

## SUMMARY

# Diabetes Best Practices Symposium— Improving Chronic Care Management

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### Background

Merck, the American Medical Group Foundation (AMGF), and the American Medical Group Association (AMGA) sponsored the 2-day Diabetes Best Practices Symposium, which was held in Detroit, Michigan, on October 21–22, 2009. The purpose of the meeting was to provide AMGA members an opportunity to share their insights, the approaches they have taken, and the resources they have utilized and/or developed to help health care providers improve the quality of care for patients with diabetes.

Case studies were solicited from AMGA members. Applicants were asked to provide a program overview describing their goals and results, interventions, leadership involvement, team composition, implementation plan, retrospective thoughts and learnings, and future steps. From the case studies that were submitted, 16 health care organizations from across the United States (see Table 1) were selected based on their ability to document improvements in clinical outcomes, service, and efficiency related to diabetes care. At the symposium, participants from these health care organizations provided a 30-minute overview of their efforts to improve the quality of care given to patients with diabetes, discussed their successes and challenges, and participated in problem-solving discussions with their peers.

**Table 1. Overview of Health Care Organizations at the Diabetes Best Practices Symposium**

Health Care Organization	Location	Facilities	Number of Physicians	Number of Office Visits Per Year
Allina Medical Clinic	Minnesota and Western Wisconsin	44 clinics 14 hospitals	575	2,700,000
Billings Clinic-Cody Diabetes Center <sup>a</sup>	Billings, Montana <sup>a</sup>	8 clinics	8 <sup>a</sup>	10,000
Diabetes and Lipids Center	Decatur, Alabama	1 clinic 5 education sites	1	3000
Dreyer Medical Clinic	Illinois	11 sites	150	500,000
Health Partners Medical Group & Clinics	Minnesota	23 clinics	600	1,000,000
Henry Ford Hospital <sup>b</sup>	Detroit, Michigan	1 hospital	1000	100,000
Holzer Clinic	Ohio and West Virginia	9 clinics	130	500,000
Mercy Clinics, Inc.	Des Moines, Iowa	44 clinics	156	844,076
Novant Medical Group	North and South Carolina, Southern Virginia	361 practices	1060	NP
Physicians of Southwest Washington	Olympia, Washington	28 practices	77	NP
Sharp Rees-Stealy Medical Group	San Diego County	19 locations	400	1,000,000
St Mary's/Duluth Clinic Health System	Northeastern Minnesota, Northwestern Wisconsin, Michigan Upper Peninsula	4 hospitals 17 clinics	438	1,000,000
Stanford Hospital and Clinics <sup>c</sup>	Palo Alto, California	2 clinics	30	750
ThedaCare	Northeastern Wisconsin	4 hospitals 22 clinics	132	420,477
University of Wisconsin Medical Foundation	South Central Wisconsin	48 clinics	1090	2,233,320
Wenatchee Valley Medical Center	Washington State	1 hospital 8 clinics	183	464,384

<sup>a</sup>Rural example; 52 physicians travel to other areas in Montana, Wyoming, and North Dakota.

<sup>b</sup>Group visit program evaluated.

<sup>c</sup>Transplant diabetes program.

NP=not provided.

## Learnings to Success

Across the various institutions that participated in the symposium, the most common elements associated with the success of the respective programs are identified in this section. It is important to note that not every element was used by every health care organization. The elements implemented by the various organizations differed depending on the type of program, team composition, patient population, and available resources.

**1. Change in Culture:** A change in the culture of the organization is critical to successfully initiate and implement a diabetes management program. Strong organizational support and leadership were considered essential to ensure program support and participation at all levels. Adoption of any changes was aided at organizations that

- a) Obtained senior leadership sponsorship
- b) Provided clinical evidence that program goals were beneficial and achievable
- c) Developed and executed a communication plan
- d) Implemented process changes to improve/streamline work-flow efficiency
- e) Monitored performance and provided feedback
- f) Coached for improvement
- g) Provided incentives and/or recognition

**2. Communication Plan:** Communication was essential to the success of these programs. A communication plan provides the framework for communicating program goals, activities, and accomplishments to team members and leadership. A communication plan should include simple, consistent, and meaningful messages that are frequently repeated. There should be follow-up to ensure that messages are received and understood. Several delivery channels can be used, including newsletters, quarterly leadership meetings, and lunch-and-learn meetings for staff. The communication plan should also provide opportunities to address/develop solutions to patient, team, and program issues and interface with all relevant departments.

**3. Program Champion:** A program champion, or advocate, was recognized as an important element to the success of several of the

programs. The program champion does not have to be a physician, but can be a pharmacist, registered nurse, or site manager. This individual is important to moving the project forward, interfacing with leadership, and combating inertia.

