Housekeeping Tips

- Microphones will be muted by the host
- Please note the audio and video controls in the top left corner
- If you would like to ask questions during the question and answer session, please type them in the chat box at the bottom right hand of your screen as pictured below
GEORGE RUST, MD, MPH
Co-Director
National Center For Primary Care At
Morehouse School of Medicine
Diabetes
Health Equity

“Of all the forms of inequality, injustice in health care is the most shocking and inhumane.”

-- Martin Luther King, Jr.
Disparities in Outcomes

- Hospital Admissions for Uncontrolled Diabetes per 100,000 population

Drivers of Health Disparities

- **Health Potential**
- **Social Determinants**
  - Health Behaviors, Self-Mgt, & Self-Efficacy
- **Food, Housing, & Resources**
- **Access to Care / Quality of Care**
Tying it All Together in a Rapid-Cycle Improvement Process

How Do We Tie it All Together?
Can we continuously improve interventions in each domain and in the spaces in-between the practice and the community or between the hospital and home, with a rapid-cycle outcomes feedback loop and provider-community coalitions all working together to keep improving connections and processes and outcomes until we achieve more optimal and equitable outcomes for all?

Clinic (PCMH)

Home & Community

Outcomes (Hospital Bed-Days, Disability, Death)

How Do We Tie it All Together? Can we continuously improve interventions in each domain and in the spaces in-between the practice and the community or between the hospital and home, with a rapid-cycle outcomes feedback loop and provider-community coalitions all working together to keep improving connections and processes and outcomes until we achieve more optimal and equitable outcomes for all?
The Core Elements

• Harvesting lessons learned, framed in the three-element model:

  – Clinical Practice Transformation
    (care mgt, panel mgt, outcomes mgt);

  – Person / Family / Community Engagement
    (treating patients as free-range humans who live in non-clinical settings making autonomous decisions)

  – Driven by Rapid-Cycle feedback loops
    – Rapid-cycle quality improvement
    – Rapid-cycle outcomes improvement
### NCQA / HEDIS Quality Measures for Comprehensive Diabetes Care

<table>
<thead>
<tr>
<th>Quality Indicator</th>
<th>Performance (Medicaid)</th>
<th>Performance (Medicare)</th>
<th>Performance (Commercial)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Good HbA1c Control (≤ 7)</td>
<td>30.9%</td>
<td>45.9%</td>
<td>41.8%</td>
</tr>
<tr>
<td>B. Partial BP Control (&lt;140/90)</td>
<td>57.3%</td>
<td>57.8%</td>
<td>61.4%</td>
</tr>
<tr>
<td>B. Good BP Control (&lt;130/80)</td>
<td>30.4%</td>
<td>30.2%</td>
<td>29.9%</td>
</tr>
<tr>
<td>C. Cholesterol Control (LDL &lt;100)</td>
<td>30.6%</td>
<td>46.9%</td>
<td>43.0%</td>
</tr>
</tbody>
</table>
# Systems Change:
## Re-Designing Processes of Care

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1</strong></td>
<td>Diabetic gets finger-stick blood glucose; patient <em>may</em> have fasted</td>
</tr>
<tr>
<td><strong>2</strong></td>
<td>Doctor sees patient, and <em>may</em> order Hemoglobin A1c test.</td>
</tr>
<tr>
<td><strong>3</strong></td>
<td>Patient <em>may</em> go to the lab and <em>may</em> wait to get their HbA1c drawn.</td>
</tr>
<tr>
<td><strong>4</strong></td>
<td>Doctor <em>may</em> notice that HbA1c is elevated</td>
</tr>
<tr>
<td><strong>5</strong></td>
<td>Dr. <em>may</em> ask staff to call patient back for follow-up</td>
</tr>
<tr>
<td><strong>6</strong></td>
<td>Doctor / nurse <em>may</em> be able to reach patient by phone.</td>
</tr>
<tr>
<td><strong>7</strong></td>
<td>Patient <em>may</em> agree to come back, and <em>may</em> actually keep appt.</td>
</tr>
<tr>
<td><strong>8</strong></td>
<td>If patient comes back, doctor <em>may</em> intensify regimen.</td>
</tr>
</tbody>
</table>
Systems Change: Re-Designing Processes of Care

