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

<table>
<thead>
<tr>
<th>Improve Access to PCP</th>
<th>Patient Navigation</th>
<th>Evidenced Based Care</th>
<th>Patient Engagement/Self Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary and Specialty Care Clinic: Improve timeliness of appointments</td>
<td>Dedicated patient navigator</td>
<td>Comprehensive service: • Primary Care • Podiatry • Ophthalmology • Endocrinology • Social Work • Education/Self Management Use of Clinical Protocols, based on national standards; share with clinical partners</td>
<td>All programmatic elements designed around social, culture, literacy level of the patients: • Literacy assessment • Interviewing techniques • Availability of print materials in languages and reading levels that are understandable • Assessment of comprehension • Alternate teaching methods</td>
</tr>
<tr>
<td>Improve referral process - streamline</td>
<td>Intake process for each patient</td>
<td>Navigates patients, tracks patient, ensures goals are met, identifies and removes barriers.</td>
<td>Improve access to patient education/self management • Marketing of existing education • Offer “Drop In” learning centers • Community Outreach education and screening</td>
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<tr>
<td>Intense discharge planning/case management – appointment with Primary Care in 5 days; expedited appointment from ED</td>
<td>Individualized care plan for each patient</td>
<td>Coordinate communication with team and patient</td>
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</tr>
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<td>Community education and screenings/referral to PCP</td>
<td>Coordinate communication with team and patient</td>
<td>Navigates patients, tracks patient, ensures goals are met, identifies and removes barriers.</td>
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<td>Navigates patients, tracks patient, ensures goals are met, identifies and removes barriers.</td>
<td>Best practices in team, interdisciplinary communication</td>
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<td>Coordinate communication with team and patient</td>
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</table>
Global Aim: Improve overall care for Patients Diabetes and Hypertension

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

Primary Key Drivers:
- Increase Access to Primary Care
- Implement Patient Navigation
- Dissemination, Educate Providers regarding evidence based care
- Patient Engagement Self-Management

Secondary Drivers:
- 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

Driver Diagram
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

<table>
<thead>
<tr>
<th>Measure</th>
<th>Source</th>
<th>Definition</th>
<th>Numerator/Denominator</th>
<th>Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lipid Management</td>
<td>Chart/EHR</td>
<td>The percentage of patients 18-75 with diabetes (type 1 or type 2) who had at least one lipid profile (or all component tests).</td>
<td>82/134</td>
<td>61.19%</td>
</tr>
<tr>
<td>Foot Examination</td>
<td>Chart/EHR</td>
<td>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.</td>
<td>47/119</td>
<td>39.50%</td>
</tr>
<tr>
<td>Eye Examination</td>
<td>Chart/EHR</td>
<td>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.</td>
<td>3/119</td>
<td>2.52%</td>
</tr>
<tr>
<td>Controlling High Blood Pressure</td>
<td>Chart/EHR</td>
<td>The percentage of patients 18–85 years of age who had a diagnosis of hypertension (HTN) and whose blood pressure (BP) was adequately controlled (&lt;140/90) during the measurement year. ESRD and pregnancy exclusions.</td>
<td>2/13</td>
<td>15.38%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care (CDC): Hemoglobin A1c (HbA1c) testing</td>
<td>MMIS</td>
<td>The percentage of patients 18-75 with diabetes (type 1 or type 2) who had an HbA1c test performed during the measurement year.</td>
<td>732/1,308</td>
<td>55.96%</td>
</tr>
</tbody>
</table>
Stage 3 Baseline Measures: Foot and Eye Exams

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

- Yes: 47 (39%)
- No/Not in Chart: 72 (61%)

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

- Yes: 3 (3%)
- No/Not in Chart: 116 (97%)
PDSA

**ACT**

- 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**

- 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

**CHECK**

- 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

**DO**

- Performance Improvement: Use of Evidence Based Guidelines
PDSA

- Developed policy & procedure to increase referrals
- Education of ED/PCP staff & physicians/registration
- A report on all ED referrals is generated weekly & sent to the Medical Director and Manager for follow up
- No significant improvement found

To establish a better referral process to primary care

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

Performance Improvement: Care Coordination

- Developed policy & procedure to increase referrals
- Education of ED/PCP staff & physicians/registration
Ongoing Monitoring
Concurrent Data Collection & Performance Monitoring
TrackVia Database

- 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.
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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