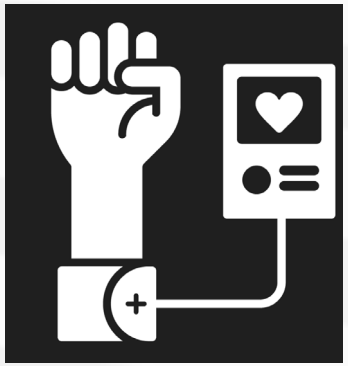

Improving Measure Outcomes:

Diabetes Management

Colleen Townsend, MD
Regional Medical Director

Amanda Kim
Improvement Advisor

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Learning Objectives

- Define the clinical background, specifications, and performance threshold definitions for the 2024 Primary Care Provider Quality Improvement Program Specifications: Comprehensive Diabetes Management - HbA1c Good Control, Retinal Eye Exam, and Blood Pressure Control for Patients with Diabetes measures.
- Apply measure specification requirements to maximize adherence and measure performance for the Comprehensive Diabetes Management – HbA1c Good Control, Retinal Eye Exams and Blood Pressure Control for Patients with Diabetes.
- Evaluate the prevalence and risk factors for diabetes mellitus and related diabetic conditions and associated health inequities prevalent in their diagnosis and treatment.
- Identify best and promising practices including access to care, successful clinical workflows, member and staff education, outreach, addressing social context which influence treatment decisions, referrals to local community resources, disproportionate prevalence and/or rates for diabetes complications and technical tips to improve Diabetes Management HbA1c Good Control rates

Overview of Clinical Guidelines for Comprehensive Diabetes Management

- HbA1c Good Control
- Retinal Eye Exam
- Controlling High Blood Pressure in Patients with Diabetes

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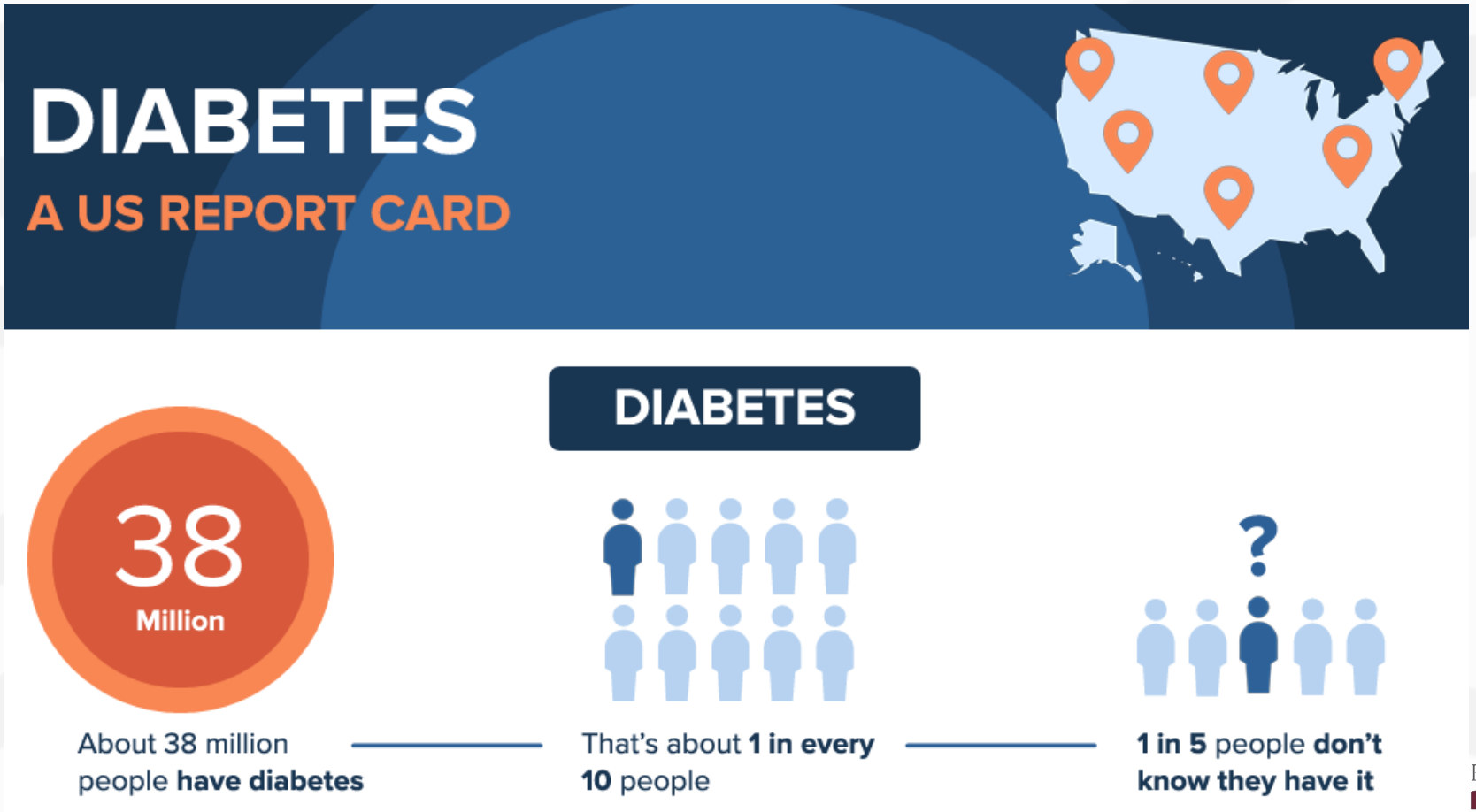
Fast Facts



www.cdc.gov/diabetes/health-equity/diabetes-by-the-umbers.html

Risk Factors for Diabetes

- Obesity, body fat distribution
- Western diet, sugar sweetened beverages
- History of diabetes in pregnancy, family history of diabetes
- Heart disease
- Metabolic syndrome, polycystic ovarian syndrome
- Certain medications - steroids like prednisone

Fast Facts

Diagnosis

Blood tests that show blood sugar is consistently elevated

- Blood Sugar
  - ≥ 126 mg/dL fasting
  - ≥ 200 mg/dL 2 hr OGT
- HbA1C ≥ 6.5% Measures glycolated hemoglobin

Impacts of Poorly Controlled Diabetes

- Fatigue, low energy
- Retinopathy / blindness
- Kidney disease
- Neuropathy
- Heart disease
- Stroke and dementia
- Poor wound healing
- Infection

Components of Treatment

- Nutrition and activity changes
- Oral medications
- Injectable medications

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Diabetic Retinopathy

- Screenings:
  - Type 1 diabetes – annual screenings beginning five years after diagnosis onset.
  - Type 2 diabetes – annual screenings beginning immediately.

- Patient education about the connection between glucose and blood pressure control is essential to decrease the risk of retinopathy or progression.

- The preferred screening method is digital retinal photography.

