KAISER PERMANENTE®
PHASE
PREVENTING HEART ATTACKS & STROKES EVERY DAY

CCI
CENTER FOR CARE INNOVATIONS

KAISER PERMANENTE®
TC3
TRANSFORMING CARDIOVASCULAR CARE IN OUR COMMUNITIES

INTEGRATE (Implementation of integrated care for Diabetes Mellitus)
Elica Health Centers

Team Members:
Scott Needle CMO
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Case Management
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WHAT ARE WE TRYING TO ACCOMPLISH

Problem Statement

What was the urgency/need that motivated this project? Increase in number of uncontrolled diabetic patients.
What was the better future you were attempting to create? Access to adequate diabetic care, minimizing short term and long-term complications, and improving quality of life.

Covid: Early studies have shown that about 25% of people who went to hospital with severe COVID-19 infections had diabetes. Improving diabetes control for our patients helps them to stay happier, healthier, and demonstrates our commitment to their well-being and the community. It will help minimize diabetes related health risks and identify problems early, initiating timely treatment. We want Elica Health Centers to be known as a leader in compassionate, patient-focused quality care for everyone. Covid-19 pandemic prompted rapid development and adoption of digital solutions to deliver/reinvent healthcare leading to accelerated implementation of telehealth giving patients options of telephone and video visits.

Aim Statement

By March 2021 improve the health and control of our patients with diabetes seen at Marysville clinic by increasing the number of patients with Hba1c <9% from 67.5% to 74.5%

Health Equity Aim Statement

Elica health centers will maintain the healtyh of Blac/African America patients with diabetes by keeping the percentage of those with uncontrolled HbA1c (>9) at below 33.3%

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WHAT CHANGES DID WE MAKE THAT RESULTED IN IMPROVEMENT

Diabetes driver diagram

Improve the health of diabetic patients by increasing the % of patients with controlled diabetes with HbA1c<9 from 67.5% to 74.5%

Primary drivers	Secondary drivers
Reporting/ Data Systems	• Monthly active surveillance of patients with a1c > 9 • Systems to identify/alert staff regarding overdue preventive care needs • Monthly/quarterly progress reports • Data Validation
Planned Care Delivery/Team based care	• Appointment reminder calls • Chart scrubbing, huddles, Pre-visit planning • Outreach and referral process. Closing the loop to completion • Use of standing orders • Pre-visit planning, follow up/case management • Access to behavioral Health • Quarterly f/u for a1c<9 and monthly f/u with a1c >9 • Schedule f/u appointments by MA as instructed by Provider • Establish structured diabetic clinic encounter/days
Patient Engagement and Self-Management Support	• Self management Goals • Motivational Interviewing • Shared goal setting • Access to behavioral health • Personalized diabetic education by dietician/ diabetic educator • Patient education materials • Reinforce Lifestyle changes and importance of medication compliance
Access	• Availability and access to diabetic appointments • Accessibility to patient portal • Access to behavioral health • Access to patient support • Transportation

