



Saint Michael's
MEDICAL CENTER
A MEMBER OF CATHOLIC HEALTH EAST

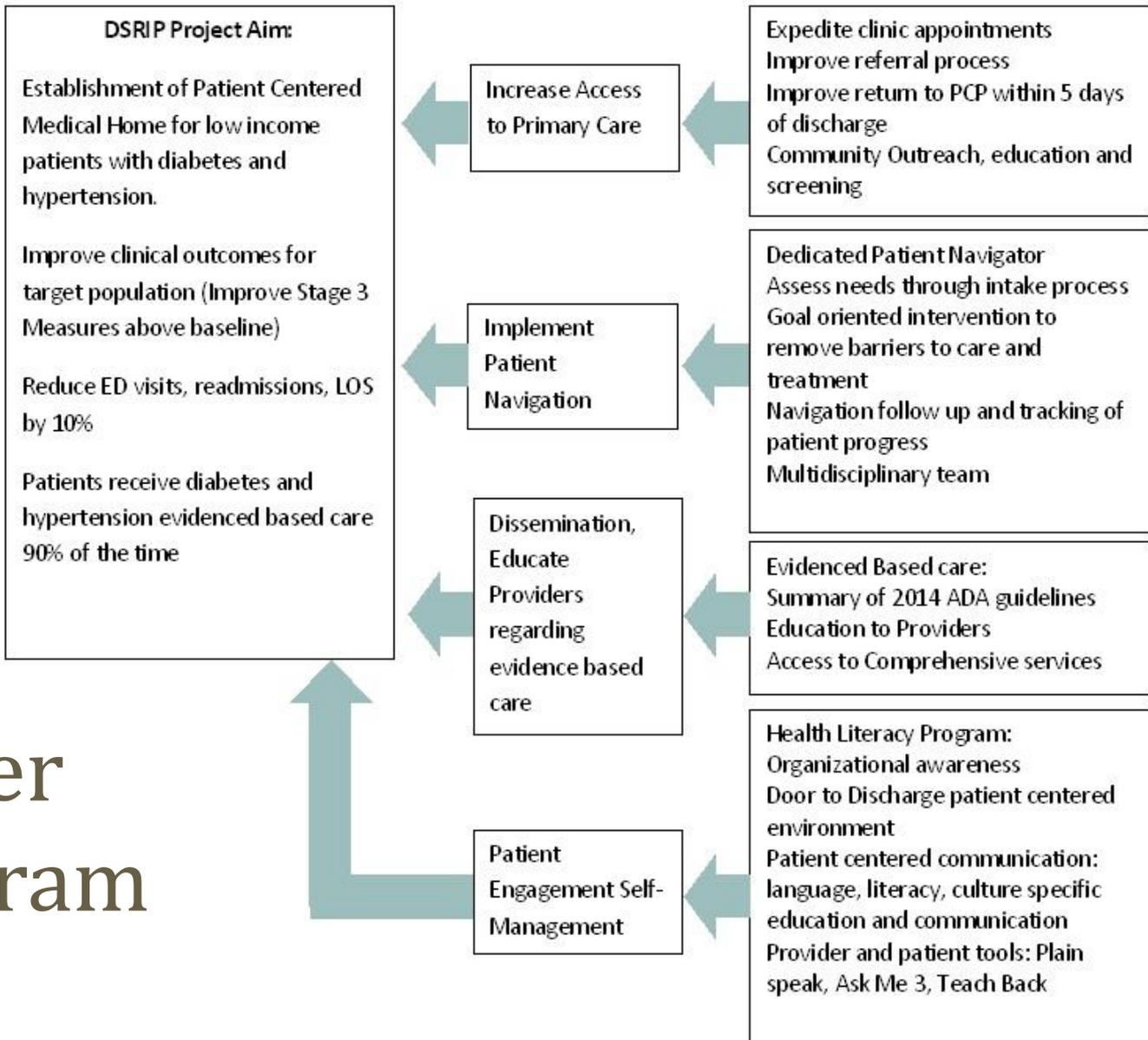
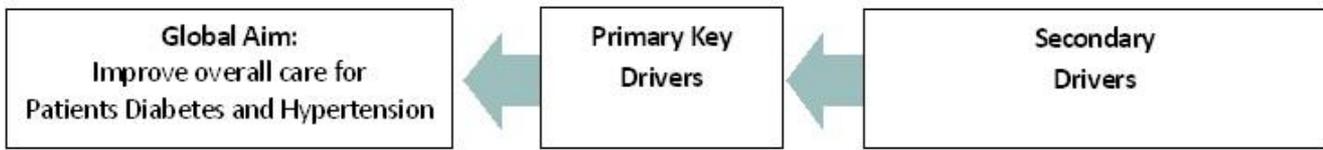
IMPROVE OVERALL QUALITY OF CARE FOR PATIENTS DIAGNOSED WITH DIABETES MELLITUS AND HYPERTENSION

