Mini Pii Session

Collaborative Approach in Managing the High Risk Diabetic Patient in a Patient-Centered Medical Home

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The Problem: 35.00% of MIHS diabetic patients had poor glycemic control evidenced by a HbA1c ≥ 9. The target benchmark was set at 16.1%. Many missed opportunities.

Interventions:
1. Identification of a multi-disciplinary task team
2. Identified best practice clinical guidelines
3. Developed a provider-led, patient-centered multi-disciplinary protocol (PCP, Care Coordinator, Clinic RN, Diabetes Educator, Medical Assistant, Pharmacy, Support Staff).
4. Maximized use of electronic health record
   a) Bulk ordering
   b) Care gaps monthly reporting
   c) EHR automated lab ordering
   d) Bulk order patient notifications
5. Education and daily huddles
6. Team engagement
7. Patient outreach and follow-up
8. Lessons Learned and Plan, Do, Check, Act process

Outcome:
1. 8% improvement; A1c’s ≥ 9 were reduced from 35.00% in Jan 2018 to 28.00% in Nov 2018
2. Increased patient adherence: 1st Quarter: 39.5% patients completed testing vs 2nd Quarter 74.2% patients completed testing.

Challenges: (managed by Care Coordinator, diabetes educator, and registered nurse)
1. Food insecurities
2. Financial Restraints
3. Health Literacy
4. Homelessness
5. Transportation Needs
6. Language Barrier
7. Behavioral Health Issues

Q: What is the licensure of the diabetic educator?  
A: Certified Diabetes Educator
Q: Are the patient “self-monitoring logs” maintained via paper or via the EHR?
A: Currently, patients maintain paper logs and these are scanned in EHR. In the future, looking at incorporating these in the patient portal (My Chart).

Q: Are the diabetic education classes individual or group?
A: Health Centers offer group education classes both in English & Spanish.

Q: What is the size of the MIHS diabetic population?
A: Very large. In the 3K-4K

Q: How do you strategically prioritize which diabetic patients need to be outreached?
A: Filter population health reports by overall high risk score and also by patients with multiple diabetic care gaps.
Background

- Safety net facility serving the community for more than 140 years
- Employ over 3500 health care professionals
- 12 Family Health Centers with over 432,600 outpatient visits annually
- Two Behavioral Health Centers
- A new Emergency Department and Behavioral Health Hospital scheduled to open in May
Customized:
- Reports by Diagnosis
- Data Collection
- Daily Schedules
- Bulk Ordering Capabilities

Management of Patients with Diabetes

- Diabetes is a leading cause of disability and death in the United States
- High quality care can improve glycemic control
- HRSA and NCQA recommend tracking HbA1c’s
- For every 1 percent reduction in HbA1c, the risk of retinal, renal, and neuropathic disease is reduced by 40 percent while the risk of MI is reduced by 14 percent.
**Problem Statement**

- 35.00% of our diabetic patients had poor glycemic control evidenced by a HbA1c ≥ 9) [Benchmark 16.1%]
- Missed opportunities
Step 1: Identified Problem

- Researched best practice
- Connected with Healthy Communities Collaborative Network (HCCN)
- Established a problem statement
Step 2 – Task Team

- Chief Medical Director
- Care Management Director
- Diabetic Educators
- IT
- Care Coordinators
- Clinic Manager
- Medical Assistant

BEST PRACTICE IDEAS

- Objective Screening Measurements
  - HbA1c >9
  - Lipid Panel
  - Urine Microalbumin
  - Retinal Screening

- Collaborative Care Coordination
  - Patient Follow-up
  - Medication regimen
  - Diabetic Education
  - Patient Engagement
Step 3: Develop a provider-led, patient-centered multi-disciplinary protocol

Primary Care Provider
- Diabetes Educator
- Care Coordinator
- Clinic RN
- Pharmacy
- Medical Assistant
- Scheduling Quality Admin IT

Care Team: Provider
- Diagnosis and treat
- Adjust medication
- Refer for consultations
- Promote DSME (Diabetes Self Management Education)
- Collaborative treatment plan
- Review and approve orders
Care Team: Care Coordinator

- Identify defined population and gaps in care
- Bulk ordering of diagnostic tests per protocol
- Conduct outreach to notify patients of care gaps needs
- Support provider with patient-centered treatment plan

Care Team: Nursing

- Promote DSME / provide diabetic education to supplement DM Educator
- Supports patient-centered treatment plan
- Supports Care Coordinator (backup) for bulk ordering of diagnostic testing
- Manually enter outside lab and retinal eye exam results
Care Team: Diabetes Educator

- Identify and address health barriers
- Provide DSME upon diagnosis, annually, when complicating factors arise, and when transitions in care occur.

