Healthy lives take *root* here

Building a Framework for Patient-Centered Diabetic Care

Bryan Health

Value Proposition

We are the catalyst for partner hospitals that want in their local communities and inspire consumers to make healthy decisions for life.

Value Propositions…*a long term commitment*

For the customer/consumer…

I am inspired to make healthy decisions about my life.

- I am in control.
- I am able to access care when and where I want.
- I am connected to life coaches and care teams who know and care about me.
- I am empowered to make knowledgeable decisions.
- I am engaged in and loyal to my local health and life services community.
- I am healthy – it is my natural state of being – and I aim to keep it that way.

For the community hospitals…

We are excited to see healthy lives take root here.

- We are in control.
- We are better positioned to excel in the future.
- We inspire our community to make healthy decisions.
- We are touching more lives in ways we never imagined possible.
- We are interwoven with the community.
- We are a healthy organization (it's rooted in our culture).

For Bryan Health…

We are elevating and sustaining the future of health for Nebraska and our neighboring rural communities.

- We inspire entire communities to bring health to life.
- We connect our partners to proven and personalized quality care (and the resources they need to transform their organizations) for the future.
- We foster collaboration to create healthy connections for life within our communities.
- We are the catalyst for partner hospitals who want to encourage healthy lives to take root in local communities.

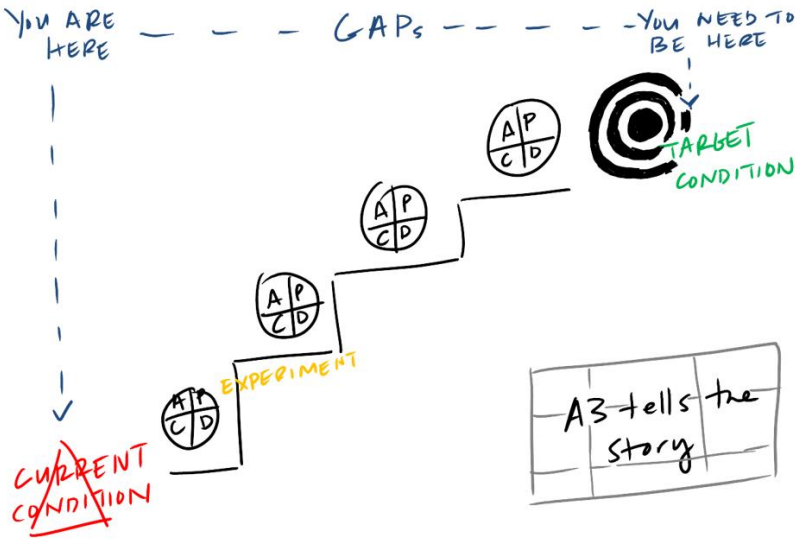
Framework for Collaborative

IHI Collaborative Model for Achieving Breakthrough Improvement

Quality Care: IHI Collaborative Model

Driving Vision:

Sound science exists on the basis of which the costs and outcomes of current health care practices can be greatly improved, but much of this science lies fallow and unused in daily work. There is a gap between what we know and what we do.



" Right care for the right person at the right time, the first time"

Carolyn Clancy, Director, Agency for Healthcare Research & Quality

IHI Framework

- Interactive learning system that brings together a small or large number of teams from hospitals and/or clinics to seek improvement in a focused topic area.
- Each team typically sends 3-4 members to attend Learning sessions (face-to-face meetings over the course of the Collaborative) to seek improvement in a focused topic area
- These team members then go back and work with additional members locally in the organization.

Learning Sessions

Learning Session 1:

Present vision for ideal care and specific changes that when applied locally will improve significantly the system's performance.

Subsequent Learning Sessions:

Teams learn even more from one another as they report on successes, barriers, and lessons learned in general sessions, workshops, storyboard presentations and informal dialogue and exchange.