Diabetes and Hypertension Care Program

Learning Collaborative 5 – July 9, 2015

Core Project Processes

Improve Access to PCP	Patient Navigation	Evidenced Based Care	Patient Engagement/Self Management
<p>Primary and Specialty Care Clinic: Improve timeliness of appointments</p> <p>Improve referral process-streamline</p> <p>Intense discharge planning/case management –appointment with Primary Care in 5 days; expedited appointment from ED</p> <p>Community education and screenings/referral to PCP</p>	<p>Dedicated patient navigator</p> <p>Intake process for each patient</p> <p>Individualized care plan for each patient</p> <p>Coordinate communication with team and patient</p> <p>Navigates patients, tracks patient, ensures goals are met, identifies and removes barriers.</p>	<p>Comprehensive service:</p> <ul style="list-style-type: none"> • Primary Care • Podiatry • Ophthalmology • Endocrinology • Social Work • Education/Self Management <p>Use of Clinical Protocols, based on national standards; share with clinical partners</p> <p>Improve timeliness and communication of referrals</p> <p>Best practice s in team, interdisciplinary communication</p>	<p>All programmatic elements designed around social, culture, literacy level of the patients:</p> <ul style="list-style-type: none"> • Literacy assessment • Interviewing techniques • Availability of print materials in languages and reading levels that are understandable • Assessment of comprehension • Alternate teaching methods <p>Improve access to patient education/self management</p> <ul style="list-style-type: none"> • Marketing of existing education • Offer “Drop In” learning centers • Community Outreach education and screening



Driver Diagram

DSRIP Project Aim:

Establishment of Patient Centered Medical Home for low income patients with diabetes and hypertension.

Improve clinical outcomes for target population (Improve Stage 3 Measures above baseline)

Reduce ED visits, readmissions, LOS by 10%

Patients receive diabetes and hypertension evidenced based care 90% of the time

Increase Access to Primary Care

Implement Patient Navigation

Dissemination, Educate Providers regarding evidence based care

Patient Engagement Self-Management

Expedite clinic appointments
Improve referral process
Improve return to PCP within 5 days of discharge
Community Outreach, education and screening

Dedicated Patient Navigator
Assess needs through intake process
Goal oriented intervention to remove barriers to care and treatment
Navigation follow up and tracking of patient progress
Multidisciplinary team

Evidenced Based care:
Summary of 2014 ADA guidelines
Education to Providers
Access to Comprehensive services

Health Literacy Program:
Organizational awareness
Door to Discharge patient centered environment
Patient centered communication: language, literacy, culture specific education and communication
Provider and patient tools: Plain speak, Ask Me 3, Teach Back

Evaluation of Pilot

Focused on Patient Navigation to
improve access/ follow-up care;
improved outcomes

Evaluation of Pilot

- Changes made in real-time throughout pilot to navigation:
 - In-person → phone intakes because patients face too many transportation & financial barriers to attend additional appointment
 - Shortened patient intake form
 - Change in “discharge” policy: active patients will never be “discharged” from the program, but rather followed up with less frequently
 - Added Well-Being scale & changed Distress Scale to one specific to diabetes (idea from Learning Collaborative)
 - Purchased & developed TrackVia (idea from Learning Collaborative)
 - Purchased blue folders for DSRIP patient charts to alert providers of enrolled patients & impending tests
- Social Worker → Clinical (RN) Navigator

Evaluation of Pilot

- Social barriers primarily resolved for pilot patients; main unresolved barrier is that undocumented patients have limited access to most prescription assistance programs
- Poor performance on foot/eye exams → currently establishing better alert system for communication with care team
- Need to expand program → strategies implemented:
 - Social Worker/ Discharge Planning rounds
 - ED Case Management rounds
 - Dedicated email address for referrals