Controlling Blood Pressure in Patients with Diabetes

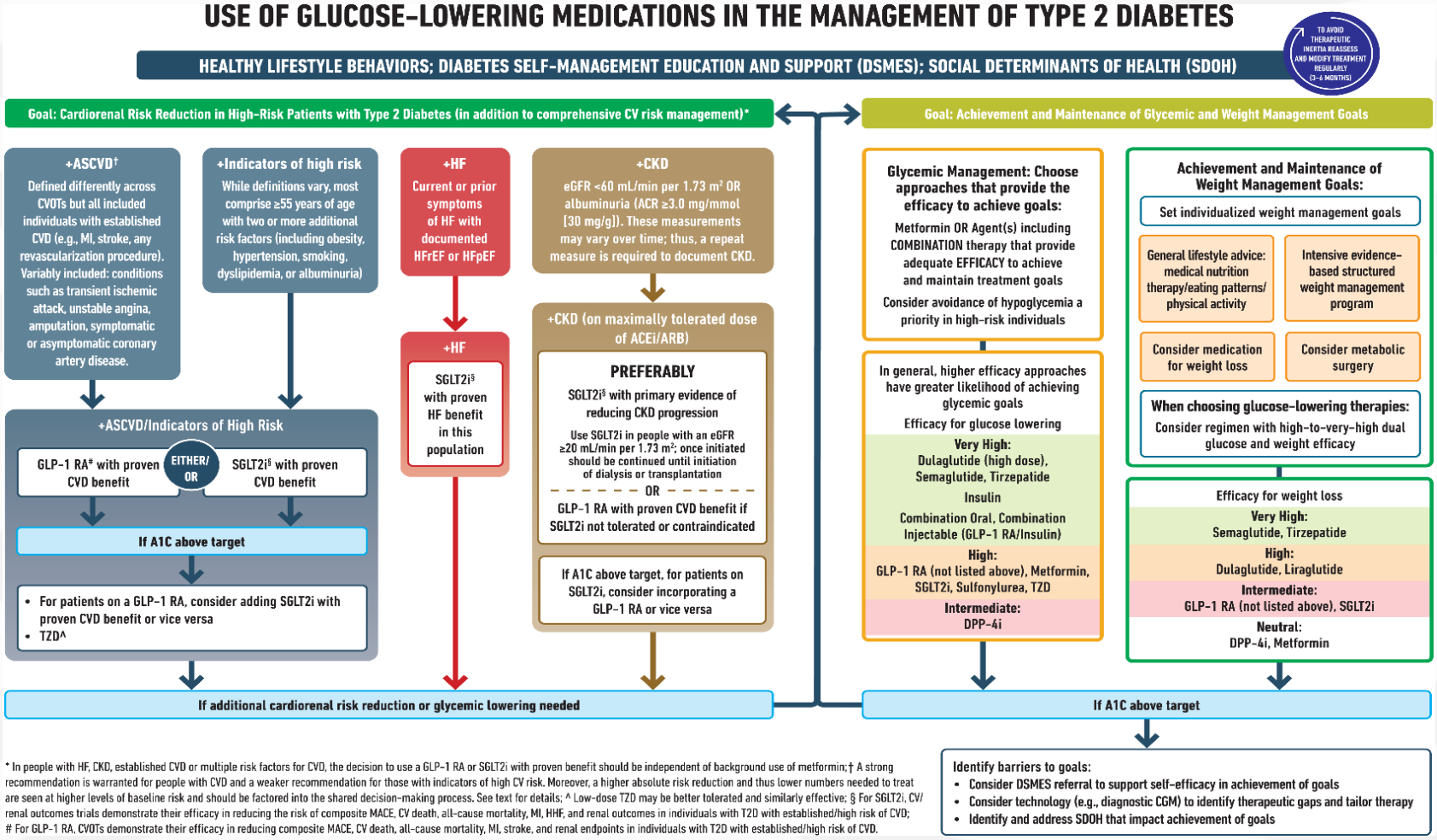
- Blood Pressure target is ≤130/90
- Blood Pressure goals should be individualized through a shared decision-making process to address
  - cardiovascular risks
  - potential adverse effects of medications
  - patient preferences
- Nutrition and activity interventions are first line treatments
- Medications and often multiple medications are needed to achieve goal BP measure

HbA1C Good Control

- Individualizing treatment based on specific patient factors is essential.
- An A1C goal for many non-pregnant adults of <7% without significant hypoglycemia is appropriate.
- Higher A1C goals (such as <8%) may be appropriate for patients with limited life expectancy or where the harms of treatment are greater than the benefits.

American Diabetes Association Clinical Care Guidelines 2023
https://doi.org/10.2337/cd23-as01

American Diabetes Association: Blood Sugar Control with Comprehensive Care



[Standards of Care in Diabetes—2023 Abridged for Primary Care Providers | Clinical Diabetes | American Diabetes Association (diabetesjournals.org)](https://diabetesjournals.org/clinical/article/41/1/4/148030/Standards-of-Care-in-Diabetes-2023-Abridged-for)

Health Disparities and Inequities

- HbA1c Good Control
- Retinal Eye Exam

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Why Collect Demographics Data

Capturing demographics data like language, race, ethnicity at the organization/clinic level may assist with:

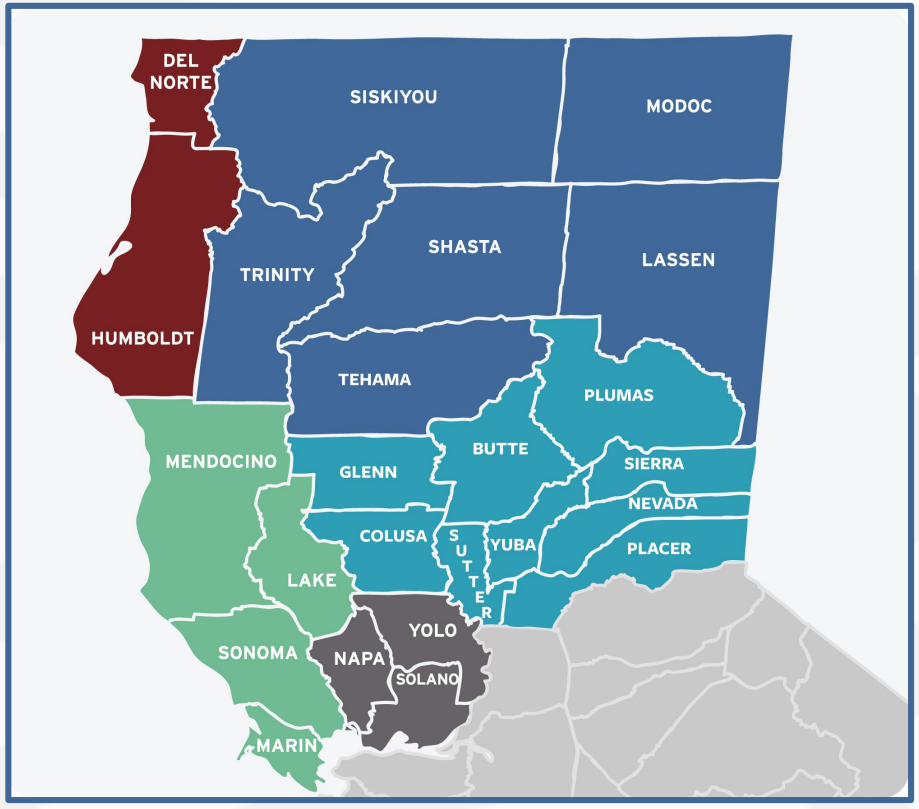
- Identifying race/ethnicity related disparities
- Enhancing availability of interpreters and translated, health-education member-facing materials
- Adaptation of existing services to better meet the cultural and health needs of members
- Improved community relations
- Improve member-clinician communication
- Improve member satisfaction

Disparities in Diabetes Rates and Complications

Diabetes Statistics by Race / Ethnicity - National	Black/African American (2021)	Native American/ Alaskan Native (2018)	Hispanic (2018)	Non-Hispanic White (2021)
DM Diagnosis (percent of adult population)	12.7	23.5	13.2	7.0
Death Rate due to DM (per 100K)	38.8	43.7	24.6	19.1
Visual Impairment	18.4	(not reported)	31.6	16
End Stage Kidney Disease (per million)	437.2	274.9	267.7	111.8