Formal academic knowledge is bolstered by the practical voices of peers who can say, *"I had the same problem; let me tell you how I solved it"*

Action Periods:

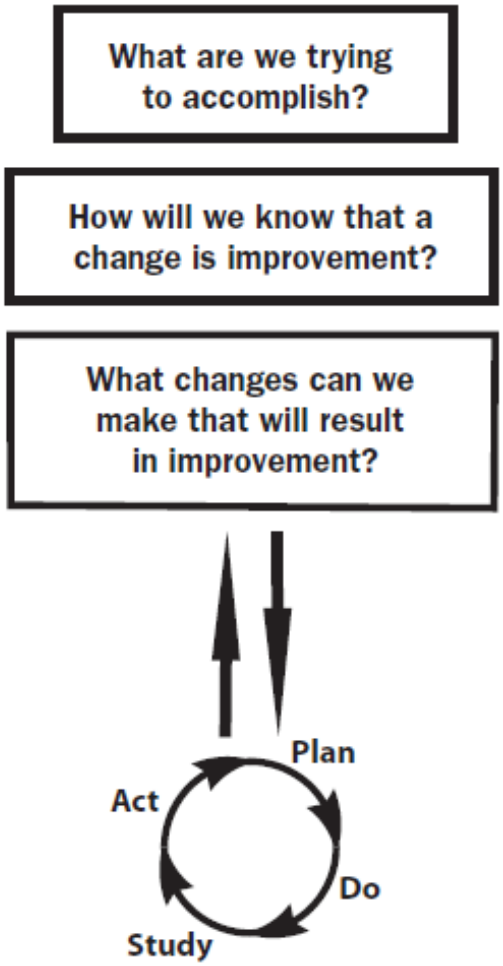
- Teams test & implement changes in their local setting- and collect data to measure the impact of the changes.
- Submit monthly progress reports for the entire collaborative to review and are supported by improvement coaches that enable them to share information and learn.
- The aim is to build collaboration and support the organizations as they try out new ideas, even at a distance.

The Model for Improvement

The Model for Improvement

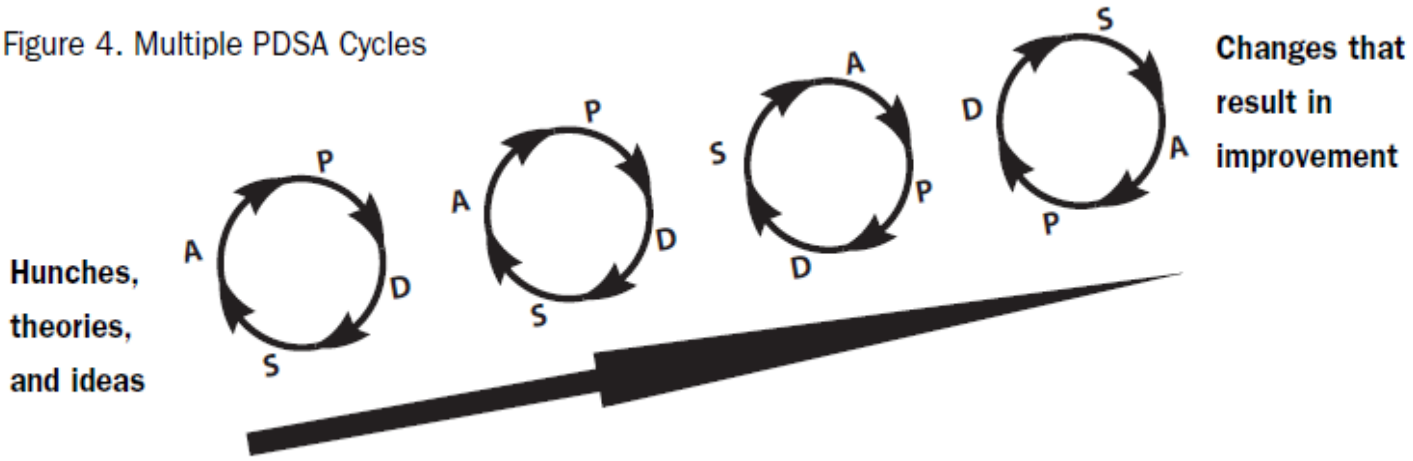
- 4 key elements of successful process improvement:
  1. Specific Measurable Aims
  2. Measures of improvement are tracked over time
  3. Key changes that will result in the desired improvement
  4. A series of testing "cycles" during which teams learn how to apply key change ideas to their own organization.

What is the answer to these 3 questions:



Who is familiar with the PDSA Cycle?

