

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

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Presented by:

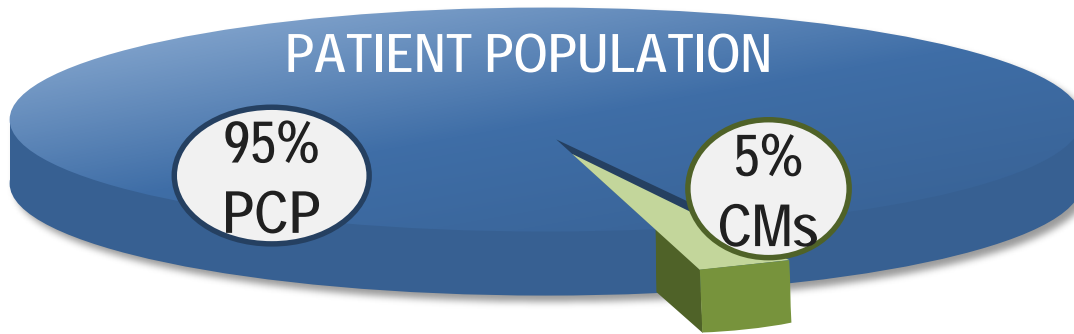
Phil Madvig

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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.

KP's Old Diabetes Care Management System

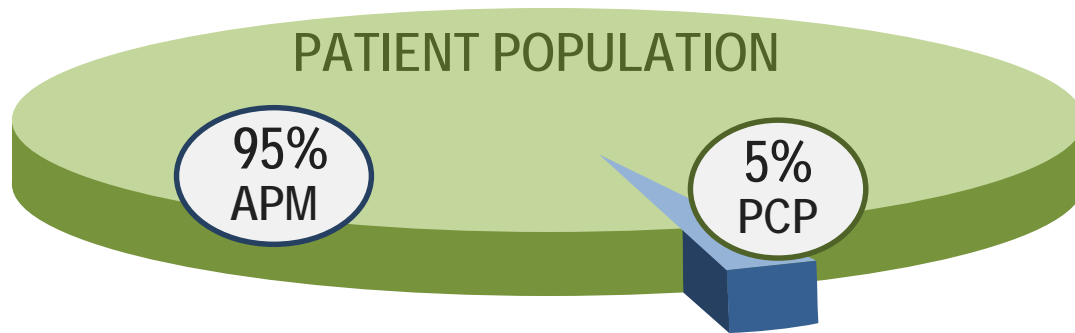


PCP's managed their panel of patients, and referred patients needing additional diabetes education or treatment intensification into Care Management.

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.

