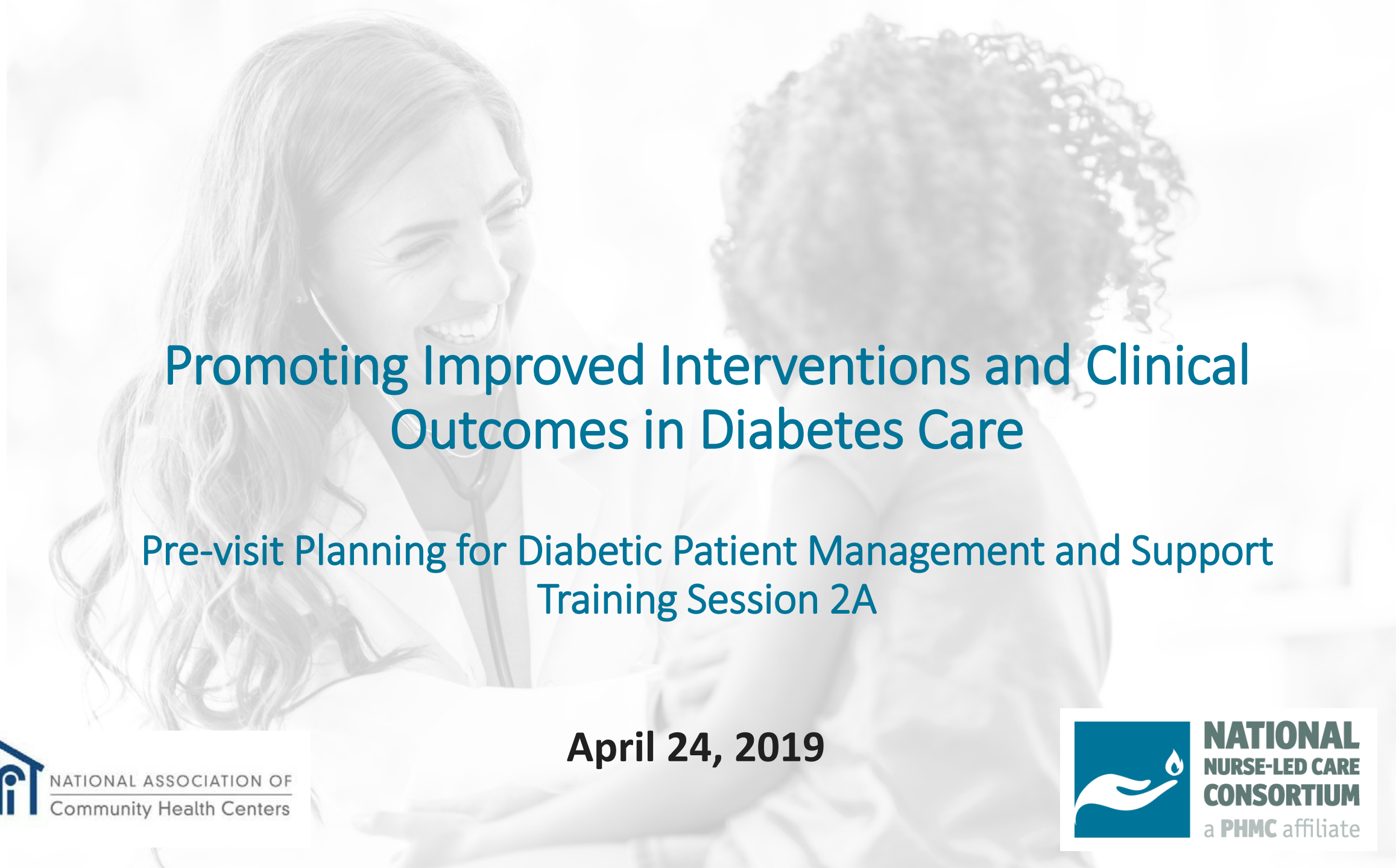

Promoting Improved Interventions and Clinical Outcomes in Diabetes Care

Pre-visit Planning for Diabetic Patient Management and Support Training Session 2A

April 24, 2019

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Hello!