Figure 4. Multiple PDSA Cycles



Healthy Lives Collaborative

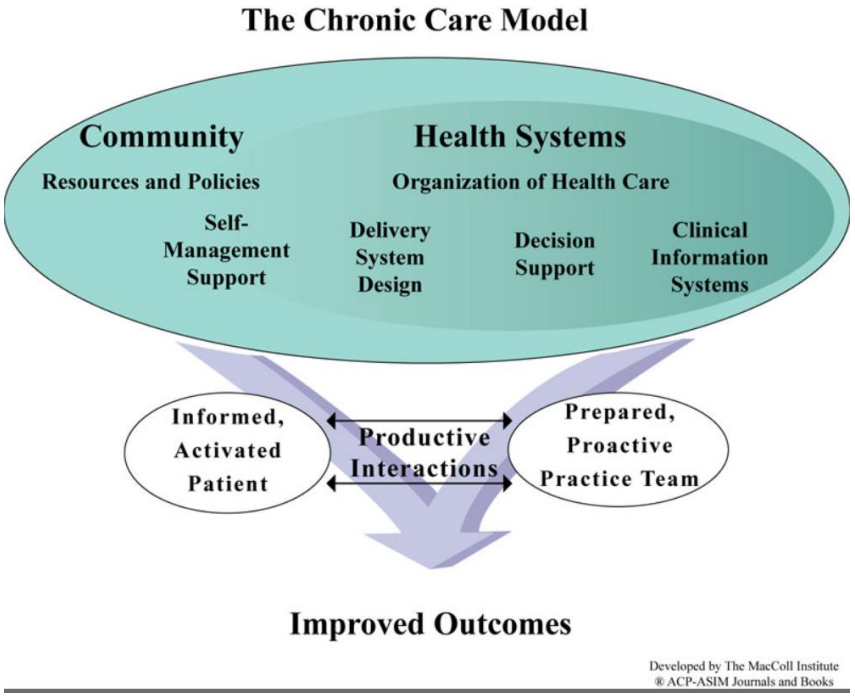
Chronic Care and Health

Reason for Action:

There is a shared need in the communities represented to come together and leverage strengths, to support rural health and share different perspectives.

The organizations will work together to standardize their approach based on best practice around chronic care & prevention to improve the health and life of their communities.

The development of a direct care model will result in improved patient outcomes increased satisfaction for patients, staff, and providers.



Importance Statement:

Diabetes patients with high A1cs typically have:

- Disease complications
- More frequent hospitalizations
- Increased cost of care

In order to be successful in a value-based environment, we need to be able to identify and intervene on high-risk diabetes patients and deliver the right care to the right patients at the right time.

This requires **collaboration** among stakeholders that goes beyond usual care to involve the entire care team and provide structured indirect care.

In the US, diabetes is the primary diagnosis for **37 million visits** to a physician's office, emergency department or outpatient hospital-based clinic every year.

How can I help patients with type 2 diabetes achieve their glycemic goals?

Diabetes is a complex illness that requires a lot of effort to manage, by both patients and their care team.

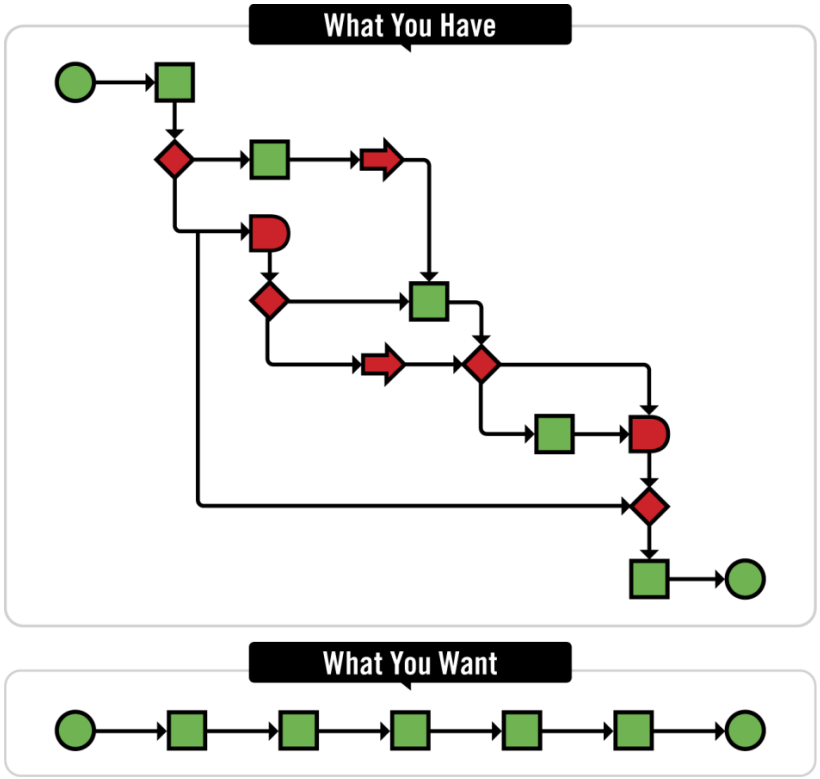
- Use a team-based approach to managing your patients with diabetes
- Engage and educate your staff and your patients
- Remember that small interventions can make a big impact

