

Are we making a difference? Early results from SDPI Community-Directed Grants in California



MONICA GIOTTA, MS, RD, CDE

GLENN STARRITT, MS, RD

HELEN MALDONADO, PA-C, CDE, IA, ADC

Objectives



- Overview of FY2011 Best Practices and outcomes
- Collaborate with each other to spread successful approaches
- Develop strong processes to overcome challenges and barriers to successful diabetes care management



- **Steve Jobs**
 - Apple Computers



“One of the big issues in the health care industry is the lack of caseworkers or advocates that are the quarterback of each team.”

Laurene Powell

Indian Health systems



- **We're better than Stanford!**

Indian health systems



- **Special Diabetes Program for Indians Community-Directed Grants**
 - Part of path to achieving optimal health care (Chronic Care Model, Improving Patient Care (IPC))
 - Funding source and programmatic guide
 - Best Practices
 - Writing Objectives, setting targets, creating processes, measuring outcomes
 - Tracking success from start to finish
 - Our Diabetes Programs are a model for IPC

FY2012 Best Practices



- Eye Care 9 pgms
- Case Management 7
- Cardiovascular Disease 5
- Chronic Kidney Disease 4
- Oral Health 4
- Depression screening, Adult Weight Management, Systems of Care, Foot Care, Other Activities 2 each
- Nutrition, Community Advocacy, DSME, Youth & Type 2 1 each



- There are now 20 IHS diabetes Best Practices
- 13 selected by California programs (35 have SDPI CD grants)
- 7 not chosen in FY2012:
 - Breastfeeding Support
 - Diabetes Prevention
 - Diabetes and Pregnancy
 - Pharmaceutical Care
 - Physical Activity in Diabetes Prevention & Care
 - School Health

What is a Best Practice?



- Each Indian Health Diabetes Best Practice provides the:
 - Purpose of the Best Practice
 - Target population
 - Intended users
 - Definition
 - Goals of the Best Practice
 - Key Recommendations and Key Measures
 - Outline for planning for your program and evaluation
 - Details on how to implement the Key Recommendations
 - Appendices including supplemental information
 - Tools and Resources
 - References

BP Key Recommendations: Depr



- **For Your Patients with Diabetes:**

- 1. Educate providers on how to screen for and treat depression.
- 2. Screen for depression in all patients with diabetes.
- 3. Provide depression care and treatment.
- 4. Recognize when to refer patients for specialist mental health care.

- **For Your Health Care System:**

- 5. Commit to improving depression care in people with diabetes.
- 6. Dedicate funds to improve depression care in people with diabetes.
- 7. Coordinate depression care between behavioral and primary care settings.
- 8. Design and implement an education program for the community and help patients connect to community resources.



Req'd Key Measures (RKM): Depr



- **These are specific measures that can be used to document changes in outcomes related to implementing the Best Practice.**
- **Note! All SDPI grant programs that choose this Best Practice must report as required in the terms and conditions attached to the notice of award on the indicated Measures. Programs may report on other measures as well.**
- *The following measures are of primary importance:
- 1. *Percent of diabetes patients who were ***screened*** for depression in the past twelve months.
- 2. *Percent of diabetes patients with documented depression that received ***treatment*** for depression in the past twelve months.
-

Change from FY2011



- Number decreased
- More attention to measurement
- Evaluated Required Key Measures (RKM)
- Evaluation of staff skill sets
- Change & improvement is slow



“If you aim at nothing you’ll hit it every
time.”

*Unknown

Pulling the data



- When does it start and where does it end?
- Not standardized
- % or count?
- Changes mid-stream
- Results before the full year is finished
- Definitions of ‘improved’
- Meeting targets

	A. Required Key Measure	B. <u>Baseline</u> or beginning value and date (collected prior to starting activities)	C. Most recent value and date (if applicable)	D. Data source (where did these numbers come from)
1.	* Percent of patients at goal for A1C < 7.0 in the past twelve months	as of	as of	
1.	* Percent of patients at goal for blood pressure < 130/80 in the past twelve months	as of	as of	
1.	* Percent of patients at goal for LDL < 100 in the past twelve months	as of	as of	
1.	* Percent of patients at goal using the most recent value in the past twelve months for the following site-selected Diabetes Care and Outcomes Audit measure:	as of	as of	
1.	* Percent of patients at goal using the most recent value in the past twelve months for the following site-selected Diabetes Care and Outcomes Audit measure:	as of	as of	
1.	* Percent of patients at goal using the most recent value in the past twelve months for the following site-selected Diabetes Care and Outcomes Audit measure:	as of	as of	

