Population Health Based Project
Diabetes & Hypertension

LEARNING COLLABORATIVE 5
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SAINT PETER'S HEALTHCARE SYSTEM

Population Health Based Project Diabetes & Hypertension

- This population health based project will assist patients in receiving the assessment, treatment, education, and follow-up to effectively manage their diabetes and hypertension.
- The Medical home offers a framework for underserved patients with diabetes and hypertension.
- The Medical home is a cultivated partnership between the patient, family, and primary care provider in cooperation with specialists.
- The patient/family is the focal point of this model, and the medical home is built around this focal point.
- The guidelines stresses care under the medical home model must be accessible, family-centered, continuous, comprehensive, coordinated, compassionate, and culturally effective.

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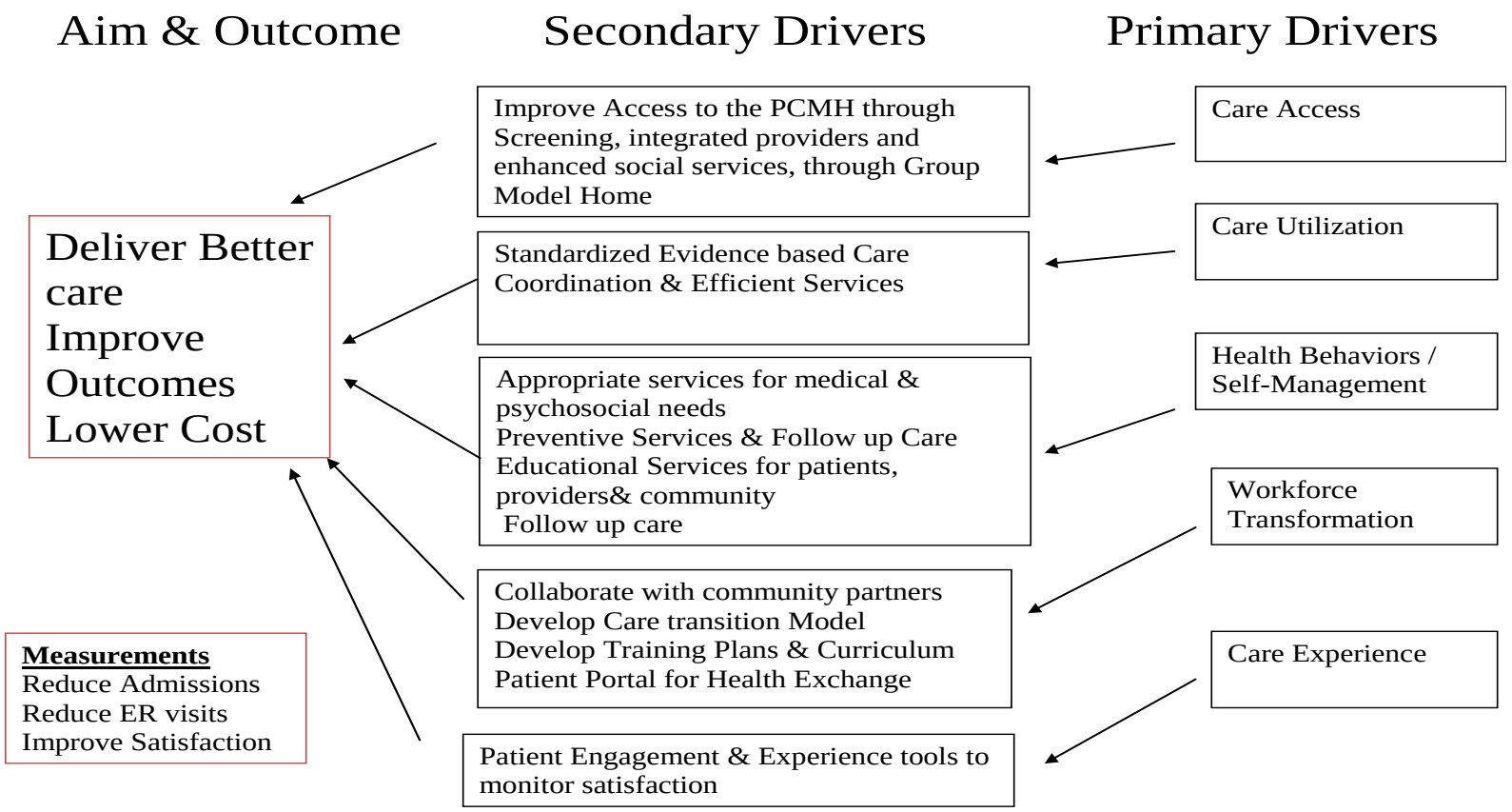
Strategy For Implementation