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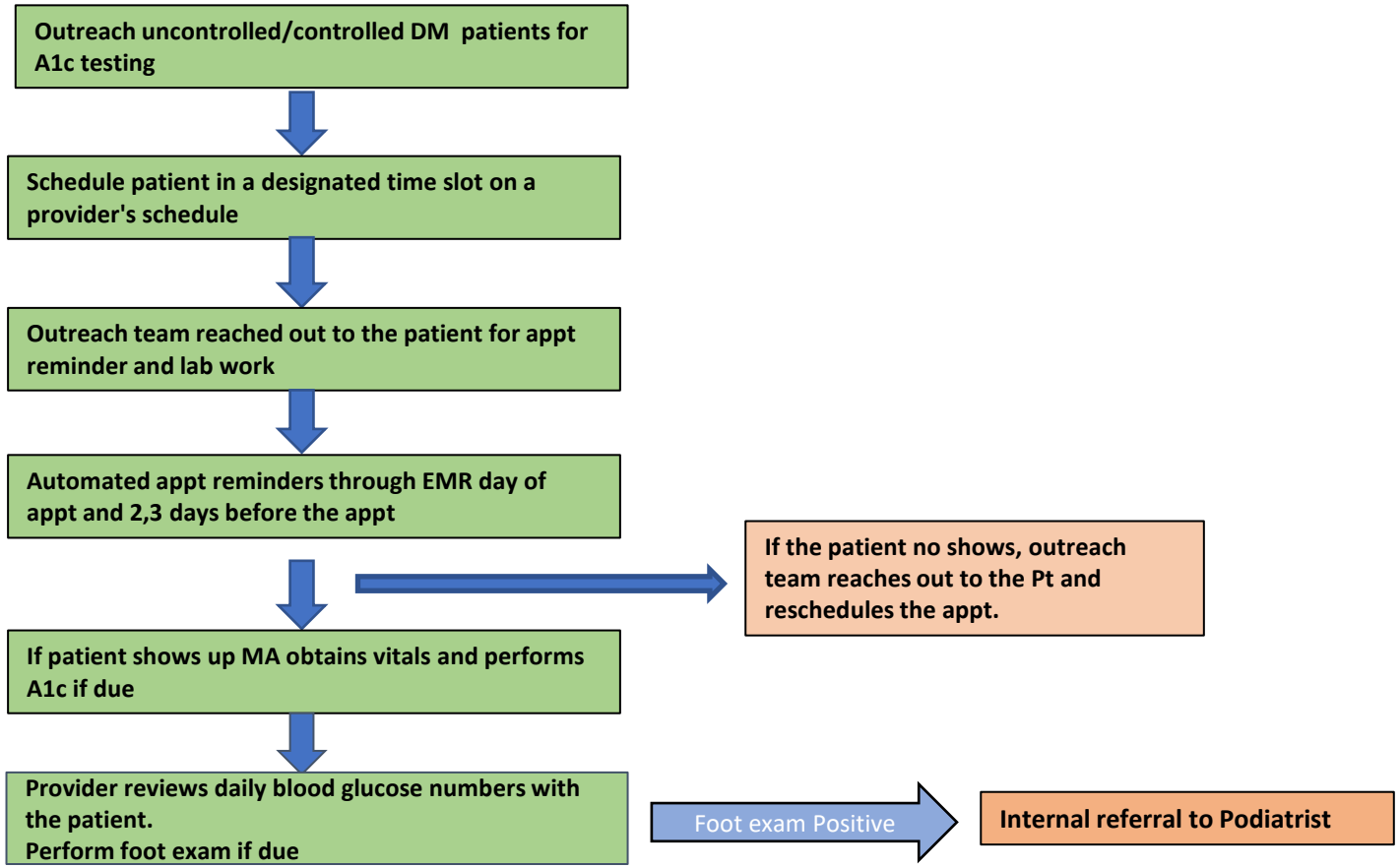
WHAT CHANGES DID WE MAKE THAT RESULTED IN IMPROVEMENT

Our Theories for Change : How we Learned About Our Process



Process Flow Map: Outreach

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WHAT CHANGES DID WE MAKE THAT RESULTED IN IMPROVEMENT

Adopted

Our Theories for Change : How we Learned About Our Process

- Medications are reviewed and adjusted taking a1c % into consideration and daily blood glucose numbers.
- Diabetes education provided using motivational interviewing
- Pt educated on daily blood glucose monitoring

If A1c >9 and on oral medications →
- Continue to motivate. Pt to f/u with nutritionist/dietician.
- Refer to case management if deemed necessary.

If A1c>9 and on insulin → Advice Pt to f/u with Pharmacist for consultation/education regarding insulin titration and daily blood glucose monitoring. Continue to motivate. Pt to f/u with nutritionist/dietician. Refer to case management/ behavioral therapy if deemed necessary.

F/u in one month to review blood glucose logs, medication adjustment if deemed necessary

If A1C <9 → F/U in three months for a repeat A1C

Self monitoring at home → Pt provided with
- Blood sugar logs
- Blood pressure logs

A f/u appt is scheduled by MA per provider recommendation.