Metrics

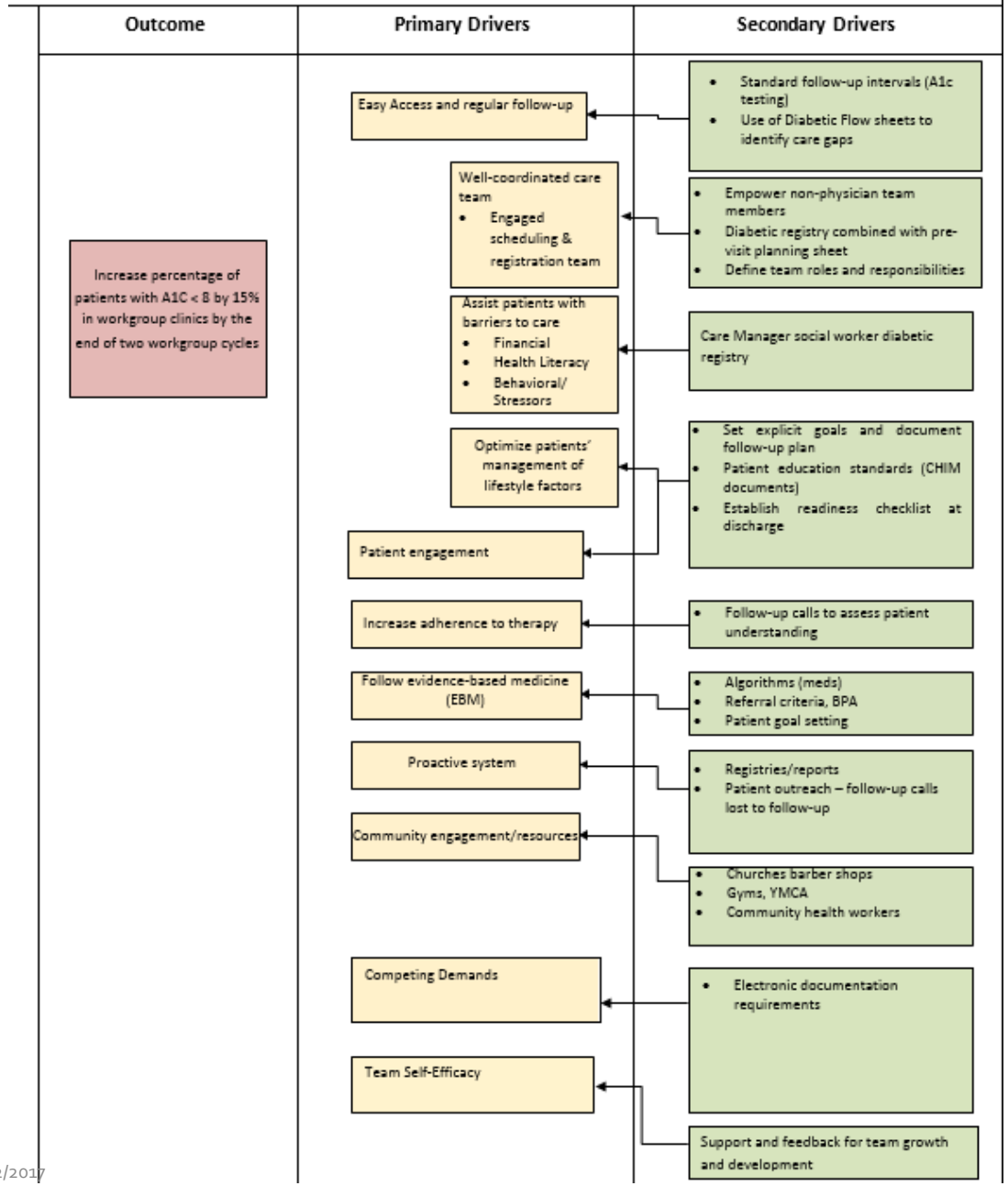
1. As a collaborative 80% of participating practices will achieve a 15% reduction in patients in poor control of diabetes as defined as % of patients aged 18-75 years who had a most recently hemoglobin A1c greater than 9.
2. Develop shared understanding of evidence based approach within medical staff. The success of which will be measured by % of providers who practice within agreed upon protocols, utilizing agreed upon standard work.
3. Reduce the need for medical intervention for diabetic patients. This will be measured by a decrease in 30 and 180 day readmission rates and ER visits of 20%
4. Increase the amount of care coordination related to the hand-off between team members within the hospital and clinic. This will be evidenced by % of diabetic patients who keep an appointment post ER/Inpatient visit.

