to a routine morning huddle activity, at which information was exchanged among the students and clinicians to raise awareness with the intention of increasing clinician ordering of vitamin B12 screening for patients taking metformin.

These two activities—pre-visit planning and holding morning huddles—form the foundation for excellence within a clinic. Unlike the solid foundation of a home, however, this foundation is malleable and can be shaped as needed to meet the evolving demands of clinic staff and patients moving forward. Learning about pre-visit planning and morning huddles, experiencing them, and changing them as conditions change is a core competency for primary care practice in 2021 and beyond.

In his article, Mays also describes the ways in which QI efforts were derailed by the coronavirus disease 2019 (COVID-19) pandemic. He describes a clinic that was not able to achieve its goal of increasing vitamin B12 levels for its population, in large part because of COVID-19. Thus, we see even more in this work. We see ourselves. We see an industry and a society being reshaped by crisis. We see a reality that spawns, by necessity, new ways to provide novel services such as telehealth at a greatly increased scale. In health care, these services retain the same goal of providing high-quality, patient-centered, high-value care. These new approaches have provided a needed lifeline for patients to access clinicians and other caregivers and a pathway

Population Health Services, Tandigm Health, Conshohocken, PA

Corresponding author: Doron Schneider, dsch2699@gmail.com

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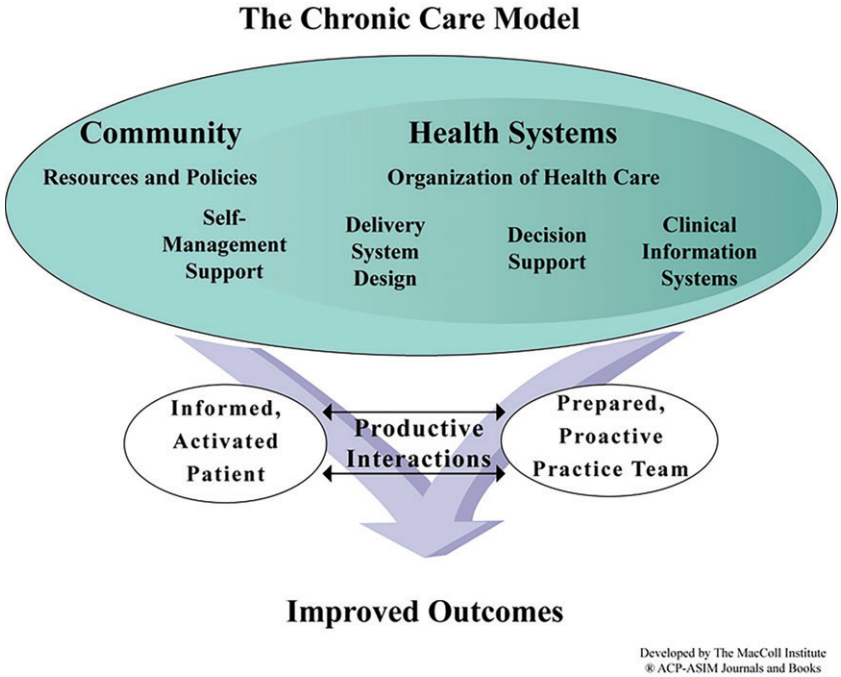

FIGURE 1 The Chronic Care Model. Copyright 1996–2020 The MacColl Center. The Improving Chronic Illness Care program is supported by The Robert Wood Johnson Foundation, with direction and technical assistance provided by Kaiser Permanente Washington Health Research Institute's MacColl Center for Health Care Innovation.

for these professionals to secure needed funds to maintain their clinic operations.

With thousands of primary care offices and clinics at risk because of the COVID-19 pandemic, we see Mays' small QI project as a candle in the darkness. The fact that his clinical team continued forward despite a shutdown and an unanticipated reorganization of the practice is a testament to the spirit of QI. The ability to conduct QI planning meetings among all stakeholders virtually, through Zoom or similar online meeting technologies, required a new skill set that was rapidly learned. These skills will now be part of the toolbox available for QI efforts of the future.

We see in the QI work by Lays and his colleagues more than a project that has a defined beginning, middle, and end. By definition, their project brought a new future to the clinic. The clinic will never be the same. Its clinicians and staff now understand how pre-visit planning and solid robust morning huddles can help to improve not only rates of vitamin B12 screening, but also so much more. Long after the students are gone, the clinic will use this new knowledge to achieve future successes. We encourage continued experimentation and innovation in care delivery and improvement, as they form the bridge to the future.

DUALITY OF INTEREST

No potential conflicts of interest relevant to this article were reported.

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