Lessons learned



- Systems
- Multi-Disciplinary Team
- Communication
- Leadership
- Case management
- Defined process for improvement

Lesson #1: Systems Change



- Diabetes Program vs. Entire Organization
- Relationship between clinic/pgm and outside entities
- Relationships to community
- Change in relationship to clients = Patient Centered Medical Home

BP: Systems of Care results



- Focused on Diabetes Audit results
- Multi-Disciplinary Team
- In FY2012, added ACIC tool

FY2011 Sys of Care – 4 sites



- Clinic “A”:
- DM Audit measures: 5/5 improved
 - HbA1c
 - Blood Pressure <130/80
 - LDL Cholesterol <100
 - Foot exams
 - Depression screening

- Clinic “B”:
- DM Audit measures:
 - 2/6 improved
 - Blood pressure <130/80
 - DM education (nonRD)
 - Reg Dietitian DM educ. ^
 - Use of ACE/ARBs
 - HbA1c<7 ^
 - LDL<100

Results: Systems of Care



- Clinic “C”:
- 2/5 DM Audit measures improved
 - HbA1c<7 ^
 - Blood Pressure ^
 - ASA/Anti-platelet use
 - ACE/ARB use
 - Foot exams
- Clinic “D”:
- 2/6 DM Audit measures improved
 - Foot exams ^
 - Dental exams ^
 - Cholesterols done
 - HbA1c<7
 - Eye exams
 - EKG last 3 years

Audit Item or other Measure	Baseline % (2009 Diabetes Audit data)	Improvement goal	Interim report %	End of Grant Year 1 Target	Final result Yr 1 (9 mos data only) and Status	Target for Yr 2 (2011)
HbA1c<7	39%	11%	29	50%	30%/goal not met, will continue	50%
Eye Exams	75%	5%	17	80%	41%/goal not met, will continue	80%
Dental exams	73%	13%	61	85%	72%/goal not met, will continue	85%

Run Charts



Systems of Care



- 2 of 4 clinics in IPC
- Another using Improvement methods
- Difficult to evaluate processes for 6 measures versus 1 in other BPs
- “improved” versus “met target”
- *

Lesson #2: Multi-Disciplinary Team



- Best Practices to illustrate –
 - Cardio-vascular Disease (short name)
 - Adult Weight Management

CVD – 5 programs



- Blood pressures at goal
- Documented CVD or Hypertension education
- Often clinics added Measures/Targets for LDL Cholesterol, Triglycerides

Blood Pressure <130/<80



Program	Baseline/final	Change in %
A	30→36%	+6
B	47→48%	+1
C	19→37%	+18
D	38→38%	-0-
E	53→45%	-8

CVD results

- LDL <100 mg/dl

- 45 → 33%
- 49 → 41%
- 59 → 54%

- HbA1c <7

- 35 → 39%
- 43 → 45%
- Process and Outcomes Measures
- Require interventions by all Team members

CVD results



- Tobacco cessation counseling

- 10 → 26%
- 27 → 67%

- Documentation

- HTN or CVD education

- All baselines zero
- Final percentages:
 - ✦ 20%
 - ✦ 43%
 - ✦ 75%
 - ✦ 0
 - ✦ 0

Know what data you will evaluate before starting

BP: Adult Weight Management



- RKM documented assessment for overweight
- Nutrition education
- Deceptively 'easy'

Adult Wt Mgmt - results



- Already at or near 100% BMI
- Issue of decreasing BMI in an entire population
- Tele-RD services: 71% of those referred decreased BMI; 29% decreased HbA1c
- Weight Watchers, Fitness trainers, cooking classes, Walking clubs, Bike Wednesdays, Senior center exercise
- Employ SMS and have clients select goals (FY2012)
- Fitness programs/activities and ‘proving’ they result in behavior and clinical improvements
- *

Lesson #3: Communication



- With the Community
- Within your Organization

- Best Practice: Community Advocacy (1 program)

Community Advocacy - results



- RKM: Community Diabetes Advocacy Group
- RKM: # health-related policies

Community Advocacy



- Community Advocacy group increased from 20 to 22 members and met regularly
- Two health policies were instituted
- Target of 2000 community contacts was set and final count was 2,753
- *

Lesson #4: Leadership



- Companion Lesson to Communication within your organization
- Leaders need to know what you are trying to accomplish
- Remove barriers and help solve problems
- *