CDC 2022. National Diabetes Surveillance System and
2021. Summary Health Statistics: National Health Interview Survey
https://gis.cdc.gov/grasp/diabetes/diabetesatlas-surveillance.htm

Partnership's Regions



Southeast: Solano, Yolo, Napa

Southwest: Sonoma, Marin, Mendocino, Lake

Northeast: Lassen, Modoc, Siskiyou, Trinity, Shasta, Tehama

Northwest: Humboldt, Del Norte

East: Glenn, Butte, Plumas, Colusa, Sutter, Yuba, Nevada, Sierra, Placer

East data Not Yet Available

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Health Equity Data* from Partnership for HbA1c Good Control

NE	NW	SE	SW
65.83	56.46	66.85	69.42

NW

Asian/Pacific Islander	63.64
Black	58.97
Hispanic	67.10
Native American	23.68
Other	65.00
Unknown	55.95
White	58.59

NE

Asian/Pacific Islander	77.91
Black	67.93
Hispanic	69.28
Laotian	79.45
Native American	52.48
Other	77.50
Unknown	63.72
White	64.97

75th%	64.48
50th%	60.10
25th%	53.04
below 25th%	

SW

Asian Indian	74.51
Asian/Pacific Islander	73.44
Black	62.21
Filipino	76.92
Hispanic	70.44
Native American	61.83
Other	69.73
Unknown	70.23
Vietnamese	83.02
White	68.06

SE

Asian Indian	76.76
Asian/Pacific Islander	61.78
Black	59.36
Chinese	93.55
Filipino	79.81
Hispanic	68.03
Native American	52.78
Other	72.48
Unknown	63.82
Vietnamese	77.59
White	60.89

*2023 QIP Data

Health Equity Data* from Partnership for Retinal Eye Exams

NE	NW	SE	SW
54.53	41.59	53.07	54.93

NW

Asian/Pacific Islande	54.55
Black	43.59
Hispanic	51.14
Native American	21.93
Other	45.00
Unknown	33.93
White	42.45

NE

Asian/Pacific Islande	65.12
Black	47.17
Hispanic	62.76
Laotian	66.67
Native American	40.43
Other	60.98
Unknown	52.19
White	53.03

75th%	56.51
50th%	51.09
25th%	45.01
below 25th%	

SW

Asian Indian	52.94
Asian/Pacific Islande	62.50
Black	46.82
Filipino	58.67
Hispanic	58.83
Native American	56.02
Other	56.76
Unknown	50.21
Vietnamese	56.60
White	48.23

SE

Asian Indian	55.99
Asian/Pacific Islande	57.59
Black	46.54
Chinese	45.16
Filipino	64.72
Hispanic	54.87
Native American	47.22
Other	52.69
Unknown	52.34
Vietnamese	60.35
White	46.31

*2023 QIP Data

Health Disparities - Potential Drivers

Barriers to diabetic care include:

- Access to healthy food options impact inequities in management and control
- Limited health care access
- Poor control seen in those without a PCP visit > 1 year
- Dietary patterns by race and ethnicity
- Implicit bias, racism
- Culturally congruent care (providers reflect culture)
- Concerns with language and immigration status
- Poverty, unequal access to health care
- Lack of education
- Lack of transportation
- Difficulty to take time off work for care - financial stressors (transportation associated costs, reduction in pay)
- Competing priorities, including caring for other children, school schedules, and caregiver's own medical needs

Overview of Measures: QIP Specifications, Tools and Resources

- HbA1c Good Control
- Retinal Eye Exam

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Comprehensive Diabetes Management
HbA1c Good Control - PCP QIP Clinical Measure

Importance

Left unmanaged, diabetes can lead to serious complications, including heart disease, stroke, hypertension, blindness, kidney disease, diseases of the nervous system, amputations and premature death (National Diabetic Statistics Report, 2020).

Denominator: The number of continuously enrolled assigned members 18 - 75 years of age as of December 31 of the measurement year with diabetes identified as of December 31 of the measurement year (DOB between January 1, 1949, and December 31, 2006).

Numerator: The number of diabetics in the eligible population with evidence of the most recent measurement at or below the threshold for HbA1c ≤9.0% during the measurement year.

Partnership's Clinical Practice Guidelines for diabetes mellitus:
http://www.partnershiphp.org/Providers/Policies/Pages/ClinicalPracticeGuidelines.aspx

Comprehensive Diabetes Management
Retinal Eye Exam - PCP QIP Clinical Measure

Importance

Left unmanaged, diabetes can lead to serious complications, including blindness (National Diabetic Statistics Report, 2020).

Denominator: The number of continuously enrolled Medi-Cal members 18 - 75 years of age (DOB between January 1, 1949, and December 31, 2006) with diabetes identified as of December 31 of the measurement year.

Numerator: An eye screening for diabetic retinal disease as identified by administrative data.

Partnership's Clinical Practice Guidelines for diabetes mellitus:
http://www.partnershiphp.org/Providers/Policies/Pages/ClinicalPracticeGuidelines.aspx

Comprehensive Diabetes Management
PCP QIP Measure Exclusions

Identify members who did not have a diagnosis of diabetes, in any setting, during the measurement year or the year prior (January 1, 2023 – December 31, 2024) and who meet either of the following criteria:

- Members receiving palliative care during the measurement year.
- A diagnosis of gestational diabetes or steroid-induced diabetes in any setting, during the measurement year or the year prior to the measurement year with a current lab value (less than 12 months old) indicating no diabetes and more recent than the last diabetic triggering event visible in eReports.
    - In the PCP QIP Measure Specifications - See Appendix V for the diabetes management table that includes lab value ranges eligible as proof for exclusions and Appendix VI for the Diabetes Exclusions Flow Chart.
- Members prescribed certain diabetes medications for weight loss (with no diagnosis of diabetes), during the measurement year or the year prior to the measurement year.

