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

DIABETES AND HYPERTENSION CARE PROGRAM

LEARNING COLLABORATIVE 5 – JANUARY 8, 2015
OVERVIEW

• GROUND UP BUILD OF INFRASTRUCTURE AS WELL AS IMPROVEMENT OF EXISTING SYSTEMS AND PROCESSES
• USES NEW AND EXISTING STAFF
• INCLUDES CLINICAL AND NON-CLINICAL COMMUNITY PARTNERS
• OVERSIGHT BY PROJECT STEERING COMMITTEE THAT INCLUDES PARTNERS, CONSTITUENTS, PROJECT TEAM
• MULTIDISCIPLINARY PROJECT TEAM, MEDICAL DIRECTOR, PROJECT CHAMPIONS
## Core Project Processes

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<th>Improve Access to PCP</th>
<th>Patient Navigation</th>
<th>Evidenced Based Care</th>
<th>Patient Engagement/Self Management</th>
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| Primary and Specialty Care Clinic: Improve timeliness of appointments | Dedicated patient navigator | Comprehensive service:  
  - Primary Care  
  - Podiatry  
  - Ophthalmology  
  - Endocrinology  
  - Social Work  
  - Education/Self Management | 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 |
| Improve referral process-streamline | Intake process for each patient | Use of Clinical Protocols, based on national standards; share with clinical partners | Improve access to patient education/self management:  
  - Marketing of existing education  
  - Offer “Drop In” learning centers  
  - Community Outreach education and screening |
| Intense discharge planning/case management—appointment with Primary Care in 5 days; expedited appointment from ED | Individualized care plan for each patient | Navigates patients, tracks patient, ensures goals are met, identifies and removes barriers. | |
| Community education and screenings/referral to PCP | Coordinate communication with team and patient | Best practices in team, interdisciplinary communication | |
PATIENT NAVIGATION

• DEFINED PATIENT NAVIGATION PROCESS
  • HIRED PATIENT NAVIGATOR: JONATHAN ROGRIGUEZ, MSW, LSW, BILINGUAL
  • CREATED PATIENT NAVIGATION MODEL SPECIFIC TO SMMC PROGRAM BASED ON PATIENT NAVIGATION PRINCIPLES DEVELOPED BY DR. HAROLD FREEMAN
  • DEFINED INTAKE PROCESS, POLICES AND PROCEDURES FOR PATIENT NAVIGATION AND INTERFACE WITH MULTIDISCIPLINARY TEAM
  • EDUCATION OF HOSPITAL/MEDICAL STAFF
  • PILOT WILL FOCUS ON PATIENT NAVIGATION, CARE COORDINATION
Patient Navigation System

Navigators identify and remove Barriers to care.

Patients are Assessed and referrals are based on the needs of the Patient.

Navigators Collaborate with all healthcare providers in an effort to Keep patient in needed care.

The Goal with B.A.C.K. is to support patients with skills for self management of their chronic disease.

Reason:
- Improve overall health of patient.
- Reduce unnecessary ED visits and admissions.
- Reduce overall costs related to a Patient’s challenging chronic disease.
Patient Navigation System Cycle within Patient Centered Medical Home Model

- Reassessment by Primary Care Physician, Medical Director to evaluate Patient medical progress
- Primary Care Physician, Medical Director Evaluation and Referral to Patient Navigator
- Patient Navigator: DSRIP Education, Comprehensive Intake Assessment and Identification of Patient barriers
- Patient Navigator Follow up within week with Patient and Patient’s support system.
- Re-evaluation by Patient Navigator to confirm removal of psychosocial barriers to treatment.
- Communication with Community Partners regarding Patient use of services and feedback.
- Referral to Community Clinical, Non-clinical partners or other outpatient services.
- Continued Monitoring by Patient Navigator
INFORMATION MANAGEMENT/PI

- USE OF TRACK VIA: LEARNING FROM THE LEARNING COLLABORATIVE
  - BUILD PATIENT NAVIGATOR INTAKE ASSESSMENT
  - REAL TIME DATA COLLECTION TO MONITOR PILOT
  - TRIGGERS/ALERTS FOR APPOINTMENTS OR ABNORMAL TESTS
  - CONCURRENT PERFORMANCE IMPROVEMENT REPORTING.
HEALTH LITERACY PLAN

- AFFILIATION WITH NEW JERSEY CITY UNIVERSITY HEALTH SCIENCES- 2 STUDENTS ASSISTING
  - MAPPING FOR LOCAL GROCERIES
  - DEVELOPED LOW BUDGET HEALTHY MENUS
  - POWER POINT PRESENTATION- HOSPITAL STAFF LUNCH AND LEARN
- EMPLOYEE AND MEDICAL STAFF NEWSLETTERS
- “UNIVERSAL PRECAUTIONS” APPROACH
- EDUCATION: ASK ME 3, PLAIN SPEAK, TEACH BACK
COMMUNITY SCREENING: DIABETES AND HYPERTENSION

• HELD ON NATIONAL DIABETES DAY 11/14
• COMMUNITY PARTNERS PARTICIPATED
• EVERY PARTICIPANT WAS COUNSELED BY SENIOR MEDICAL RESIDENTS
• HEALTH STUDENTS PREPARED EDUCATION MATERIALS –MET OUR GUIDELINES FOR LANGUAGE AND LITERACY. REVIEWED WITH PARTICIPANTS BY MEDICAL RESIDENTS.
EVIDENCE-BASED CARE

- SUMMARIZED 2014 ADA CLINICAL CARE GUIDELINES ON A ONE-PAGE DOCUMENT
- AVAILABLE IN CLINICS AS REFERENCE, SENT TO PARTNERS
- EDUCATION OF MEDICAL STAFF, RESIDENTS, CLINICAL PARTNERS, PROVIDERS
- PROJECT PI, BASELINE ON MEASURES AND ONGOING MONITORING
RESPONSES TO LC SURVEY

• ADDRESSED ALL APPLICATION ELEMENTS
• CREATIVE PROBLEM SOLVING AND USE OF RESOURCES
• INTERIM SOLUTION TO INFORMATION SYSTEM OBSTACLE WITH USE OF TRACK VIA
• ACTIVE PDSA CYCLES OF IMPROVEMENT
PROJECT ACHIEVEMENTS

• BUILDING MOMENTUM FOR PROGRAM
• COMMUNITY COLLABORATIONS INCREASING; INVITED TO COMMUNITY FORUMS TO ADDRESS RISK POPULATIONS
• DEVELOPMENT OF EVIDENCE-BASED GUIDELINE TOOL, USEFUL FOR PRACTITIONERS
• DEVELOPED UNIQUE PATIENT SATISFACTION SURVEY, LOW LITERACY, TWO LANGUAGES
• HOSPITAL WIDE, COMMUNITY ATTENTION TO THE PROGRAM AND HEALTH LITERACY
PROJECT OBSERVATIONS/CHALLENGES

- MORE TO LEARN AND IMPROVE
- FINDING UNTAPPED RESOURCES TO SUPPORT PROGRAMS
- UNDERSTANDING THE ATtribution MODEL AND HOW IT RELATES TO THE PROSPECTIVE PATIENT POPULATION
QUESTIONS OR SUGGESTIONS?

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