What systems of care do you typically use?

- What systems are working well?
- What systems could be improved?



Diabetes Workgroup Key Driver Diagram



2017 Collaborative Timeline Q1

- Jan 2017: Kickoff Meeting, Charter, Gap Analysis
- Feb 2017: "Don't drop the patient!"
  - Pilot tracking 50 pts ER
  - Follow up Appointments scheduled in clinic prior to discharge
  - No-show appointments? How many?
- March 2017: "Who owns the patient?"
  - Empanelment
  - Diabetic Registry
  - Diabetic Flow sheet

Clinical Information Systems:

Timely, useful information about individual patients and populations of patients with chronic conditions is a critical feature of effective programs, especially those that employ population-based approaches.

Baseline Data

Facility	Total Number of Clinic Patients	Total Diabetic Patients	Total with A1C>9
#1	5,302	412	41
#2	8,143	762	52
#3	7,800	746	47
#4	7,741	568	63
#5	7,643	369	6
TOTAL	**36,629**	**2,857**	**209**

2017 Collaborative Timeline Q2

- April 2017: "Connecting patients to community resources"
  - Coordination of Care Transitions/ Discharge Checklists
  - Community Resource Lists
- May 2017: "Identifying & filling care gaps for uncontrolled patients"
  - Which uncontrolled patients are outside of protocols into clinic?
  - How can your clinic ensure each patient gets everything outstanding so they don't have ANY care gaps until the next time they are due by protocol to come in?

Community Linkages:

Linkages between your practice and community resources play an important role in the management of your patients' chronic illnesses.

Organization of My Practice:

Treatment of chronic diseases is more effective if the office practice in which care is provided has clearly defined strategies and protocols for dealing with chronic diseases.

2017 Collaborative Timeline

- June 2017: Review of Physician Leader Expectations
  - Ensure the data (i.e. via provider scorecard) that is provided to practitioners is accurate.
  - Ensuring we are scheduling diabetic patients at the appropriate intervals based upon their acuity.
  - Implement a system that identifies those patients that haven't been seen in the appropriate interval and intervening with them to schedule an appointment.

Delivery System Design:

Effective chronic illness management usually requires changes in the way offices provide care for patients—that is, changes in your office systems and your way of doing daily business. Teamwork and follow-up are two important elements of effective chronic disease management.

2017 Collaborative Timeline

- July 2017: "Truly Patient Directed, Person Centered Care"
  - Care Planning/Goal Setting
  - Risk Stratification- "How do you work smarter not harder?"
  - QI focus: Has a lipid panel been completed on each uncontrolled patient if appropriate?
- Aug 2017: "Protocols to Support Sharing the Care"
  - Protocols- Visit Intervals, Medication Refill, Inpatient Insulin
  - Diabetic Care Gap Protocols: Pre-visit A1C, Pre-visit lipid panel, micro albumin, serum creatinine
  - Expanded Rooming: Foot exam, Eye exam, depression/mood disorder screening, Vaccinations (influenza, pneumococcal, tdap)

Self-management Support:

Effective self-management support can help patients and families cope with the challenges of living with and treating chronic illness. It can reduce complications and symptoms and improve patients overall sense of health and well-being.

