7 INTRODUCTION OF MĀORI AND PACIFIC NURSE NAVIGATORS TO IMPROVE EQUITY IN SURGICAL PATHWAY IN AUCKLAND, NEW ZEALAND

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Background Health outcomes for Māori and Pacific within New Zealand significantly poorer than for European New Zealanders. One identified inequity is the delay in receiving planned surgery. As a result of reduced surgery during the Covid-19 lockdown, these inequities were exacerbated.

Objectives Improve key metrics for Māori and Pacific patients receiving surgery (increase volume receiving surgery, decrease waiting times and decrease cancellation of surgery as well as identify systemic barriers to equitable care delivery).

Methods Ten Māori and ten Pacific nurse specialists were seconded to walk alongside patients awaiting surgery to identify and resolved immediate issues preventing progress. Care navigation by clinical staff, using Māori and Pacific health models in their interactions, allows patients to progress through their pathway through active engagement with the services. It is also allows for the gathering of data (quantitative and narrative) to understand where processes need to change to ensure equitable and timely care is provided. Through the experiences of those currently on the surgical wait list, alternative surgical models of care can be defined.

Results Early results suggest that the key metrics (days waiting, proportion of surgeries completed for Māori and Pacific patients and proportion of surgeries proceeding as planned) are improving. Qualitative feedback from patients and staff is clearly identifying opportunities as well as demonstrating the early value of having clinical staff supporting patients through their journey applying culturally safe and appropriate support.

Conclusions While still early in the development of the approach, initial results are highly promising and demonstrate

that often what is missing in a patient's surgical journey is a consistent voice that provides certainty for patients and their families. Through the patient experiences gathered, service redesign will be possible that supports Māori and Pacific patients to achieve the outcomes they want.

8 RAPID CYCLE IMPROVEMENT IN THE HOT ZONE

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Background UNTHSC opened Fort Worth's first drive-through coronavirus testing site which functioned as both a community service and an opportunity for health professional students to learn rapid cycle improvement. Nasopharyngeal swabs were administered through vehicle windows in what was referred to as 'the hot zone.' Throughout 12 weeks many changes were made to the hot zone, including installing a tent, adding a second lane, improving hot zone staff training, and staggering opening times.

Objectives To ensure safe, efficient, and effective SARS-CoV-2 testing for patients and staff.

Methods Total tests and times per test were recorded. Time in PPE was calculated from the time PPE was donned to average time doffed. Positive test count was used as a metric for pathogen exposure. Total cases among staff were also recorded along with near misses, incidents, and good catches as discussed in daily team debrief. Training was standardized and videos were created for hot zone and safety officer staff.

Results The site was open from March to June. With the tent, the accidental hot zone entry rate dropped from average of almost once per day to only once in 11 weeks. There were only 3 heat related incidents intercepted and 0 cases of COVID-19 among the 400 students and faculty. 8 safety incidents occurred. An average of 4 good catches or incidents prevented were counted per week. With staggering, time in full PPE was reduced from 165 minutes to 120 minutes. The

Abstract 8 Figure 1

record for most tests administered per shift increased from 55 for one lane to 112 for two lanes (figure 1).

Conclusions Lessons learned here about heat safety, pathogen safety, and hot zone training can be applied to all drive thru testing sites. With this ongoing pandemic, it is wise to look for ways to improve test sites as well as potential vaccination sites.

9 RHEUM SERVICE: IMPROVING VIRTUAL CARE DURING COVID-19

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Background During COVID-19, rheumatology outpatients need timely access to care while social distancing. Video consults have potential to improve virtual assessments, however, some patients and providers are apprehensive about using this technology.

Objectives Provide delightful and effective video consults for 90% of new patients by July 1.