Patient Engagement

Health Literacy Campaign

Health Literacy Campaign

- Bilingual providers
- Group Diabetes Education courses for Spanish speakers
 - 8 class hours over 4 weeks
 - Rotating topics each week; nutrition addressed in every class
 - Follow-up to ensure make up of missed classes
 - 2 courses implemented since end of April
- Rollout of Ask Me 3 in Spanish & English

Baseline Measures

Pre-Navigation

PDSA

Improved foot/eye exams

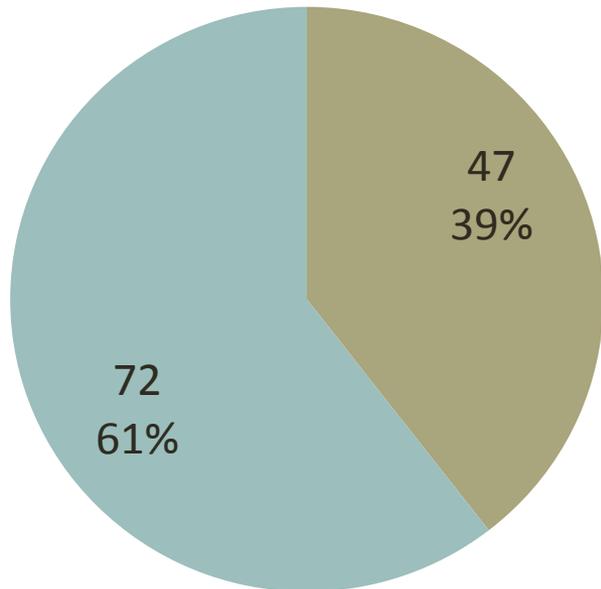
Primary Care Access

Stage 3 Baseline Measures

Measure	Source	Definition	Numerator/ Denominator	Performance
Lipid Management	Chart/EHR	The percentage of patients 18-75 with diabetes (type 1 or type 2) who had at least one lipid profile (or all component tests).	82/134	61.19%
Foot Examination	Chart/EHR	Percentage of patients who received at least one complete foot exam (visual inspection, sensory exam with monofilament, and pulse exam). Patients with bilateral foot amputation excluded.	47/119	39.50%
Eye Examination	Chart/EHR	The percentage of patients 18-75 years of age with diabetes (type 1 or type 2) who had a dilated retinal eye exam by an ophthalmologist or optometrist.	3/119	2.52%
Controlling High Blood Pressure	Chart/EHR	The percentage of patients 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (<140/90) during the measurement year. ESRD and pregnancy exclusions.	2/13	15.38%
Comprehensive Diabetes Care (CDC): Hemoglobin A1c (HbA1c) testing	MMIS	The percentage of patients 18-75 with diabetes (type 1 or type 2) who had an HbA1c test performed during the measurement year.	732/1,308	55.96%

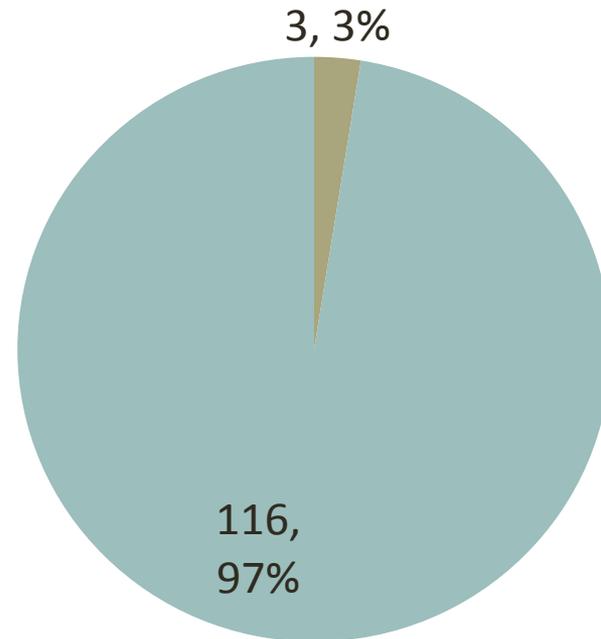
Stage 3 Baseline Measures: Foot and Eye Exams

