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

DIABETES AND HYPERTENSION CARE PROGRAM

LEARNING COLLABORATIVE 5 – JANUARY 8, 2015

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

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

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

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.
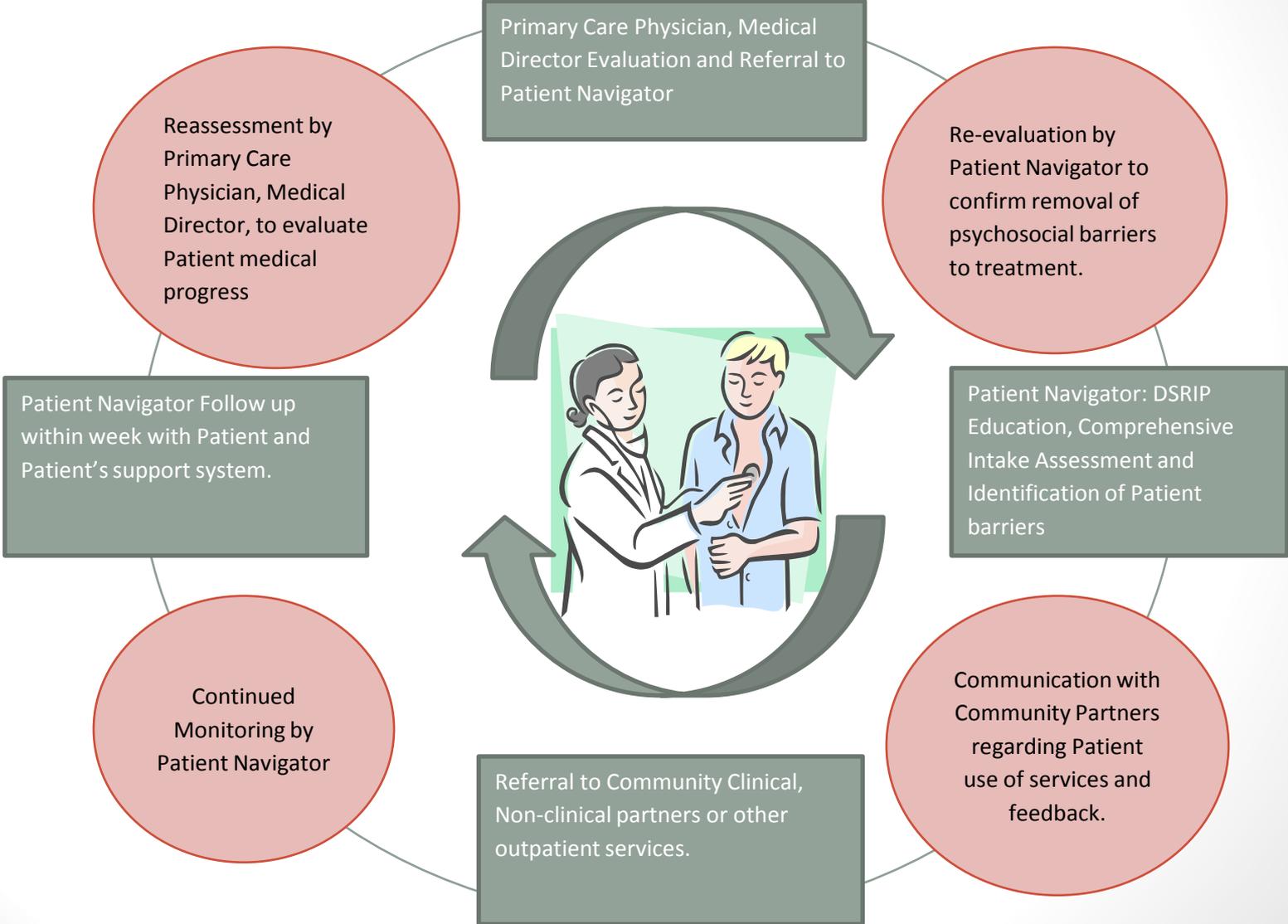
Reason:

- Improve overall health of patient.
- Reduce unnecessary ED visits and admissions.
- Reduce overall costs related to a Patient's challenging chronic disease.

- **B**arrier Focused Intervention

- **A**ssess and refer

- **C**ollaborate

- **K**eep Patient in care

Patient Navigation System Cycle within Patient Centered Medical Home Model

Primary Care Physician, Medical Director Evaluation and Referral to Patient Navigator

Re-evaluation by Patient Navigator to confirm removal of psychosocial barriers to treatment.

Patient Navigator: DSRIP Education, Comprehensive Intake Assessment and Identification of Patient barriers

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

Patient Navigator Follow up within week with Patient and Patient's support system.

Reassessment by Primary Care Physician, Medical Director, to evaluate Patient medical progress

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

- AFFLIATION WITH NEW JERSERY 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 PRECATIONS" 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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