Reminder outreach

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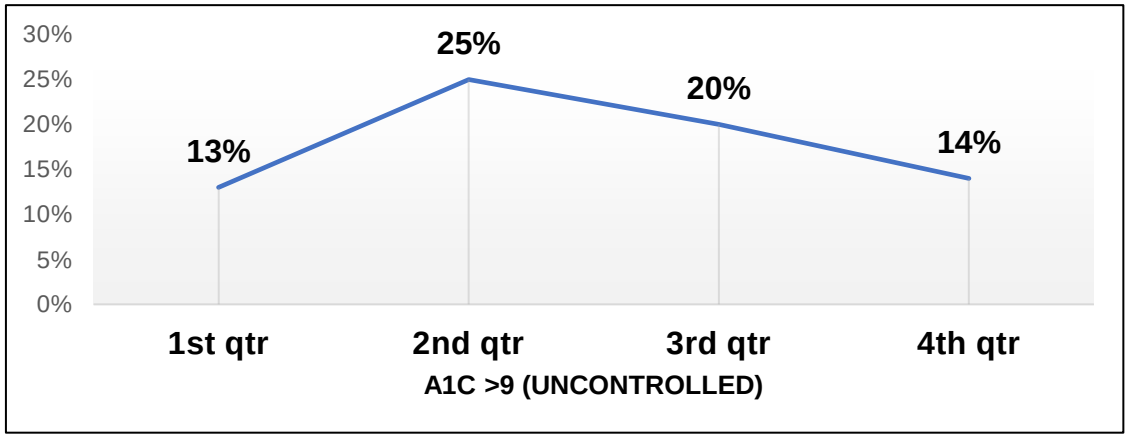
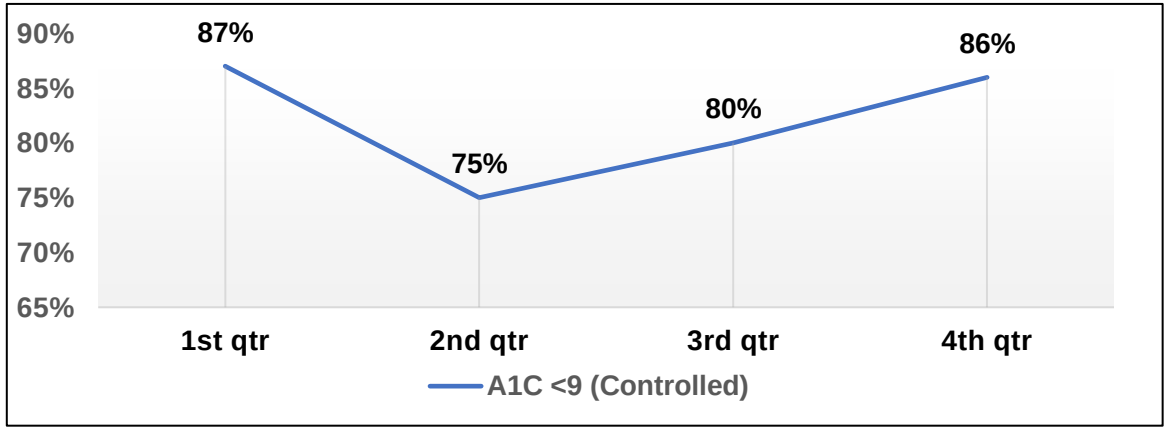
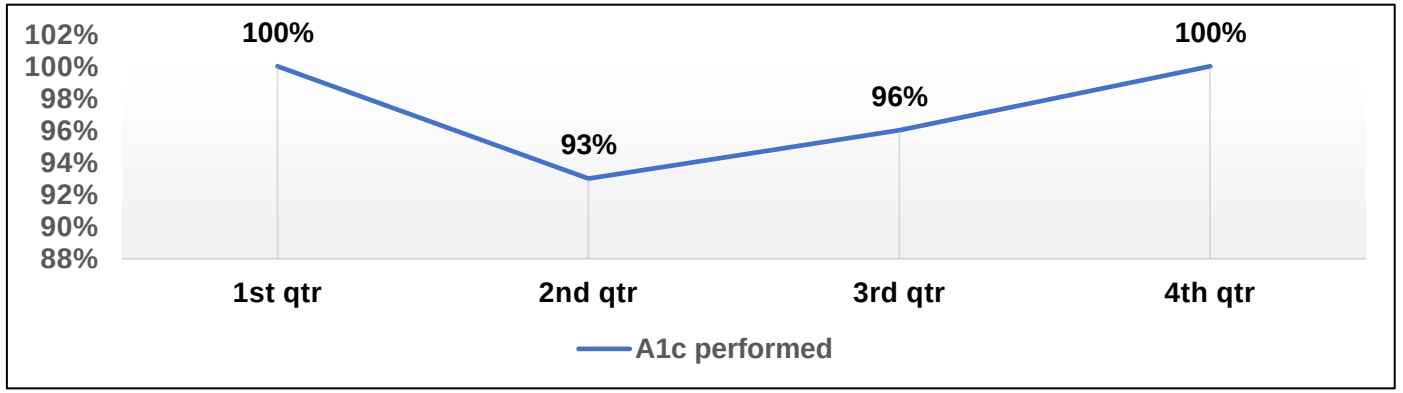
Process Flow Map: During the Visit