Annual Foot Exam Performed?
Low Income Attributed Population;
1/2014 – 12/2014



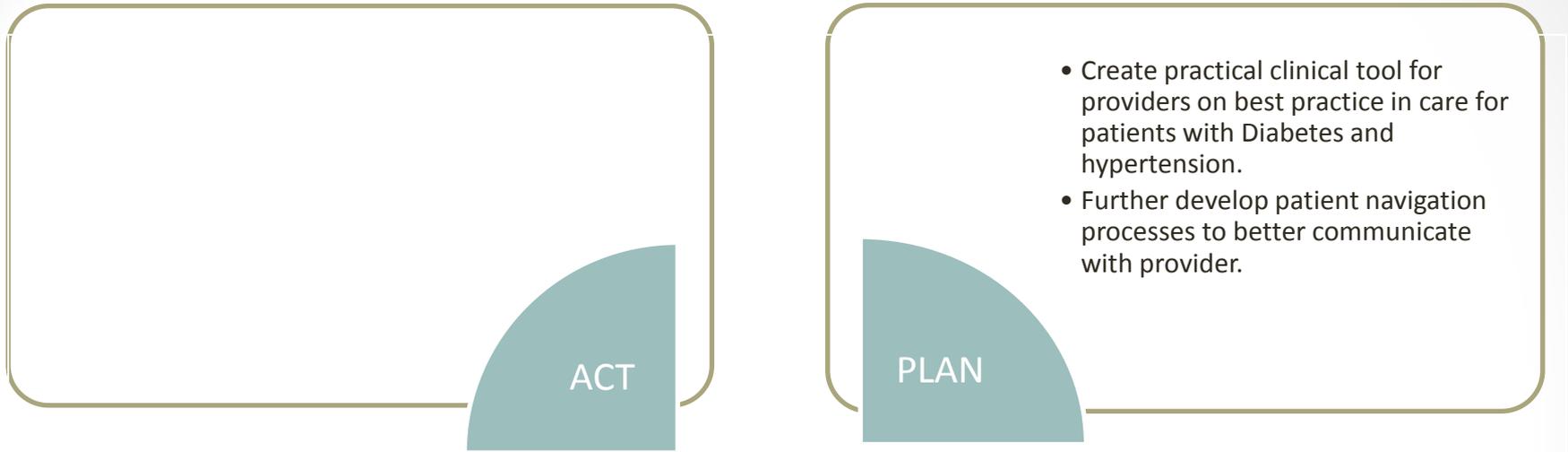
■ Yes ■ No/ Not in Chart

Annual Dilated Retinal Exam?
Low Income Attributed Population;
1/2014 – 12/2014



■ Yes ■ No/ Not in Chart

PDSA

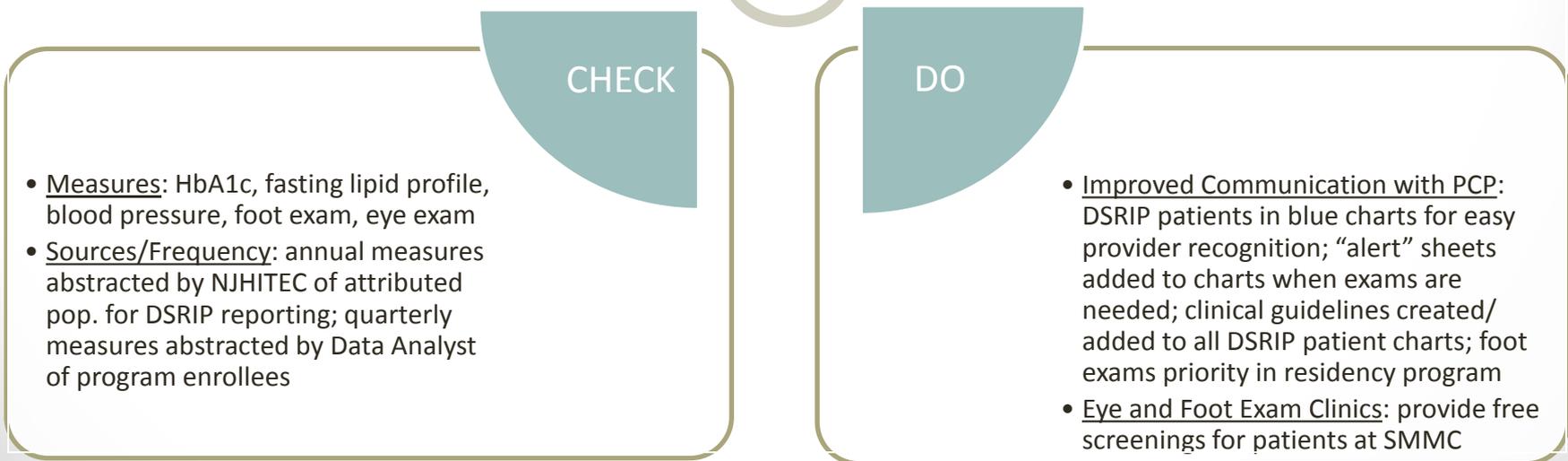


- Create practical clinical tool for providers on best practice in care for patients with Diabetes and hypertension.
- Further develop patient navigation processes to better communicate with provider.

PLAN

ACT

Performance Improvement: Use of Evidence Based Guidelines



- Measures: HbA1c, fasting lipid profile, blood pressure, foot exam, eye exam
- Sources/Frequency: annual measures abstracted by NJHITEC of attributed pop. for DSRIP reporting; quarterly measures abstracted by Data Analyst of program enrollees

CHECK

DO

- Improved Communication with PCP: DSRIP patients in blue charts for easy provider recognition; “alert” sheets added to charts when exams are needed; clinical guidelines created/ added to all DSRIP patient charts; foot exams priority in residency program
- Eye and Foot Exam Clinics: provide free screenings for patients at SMMC

PDSA

- Hired scheduler to work in ED to ensure referrals made to clinic appropriately & appointments are made before discharge

ACT

- To establish a better referral process to primary care

PLAN

Performance Improvement: Care Coordination

CHECK

- A report on all ED referrals is generated weekly & sent to the Medical Director and Manager for follow up
- No significant improvement found

DO

- Developed policy & procedure to increase referrals
- Education of ED/PCP staff & physicians/registration

Ongoing Monitoring

Concurrent Data Collection &
Performance Monitoring

TrackVia Database