Cheryl Fattibene

Jillian Bird

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Promoting Improved Interventions and Clinical Outcomes in Diabetes Care

- 1A: Care Teams Training
- 1B: Care Teams Facilitation
- **2A: Pre-Visit Planning Training –Today**
- 2B: Pre-Visit Planning Facilitation – Wed., May 8, 2:00-2:30 PM EDT
- 3A: Patient Engagement Training – Wed., May 29, 1:00-2:30 PM EDT
- 3B: Patient Engagement Facilitation – Wed., June 12, 1:30-2:00 PM EDT

National Nurse-Led Care Consortium

The **National Nurse-Led Care Consortium (NNCC)** is a membership organization that supports nurse-led care and nurses at the front lines of care.

NNCC provides expertise to support comprehensive, community-based primary care.

- Policy research and advocacy
- Technical assistance and support
- Direct, nurse-led healthcare services

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Acknowledgements

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This learning collaborative was sponsored by the National Association of Community Health Centers (NACHC) and draws upon tools, resources, and best practices developed by NACHC and the Clinical Advisory Group convened by NACHC to provide subject matter expertise for its *Improve Diabetes Care in Health Centers* project.

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Welcome & Introductions

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Getting to know you…

In the chat box, for each participant, please enter:

1. Your name and email (necessary for CE credit)
2. Your role.
3. Your organization.
4. Something you want to learn/share today about pre-visit planning for diabetics.

Learning Objectives

1. Identify the purpose and benefits of implementing pre-visit planning

2. Describe tools useful for pre-visit planning that can improve the patient experience

3. Create a plan to implement pre-visit planning tools that improve practice efficiency

Today's Schedule

Time	Module	
15 minutes	Welcome and Introductions	• Orientation to the session and goals • Review of Care Team work
15-20 minutes	Topic 1: Pre-Visit Planning Overview	• Standing order • Huddles • Risk Stratification
10-15 minutes	Diabetic Risk Stratification Exercise	
15-20 minutes	Pre-visit Intra-visit Post-visit	• Introduction of standardized check lists • Utilization of PDSA for implementation
10-15 minutes	Q+A	
5 minutes	Conclusion/Wrap-Up Practice Transformation Work: PDSA of choice	

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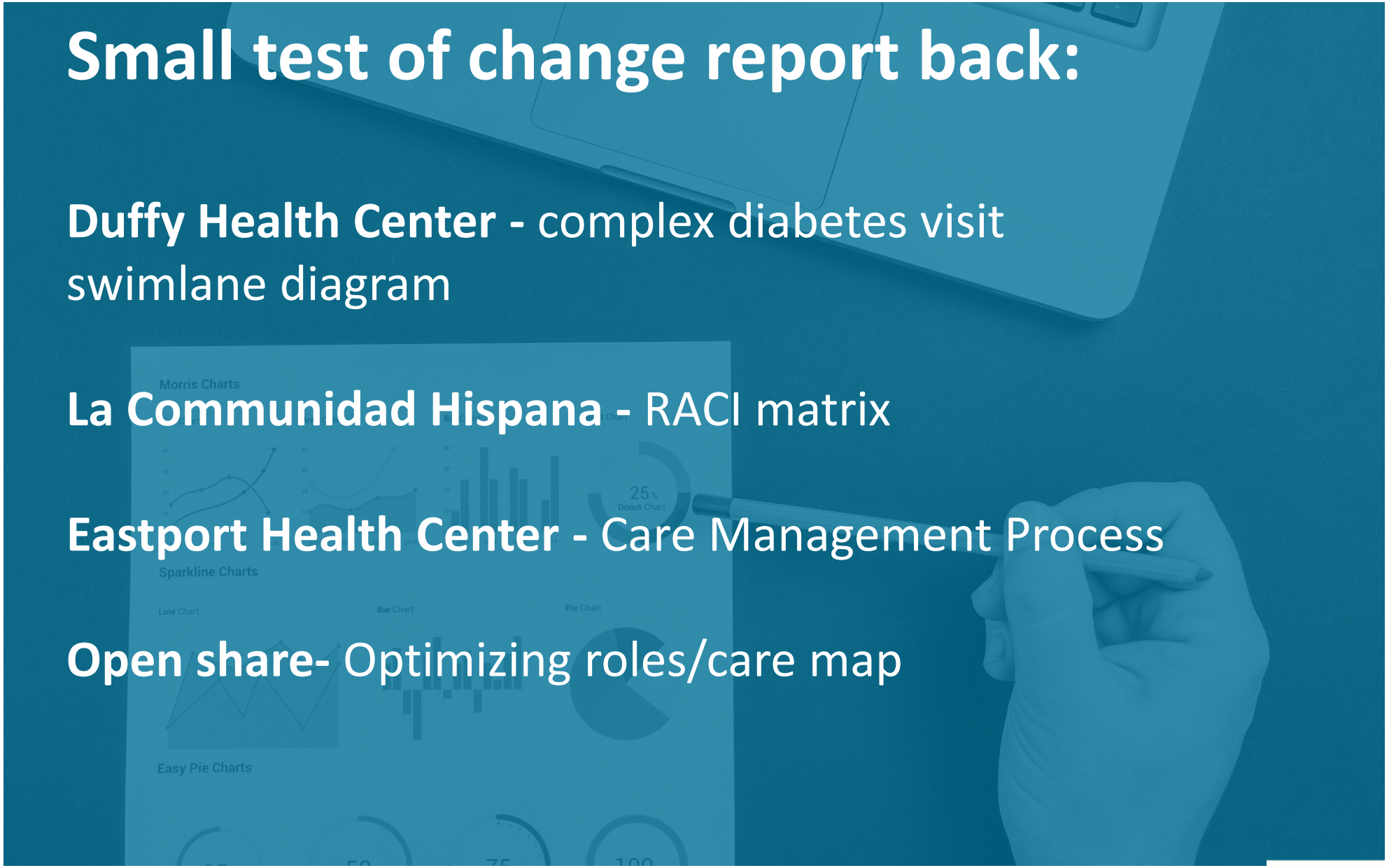
Small test of change report back:

Duffy Health Center - complex diabetes visit swimlane diagram

La Communidad Hispana - RACI matrix

Eastport Health Center - Care Management Process

Open share- Optimizing roles/care map



Review of Care Team Formation

- Shared Vision
- Define Goals for team
- Clarify/Optimize roles
- Minimal Competencies for team members
- Align admin systems to support care goals
- Prioritize communication systems
- Use data to assess progress: monthly, often
- Be innovative and practice team work
- Share with others your success

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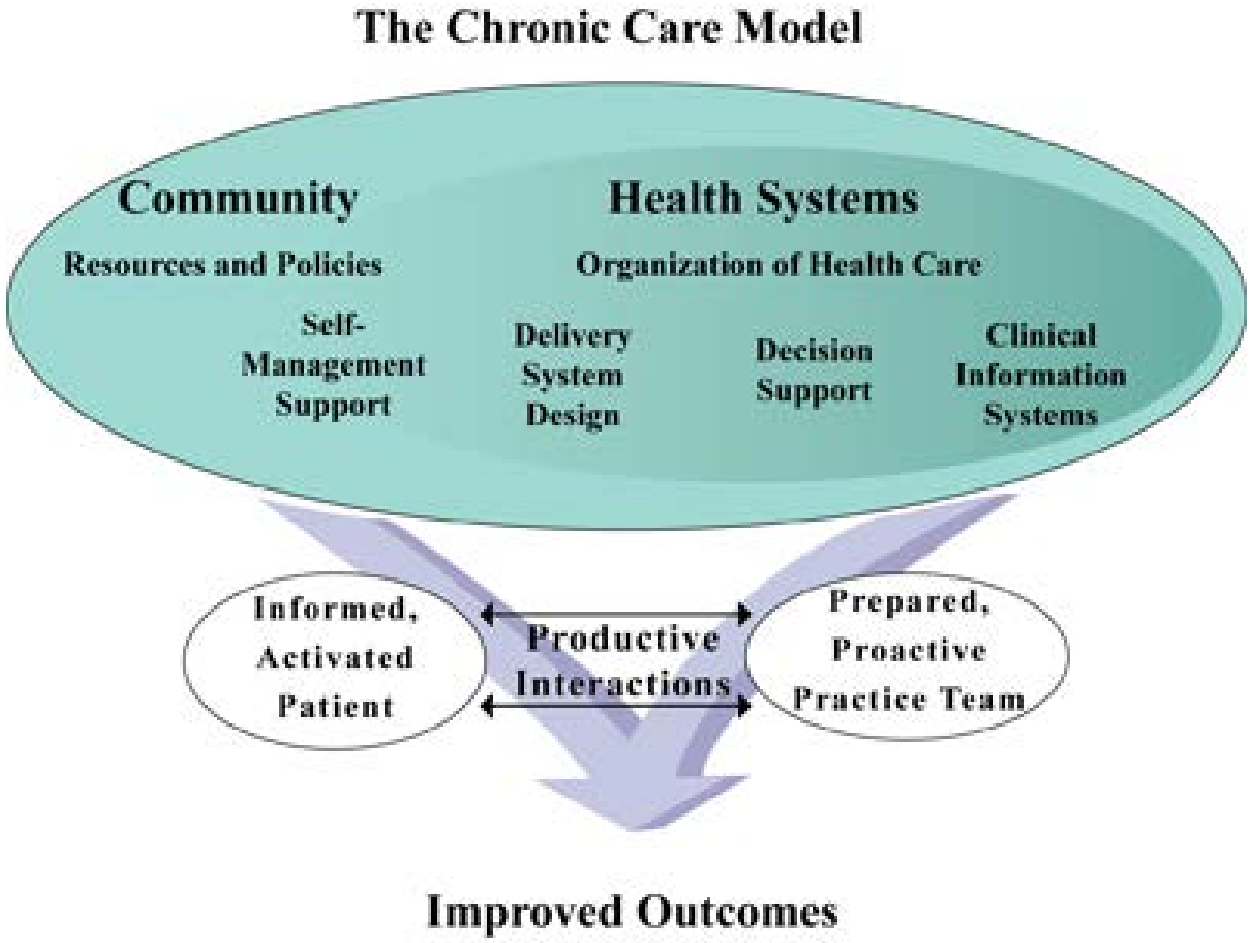
The Chronic Care Model