Step 1
- Nurses follow standing order for fingerstick Hgb A1C on every diabetic

Step 2
- Results on chart when doctor sees patient;

Step 3
- Doctor *may* intensify regimen

- Avg A1c 8.55 before
- Avg A1c 7.84 after

- Re-set the default setting to do the right thing *automatically* unless the clinician says no!
Teamwork: Everyone works up to the Level of their License

- Example: Empower More Clinical Staff to Initiate Preventive Services
  - Medical assistants and Licensed Practical Nurses offer mammography as a routine part of the clinic encounter

Group Visits and Panel-Based Care Mgt

Community outreach and education is closely coordinated with the clinical primary care team and activities in the health center, such as “Stop Diabetes Fridays at Alivio”.

ALIVIO MEDICAL CENTERS – MY HEALTH COMES FIRST
Teamwork!

- Community Health Workers (*Promotoras*)
- Medical Assistants
- Nurses / Nurse Practitioners
- Pharmacists
- Social Workers
- Health Educators
- Respiratory Therapists
- Physical Therapists
- Primary Care Practitioners
- Psychologists
- Behaviorists
- Sub-Specialists
- Administrators
Mental Health ↔ Physical Health

• “Baseball is 90% mental -- the other half is physical.”
  -- Yogi Berra

• Stress
• Depression
• Anxiety
• Substance Abuse
• Domestic Violence
• Schizophrenia
• Bipolar Illness

• Nervios
• Susto
• Mal de Pelea
• Social Isolation
• Migration Stress
• Acculturation Stress
Doctor-Centered Medical Home: the Exam Room and the Doctor-Patient Visit
Free-Range Humans

(when patients escape from the exam room!)
Why Integration?

Example: To prevent complications of obesity and diabetes, **all you have to do** is modify a person’s health beliefs and attitudes, daily habits, eating preferences, daily activities, exercise habits, grocery stores, neighborhood walk-ability, food advertising, self-care, employability, economic empowerment, access to medical care, provider quality, and medication adherence, all in the context of his or her family and social relationships.
Promotores / Promotoras & Community Health Workers

- Enhanced Use of Complex Health Systems (Navigators)
- Immunization Rates
- Healthy Eating & Exercise
- Control of Household Asthma Triggers
- Farmworkers Eye Safety
- Compliance with TB Treatment
- Breast & Cervical Cancer Screening
- Blood Pressure Control
Partnership with Community

Integration means working seamlessly together on a shared agenda!
Tying it All Together
Making the Clinic – Community Connection

How Do We Weave Clinic & Community Together? Can we continuously improve interventions in each domain and in the spaces in-between the practice and the community until we achieve more optimal and equitable outcomes for all?

Clinic (PCMH)

Home & Community

Outcomes (Hospital Bed-Days, Disability, Death)
Group Visits and Panel-Based Care Mgt

Who says group visits have to happen in the clinic?
Cultural Relevance / Cultural Ownership

South Central Foundation – Anchorage, Alaska
Tying it All Together in a Rapid-Cycle Improvement Process

How Do We Tie it All Together?

Can we continuously improve interventions in each domain and in the spaces in-between the practice and the community or between the hospital and home, with a rapid-cycle outcomes feedback loop and provider-community coalitions all working together to keep improving connections and processes and outcomes until we achieve more optimal and equitable outcomes for all?
Achieve Equality in Outcomes
Requires an Outcomes Data Feedback Loop

• Community Level Metrics
  • Mortality
  • Hospital Bed-Days
  • Preventable Adverse Events (e.g., amputations)

• Practice-Level Data
  • ED Visits
  • Hospital Bed-Days

• Person-Level Feedback
  • Missed refills
  • Inadequate Care
  • ED Visit yesterday!
Managing Transitions, Managing Between the Lines