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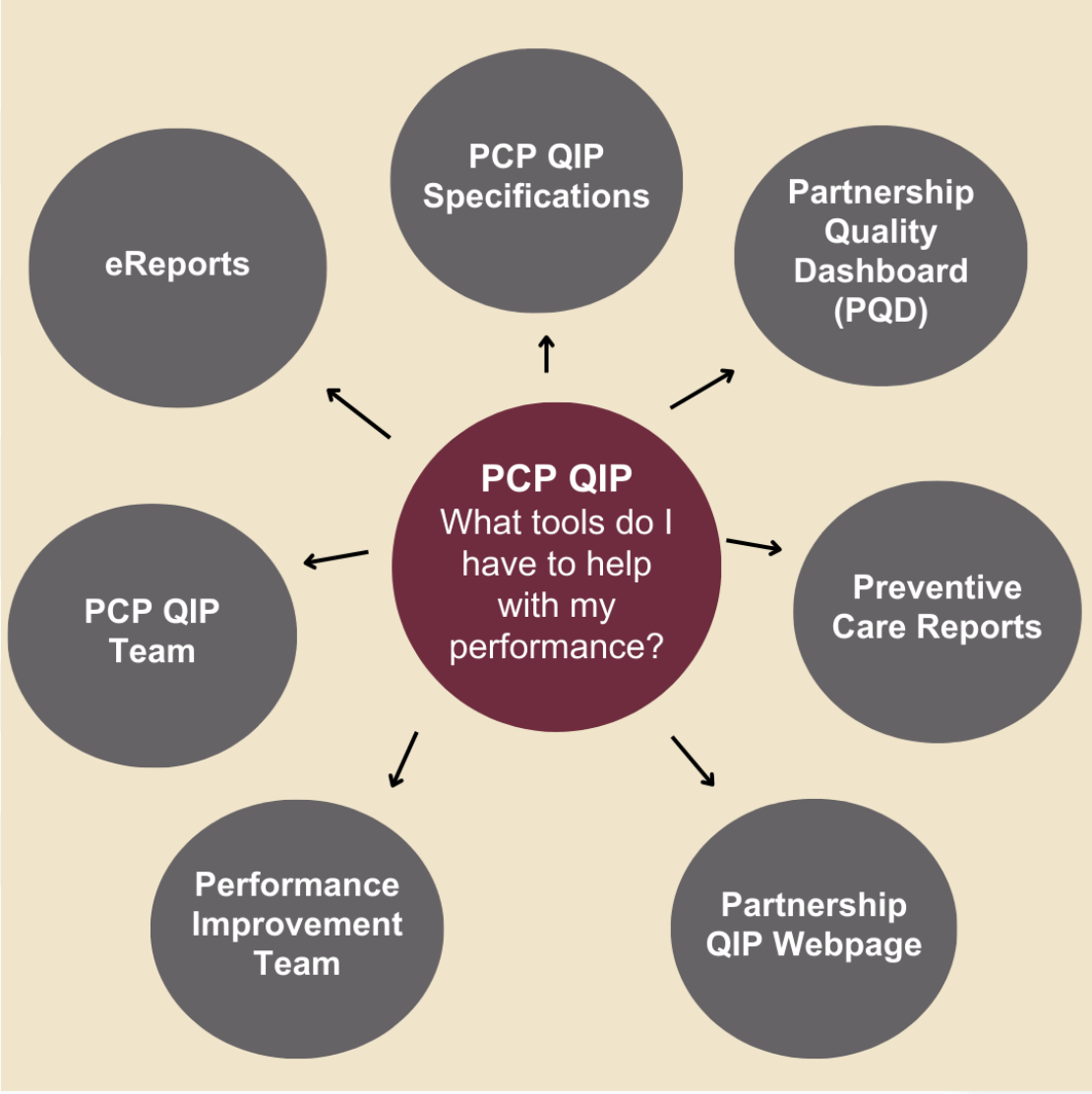
Quality Incentive Program Tools



Primary Care Provider Quality Improvement Program (PCP QIP)

To get to this page:
PartnershipHP.org > Providers > Quality > Quality Improvement Programs (QIP) > Primary Care Provider Quality Improvement Program (PCP QIP)

Click “Learn More about the 2024 PCP QIP”

PCP QUALITY IMPROVEMENT PROGRAM

The Primary Care Provider Quality Improvement Program (PCP QIP), designed in collaboration with Partnership HealthPlan of California providers, offers substantial financial incentives, data resources, and technical assistance to primary care providers who serve our capitated Medi-Cal members so that significant improvements can be made in the following areas:

- Prevention and Screening
- Chronic Disease Management
- Appropriate Use of Resources
- Primary Care Access and Operations
- Patient Experience

Contact Us

Email: QIP@partnershiphp.org (please allow two business days for a response)
Fax: (707) 863-4316

PCP QIP Overview

To help orient our providers to the PCP QIP year, we have provided measurement set documents, a code list, and other useful tools and resources.

Learn More about the 2024 PCP QIP

New 2023 Equity Adjustment

Webinars

PCP QIP webinars

Upcoming Webinars and Trainings

On Demand Courses

PCP QIP Page

- What are the measures and changes from 2023 to 2024?
- Specifications Summary
- Non-Clinical Code Lists
- eReports Link
- Annual Timeline Recommendations

PCP QIP 2024

This page includes measurement documents and tools referring to the last and current program years spanning
January 1, 2023 – December 31, 2024.

Approved 2024 PCP QIP Measure Summary (Added January 3, 2024).

Measurement Set Documents

Measure Specifications

Measures vary by practice type. The following document includes measure descriptions and requirements as well as data submission processes by type.

2024 Specifications Manual

Code List

Clinical Measurement Set - Please use eReports Diagnosis Crosswalk to view the code set.

Non-Clinical Measures - Non-clinical code set (Updated October 12, 2022).

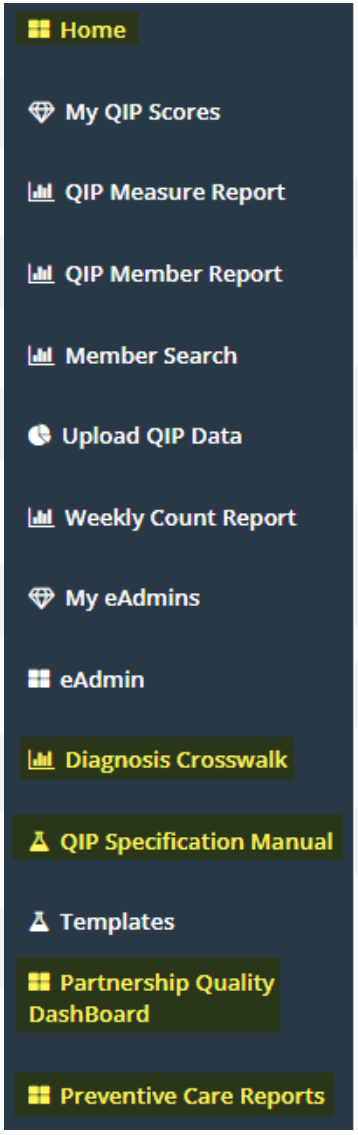
Tools

Click here for eReports

Please refer to the specifications document for your practice type for a data submissions timeline and submission templates.

Timeline for Addressing 2024 and 2025 PCP QIP Measures
Added January 3, 2024

eReports Menu



- Home screen
  - Home button takes you to your current performance dashboard
- Diagnosis Crosswalk
  - Billing codes for numerator compliance
- QIP Specification Manual
  - Detailed specifications
- Partnership Quality Dashboard (PQD)
  - Historical performance view
  - Estimated QIP dollars
  - QIP Stoplight report
- Preventative Care Reports
  - Immunizations and well-care visits

eReports: Diagnosis Crosswalk Coding Questions

- Home
- My QIP Scores
- QIP Measure Report
- QIP Member Report
- Member Search
- Upload QIP Data
- Weekly Count Report
- My eAdmins
- eAdmin
- Diagnosis Crosswalk
- QIP Specification Manual
- Templates
- Partnership Quality DashBoard
- Preventive Care Reports

Back to Basics

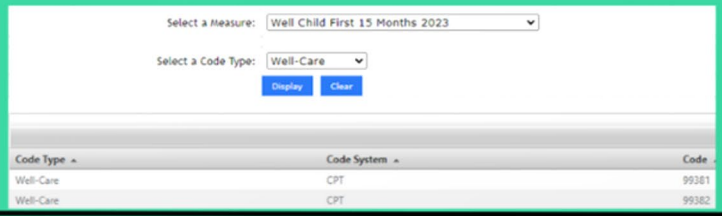
DID YOU KNOW?

About the

Diagnosis Crosswalk

Found in eReports, the **Diagnosis Crosswalk** contains billing codes required for numerator compliance for *all* QIP clinical measures.

Choose your measure of interest and all codes included in the measure logic are listed.