Methods We redesigned video appointments to create a seamless virtual experience. PDSA Series 1 identified improvement opportunities with a process map, fishbone, and driver diagram. PDSA Series 2 tested and implemented change ideas: digital appointment confirmations, reminders, and forms; video consults with limited pre-call testing; digital reports, requisitions, and messaging. PDSA Series 3 refined changes by decreasing reminders, increasing pre-call tests, and adding backup video platforms. Outcome measures were: 1)% consults by video, 2)% requesting more video appointments. Process measures were: 1) pre-call tests completed, 2) technical difficulties. Our balance measure was% virtual diagnoses modified after in-person visits. We collected data over ten weeks and emailed anonymized patient surveys one week after video consults. We analyzed data with run charts and descriptive statistics.

Results We scheduled 135 new consults: 120 (89%) video, 14 (10%) phone, and 1 (1%) office. Twenty-one patients (16%) did not own a video-enabled device. Pre-visit, 12 patients (10%) participated in pre-call testing. Video consults were initiated for 97% of scheduled patients; of these, 6% suffered technical difficulties, requiring a switch to phone or another video platform. Surveys were completed after 40% (48/120) of video visits: 68% of patients wanted another video appointment; 28% were 'not sure'; 4% declined. Virtual diagnoses stayed the same for 84% (32/38) of patients with follow-up in-person assessments.

Conclusions While video consults proved effective for most patients, sociodemographic and technological barriers prevented others from participating. Next steps include improving access to video-enabled devices and providing more pre-visit training to reduce these barriers.

10 USE OF MANAGERIAL EPIDEMIOLOGY BY HEALTHCARE LEADERS IN AMBULATORY SETTINGS

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Description Despite many health reforms, the United States continues to struggle with limited healthcare access, exponential healthcare costs, and poor quality of care. Overcoming these challenges requires healthcare leaders' effective navigation of industry transformation towards population health and a shift in patient volume to ambulatory healthcare settings. Research has demonstrated that the use of managerial epidemiology, an application of epidemiology tools and principles to management decision-making within healthcare organizations, can better serve the health of the population and could improve the triple aim of inadequate access, high costs, and poor quality. However, the adoption of this practice is weak and its utilization by current healthcare leaders has not yet been studied. Diffusion of innovation theory framed this qualitative study to understand the perspectives of ambulatory healthcare leaders on using managerial epidemiology within their leadership approach as well as understand the spread of this practice and associated barriers. Twelve healthcare leaders participated in semistructured interviews. Findings from open-axial coding of the interview data indicated managerial epidemiology is critical and validated the importance of managerial epidemiology for impacting the triple aim, population health, and overall system performance. Additionally, this study provided steps to accelerate the adoption and highlighted the use of managerial epidemiology during a pandemic, which has worldwide implications for improving health and performance of healthcare globally therefore promoting social change.

11 FRAMING EQUITY, DIVERSITY & INCLUSION EFFORTS ACROSS THE CONTINUUM OF MEDICAL EDUCATION USING IHI MODEL FOR IMPROVEMENT

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Background Medical education (ME) must create equitable, diverse, and inclusive (EDI) training environments for our learners, faculty, and staff and equitable care for the patients they serve. As ME leaders spanning students to CME and libraries, we are accountable for addressing structural 'isms' in all forms (eg, race, gender-identity, religion).

Objectives Our purpose is to be intentional and public in our actions to address EDI across the continuum of medical education using the IHI Model for continuous improvement. We have 3 specific objectives, one each at the micro, meso, and macro levels.

Methods Each education department leader provided their current EDI activities and focal areas for future work along with proposed measures. These interventions were then reviewed to identify actionable interventions and associated metrics across the ME continuum seeking to use existing data for longitudinal tracking when possible. The document was shared and discussed with key stakeholders with iterative revisions to develop and assure plan engagement and support.

Results Four actionable EDI education-related categories were agreed upon: (1) purpose & culture; (2) recruitment and retention; (3) curriculum and program structure; (4) evaluation and assessment (figure 1). Within each category 2–3 specific PDSA interventions were identified for action within