Care Team: MA's

- Schedule appointments for PCP follow up, diabetes education, lab, retinal exams, referrals
- Review daily provider schedule to identify diabetics with gaps in care
- Provide patient with blood glucose self-monitoring logs

Medical Assistant
Care Team: Pharmacy

- Identify and notify provider, RN, or care coordinator of those patients not picking up prescriptions
- Promote DSME
- Medication reconciliation

Care Team: Support Staff

- Schedule appointments
- Monitor and provide feedback on core measures and quality improvement
- Stuff envelopes and mail patient letters
- Develop and support EPIC processes

Scheduling

Quality

Admin

IT
Harnessing our EMR

- IT developed a bulk ordering system
- Care Coordinator runs monthly report to identify diabetic patients with care gaps
- EPIC rule-based logic generates orders:
  - A1c’s based on clinical guidelines (every 3 or 6 months)
  - Microalbumin if > 1 year since last test
  - Lipid Panel if > 1 year since last lab test
  - Retinal Eye Exam if > 1 year
- Orders to route to PCP for review and authentication
- Bulk communication to notify patient of gaps

Bulk Communication

- Bulk communication is sent to patient via their preferred method of communication.
- Communication notifies patient of care gaps and requests patient call office to schedule an appointment to address care gaps.

- MyChart Message
- Phone Call
- Letter
Steps 4 & 5: Education plan and roll out

Protocol approved by Medical Executive Committee

Presented at Medical Director / Clinic Manager Meeting

SBAR, staff education on protocol

Daily Huddles

Step 6: Implementation

Go Live: July 2018
Team Engagement

- Care Gaps discussed at morning huddles
- Patients identified on daily schedule
- Staff and providers can see at a glance the date and value of last Hgb A1c, and if patient has open bulk orders
- Care Gaps are closed at the visit
- Labs drawn & Referrals processed

Formatted daily patient schedules to quickly identify patients who are high risk and have care gaps
Outreach Follow up

Monthly follow up reports identify:

- Patients who have not responded to outreach or scheduled follow up visit to close care gaps
- Patients who have not read their MyChart message so team can outreach via phone or mail

Retinal Screening Referrals processed and labs drawn at visit
Outreach Follow up

Monthly follow up reports identify:

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Step 6: Lessons Learned & “PDCA” Plan
Do Check Act

- Social Determinants of Health
- Complexity of care
- Patient engagement, high no show rate
- Staff engagement with new roles and responsibilities, new workflows
- Provider panel discrepancies
- Organizational dissemination of information
**Post-Protocol Data**

![Ambulatory Care Table]

- Even with the many challenges, we *have* made a difference for our patients.
- A1c’s ≥ 9 were reduced from 35.00% in Jan 2018 to 28.00% in Nov 2018 (8% improvement).

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**Increased Patient Adherence**

- **1st Quarter of protocol (Jul.-Sept. 2018)** 39.5% [490/1240] of patients with HbA1c’s ordered completed the testing.
- **2nd Quarter of protocol (Oct.-Dec. 2018)** 74.2% [1024/1380] of patients with HbA1c ordered completed the testing.
Ongoing Challenges

Food Insecurities

- No grocery stores
- No farmers' markets
- Surrounded by fast food, junk food, or food high in sugars and fats
Financial Restraints

- Medications
- Co-payments
- Specialty Care Needs
- Donut Hole
- Eating Healthy
- Deductibles
- Diabetic Supplies
- Wound Care Supplies

Health Literacy

The ability to obtain, interpret and understand basic health information and services, and to use such information in ways that enhance health
Homelessness

- Difficulty taking medications as ordered.
- Problems protecting medications when living on the street.

Transportation Needs

- Advance notice required by health plan.
- Limited cell minutes.
- Difficulty navigating phone tree.
Language Barrier

Behavioral Health Issues

General Mental Health

Seriously Mentally Ill

LOVELINESS  ANGUISH  HOSTILITY

DISTRACTED  CONFUSION

GRIEF  ANGER  MANIC

depression  bipolar  schizophrenia
addiction  OCD  PTSD
• Integrated Health Clinic pilots to connect our behavioral health patients with medical care and community resources
  – Initial pilots are located in three facilities
    • Avondale
    • 7th Avenue
    • Mesa
  – Planned future integration in all ambulatory care clinics
Bibliography

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