How did we know the changes were an Improvement

Results: Run Charts







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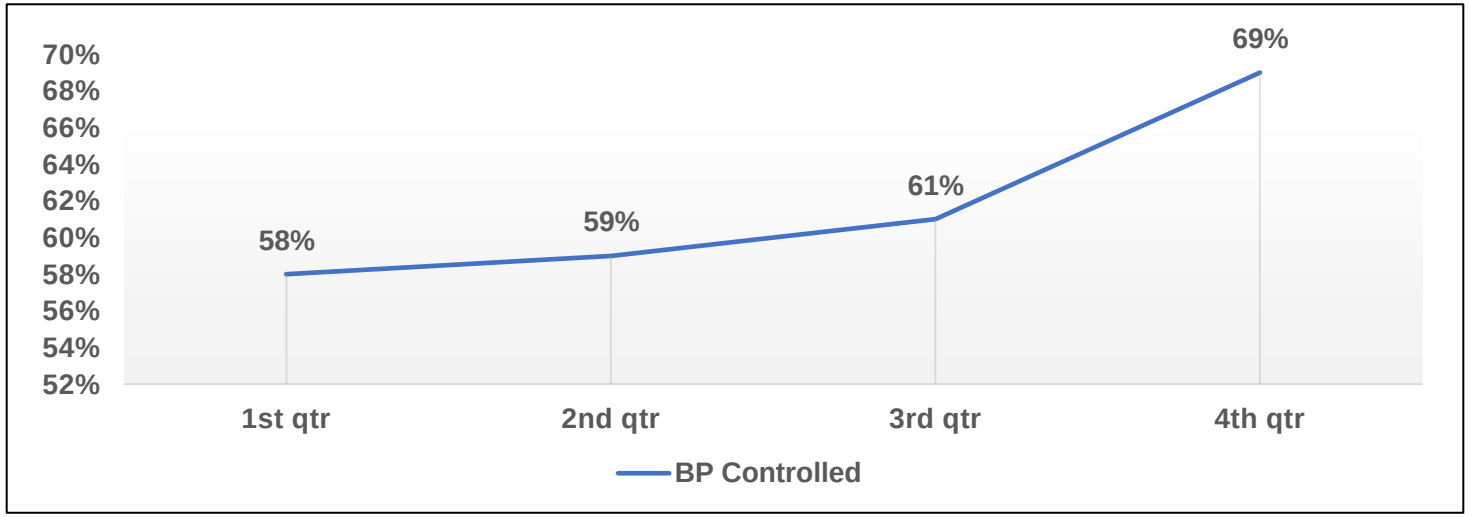
How did we know the changes were an Improvement

Results: Run Charts



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How did we know the changes were an Improvement

The Challenge of COVID-19 Pandemic

Patients often didn't want to come in for in-person appointment
Patients not getting labs done at outside labs
Workforce issues
Long delays getting blood pressure cuffs via insurance plans

Overall Challenges

Challenge	How We Overcame/Resolution
Increase no-show rate	Telemedicine: Telephone and Video visits
Patient engagement	Case management: case managers reaching out to patients
Labs not being completed	Drive thru A1c
Staffing shortages	Remote work schedules
Technology	

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How Did We Know the Changes Were An Improvement?

Here's What We Learned

Bright Spots/Accomplishments

- What stands out most about the work of PHASE/TC3 2020-2021
  Trying new things, ideas, teamwork

- What are you most proud of?
  Improved A1c results, and all we have accomplished with phase

- What surprised you?
  Patient eagerness to learn, change, be a part of the team. Adaptability

- What did you learn about the process of change?
  watch speed and check your rearview mirror

- What did you learn about your team?
  Leadership, focused, diverse, fun, honest, resilient

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What's Next for PHASE/TC3?

Here's How We Will Continue the Work

New Aim Statement and Focus Areas for Change

- What new aim will you set globally to improve the health of the PHASE/TC3 population?
  Race data on all patients
- What new aim will you set for your health equity focus?
  Eliminating disparities
- What specifically might you focus on (think about primary drivers)?
  Analyzing outcomes based on race
- What change ideas will you test (think about secondary drivers)?
  Registration workflow: collecting information like race/ethnicity and documenting correctly

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What's Next for PHASE/TC3?