- a widely adopted approach to improving ambulatory care
- guiding clinical quality initiatives in the United States
- evidence on the CCM is encouraging
- support practices to improve their systems
- studies suggest that redesigning care using the CCM leads to improved patient care and better health outcome



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https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5091929/

Topic 1: Pre-Visit Planning Overview

Pre-visit Planning

Pre-visit planning for diabetes-focused care visits helps ensure that both patients and practice staff are prepared for visit.

Ideally, pre-visit preparation starts at the end of the current visit.

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Pre-visit Planning Research

"…pre-visit preparation may be a key strategy for primary care practices to improve areas critical for chronic disease management, such as patient engagement, appointments kept, and compliance with recommended screenings, tests, and services."

Rivo, J., Population Health Management 2016.

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“An internal medicine practice in Boston found that pre-visit laboratory testing reduced the number of letters and phone calls by more than 80% and saved $25 per visit in physician and staff time.”

J. Benjamin Crocker, MD Internal Medicine, Ambulatory Practice of the Future, Boston, MA

- No additional staff needed to be hired
- Follow up appts scheduled one year in advance
- Automated reminders for labs 3, 6 and 12 months out
- Useful for other diagnostic tests as well, pre-visit
- A missed lab appointment prompts a follow up call
  - to assess for status changes
  - reschedule labs immediately
  - use as a reminder for up coming provider visit

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Benefits of Pre-visit Planning

- Improved communication within team and neighborhood
- Enhanced job satisfaction within care team
- Streamlined scheduling of appointments
- Enhanced care team efficiency:
  - During appointment, between visits, and at next visit
- Enhances patient experience
- Increases patient involvement
- Improves overall practice efficiency

Pre-visit Strategy Goals

- Proactively identify patients who have care gaps
- Contact Patients prior to visit
  - Lab reminders
  - Meet with diabetes educator
  - Self-management referral follow up
- Activate patient for upcoming visit
  - Prepare questions
  - Create diaries/logs of SMBG/activities
  - Goals sheets completed to share

Pre-visit Strategies

1. Standing Orders
2. Huddles: scrubbing charts, no show risks
3. Risk Stratification

Strategy #1:
Standing Orders

- is a prescribed procedure that remains in place as guidance for administering healthcare until changed or canceled
- considered best practice guidelines
- are established by providers but implemented by nurses or MA without direct order by the provider every time the practice is enforced
- example: children's vaccines
  - at certain age or after a given increment of time vaccines are administered without verbal or written authorization
  - it is up to MA or nurse to determine if children are due for vaccinations

Standing Orders

Diabetes Care Standing Orders

KENTUCKY DIABETES NETWORK, INC.