<table>
<thead>
<tr>
<th>Element C: Coordinate With Facilities and Manage Care Transitions</th>
<th>6 points</th>
</tr>
</thead>
<tbody>
<tr>
<td>On its own or in conjunction with an external organization, the practice systematically:</td>
<td></td>
</tr>
<tr>
<td>1. Demonstrates its process for identifying patients with a hospital admission and patients with an emergency department visit</td>
<td></td>
</tr>
<tr>
<td>2. Demonstrates its process for sharing clinical information with admitting hospitals and emergency departments</td>
<td></td>
</tr>
<tr>
<td>3. Demonstrates its process for consistently obtaining patient discharge summaries from the hospital and other facilities</td>
<td></td>
</tr>
<tr>
<td>4. Demonstrates its process for contacting patients/families for appropriate follow-up care within an appropriate period following a hospital admission or emergency department visit</td>
<td></td>
</tr>
<tr>
<td>5. Demonstrates its process for exchanging patient information with the hospital during a patient’s hospitalization</td>
<td></td>
</tr>
<tr>
<td>6. Collaborates with the patient/family to develop a written care plan for patients transitioning from pediatric care to adult care (NA for adult-only or family medicine practices)</td>
<td></td>
</tr>
<tr>
<td>7. Demonstrates the capability for electronic exchange of key clinical information with facilities</td>
<td></td>
</tr>
<tr>
<td>8. Provides an electronic summary-of-care record to another care facility for more than 50 percent of transitions of care**</td>
<td></td>
</tr>
</tbody>
</table>

Process for knowing right away when your patient has been to the ER

Able to exchange patient info with the hospital during a patient’s hospitalization
Democratizing the Data

Outcomes
Data
Feedback
Loops with Community Stakeholders:
Tying it All Together in a Rapid-Cycle Improvement Process to Achieve Optimal, Equitable Health Outcomes for All

Primary Care
Health Home

Community Health Promotion

Ideal Future

Present Situation

Health Outcomes
20th Century Primary Care
Humility in Working Together

“We are all as angels, with only one wing; We can only fly when we embrace each other.”

-- Luciano de Crescenzo
SABRINA JACKSON, PA–C
Project Co–Director
Partnership for Diabetes Health Equity
at Morehouse School of Medicine
What is a learning collaborative?

- Systematic approach to improvement for a defined period of time
- Best Practices
- Team based learning and sharing
- Test and implement system changes
- Measure the impact
- Method to close the gap that currently exists in diabetes related outcomes
What is the proposed aim?

The ultimate goal: Create or improve a system of care that is person-centered, coordinated and quality measured.

- Over a period of twelve (12) months, PDHE 3–Element Diabetes Care Collaborative Partnership Teams consisting of a clinical entity, a community partner and an external outcomes data source will work to implement the missing 3rd element and build a seamless process of organizational coordination.

- Together the teams will make and measure changes in a rapid cycle to ultimately improve the health status and outcomes of individuals who have diabetes.
How will we accomplish this?

The Learning Collaborative will assist organizations to:

- Adopt and improve *clinical* care, systems, and processes (i.e. workflows)
- Build *community* partnerships and collaborations
- Define and adopt effective *data* collection
- Establish methods of multiagency communication
- Effectively use clinical information systems
*Schematic is based on IHI Breakthrough model of improvement*
Why join this collaborative?

- Rapidly changing healthcare environment
- Need for quality based healthcare
- Redesign of organization systems
- Positioning for funding
Who are we seeking?

Faculty Mentors

- Subject matter experts in care coordinated clinical diabetes care, clinic transformation, community partnerships and engagement, quality improvement, medical data collection and analysis.
Who are we seeking?

Participants/Mentees

- 15–18 teams representing **different** vulnerable populations in varied geographical areas across the country

- Have a lead organization with at least 2 partner organizations or a diabetes or health equity coalition as lead

- Have already demonstrated strength in 2 of the 3 elements (clinic/community/outcomes data)

- Ex. Diabetes coalition consisting of FQHC, local YMCA health and wellness leaders and hospital sharing data through a diabetes registry of patients presenting through ER or being hospitalized.
When will it begin?

Collaborative Dates  9/1/15 – 8/31/16

Application Dates

- March 31, 2015  Applications Available
- April 6–27 2015  Weekly Monday Conference calls regarding questions on application
- May 1, 2015  Applications due
- May 31, 2015  Decisions Announcement
- Sept 1, 2015  Collaborative Begins
Faculty

Participant Referrals
Questions ?
PDHE Announcements

PLEASE CLICK HERE to visit our Learning Collaborative page on our website for more information!

Would you like to attend this live meeting again? Please join us MARCH 4, 2015 from 1PM – 2PM EST. Check the EVENTS page for details.

To join the Learning Collaborative and get more information please provide info here.