

#### **PHLN Year 2 Project Aim**

By March 31, 2020 we will improve health of our diabetic patients, as evidenced by increased rates in HgbA1c testing (3%), annual foot exams (11%), and annual retinal screens (12%), through improved care team communication and improved accessibility of decision support tools.

#### **Measures for Success**

- HbA1c testing
  - Point of care alert closure HbA1c Testing
- Diabetes foot exams
  - Point of care alert closure Foot exam
- Diabetes retinal exams
- HbA1c > 9 or Untested

# Changes

#### **Tested Changes**

- Visit prep for care coordinators
- Health educators completing foot exams
- MAs completing visual check foot exam
- Pharmacy using integrated PVP alerts

### **Implemented Changes**

- Shared meetings with MAs and **Providers**
- Integrated decision support/ care alerts into the NextGen EHR (access for all staff)
- New retinal photo in-reach and out-reach strategy



## **Using Data for Improvement**

We chose to focus on diabetes management because of our robust diabetes program we launched in 2013. The program focuses on providing intensive, tailored care to people living with uncontrolled diabetes, and serves as an intersection for all of the staff (providers, medical assistants, health educators, and the quality improvement and population health teams) as well as the processes (visit planning, group classes, huddles, population health management techniques) that we hope to leverage to improve and standardize these systems. We are collecting monthly data on process measures (see below) and want to maintain an outcome measure of HbA1c > 9 or untested at 20% or below. The idea is to track progress on overall structural and systemic improvements. From this data collection, we have been able to implement the integration of the Patient Visit Planning report into our EMR system to allow for accurate and easily accessible alerts related to gaps in care. We have also listed our milestones and key activities.

Key Activity/Milestone									Key Activity- Milestone		
Create Care Team Workgroup	05/01/ 19	IP	IP	С	_c	С	C	C	С		
Evaluate MA role: care team workflows, nuddles, tools	08/30/ 19	IP	IP	IP	IP	IP	IP	IP			
Create strategy to gather ongoing feedback from Mas	09/15/ 19	IP	IP	IP	IP	IP	IP	IP	IP		
Evaluate Azara DRVS PVP alerts and establish actions for care teams	07/15/ 19	NS	NS	NS	NS	IP	IP	IP	IP		
ntegrate DRVS PVP into NextGen	07/15/ 19	NPs	₩s	IP	С	ÑS.	С	C	С		
Roll out PVP workflow to all teams at Rose	08/15/ 19			NS	NS		IP	IP			

Measure	Baseline April 2019	May-19	Jun-19	Jul-19	Aug-19	Sep-19	Oct-19	Goal	Improvem ent	
			Proces	ss Measur	es					
HbA1c testing	94%	94%	94%	94%	94%	94%	94%	96%	0%	
Diabetes foot exams	70%	72%	71%	71%	71%	74%	74%	80%	4%	
Diabetes retinal exams	59%	59%	59%	61%	59%	62%	60%	65%	1%	!
Point of care alert closure - HbA1c Testing	43%	42%	57%	48%	50%	56%	56%	75%	13%	(
Point of care alert closure -										
oot exam	26%	17%	20%	26%	25%	28%	28%	75%	2%	(
			Outcor	me Meası	ıre					
HbA1c > 9 or Untested	29%	27%	27%	27%	27%	27%	26%	20%	3%	:
Measure Tracking								60%		

						Ро	int of	f			
October		Care Data									
Foot Exa											
Nι	um #	w/ Aler	t	N	Num # w/ Alert						
26-											
Oct	7	29		26-Oct	6	11					
19-											
Oct	8	28		19-Oct	6	14					
12-											
Oct	11	32		12-Oct	6	8					
5-Oct	t 4 20		5-Oct	6	10						
Total	30	109	28%	Total	24	43	56%				
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# **Strategies for Success**

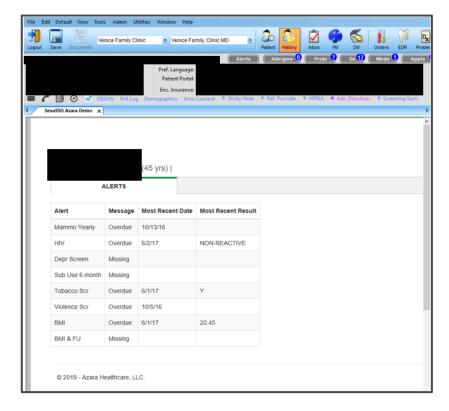
- Increasing the frequency of **team** meetings
- Involving front line staff whenever possible

**PHLN Coaching** 

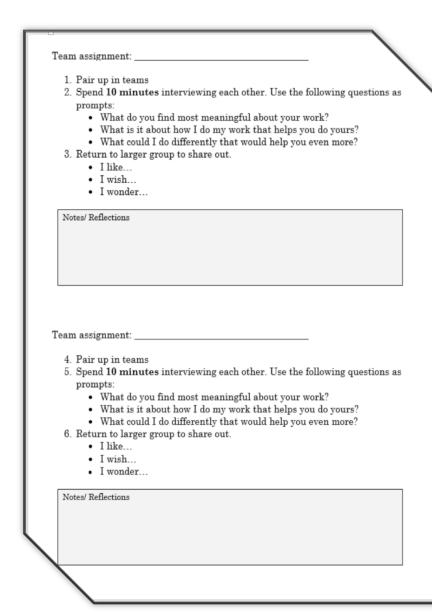
**Standardizing** and sharing workflows



# **Key Tools & Resources**



**PVP / NG Integration** 



MA/Provider interviewing activity

# **Current Challenges or Barriers**

Limited staff meeting time to focus on PDSAs and moving PHLN work forward.

We feel a bit stuck with our current care team model, and aren't sure how best to make changes. Should we make incremental changes, or do an overhaul?



# **Next Steps**

#### **Spreading**

- ❖ More care team members now have access to the integrated PVP tool
- Spreading visit planning for care coordinators PDSA in December 2019
- New retinal exam workflow and outreach process will be going live in the next few weeks
- Finalize ongoing schedule/agenda for MA/Provider meetings

### **Sustaining**

- MAs and other care team member will continue to
- Ongoing shared meetings between MAs and Providers will ensure we maintain communication and teamwork
- ❖ PVP integration into EHR will be ongoing and covered through other funding