Here's How We Will Continue the Work

Spread

Spread: have to organize spread otherwise it won't happen
Types of spread Elica Health Centers will implement

- **One team: Pilot team, learners, experimenters to other teams.**
- **One site, team to more locations, teams.**
- **One care pathway to other pathways of care for different conditions or different populations of people. Lot of changes in diabetes can be applied to other chronic conditions like Asthma, Hypertension, Depression screening**

What to spread: Actions, behaviors, Habits
To whom: The people/sites/work roles
By When: target date/deadline

Sustainability

- **Measure**
- **Monitor**
- **Communicate**

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What's Next for PHASE/TC3?

Spread AIM

By Dec 31,2021 we will implement six key changes of our new care model: Integrated care for Diabetes Mellitus for five clinic sites.

Key Changes

- **Care management**
- **Patient education by Pharmacist**
- **Behavioral**
- **Regular follow up with patients**
- **Data driven approach**
- **Patient feedback: Pt satisfaction surveys**

Increase healthcare experience for patient

Patient Engagement/ Patient Empowerment

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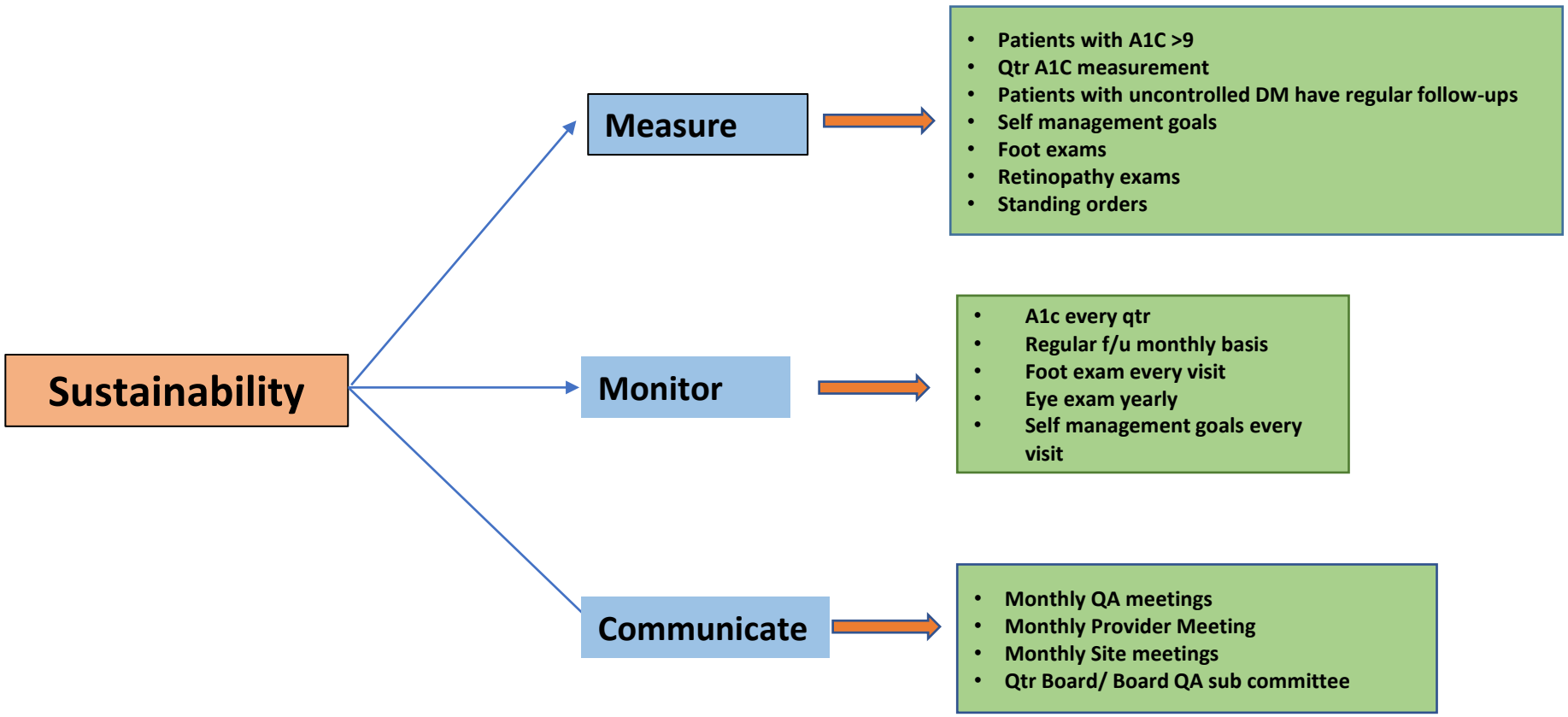
What's Next for PHASE/TC3?



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