Moving from Care Management to Population Care

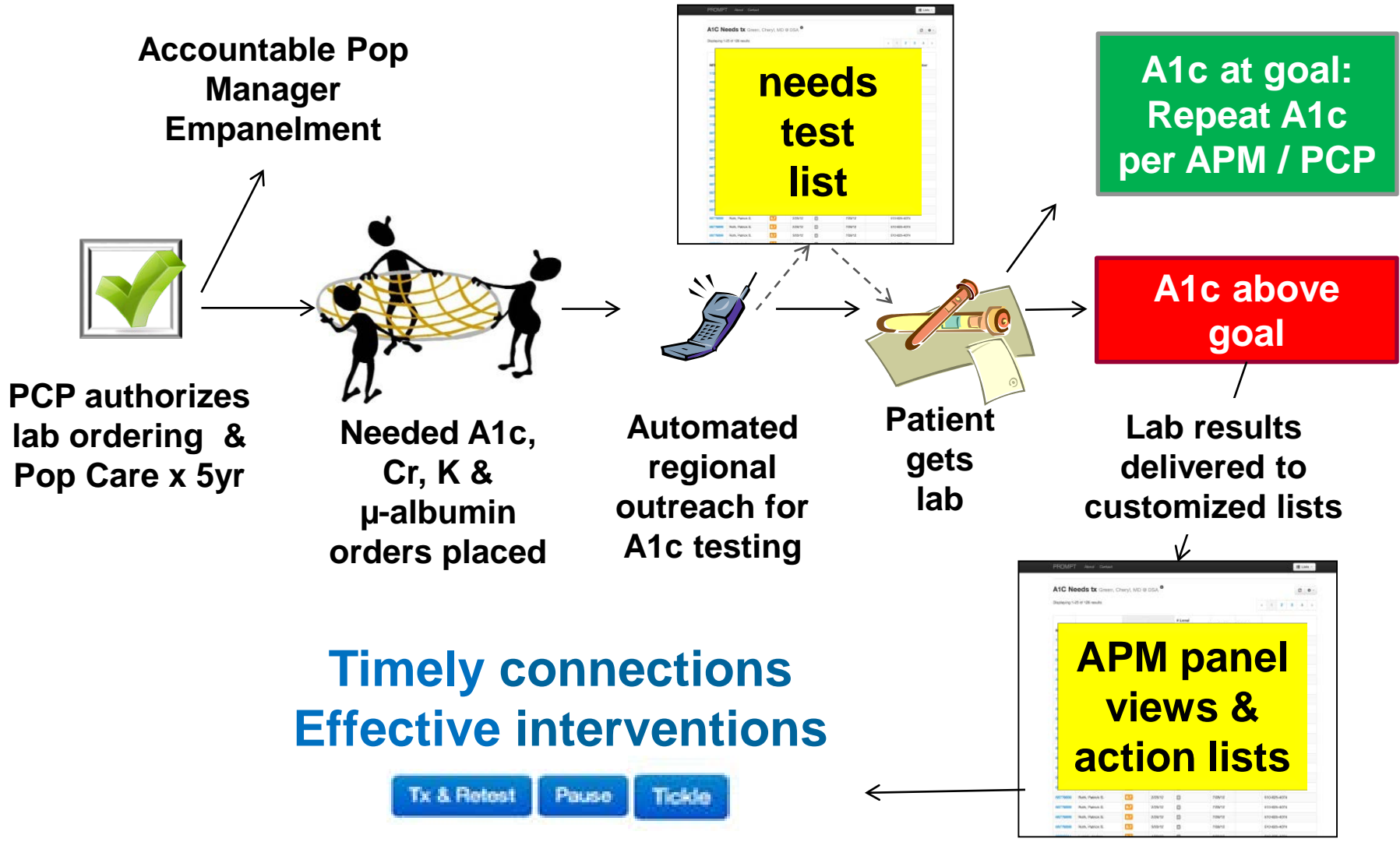


PCP's authorize those patients with diabetes they feel would benefit from a population care manager's help monitoring the patients' diabetes care needs.

Patients are empaneled to an Accountable Population Care manager (APM) – an RN 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



APM's Have Information on Their Desktop

Hyperspace - Epic - Home - Schedule - In Basket - Chart - Enc - Tel Enc - Ref Enc - Ancil Ord Enc - Pt Lists - Secure - User Dictionaries - Print - Log Out

PROMPT (F12) - Close X

PROMPT - Lists

PHASE Panel : Green, Jane, RN

List Parameters ⓘ

Displaying page 1 of 13 (1207 total records)

MRN	Name	A1C Value	A1C Date ↓	Statin	Language	Phone Number
		9.9	10/26/2015	Rx?		
		8.9	10/26/2015	Rx?		(925)
		13.8	10/26/2015	✓		(925)
		5.8	10/26/2015	✓		(925)
		6.7	10/26/2015	✓		(925)
		7.4	10/26/2015	✓		(510)
		7.8	10/25/2015	Rx?		(925)
		9.0	10/24/2015	Rxd		(925)
		9.0	10/24/2015	✓		(510)
		8.1	10/24/2015	✓		(925)
		9.2	10/24/2015	✓		(925)
		8.1	10/23/2015	✓		(925)

APM's review lists daily. With a click, they jump directly into the medical record for more information and to take action

An Optimized EMR Supports Coordinated Care

The screenshot shows a patient's record in an EMR system. The patient's name is PROMPT / PHP, and the record is titled PROMPT. The interface includes a sidebar with navigation options: Review/SnapShot, Medications, and Review Flowshe... The main content area displays a table of health metrics:

APM	Value	APM Name	Status	Last	Due
	8.1	A1C	needs tx	10/24/2015	N/A
	✓	Ret	up to date	09/25/2014	09/25/2016
	✓	Statin	on rec rx	10/17/2015	

A callout box points to the APM icon in the first row, containing the text: **Green, Jane, RN**

Authorized and APM empanelled patients with DM have an APM icon. All providers can hover over to view the APM name.

An Optimized EMR Supports Coordinated Care

PROMPT / PHP

PROMPT

Review/SnapShot

Medications

Review Flowshe...

APM	Value	
+ A1C	8.1	tx in progress Last: 10/23/2015 Due: 01/27/2016
+ Ret	✓	up to date Last: 05/28/2014 Due: 05/28/2016
+ Statin	✓	on rec rx Last: 10/27/2015 Due:

Post Tx intensification

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.

Drill Down Report Showing APM Performance

APM	A1c Test Rate	A1C Under 8	A1C Under 9	A1c Denom	5 Day Denom	5 Day Tx	5 Day Touch	1 Month Denom	1 Month Tx	1 Month Touch	5 Month Effectiveness
	96.4%	69.7%	78.8%	858	9	77.8%	100.0%	8	62.5%	100.0%	50.0%
	97.8%	71.7%	83.3%	1,033	17	64.7%	94.1%	16	93.8%	100.0%	33.3%
	97.7%	75.4%	86.0%	1,368	20	70.0%	100.0%	9	66.7%	100.0%	64.2%
	97.7%	73.6%	84.7%	1,024	18	77.8%	100.0%	18	83.3%	100.0%	60.0%
	96.9%	74.1%	86.1%	1,012	14	71.4%	100.0%	10	70.0%	100.0%	60.0%
	98.2%	79.2%	89.0%	993	23	82.6%	100.0%	10	90.0%	100.0%	42.4%
	97.1%	71.8%	85.2%	521	7	57.1%	100.0%	4	75.0%	100.0%	60.9%
	97.3%	77.6%	87.8%	1,333	18	50.0%	100.0%	11	81.8%	100.0%	59.0%
	97.5%	80.6%	89.4%	566	9	55.6%	100.0%	4	75.0%	100.0%	41.7%
	98.3%	79.0%	89.2%	1,360	10	100.0%	100.0%	15	86.7%	100.0%	54.7%
	98.5%	77.6%	88.6%	1,358	16	81.3%	100.0%	22	77.3%	100.0%	52.6%
	97.2%	75.6%	85.3%	1,336	14	100.0%	100.0%	18	83.3%	100.0%	61.1%
	96.4%	82.0%	88.9%	826	3	100.0%	100.0%	2	100.0%	100.0%	59.5%
	97.4%	75.0%	85.7%	14,094	190	74.7%	98.9%	161	79.5%	100.0%	56.3%

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