Lesson #5: Case Management



- Results from 8 programs
- RKM: Multi-disciplinary CM Team
- RKM: Improvement in 2 or 3 clinical goals for clients in CM program as opposed to those not receiving CM

participants in CM



Pgm	Pre/Post # of clients in Case Mgmt	Different Types of Case Management
1	100 → 95	Basic: appt reminders, phone follow-up
2	10 → 10	High Risk: difficult to recruit, High A1c often targeted, clients have many challenges
3	22 → 21	Advanced intervention: SMS model, client-defined goals
4	27 → 37	
5	33 → 38	
6	15 → 37	
7	0 → 8	
8	0 → 16	

CM Innovations



- Data comparisons to Control group
- Patient satisfaction high
- CM for pre-diabetes
- EHR charting of care plans
 - All staff can see goals
 - System can notify you when follow-up due
- Birthday Incentive Program
- Stages of Change training for staff
- Broaden cohort to anyone interested in focused CM

CM assessment tool



Components	Level C	Level B	Level A
Tracking System/Registry	<p>...No systematic process for tracking data, or</p> <ul style="list-style-type: none"> -Manual tracking registry/system but no way to generate reports, or -Diabetes Registry in place but not updated periodically or used for managing patients; reports not generated <p>0 1</p>	<p>...Registry updated more than once/year</p> <ul style="list-style-type: none"> --Electronic system (RPMS or other) in place -Systematic process for generating reports and sharing data with Team in place <p>2 3</p>	<p>...Registry updated, reports generated and info shared with Team on a regular basis</p> <ul style="list-style-type: none"> -Mechanism to contact pts needing care and ability to track care of pts with special needs (including referrals and follow-up) -Additional specialty registries (e.g. Pre-DM and CKD) in place and used for patient care <p>4 5</p>
DM Standards of Care (SOC)	<p>...Don't know if SOC are in place or followed</p> <p>0 1</p>	<p>...SOC in place, but inconsistency among providers with use of standards</p> <p>2 3</p>	<p>...SOC are consistently used and drive patient outcomes</p> <ul style="list-style-type: none"> -Use of SOC are supported by policies and procedures (P&P), protocols and standing orders <p>4 5</p>
Diabetes Case Manager(s)	<p>...do not exist OR 1 CM identified but activities are limited</p> <p>0 1</p>	<p>...exist and CM activities include tracking SOC, computer skills to track population AND beginning stages for pt assessment, pt education and care plans</p> <p>2 3</p>	<p>...all of Level B plus SMS added to care plan for MOST Active pts, ability to follow-up at designated intervals, mechanism to report back to PCP and others</p> <p>4 5</p>

Lesson #6: Process for Improvement



- **Results for:**
 - DSME
 - Oral Health
 - Eye Care
 - Pharmaceutical Care
 - Foot Care
 - Youth & Type 2
 - Nutrition

DSME – 2 programs



- RKM: # clients who complete or partially complete the DSME process
- RKM: Changes in clinical and behavioral outcomes
- Other Measures chosen: Accreditation, # referrals to DSME

DSME results (1)



- Clients in program increased from 16 to 24 in FY2011
- A1c improved in 62% of participants
- Barrier: developing a systems for tracking all the various elements was difficult (participants, referrals enrolling in program within 6 months, etc.)

Best Practice (# programs)	Results
Pharmaceutical Care (1)	30% of all Active pts had med review 27% of pts on ≥ 8 meds met with Pharmacist Meds of 98 pts w/CKD evaluated
Foot Care (1)	Foot exams 62 \rightarrow 90%
Youth & Type 2 (1)	56 kids age 10-18 screened EMR Tracking report created Screening protocol done
Nutrition (1)	RD education 52 \rightarrow 82% 8 \rightarrow 10 partnerships RD referral protocol & provider training

Oral Health results

Measure	A	B	C
Dental exams	46 → 49%	9 → 45%	49 → 55%
Dental educ	n/a	n/a	Dentrix issue = 0
Treatment	0 → 79%		
Team w/Dentist		Done	
Innovations	“Dental Dollars”	Protocol for recall system	

Eye Care results



Measure	A	B	C
Eye Exams	33 → 66%	45 – 51%	67 → 35%
Eye education	0 → 91%		
Protocol	Yes		Yes
Treatment		85% of those needing	
Retinal camera	Yes	yes	

What will it look like?