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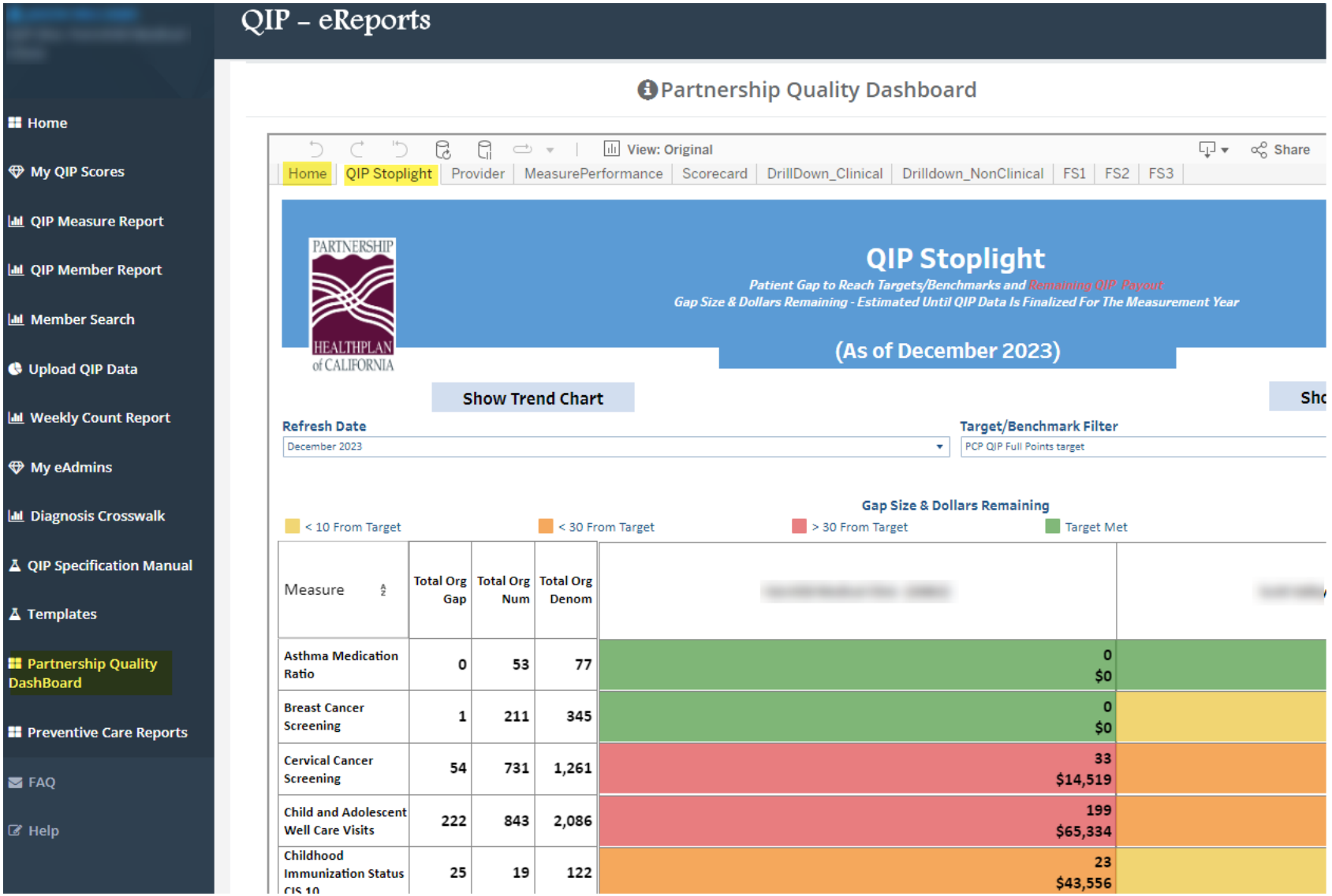
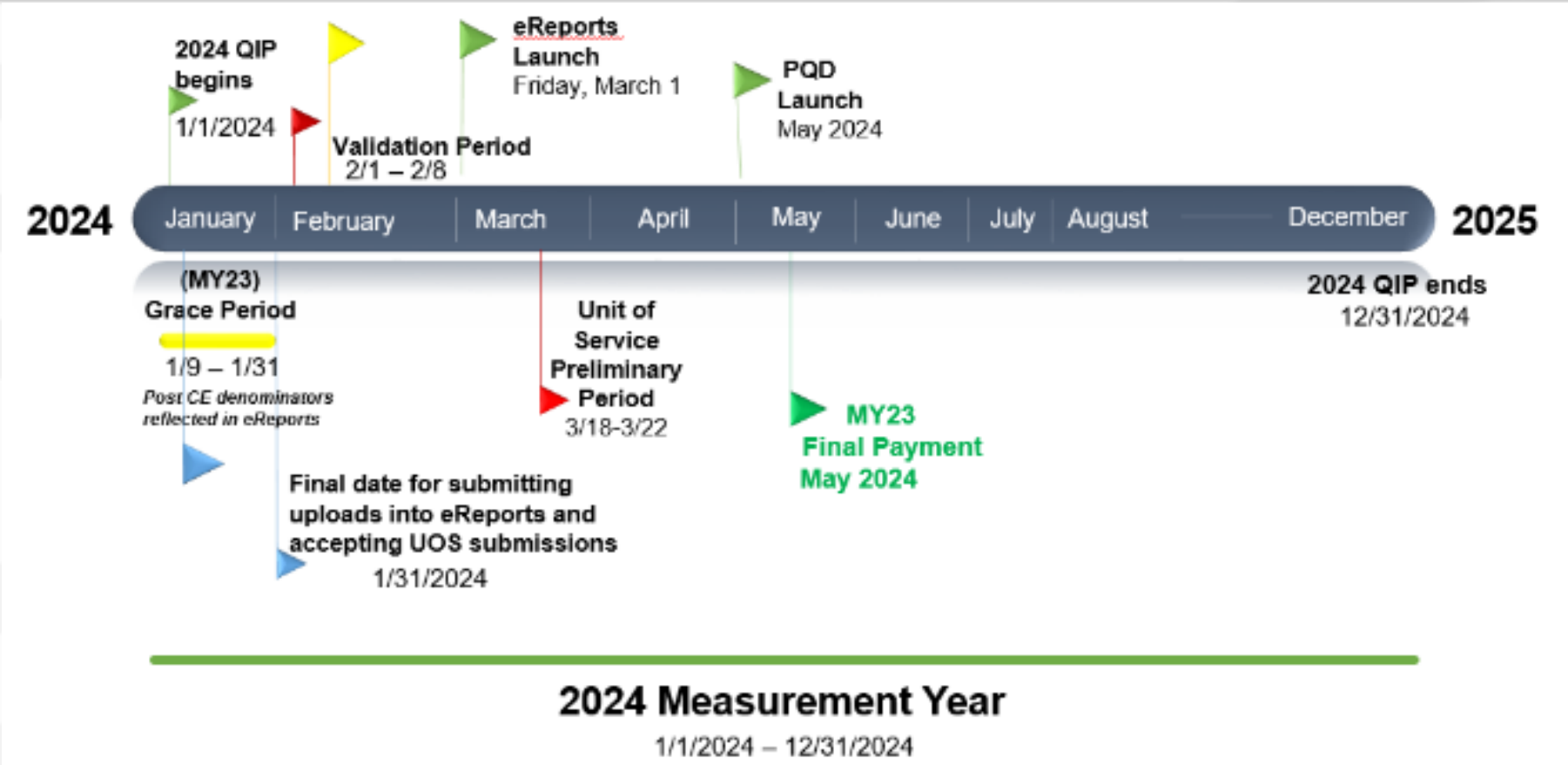
eReports: PQD - QIP Stoplight Report



Additional Resources

- Need to reach the PCP QIP Team? QIP@PartnershipHP.org
  - eReports access
  - Measure specification questions
- Need a resource for improving performance? Reach out to the Performance Improvement Team: ImprovementAcademy@PartnershipHP.org
  - Coaching, measure best practices, sounding board, project planning guidance, facilitation
- Partnership Quality Dashboard (PQD) User Guide
- Link to PCP QIP Webinars Page: 2024 Kick-Off Webinar recordings are now available for PCP QIP and eReports