2017 Collaborative Timeline

- Sept 2017: "What story does the data tell?"
  - Engaged over 20 patients each month to close identified care gaps (lipids)
  - What are individual community barriers now that each patient has a name? How could we work to overcome them?
  - QI focus: Completing annual diabetic education on each uncontrolled patient- in reach & outreach
- Oct 2017: "Can the stoic sick & worried well get in?"
  - Panel Risk Stratification
  - Coordinated care team including scheduling & registration team members
  - Measuring Access

Decision Support:

Effective chronic illness management programs ensure that physicians have access to evidence-based information necessary to care for patients and assist them in decision making. This might include evidence-based practice guidelines or protocols and other information sources that are readily available at the point of care.

Collaborative Learnings

For many physicians, sharing what traditionally has been physician work with the team is hard to do.

- Having physicians dialogue about what team based strategies work in their office is powerful.
- Then, sharing the exact standard work that team uses so they don't have to reinvent the wheel is key!

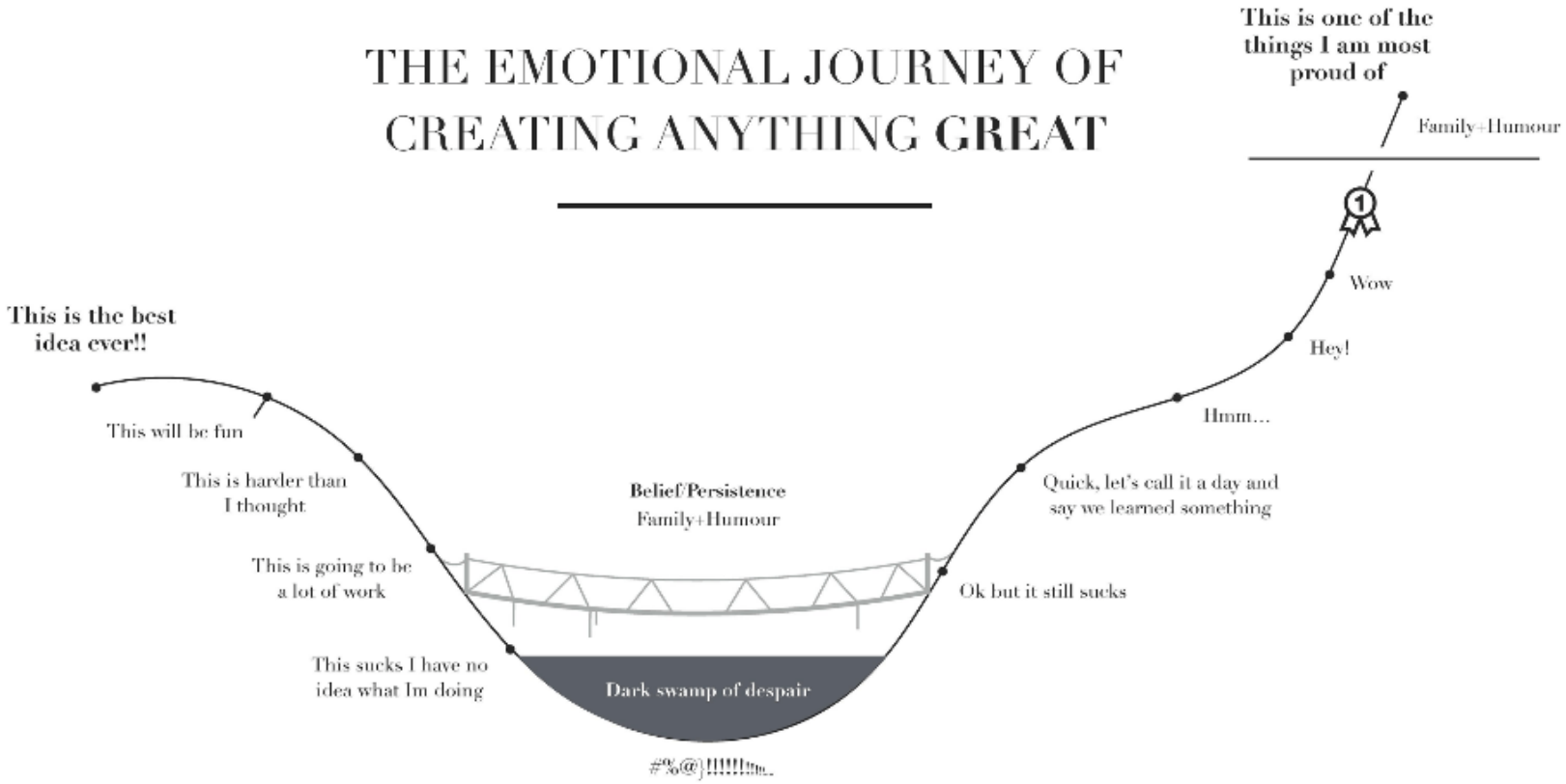
Actionable data is key!