**Planning
months**

**Start of Grant
12 months**

2 months

3 months

4 months

6 months

10

Objectives

End of
data

Final Grant

Baseline

Measurement

Plan classes

Advertising

Protocols

& Implementation

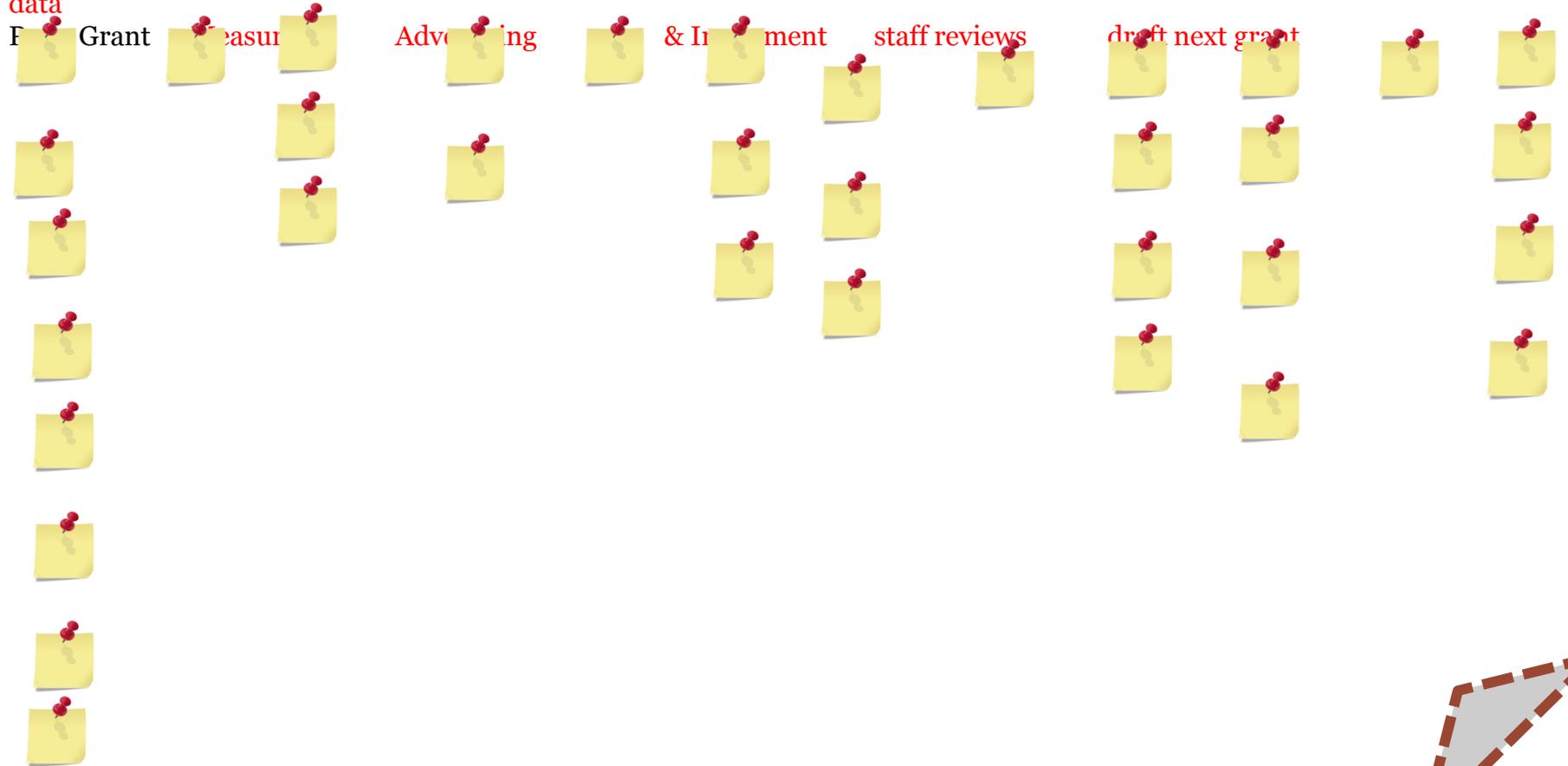
Client feedback

staff reviews

Check data

draft next grant

Check



CAO Grant – Systems of Care



- See our Storyboard
- For FY2011, met or exceeded 5 f 6 Diabetes Audit measures
 - Blood Pressure at goal
 - Eye Exams
 - Diet/Nutrition Education
 - Exercise Education
 - Depression Screening

 - Did not meet target for HbA1c

Our vision for our clients



- Quality of Life
- Keep on truckin' for FY2013
- Remember, we're better than Stanford !
- Thank you for all your hard work, innovation, and caring !!