PCP QIP Timeline



Putting Quality Into Practice

- Measure Best Practices
- Resources
- Voices from the Field

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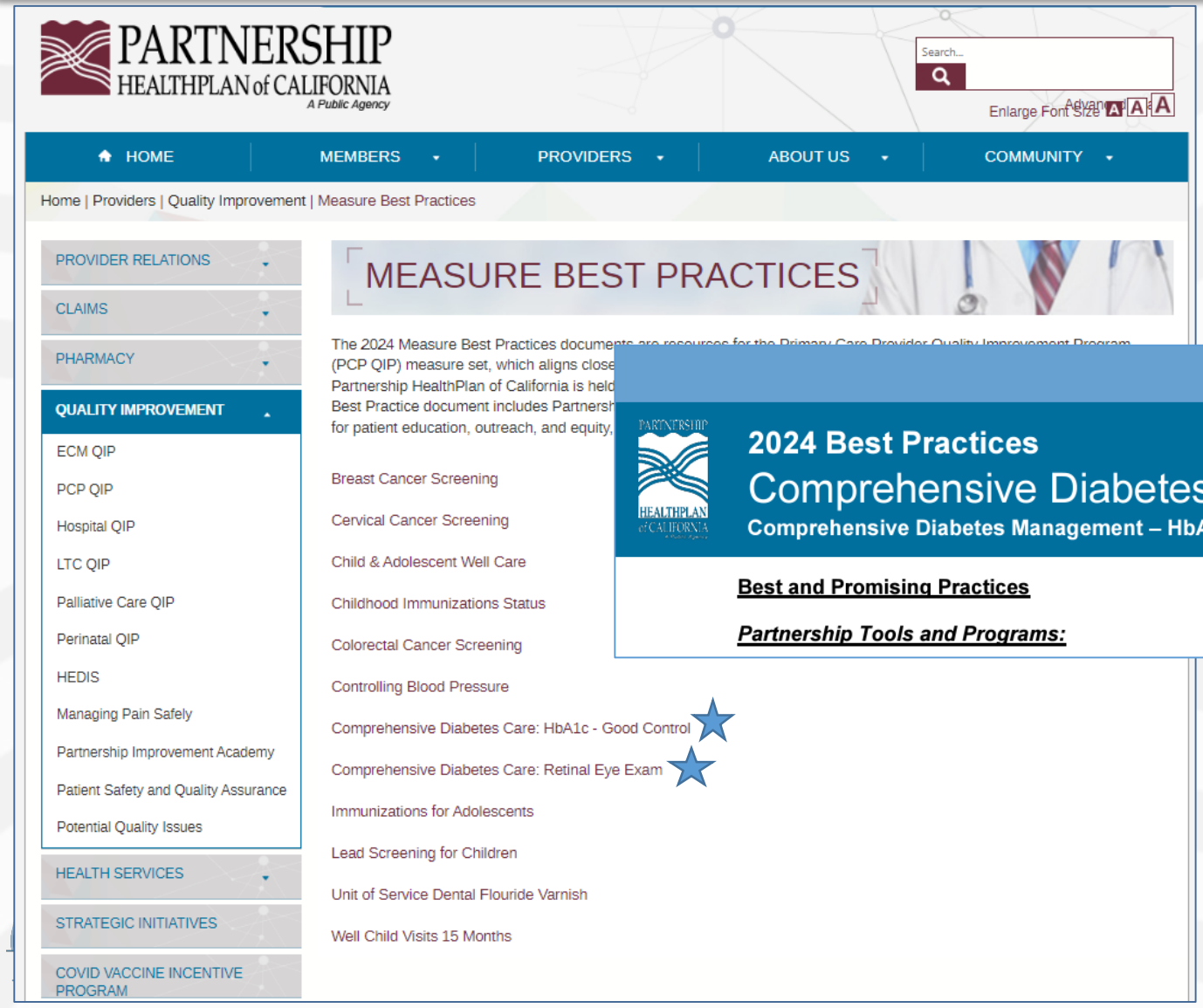
Measure Best Practices - Diabetes Management



Link to Measure Best Practices

Measure Best Practices - Diabetes Management

Outreach

- Designate a team member to contact patients due for testing (phone call, post card, letter signed by provider, text).
- Call patients within a week to reschedule missed in-house blood draws.

Patient Education

- Reinforce medication use and physical activity.
- Refer to nutrition education, in-house, or via telehealth.
- Use all visits to increase health literacy.
- Ensure information is person-centered.
- Reinforce the importance of self-testing and self-management.

Measure Best Practices - Diabetes Management

Workflows

- On-site HbA1c testing, possibly performed while rooming patients.
- Perform/order testing regardless of the reason for the office visit.
- Leverage telehealth - Utilize team members at the top of their scope of practice.
- Cross-departmental coordination of care.
- Ensure patients are informed of results and next step(s).
- Submit claims and encounter data within 90 days of service.
- Refer/enroll with Chronic Case Management.
- Consider holding a diabetes management day every quarter: HbA1c checks, eye exams, foot screenings, consults (education, nutritional info).

Measure Best Practices - Diabetes Management

Diabetic Eye Exams

- If your practice offers vision services, schedule the patient's diabetic retinopathy exam visit during check-out, or as part of the rooming process.
  - Or search for VSP locations with the American Diabetes Association logo.
  - Or consider adding retinal photography to clinic services with remote reading by experts.
- Follow up on referral processes and ensure completion of visit and results received.
- EHR alert when patient are due for a comprehensive eye exam.

Measure Best Practices - Diabetes Management

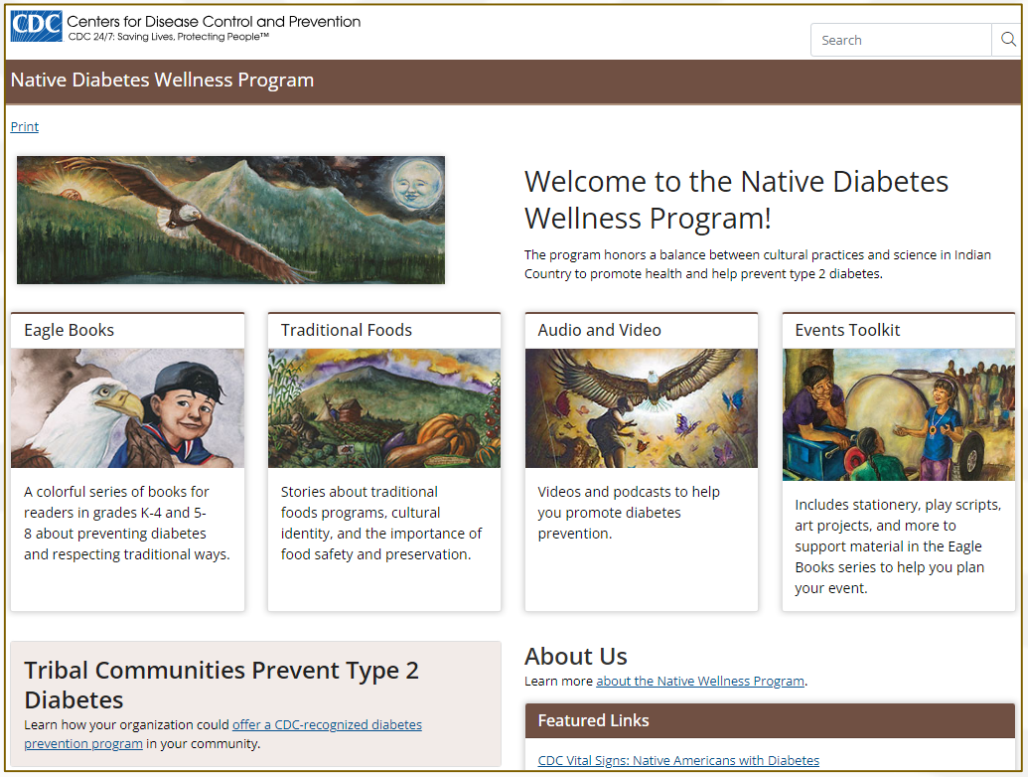
Strategies with a Health Equity Focus

- The DrillDown Clinical tab in the eReports portal shows race/ethnicity information for each member included in the measure. Export this dashboard to look at Comprehensive Diabetes Care compliance rates by race and ethnicity to learn more about inequities within your patient community.
- Identify possible barriers by specific communities (race, ethnicity, location by zip code, and preferred language).
- Ensure member information is consistent, welcoming, plain and person-centered, language appropriate, and delivered in traditional and electronic applications, per patient's preference.
- Identify and address barriers to care (transportation, language, and cultural beliefs). Partner with established community agencies such as schools, community centers, and faith-based organizations.

