Systems, People and Technology: Building a More Effective and Integrated Diabetes Care Model

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Recent Innovations in Our Diabetes Care

- Describe our move from a diabetes care management model to diabetes population care

- Show how an optimized EMR is supporting care coordination and communication

- Describe our efforts to bring emerging best practices from innovative medical centers to our entire region.
PCP’s managed their panel of patients, and referred patients needing additional diabetes education or treatment intensification into Care Management.

Patients moved into and out of Care Management based on their short term clinical needs.

Care management was considered specialized care: some members didn’t need it, some needed a little, some needed a lot.
PCP’s authorize those patients with diabetes they feel would benefit from a population care manager’s help monitoring the patients’ diabetes care needs.

Patients are empaneled to an Accountable Population Care manager (APM) – an RNX or PharmD – for long term monitoring.

Population care is supporting an ongoing partnership between PCP’s and their APM’s. This model is now our standard diabetes care, appropriate for the majority of members with diabetes.
Technology Supporting DM Population Care

Accountable Pop Manager Empanelment

PCP authorizes lab ordering & Pop Care x 5yr

Needed A1c, Cr, K & μ-albumin orders placed

Automated regional outreach for A1c testing

Patient gets lab

A1c above goal

Lab results delivered to customized lists

A1c at goal: Repeat A1c per APM / PCP

needs test list

Timely connections
Effective interventions

Tx & Retest  Pause  Tickle

APM panel views & action lists
APM’s review lists daily. With a click, they jump directly into the medical record for more information and to take action.
Authorized and APM empanelled patients with DM have an APM icon. All providers can hover over to view the APM name.
After APM’s take action, flagging color and treatment status information changes, making DM care visible to all.
Monitoring Our Performance

- Process and outcome measures are reviewed weekly
  - Timely Touch: 66% w/in 5 business days
  - Timely Treatment: 51% w/in 5 business days
  - Effectiveness: 55% sig. improved w/in 5 mo.
  - A1c performance: A1c < 8 = 69%
    A1c < 9 = 81%

- PCP and APM level drill down reports allow physician leaders and quality managers to identify best practices and improvement opportunities.
This weekly report shows one medical center’s APM performance.

**Accountability and Trust:** Rolling 1 year A1c testing and control rates, APM panel size and ‘timely touch’ / ‘timely treatment’ rates build PCP trust that patients are being well managed.

**Long term outcomes:** Monitoring A1c improvement 5 months after documented treatment intensification drives follow up care touches.
What Our High Performers are Doing

Leadership Sponsorship and Alignment
- Monthly medical Center leadership “Total Quality Committee”
- Vision is Critical! ‘No member will suffer from a preventable complication of their diabetes due to lack of appropriate care’.

Training and Work Flow Follow Up
- PCP / APM meetings: initially every two weeks, now monthly
- Escalation / Care coordination agreements builds trust
- Communicating progress and maintaining focus builds momentum

Monitoring for Outcomes
- Physician champions and APM managers review weekly reports
- Ongoing collaboration drives continuous performance improvement
Sharing Best Practices

- Several medical centers are reporting better outcomes and higher clinician satisfaction after successful efforts to strengthen APM and PCP relationships.

- We are learning from these medical centers and sharing their innovative approaches throughout Northern California.

- We are committed to our new population care model and feel it supports our members and their physicians.
Questions