### **4. Patient Involvement and Education:**

Patient participation and education are valuable components to the success of any diabetes care program. Various approaches can be used to determine individuals' confidence, knowledge, skills, attitude, and motivation toward their health. This can include questionnaires, one-on-one interactions, group classes, etc. Questionnaires can be used to help patients report symptoms/changes and determine the patients' knowledge; scorecards can be used to teach patients how to monitor critical elements for increased health; and a diabetes fact sheet can be used to ensure that patients have the most current information concerning the impact of diabetes on their health, medications, and educational programs. One-on-one interactions or group classes can provide opportunities for patients to review laboratory results and goals, address questions and misconceptions, and receive reinforcement that can significantly impact patient participation and successful disease management. Educational programs can focus on dietary instruction, weight management, medication management, insulin pumps, diabetic foot care, gestational diabetes, and diabetes prevention. These programs can be internally developed but can frequently be coordinated with community affiliates.

**5. Registry:** A registry (or database) was considered an important contributor to the success of several of the programs. The registry should be well developed, easy to use/navigate, and maintained and reviewed regularly. Some of the health care organizations developed their own registry/database and others obtained funding or collaborated with community partners (eg, local university) to develop one. Features of a diabetes registry that were useful in the diabetes programs included identification of patient populations, tracking of patient visits and clinical results, appointment alerts, prompts for needed interventions (eg, vaccinations), and flags for noncompliance to alert teams for intervention. Registries were also used to

generate patient summary reports (eg, number of patients reaching goals), patient report cards for patient use, actionable lists to engage patients, and physician/staff performance reports.

**6. Electronic Medical Records:** Electronic medical records were used by most of the health care organizations. The software should be easy to use and automated. The ability of the electronic medical record software to interface with the registry should be a consideration. Electronic medical records can be used to maintain patient histories and medication management, to generate templates (eg, standard documentation, diabetes care plan template, letters, etc), and for best practice alerts.

**7. Team Development:** The successful implementation of any program requires interactions between many team members, the composition of which can vary greatly. Team members can include physicians, nurses, pharmacists, nutritionists, health coaches, receptionists, and administrators. Considering the varying skill levels of team members, practice-wide understanding of program goals and status of the goals is critical. Interactions between team members are the most productive and satisfying when

- a) Each team member has clearly defined roles/duties (eg, database entry, patient contact for visits, refills)
- b) Team meetings are used to discuss, address, and develop solutions to patient, team, and program issues
- c) Team members are given appropriate training (eg, program training, training specific to disease management issues, database training, leadership training, lunch-and-learn meetings)
- d) Team members are encouraged to work individually and collaboratively to reach team and patient goals
- e) Incentives, recognition, and rewards are used to motivate team members

**8. Physician Support:** Physician support was critical to the success of most of the programs. In many cases, there initially was considerable resistance to change (eg, fear of increased work demands with no increased benefit). This was particularly true in those instances in which a direct benefit was not clearly linked to

the proposed change. Physician support and participation was easier to obtain after they were shown clinical data that demonstrated the importance and applicability of the program goals. Compliance was better at organizations that reported program results—by physician, department, and location, and in comparison to national results. Organizations that provided feedback on performance and provided incentives and recognition had better outcomes.

**9. Program Goals:** Clearly defined program goals are essential for program success. Depending on the health care organization, program goals can be defined by leadership and/or by the health care team; however, strong leadership support is essential to promote, maintain, and advance program goals. Program goals can vary, focusing on patient satisfaction and improvement of diabetes management measures, performance measures (eg, Healthcare Effectiveness Data and Information Set [HEDIS]), or specific clinical outcomes (eg, levels and control of HgbA1c, low-density lipoprotein, and blood pressure levels). However, program goals should always be linked with clinical performance measures.

**10. Transparency of Results:** Feedback on performance related to goals, including program results, can significantly contribute to the success of a program. Regular, honest, and direct feedback provides opportunities for learning and program and team growth. Data can be shared at team meetings and presented in newsletters or monthly/quarterly/annual reports. Frequent updates and comparisons to other departments, health care organizations, and national standards are beneficial when they are presented in a nonthreatening format.

## Challenges and Obstacles

All of the 16 health care organizations identified the major challenges they encountered, the most common of which included aspects associated with changes to the culture of the health care system, obtaining physician support, and limitations of the registry/database.

### *Culture*

All of the health care organizations required a culture change, to one degree or another, to achieve their goal of improving diabetes care and patient outcomes. This was the most common and significant challenge for all of the organizations. Successful programs introduced system and process changes (eg, work flow, work sheets) that were initially met with resistance. Strong leadership was critical to implement these process changes and to develop, maintain, and advance the specific programs in the face of procedural and personnel challenges (eg, physician support, team training, delegation of responsibilities).