Resources - CDC

Information for Diabetes Professionals:
https://www.cdc.gov/diabetes/professional-info/index.html

The Native Diabetes Wellness Program
https://www.cdc.gov/diabetes/health-equity/indian-country.html



Resources - Partnership

- Partnership Website - Provider Diabetes Resources: https://www.partnershiphp.org/Providers/HealthServices/Pages/Health%20Education/Diabetes.aspx
- TeleMed2U – Paid by Partnership
  - Program Link
  - Link to Partnership Referral Instructions
- Medical Nutrition Therapy (MNT) - More Information
- Partnership Care Coordination Department
  - Patient call (800) 809-1350
  - Provider secure email to: CareCoordination@PartnershipHP.org
- Covered Diabetic Medications: Medi-Cal RX Contract Drug List

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Voices from the Field

Martha Ugbinada, Clinical Systems Tech

Mountain Valleys Health Centers

2023

DIABETES – HbA1c

Mountain Valleys
HEALTH CENTERS

Martha Ugbinada
Clinical Systems Technician
530.999.9030 ext. 5161
mugbinada@mountainvalleys.org

Mountain Valleys
HEALTH CENTERS

Mountain Valleys Health Centers (MVHC) are located in the heart of beautiful, northeastern California. We offer seven clinics spanning over a *200-mile* radius, including ***Big Valley, Fall River Mills, Burney, Butte Valley, Tulelake, Mount Shasta and Weed,*** *MVHC served over 11,400 patients in 2023.*

Mountain Valleys
HEALTH CENTERS

MVHC had 229 total Partnership Diabetics in the denominator - of those 180 are in the Numerator for the Diabetes - HbA1C Good Control for the calendar year 2023.

79%

Mountain Valleys
HEALTH CENTERS

MVHC has POC HbA1c machines at all 7 sites.

Mountain Valleys
HEALTH CENTERS

MVHC provided Back-Office Standing Orders/Guidelines for staff

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HEALTH CENTERS

Back-Office Standing Orders/Guidelines

DIABETES	
These standing orders are protocols that authorize designated staff members to complete certain tasks without first having to obtain a provider's order.	
Diabetes Management	❖ Retinal/Eye Exam 1 time per year ❖ Foot Exam 1 time per year ❖ Urine Microalbumin 1 time per year ❖ HbA1c • Uncontrolled HbA1c >9 ○ DM Visit every 3 months ○ HbA1c every 3 months • Controlled HbA1c <9 ○ DM Visit every 6 months ○ HbA1c every 6 months

Mountain Valleys
HEALTH CENTERS

The Workflow

For the 2023 CY, our Population Health Advocate (PHA) recalled diabetics. She scrubbed the chart, ensuring the patient was due for a diabetic exam, capturing the date of the last HbA1c, and then sending out a diabetic recall letter.

However, toward the middle of the third quarter (due to staffing shortages/turnover), the PHA would make the call and transfer it to the FO for the patient to be scheduled. ***This was more work but successful.***

Mountain Valleys
HEALTH CENTERS

MVHC utilizes CPTII codes when doing the vitals. We have HbA1c as a standing order and the clinical support staff obtain an A1c prior to the provider being in the exam room.

CPTII Codes Utilized:

- **HbA1C Codes:**
  - **3044F <7.0%**
  - **3051F =>7.0% and <9.0%**
  - **3052F >9.0%**

Mountain Valleys
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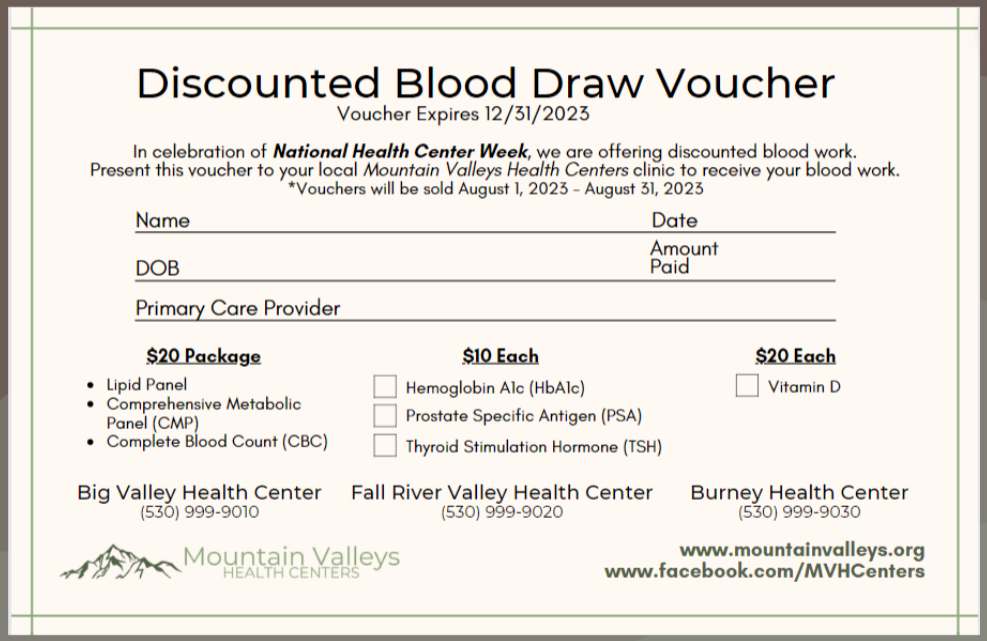
MVHC also offers Wellness Labs at a flat rate in August and the voucher is good until 12/31 for those patients with private/no insurance.