The screenshot displays the TrackVia database interface. At the top, there is a navigation bar with the TrackVia logo, 'PRO', 'PATIENT TRACKER', and 'Admin' options. Below this is a secondary navigation bar with tabs for 'Case Management', 'Patient Dashboard', 'Screening Scales', 'Intake Dashboard', and 'Core Measures'. The main content area is titled 'Core Measures' and contains three sections: 'Clinical Measures: New Record', 'Core Measures Form', 'Hemoglobin A1C (HbA1C)', and 'Fasting Lipid Profile'. Each section contains input fields for patient information, test dates, and results, along with dropdown menus and goal indicators.

TRACKVIA | PRO PATIENT TRACKER Admin Go to...

Case Management Patient Dashboard Screening Scales Intake Dashboard Core Measures

Core Measures

Clinical Measures: New Record

Core Measures Form

PATIENT PROGRAM ENROLLMENT DATE

Patient + Program Enrollment Date

TEST EVER COMPLETED

Select...

Hemoglobin A1C (HbA1C)

HBA1C TEST DATE HBA1C RESULT (GOAL <7%)

MM/DD/YYYY HbA1C Result (goal <7%)

Fasting Lipid Profile

LDL TEST DATE LDL (GOAL <100MG/DL)

MM/DD/YYYY LDL (goal <100mg/dL)

- TrackVia, a customizable cloud-based database, has been fully implemented for enrolling, tracking and monitoring patients. We created several different types of dashboards:
 - Contact & Demographic Information
 - Patient Social Information (transportation, support systems, etc.)
 - Goal Tracking
 - Clinical Measures
 - Appointments
 - ED/Inpatient Admissions
- Each dashboard contains a form for inputting data & data summary charts/ graphs that can be filtered within the program or exported to Excel

TrackVia Alerts

Patient	HbA1C Test Date	HbA1C Result (goal <7%)	HbA1C ALERT
	05/04/2015		7.5 ALERT

Total Rows: 1 Jump to row

In addition to basic summary charts, we created “alert” charts for clinical measures, well-being scales and other important measures to indicate areas that the patient navigator should address.

QUESTIONS OR SUGGESTIONS?

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