Diabetes mellitus Patient care Model Home Driver Diagram



DSRIP Organizational Structure &Teams

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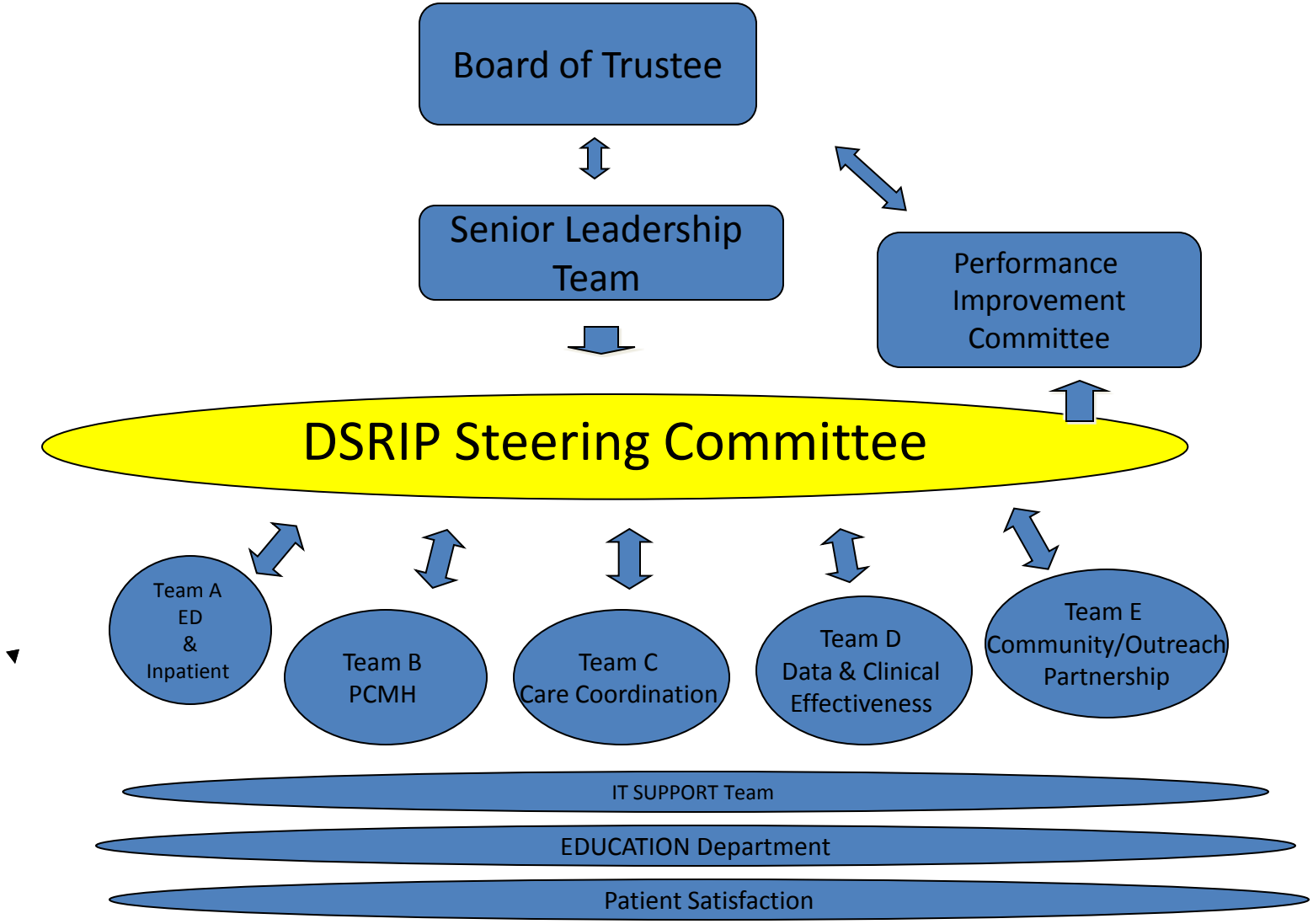
Treating you better...for life.



Goals of Steering Committee

Provide oversight and accountability of the DSRIP Project Teams to achieve Goals of the Diabetes and Hypertension project.

- Sustain DSRIP Funding
- Reduce Admissions
- Reduce Emergency Visits
- Improve care Processes
- Increase Patient Satisfaction
- Improve Stage 3 & 4 Measures performance
- Compliance with Reportable Requirements

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DSRIP Core Project Teams

Team A – **Emergency Department and Inpatient**

Team Leaders

- Heather Veltre, Administrative Director, Emergency Services
- Sharon Haskins, Nursing Director, Adult and Critical Care areas

Roles & Responsibilities

- Identify target population
- Develop health assessment, risk stratification, and education tools to assist in identifying the health risk of project participants
- Develop quality improvement-reportable measures

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DSRIP Core Project Teams

Team B – **Patient Centered Medical Home (How Lane)**

Team Leaders – Nayan Kothari, M.D., Chair, Department of Medicine; Alejandro Herrera, M.D.; Anne Marie Van Hoven, M.D.; Marygrace Zetkulic, M.D.; and Renee Di Marzio, Administrative Director, Department of Medicine

Roles & Responsibilities

- Develop and implement a medical home for the underserved population with diabetes and hypertension
- Provider of outpatient education for nutrition and disease management
- Develop and implement education to include risk stratification and health assessment tools

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DSRIP Core Project Teams

Team C – **Care Coordination**

Team Leaders – Ann Scotti, Director of Care Coordination, Karen Knipe-Simone, Senior Care Coordination Nurse , and Julie Clark, Manager of Social Work

Roles & Responsibilities

- Develop medication/supplies assistance protocol
- Develop transportation assistance protocol
- Plan kick-off call re: Allscripts care director
- Customize risk stratification tool to be ready to launch with Allscripts care director
- Recruitment for DSRIP care transitions nurse

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DSRIP Core Project Teams

Team D – **Data and Clinical Effectiveness**

Team Leaders – Luis Perez, Analyst, Quality, and Teresa Artz, Manager, Clinical Effectiveness

Roles & Responsibilities

- Procurement of data
- Data query development
- Validation of data for accuracy and reliability
- Develop protocols for chart reviews
- Conduct ongoing chart reviews
- Provide baseline data and monthly reviews of data
- Work effectively with all teams towards performance improvement

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DSRIP Core Project Teams

Team E – **Marketing, Community Outreach, and Partners**

Team Leaders – Marge Drozd, Director, Community Mobile Health Services; Michelle Lazzarotti, Director, Marketing/Media Relations; and Tab Chukunta, Executive Director, Community Outreach

Roles & Responsibilities

Market services and raise awareness of the patient centered medical home in the community through:

- community outreach and screenings
- paid advertising in venues that target the DSRIP population
- web-based media
- the professional healthcare community in the hospital's primary and secondary service areas
- continual monitoring to judge effectiveness of marketing strategies for the DSRIP project

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DSRIP Core Project Teams

Roles & Responsibilities (continued)

Secure community partners to collaborate in assuring seamless care for our DSRIP population, federally qualified health centers (FQHCs), pharmacies, food outlets, physical fitness centers, etc.

- soliciting contracts/memorandums of understanding/letters of engagement with our identified partners
- mutually determining and obtaining feedback on our joint partnership responsibilities
- educating them on our protocols for our DSRIP population

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Supportive Project Teams

IT Support Team

Team Leaders

Eliot Heller, M.D., Chief Medical Information Officer

Leslie Christmas, Manager, Clinical Systems

Roles & Responsibilities

- Configure applications to support/screen for the assessment, treatment, and education of the target population

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Supportive Project Teams

Education Team

Team Leader – Linda Carroll, Director, Professional Practice

Roles & Responsibilities

- Support Core Project Teams with the roll-out of team activities, information, and provider education
- Develop an educational plan based on provider assessment, treatment, and educational tools to be utilized for the project
- Ongoing provider and staff education of project accomplishments

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Supportive Project Teams

Patient Satisfaction Team

Team Leader – Lisa Drumbore, Director, Service Excellence

Team members: Renee Di Marzio, Administrative Director, Department of Medicine; Angella Reid, Manager, Department of Medicine/How Lane Clinic; and Linda Van Allen, Coordinator, Service Excellence

Roles & Responsibilities

- Support Core Project Teams as necessary and provide information and service recommendations
- Develop patient satisfaction improvement tool and reportable data measures and feedback
- Facilitate awareness of patient feedback to providers and staff

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It all came together -------

Patient Centered Model

Population Health

Implementation Phases

Pilot

Start Date

July 1, 2014

Start with Team with Target population of 260

Hire New Staff

Role Expansion of Existing Staff

Complete Pilot

December, 2014

Start with Team with Target population of 260

Full Implementation

March 2015

Implement no more than **two**

Teams

Sustain/Improve

Standardized & Monitor

Project Time Line

2014 – 2017

PROJECT UPDATE

- CURRENTLY 179 PATIENTS
- IMPROVED ACCESS TO SPECIALTY CARE
- OPHTHALMOLOGIST IS NOW AT SITE
- COMMUNICATION WITH PODIATRIST
- CONTRACT WAS SIGNED WITH AN ENDOCRINOLOGIST
- PATIENT SATISFACTION SURVEYS IN SPANISH AND ENGLISH
- DY3 QUARTER 2 PROGRESS REPORT WAS SUBMITTED

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LESSONS LEARNED

- PDSA METHODOLOGY
- EXPAND PATIENT NAVIGATION FROM THE ED OR AS INPATIENTS TO THE PCMH
- RUNNING DAILY REPORTS AND PATIENTS DISPOSITION
- ASSESSMENT OF REFERRAL PROCESS (OUTREACH)
- INCORPORATE SELF MANAGEMENT BEHAVIOR
- CAPTURING READMISSIONS AND ED VISITS
- POINT OF CARE TESTING FOR OUT PATIENTS

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Questions ?
Journey Continues .....