- It's painful, but building a registry or dashboard at a practice and even physician level gets rid of assumptions.

Teamwork & collaboration

- Rural healthcare can be isolating.
- Building trust & networking with other people who are working on the same things- talking to each other about what works and more importantly what doesn't work is important for implementing office based solutions.

Get Buy-in for Change



Merrick Medical Center

- MMC traveled a long distance in 10 months.
- In this short time, they:
  - Established a diabetic registry
  - Empaneled their patients
    - **This was vital in ensuring continuity of care for our patients.**
  - Implemented pre-visit labs on diabetic patients
  - Implemented 5 protocols to support team based care for the following:
    - Vaccinations
    - Pre-visit Labs
      - Historically, the nurse would track down the patient by phone or mail with their results. Now, the patient and provider can have a meaningful dialogue related to their results and establish a care plan based upon these results.
    - Medication Refills
    - Diabetic Education
    - No show/Late Arrivals
  - Implemented pre-visit planning
    - Established a flow sheet that each provider nurse preps each chart with related to results and gaps in care

Merrick Medical Center

- Established a follow up appointment workflow
  - Established blue cards that were given to the patient at the end of their appointment. The front desk stops the patient, reviews the card and schedules the follow up appointment for the patient.
  - In addition, the front desk calls all patients the day prior to their appointment. This has drastically reduced the no show rate.
- Established Pre-Visit Planning Sheet
  - This acts as a catalyst for dialogue between the patient and provider related to exercise expectations. The provider relates what they would like the patient to do. The patient keeps the sheet, records activity and brings with them to their visits.
- Identified non-compliant patients
  - Each provider is given a list of their non compliant patients at the provider meeting. Strategies are discussed amongst the team about how to reach these patients.

Lessons Learned

- Gathering data from the EHR can be frustrating!
  - It has taken us a significant amount of time to mine the data in our system to obtain information related to empanelment and the diabetic registry.
  - We are still working with our vendor (Greenway) to establish some standard interfaces and reports that will hopefully make this a less manual process.
- Having a Physician Champion or Leader is imperative for the success of the program.
  - Without their support, the implementation of standing protocols isn't feasible.
- Ensure that everyone in the clinic has shared understanding of how they impact patient care.
  - Involving the front desk in ensuring they are scheduling patients with their provider and having them call patients the day prior to their appointment has made them feel more part of the patient care team.
- Once a patient panel has been established, ensure that it is refined and reviewed on monthly or at least a quarterly basis.

References

- AAFP Metric Diabetes Module

http://www.aafp.org/cme/cme-topic/all/metric-diabetes.html

- AMA Steps Forward: Preventing Type 2 Diabetes in At Risk Patients

http://www.aafp.org/cme/cme-topic/all/metric-diabetes.html

- IHI Breakthrough Series model

http://www.ihi.org/resources/Pages/IHIWhitePapers/TheBreakthroughSeriesIHIsCollaborativeModelforAchievingBreakthroughImprovement.aspx

Questions?

Six broad steps to develop an efficient team-based approach to managing diabetes

1. Engage your team
2. Identify the impact of poor glycemic control on your practice
3. Choose one aspect of diabetes care to address first
4. Pilot an intervention with your team
5. Optimize medications
6. Engage your patients in the treatment plan

Bryan Health

What are some aspects of diabetes care I should focus on?

- Help your patients understand the A1C test
- Provide lifestyle education
- Perform foot exams
- Screen for depression
- Screen for early renal dysfunction
- Optimize patient medications

Next Steps: