

## CASE STUDY FOR QUALITY IMPROVEMENT

# Team-Based Diabetes Care Management

## HEALTHPARTNERS MEDICAL GROUP & CLINICS

### Organization Profile

Established in 1956 in Minnesota, offering both care and coverage, HealthPartners Plans and HealthPartners Medical Groups and Clinics is the only care delivery system with integrated health services: medical, specialty care, dental, pharmacy, hospital, home care, and hospice. The system includes 23 clinics, 600 physicians, 1 million+ outpatient encounters in 2008, and 13,000+ patients with diabetes. Patients have access to their health information 24 hours a day as well as to online patient services with appointment scheduling, test results, urgent care, and more.

### Project Summary

To improve diabetes care measure performance, particularly among low-performing sites HealthPartners' Team-Based Diabetes Care Management uses principles of deliberate design for reliability: reliability occurs by design not by accident; process is the action point of all improvement methodologies; segmentation allows the perfection of the design.

HealthPartners Diabetes Care Management follows a standardized process: patients are notified to have pre-visit labs completed. The process includes a "redundancy step" that allows for labs to be done the day of their visit if the team was unable to reach the patient or if preferred by the patient.

The next step, redesign, uses several best practice ideas from clinics and collaboratives (AMGA, ICSI, etc).

### Goals and Objectives

Several goals/objectives guide the Team-Based Diabetes Care Management project. They include:

- Improve diabetes care measure performance, particularly among low-performing sites to help low-performing sites meet the performance levels of the other sites
- Refine how providers, care teams, and clinics organize and execute their work—the goal is to organize and execute as a team
- Share responsibility and action for promoting care across a broader team—PCP, diabetes educator, clinical pharmacist, RN, rooming staff, receptionist, dietitian
- Enable each team member to bring his/her skills and expertise to bear when and where they are most needed
- Encourage Care Management team members both to work individually and to collaborate as needed to reach team and patient goals

### Team Composition

Clinical content expertise for this initiative comes from the Diabetes Expert Panel. The Team-Based Diabetes Care Management team includes the following professional staff:

- Physician leader
- Nurse leader
- Participants:
  - Nursing supervisors
  - Clinic business supervisors
  - Clinical pharmacists
  - Registered dietitians/certified diabetes nurse specialists
  - Quality project manager (consultant)

## Project Details

*The Care Model Process/Standardization—how it works*

- Patients had an acute care visit for another reason
  - Standard pre-visit planning and update chronic care at all visits
  - Insert decision support into EMR to flag needed testing and parameters if not at goal or patient didn't return for recommended follow-up
  - Sort registry and reach out to patients who are up to date with testing but whose parameters are not at goal
  - Diabetes support: phone call for medication change, visit, diabetes education, pharmacist visit, etc.
- Segmented registry by the above components specific to each patient for that provider
- Diabetes exception report

## Measures Used

Composite (“optimal care”) measure of the percentage of adult patients who have type 1 or type 2 diabetes with optimally managed modifiable risk factors. Bundle measure (percent of diabetes patients meeting all 5 optimal components) publicly reported at clinic-level are:

- Controlled blood sugar (A1C < 7.0%, A1C < 8.0% after ACCORD study findings released)
- BP control (< 130/80 mmHg)
- Cholesterol control (LDL < 100 mg/dL)
- Daily aspirin use (for patients 40+)
- Non-tobacco user

The data source for HealthPartners measures is the EMR software, EPIC.

## Diabetes Intervention and Population Baseline

The diabetes population (identified monthly) was identified as those patients with 2 office visits in primary care and/or endocrinology with a diabetes diagnosis in past 24 months. The median age is 58, and 93.7% speak English. All but 2% were insured, the majority (63%) with commercial (private) insurance, followed by those on Medicare (25%) and then Medicaid (10%). Further population identifiers are: race/ethnicity: white: 72%, patients of color: 27%; and patients with access to online services: 38.3%.

Patient Group	Care Approach	Lead Team Member	Starting Point	Methods
1. Up-to-date & at goal	Maintenance re-measurement and follow-up	Reception staff	Exception report	<ul style="list-style-type: none"> <li>• Calls from receptionist to update labs or office visit</li> </ul>
2. Near Goal	Intensify therapy and rapidly re-measure	RN	Exception report	<ul style="list-style-type: none"> <li>• RN calls to triage to PCP, DNS, or MTM based on care needs</li> <li>• Make therapy changes then short interval follow-up</li> </ul>
3. New DM diagnosis	Intensive education, medical nutrition, +/- medication management	Diabetes educator	Provider diagnosis	<ul style="list-style-type: none"> <li>• Education</li> <li>• Medication initiation and titration</li> <li>• Re-measurement prior to return to PCP</li> </ul>
4. Willing but distant from goal	Intensive management	PCP + Care Mgmt (diabetes educator, clinical pharmacist, PCP, RN, nurse supervisor)	Exception report	<ul style="list-style-type: none"> <li>• Care Team Meetings</li> <li>• Personal invitation to come in for needed services</li> <li>• Medication adjustment</li> <li>• Close, frequent follow-up (q1-2 weeks in person or by phone) until at goal</li> </ul>
5. Patients not ready to make changes toward optimal care	Support and check back	RN and PCP	Exception reports. Medication refill encounters. Episodic encounters.	<ul style="list-style-type: none"> <li>• Consistent routine labs and provider follow-up, prompted by med refills, incidental encounters and intervals for labs due</li> <li>• Screen for depression</li> </ul>

The system is able to produce Diabetes Exception Reports, which itemize a monthly list of patients and their missed “optimal care” components, as well as provide a due date for proactive outreach to patients currently at goal.

Care teams used the list to triage patients into 5 segments:

- At goal (optimal care)
- Near goal
- Newly diagnosed
- Distant from goals
- Precontemplative/disengaged

For each segment there were defined care approaches and tactics, lead team members, work tools, and standardized communication and documentation methods—each based on the care needs of that specific diabetes population segment.

*A number of tools for planning and patient outreach are available through the EMR (EPIC):*

- Diabetes Care Plan template
- Templates for outreach phone calls serve 2 purposes:
  - Scripting for nurses and reception staff (local team leaders reviewed with receptionists; nursing supervisors with RNs)
  - Standard documentation of between-visit care
- Letter templates (if can’t be reached by phone)
- Best Practice Alerts
- Online Patient Portal

The team found the EMR needing more automation, thus it was too hard to use. They did use the Patient Activation Measure (PAM), a self-assessment survey tool for disease management developed by Judith Hibbard, PhD, and her colleagues at the University of Oregon. The self-assessment tool is used to determine an individual’s confidence, knowledge, and skills needed to successfully manage his or her own health and health care across 4 activation levels.

Reception staff was used to call those patients up-to-date and at goal. RNs made calls to triage PCP, DNS or MTM of those near goal.

And educators were charged with reaching out to newly diagnosed patients within 48 hours.

Recommended but not utilized by all sites were monthly 30-minute lunchtime Care Team meetings. The physicians saw value of these meetings to focus primarily on patients in segment four, those patients willing but distant from goal.

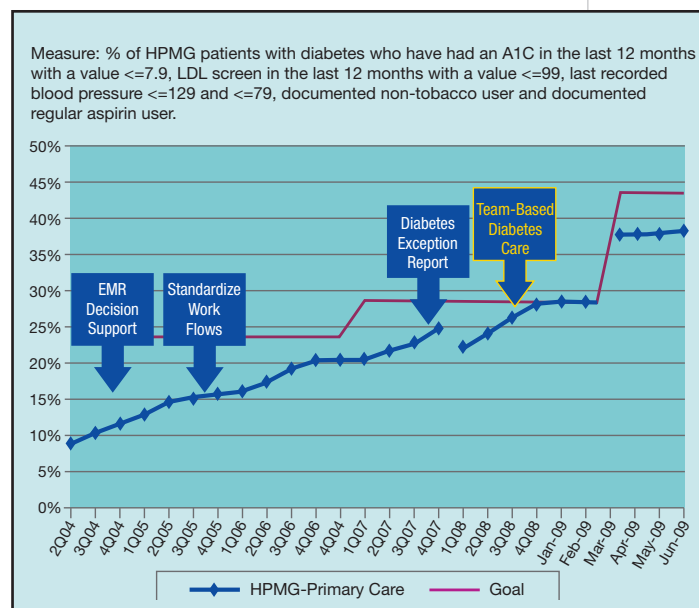
Smarttext for diabetes care plan is included in the EMR problem list. It serves as the site for locating goals and plans for the diabetic patient. The comments section of this diagnosis may be populated with information to facilitate communication and coordination among care team members.

The template includes

- Diabetes treatment segment
- Individualized A1C goal
- Exercise plans
- Future treatment and measurement plans

Comments change as segment, goals, and plans change. All individuals involved in planning or adjusting the care of the patient (RN, DNS, MTM, Physician, APP) are responsible for updating the Problem List Care Plan with current information. All entries and updates are expected to be dated. This results in greater efficiency in documenting communication and the treatment approach used.

## Diabetes Care Measure



## System Challenges or Obstacles

- Varying skill level and engagement of local leaders
- Time and resource constraints
- Care plan—good concept, poorly designed

Local leadership skills, the degree of local leadership engagement, and the thoroughness and speed of implementation of the various workflow components was moderate and varied from site to site.

## Time/Resources

While the Care Plan was a good concept, it was poorly designed. Ideally, care teams should be able to document patients' care plans in a single location; information from the care plan could then be automatically pulled into other locations in the medical record, enabling efficient and effective communication among providers as well as between providers and patients regarding goals and planned follow-up care.

## Future Steps

Moving forward, the Diabetes Care Management Team at HealthPartners Medical Group and Clinics intends to

- Spread segment one workflow, which involves scripted outreach by receptionists, to at-goal patients to prompt lab and clinic visits for testing and clinical follow-up that is due or soon to be due
- Integrate leanings and workflows for other segments into re-design work for Medical Home
- Consider providing training and supervised guidance to local leaders to strengthen their skill sets for implementing process and culture changes
- Customize diabetes support for self-management

## Lessons Learned

Among the lessons that will guide the team as it continues to improve on its Diabetes Care Management program are:

- Reliability in clinic processes is essential.
- Implementation of complex interventions requires strong local leadership.
- Patients appreciate organized outreach.
- Sites that *did* set aside time for Care Team meetings felt it fostered teamwork and communication.
- Improving the percent of patients meeting optimal care goals requires more effort than maintaining a high percent of optimal patients.
- Don't give up on patients.