

CASE STUDY FOR QUALITY IMPROVEMENT

Improving Diabetes Outcomes

ALLINA MEDICAL CLINIC

Organization Profile

A multispecialty medical group serving more than 40 communities in Minnesota at 44 clinic locations and 14 hospitals, the Allina Medical Clinic is part of Allina Hospitals and Clinics, a not-for-profit network of hospitals, clinics, and other health care services, providing care throughout Minnesota and western Wisconsin.

With 3,800 clinic employees, including 575 physicians (400 primary care physicians and 175 specialists) and 170 advanced practice clinicians (Nurse Practitioners, Physician Assistants, etc.), Allina Medical Clinic provides more than 2.7 million outpatient visits annually. From 2004-2008 Allina implemented an EMR (Epic) to manage care connecting offices, emergency departments, and hospitals.

Project Summary

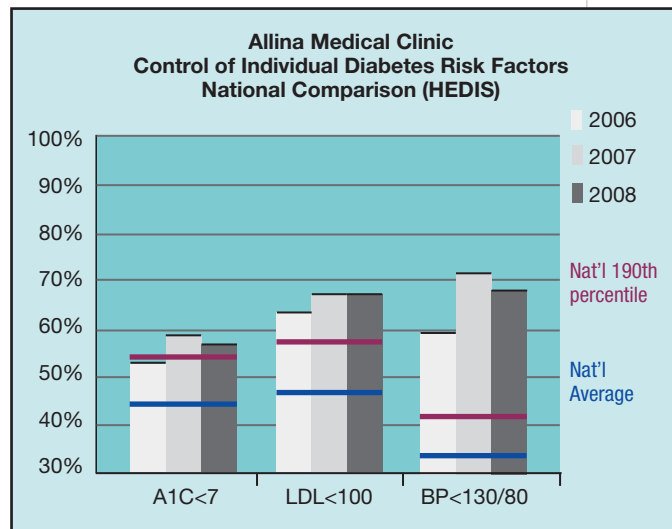
The Allina program focused on implementation of an Improvement Model that calls for controlling glucose aggressively *early in the course* of diabetes.

Goals and Objectives

Allina Medical Clinic's program, Improving Diabetes Outcomes, strives to help patients with diabetes achieve 5 care goals in control of each diabetes risk factor (HEDIS):

- Have an A1C level of less than 8 percent.
- Have an LDL cholesterol level of less than 100.

- Have a blood pressure rate of less than 130/80.
- Take aspirin daily (ASA use).
- Stay or become tobacco-free.



Improvement Model

To achieve its goal of improving diabetes outcomes, Allina implemented an integrated 9-step improvement model that can work for most diseases. This model includes full participation of the clinic community.

As demonstrated here, the model is well-suited to achieving the goals for diabetes patients:

- 1. Establish the "why" and create a tangible vision.** An important first step, this calls

Diabetes Population and Registry

Influential to the success of the program are the elements of Allina's distinctive Diabetes Population & Registry affecting quality measures and outcomes:

- All patients with type 1 or 2 diabetes based on ICD-9 codes.
- Only patients age 18–75 are included in quality measures.
- Demographics (population included in quality measure):
 - 1% Medicaid, 30% Medicare, 47% Commercial/FFS, 20% Charity Care
 - 25% age 18–49 and 75% age 50–75
 - 16% urban, 55% suburban, 29% rural
 - Significant ethnic groups include Hispanic, Russian, Hmong, Somali, Northern European
- 2009 registry currently includes 20,200 unique patients.
- Captures PCP, clinical, lab, medication and visit data.
- Reports are produced for the group overall as well as for district, site, and individual physicians.

Improvement Model (cont.)

upon project organizers to present the evidence that establishes the proof that the goals are achievable.

- 2. Align leadership.** The next step ensures leadership buy-in and involvement by engaging a “guiding coalition” of personnel to manage and implement the process. The Allina “coalition” included the Diabetes Clinical Action Team, Clinical Practice Council, and internal opinion leaders. Together, the coalition was charged with establishment and oversight of project goals. Administrative and physician leaders have the same clinical and operational goals with a necessary balance of threshold goals and relative improvement.
- 3. Develop and execute a communication plan.** A communications plan provides a framework for communicating the project activities and accomplishments to key stakeholders. It should include simple, consistent messages that are meaningful and transmissible.

To ensure message acceptance, messages must be tailored to each target audience and

dissemination planned to include specific delivery channels for reaching all audiences. Allina used these message delivery channels to promote their messages:

- Newsletter
- Quarterly Leadership Meeting
- Local leaders trained to deliver the message at site meetings
- Lunch & Learns for staff done by local MD experts (nephrology, endocrinology)
- Repetition: create a “drum beat”
- Leader rounding

Finally, follow-up is necessary to ensure the message was not only received, but also understood and utilized.

- 4. Educate physicians—establish a common knowledge base.** Topics included in Allina's educational component and a required CME for all new hire and low-performing physicians are:

Patient-based

- The evidence for tight risk factor control
- Algorithm-based approaches to clinical challenges (e.g., resistant HTN)
- Increasing the tempo of treatment through repeat visits
- How to maximize patient adherence (e.g., address cost concerns, keep regimen simple, printed instructions, how to ask about adherence)
- Understand the patient experience (e.g., doctors participated in self-injection of saline using insulin syringe)

Practice Management

- How to work as a team with nursing staff—awareness that the nurses need to know what's going on at all times
- Collaboration with RN Certified Diabetes Educator for low-performing physicians (CPR for physicians)—includes CDEs coaching physicians and seeing patients with the physician
- Specific advice based on chart reviews
- Strategies for motivating patients

5. Implement process changes—be specific about the “what” and the “who.”

- Standardized and efficient rooming standards for clinical assistants help to maintain patient flow, maximize physician time spent with each patient, and streamline the clinical process. Allina’s improvement model includes the following rooming standards for diabetic patients:
 - Chart prep for last A1C, LDL
 - Standing orders for pre-visit point-of-care A1C testing, LDL testing, and DM education
- Give patients “score card” with current lab values and goals with follow-up instructions to help them see their progress and take ownership of goals
- Schedule future labs, visits, and CDE appointments before the patient leaves to help patient plan and to encourage visit regularity/consistency
- Rx refill policy: limit refill of diabetes meds to 6 months to ensure return visits
- Quick Start Insulin Program—to provide on-site RN patient education for newly diagnosed patients
- Include RN CDE Medication Management (titration) visits
- MAs “work” the registry report—update registry regularly (deceased, transferred care)
- Contact patients who are due for labs and/or a visit to ensure they will be there
- Schedule BP check nurse visits

6. Check back on the implementation. As with any process, follow-up and reinforcement are crucial to the project’s long-term successful operation. Two primary recommendations for follow-up were part of the Allina model:

1. Leader rounding
2. Check in with every care team

7. Provide transparent feedback. Ultimate project success relies on mutual learning. This mutual learning comes, in part, from regular, honest, and direct feedback opportunities that include the entire team. Transparent feedback should be a 2-way street that engenders growth and places value on the knowledge and opinions of all members of the project team. Allina offers strong feedback recommendations:

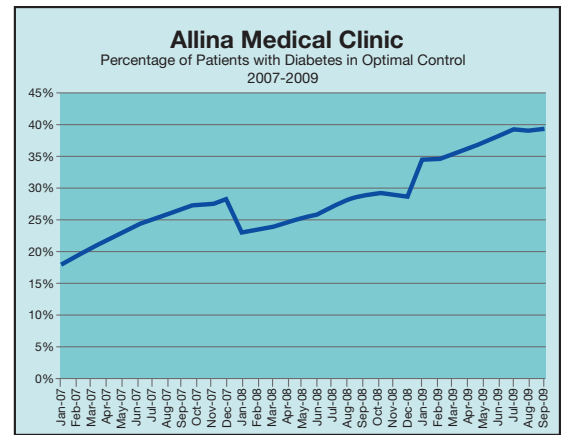
- Share data at team meetings with all physicians and staff monthly to help build collective knowledge
- Use un-blinded site and physician-specific data—ask about/discuss specific patients
 - › Comparative data are powerful; however, physicians tend to doubt “the numbers”
 - › Individual patient data are more powerful; when the focus is brought down to the care of individual patients there can be no excuses

8. Coach for improvement. As demonstrated, to improve outcomes the model offers several suggestions for improving physician and staff performance by focusing on individual patients rather than numbers. Successful methods include rotating sessions, dealing with resistance through role-playing, and physician-to-physician coaching.

- **Teach leaders to lead.** To ensure project leaders provide effective leadership to help the team reach its goals, the model ends with suggestions for providing leaders with leadership skills. The skills begin with leader willingness to actively participate in professional learning such as role-playing and expertise sharing. Allina’s follow-up concludes that leaders need to possess the skills and desire for: communicating the evidence and importance; influencing team skills; dealing with any resistance they may encounter; follow-through such as checking back and leader rounding on staff; and coaching for 1:1 meetings with physicians involved in the project.

Outcomes

Outcomes are demonstrated in the chart at right, which shows an increase in the percentage of patients with diabetes in optimal control from less than 20% to greater than 40%.



Lessons Learned

- Well-developed systems can provide consistency, support practice, and improve care.
- The power of nursing is more than just team work—the nursing staff helps drive system changes.
- Culture through action—“Culture is everything you promote and everything you tolerate.”
- Leadership is everything—financial incentives are not necessary if there are strong moral and social incentives.