Discounted Blood Draw Voucher

Voucher Expires 12/31/2023

In celebration of ***National Health Center Week***, we are offering discounted blood work.
Present this voucher to your local *Mountain Valleys Health Centers* clinic to receive your blood work.
*Vouchers will be sold August 1, 2023 – August 31, 2023

Name _____ Date _____

DOB _____ Amount Paid _____

Primary Care Provider _____

$20 Package

- Lipid Panel
- Comprehensive Metabolic Panel (CMP)
- Complete Blood Count (CBC)

$10 Each

- ☐ Hemoglobin A1c (HbA1c)
- ☐ Prostate Specific Antigen (PSA)
- ☐ Thyroid Stimulation Hormone (TSH)

$20 Each

- ☐ Vitamin D

Big Valley Health Center (530) 999-9010
Fall River Valley Health Center (530) 999-9020
Burney Health Center (530) 999-9030

Mountain Valleys HEALTH CENTERS

www.mountainvalleys.org
www.facebook.com/MVHCenters

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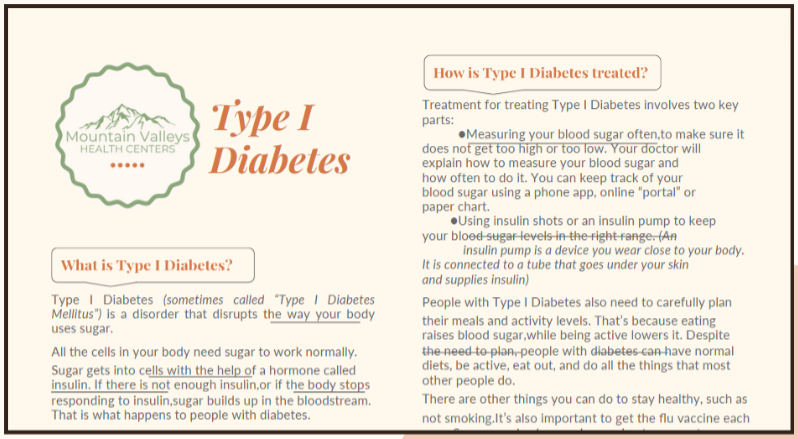
Provider Education

MVHC providers offer patient education for all diabetics.

The standard is if an HbA1c is below 7, the patient should be seen every 6 months.

If the HbA1c is above that, they must be seen every 3 months and more frequent if above 9.

This varies by provider/patient adherence.



Mountain Valleys HEALTH CENTERS

Type I Diabetes

What is Type I Diabetes?

Type I Diabetes *(sometimes called "Type I Diabetes Mellitus")* is a disorder that disrupts the way your body uses sugar.

All the cells in your body need sugar to work normally. Sugar gets into cells with the help of a hormone called insulin. If there is not enough insulin,or if the body stops responding to insulin,sugar builds up in the bloodstream. That is what happens to people with diabetes.

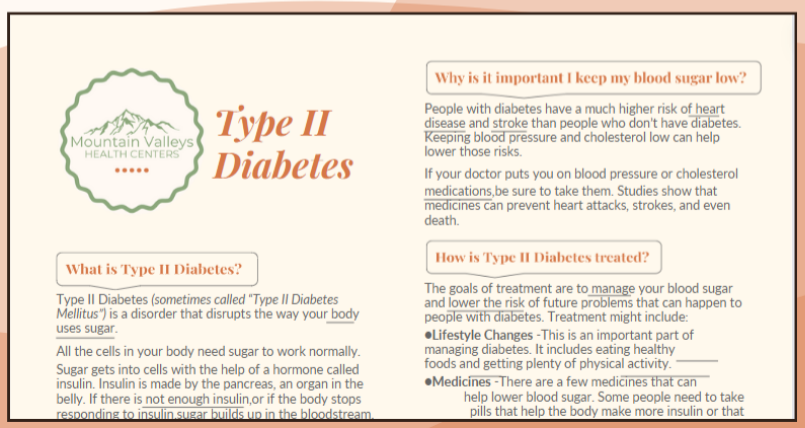
How is Type I Diabetes treated?

Treatment for treating Type I Diabetes involves two key parts:

- Measuring your blood sugar often,to make sure it does not get too high or too low. Your doctor will explain how to measure your blood sugar and how often to do it. You can keep track of your blood sugar using a phone app, online "portal" or paper chart.
- Using insulin shots or an insulin pump to keep your blood sugar levels in the right range. *(An insulin pump is a device you wear close to your body. It is connected to a tube that goes under your skin and supplies insulin)*

People with Type I Diabetes also need to carefully plan their meals and activity levels. That's because eating raises blood sugar,while being active lowers it. Despite the need to plan, people with diabetes can have normal diets, be active, eat out, and do all the things that most other people do.

There are other things you can do to stay healthy, such as not smoking.It's also important to get the flu vaccine each



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Type II Diabetes

What is Type II Diabetes?

Type II Diabetes *(sometimes called "Type II Diabetes Mellitus")* is a disorder that disrupts the way your body uses sugar.

All the cells in your body need sugar to work normally. Sugar gets into cells with the help of a hormone called insulin. Insulin is made by the pancreas, an organ in the belly. If there is not enough insulin,or if the body stops responding to insulin,sugar builds up in the bloodstream.

Why is it important I keep my blood sugar low?

People with diabetes have a much higher risk of heart disease and stroke than people who don't have diabetes. Keeping blood pressure and cholesterol low can help lower those risks.

If your doctor puts you on blood pressure or cholesterol medications,be sure to take them. Studies show that medicines can prevent heart attacks, strokes, and even death.

How is Type II Diabetes treated?

The goals of treatment are to manage your blood sugar and lower the risk of future problems that can happen to people with diabetes. Treatment might include:

- **Lifestyle Changes** -This is an important part of managing diabetes. It includes eating healthy foods and getting plenty of physical activity.
- **Medicines** -There are a few medicines that can help lower blood sugar. Some people need to take pills that help the body make more insulin or that

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MVHC had Appointment cards in the exam rooms that providers utilize (some) and give to the patients so they can stop at check out and schedule their follow-up appt.

Advanced Scheduling

Please contact your clinic if you are unable to keep your appointment.

Date	Time	Provider	Location	Appt. Type
Date	Time	Provider	Location	Appt. Type
Date	Time	Provider	Location	Appt. Type
Date	Time	Provider	Location	Appt. Type
Date	Time	Provider	Location	Appt. Type

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MVHC had staff awareness of the QIP score by site and lists would be worked by staff intermittently as well during down time at select locations.

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Our QI focus for this 2024 CY is Retinal Eye Exams. MVHC has 2 Retinal Eye camera's that we can use and travel with from clinic to clinic.

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Thank you Partnership for Your Continued Support!

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Upcoming Opportunities and Evaluation

Upcoming Trainings:
Improving Measure Outcomes Webinar Series

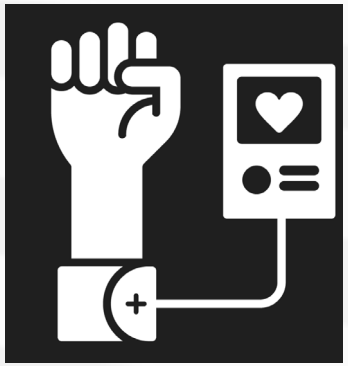
Improving Measure Outcomes Webinar Series

2024 Remaining Sessions:

- April 10, 2024 - Breast and Cervical Cancer Screenings
- April 24, 2024 - Perinatal Care and Chlamydia Screening

Registration: http://www.partnershiphp.org/Providers/Quality/Pages/Quality_Events.aspx

Contact: improvementacademy@partnershiphp.org



Improving Measure Outcomes Series

We are requesting feedback for the Improving Measure Outcomes Webinar Series.

For those who have attended **two or more** webinars in our series, you will be sent a nine question evaluation rating this series on April 29.

Your candid feedback is requested.

For taking the time to complete, one lucky provider office will receive a gift from Edible Arrangements® to share with their staff!

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Upcoming Trainings:
ABCs of QI In-Person Trainings

ABCs of Quality Improvement

Wednesday, May 1 in Chico - 8:30 a.m. to 4:30 p.m. - **IN PERSON**
Enloe Conference Center, 1528 Esplanade
Breakfast and lunch included for attendees

Registration: http://www.partnershiphp.org/Providers/Quality/Pages/Quality_Events.aspx

Contact: improvementacademy@partnershiphp.org

Contact Us

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Colleen Townsend, MD

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QI/Performance Team:
ImprovementAcademy@partnershiphp.org

Evaluation

Please complete your evaluation. Your feedback is important to us!