### *Physician Support*

Physician support was identified as being critical to the success of many of the programs. In many cases, not all of the physicians believed that change was needed, and as a result, there was a considerable amount of initial resistance (eg, fear of increased work demands with no increased benefit). This was particularly true in those cases in which a direct benefit was not clearly associated with the proposed changes.

Participation and support were easier to obtain after physicians were shown clinical data that demonstrated the importance and applicability of the program goals. Compliance was better at organizations that reported program results in some manner—by location, physician, and department, and in comparison to national results. Organizations that provided team training, performance feedback, and incentives and allowed for some form of recognition (eg, recognition from the American Diabetes Association, internal recognition) also had better outcomes.

### *Registry/Database*

The diabetes registry/database was identified as an important contributor to the success of most of the programs. The presenters from the health care organizations stressed that the registry/database should be user friendly, well planned/designed, and properly maintained. Several presenters suggested that the responsibility of populating the registry be assigned to 1 individual to allow consistency and accountability of the data. They also stated that it was important to allow time for data entry.

## Chronic Care Model Elements

The Chronic Care Model identifies 7 essential elements of a health care system that encourage high-quality disease care: the health system, delivery system design, decision support, clinical information systems, self-management support, the community, and integration of the Chronic Care Model components. The presentations from the 16 health care organizations were reviewed and organizations whose systems provided useful examples of the individual elements of the Chronic Care Model were identified.

## Conclusions

This summary of the Diabetes Best Practices Symposium identifies some of the elements that have contributed to the success of the diabetes care programs of 16 health care organizations across the United States, all members of the AMGA. It is important to note that no single organization adopted all of the elements that were identified.

Organizations that are considering developing a diabetes care improvement program may consider incorporating the individual elements that are applicable to their program goals and that they are capable of introducing. For each of the 16 health care organizations, this transformational process required a commitment of time and energy, which, while challenging, resulted in significant improvements in patient outcomes. Although there is still much to do, all of the organizations have seen significant benefits with their program.

## Appendix: Description of Chronic Care Model Elements

For more detailed information regarding the 7 Chronic Care Model elements, please refer to the Chronic Care Model Web site (<http://www.improvingchroniccare.org>)

### 1. **Health System:** *Create a culture, an organization, and mechanisms that promote safe, high-quality care*

- Visibly support improvement at all levels of the organization, beginning with the senior leader
- Promote effective improvement strategies aimed at comprehensive system change
- Encourage open and systematic handling of errors and quality problems to improve care
- Provide incentives based on quality of care
- Develop agreements that facilitate care coordination within and across organizations

### 2. **Delivery System Design:** *Assure the delivery of effective, efficient clinical care and self-management support*

- Define roles and distribute tasks among team members
- Use planned interactions to support evidence-based care
- Provide clinical case management services for complex patients
- Ensure regular follow-up by the care team
- Give care that patients understand and that fits with their cultural background

### 3. **Decision Support:** *Promote clinical care that is consistent with scientific evidence and patient preferences*

- Embed evidence-based guidelines into daily clinical practice
- Share evidence-based guidelines and information with patients to encourage their participation
- Use proven provider education methods
- Integrate specialist expertise and primary care

### 4. **Clinical Information Systems:** *Organize patient and population data to facilitate efficient and effective care*

- Provide timely reminders for providers and patients

- Identify relevant subpopulations for proactive care
- Facilitate individual patient care planning
- Share information with patients and providers to coordinate care
- Monitor performance of practice team and care system

### 5. **Self-Management Support:** *Empower and prepare patients to manage their health and health care*

- Emphasize the patient's central role in managing his or her health
- Use effective self-management support strategies that include assessment, goal setting, action planning, problem solving, and follow-up
- Organize internal and community resources to provide ongoing self-management support to patients

### 6. **The Community:** *Mobilize community resources to meet needs of patients*

- Encourage patients to participate in effective community programs
- Form partnerships with community organizations to support and develop interventions that fill gaps in needed services
- Advocate for policies to improve patient care

### 7. **Integration of Chronic Care Model**

**Components:** *Integrate and combine all elements of the Chronic Care Model to develop an effective system of care*

- Inform patients about guidelines and provide appropriate materials
- Utilize information systems and registries
- Provide regular feedback to the health care system regarding the patients' progress and use the information to modify programs to better meet patient needs
- Utilize organizational planning for chronic illness care—proactively plan population-based care
- Ensure routine follow-up for appointments, patient assessments, and goal planning
- Develop guidelines for chronic illness care that consider patients' goals and readiness to change