Patient Name:_____ DOB:_____

Type of Diabetes: 1 2 (circle one) Year of Diabetes Diagnosis:_____

This tool is based upon the 2013 American Diabetes Association's Clinical Practice Recommendations. It is not intended to replace or preclude clinical judgment or more intensive management. Use it as a reminder, to simplify ordering procedures and as a way to continually improve care to all patients with diabetes. Upon approval from the practicing physician / clinician, standing orders may be initiated by approved office staff. When instituting orders, review information from the patient and his/her chart to apply the protocol appropriately. Diabetes Care Standing Orders may be applied at any patient encounter (does not have to be a diabetes-focused visit).

1. **Standing Lab Orders:**
   - **A1C:** If A1C result not available within past 2-3 months, provide/schedule A1C test.
   - **Lipid Panel: A.** If most recent lipid panel is more than 12 months old: schedule for a fasting lipid panel. (Can extend to every 2 years with low-risk lipid values - LDL < 100 mg/dl, HDL >50 mg/dl, triglycerides < 140 mg/dl). **B.** For ages 2 to 10 with unknown history/positive family history of hypercholesterolemia/premature CVD event: draw lipid panel soon after diagnosis and after glucose control is established. **C.** Otherwise at age 10: begin lipid testing soon after diagnosis and glucose control is established, and repeat every 5 years. **D.** If lipids abnormal: schedule annual lipid panel.
   - **Assess Urine Albumin Excretion:** If test for urine albumin excretion is more than 12 months old, provide/obtain test (for Type 1 – initiate at ≥5 years of diabetes duration; for Type 2 – begin test at diagnosis).
   - **Serum Creatinine:** If most recent test is more than 12 months old, schedule serum creatinine test for all adults to estimate glomerular filtration rate (GFR) and stage the level of chronic kidney disease, if present.
2. **Dilated Retinal Eye Exam:**
   If no dilated retinal eye exam result recorded within the last 12 months, refer to an eye care provider for DILATED and comprehensive eye examination (for Type 1 – age 10 years or older, begin within 5 years of diabetes diagnosis; for Type 2 – begin at diagnosis).

Community Health Centers

Can be tailored to meet care team available to implement

Include specialized care focus (DM2) and general preventative care

Improves immunization rates

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Strategy #2:
Huddles

Huddles are short, daily meetings in which a "teamlet" or pod (a Primary Care Provider/Clinician and an RN/MA/LPN and other support staff) reviews their patient list for the day for coordination, continuity, and efficiency.

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Characteristics of Successful Team Huddles

- No longer than 10 minutes
- Schedule time & place
- Identified team members present
- No interruptions
- Complete pre-work (agenda, chart reviews, SBAR, etc.)
- Designate facilitator & time keeper

Huddles are not Meetings or Case Conferences

What is the difference between a Team "Meeting" and a "Huddle"?

	TEAM MEETINGS	"HUDDLES"
Meeting Frequency	○ Goal: weekly ○ Minimum: biweekly	Goal: before each session (AM & PM)) Minimum: once a day Ideal: In addition, post-session quick huddle for f/u tasks
Amount of Meeting Time	30-60 minutes depending on weekly/ biweekly *This meeting time should occur during a time when team members CAN ATTEND and coverage for their work is available. Team meetings are part of administrative time for providers.*	Average 10 minutes or less! * Who's coming in today: what do they need? * Who was in the hospital/ED and what is the plan for f/u?
Attendees	All assigned members of the Planned Care Team **Required participants:** Provider, Nurse, Medical Assistant, Medical Receptionist, Planned Care Coordinator, and Complex Care Managers (for high risk case discussions)	• A provider and the MA who are working • together to see the patient that day. • The receptionist joins the team if at all possible to assist with scheduling of appointments. • The team RN connects with this team either

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Excerpts from Cambridge Health Alliance Team-Based Care Toolkit ©

Duration and frequency

Daily or several times in a day

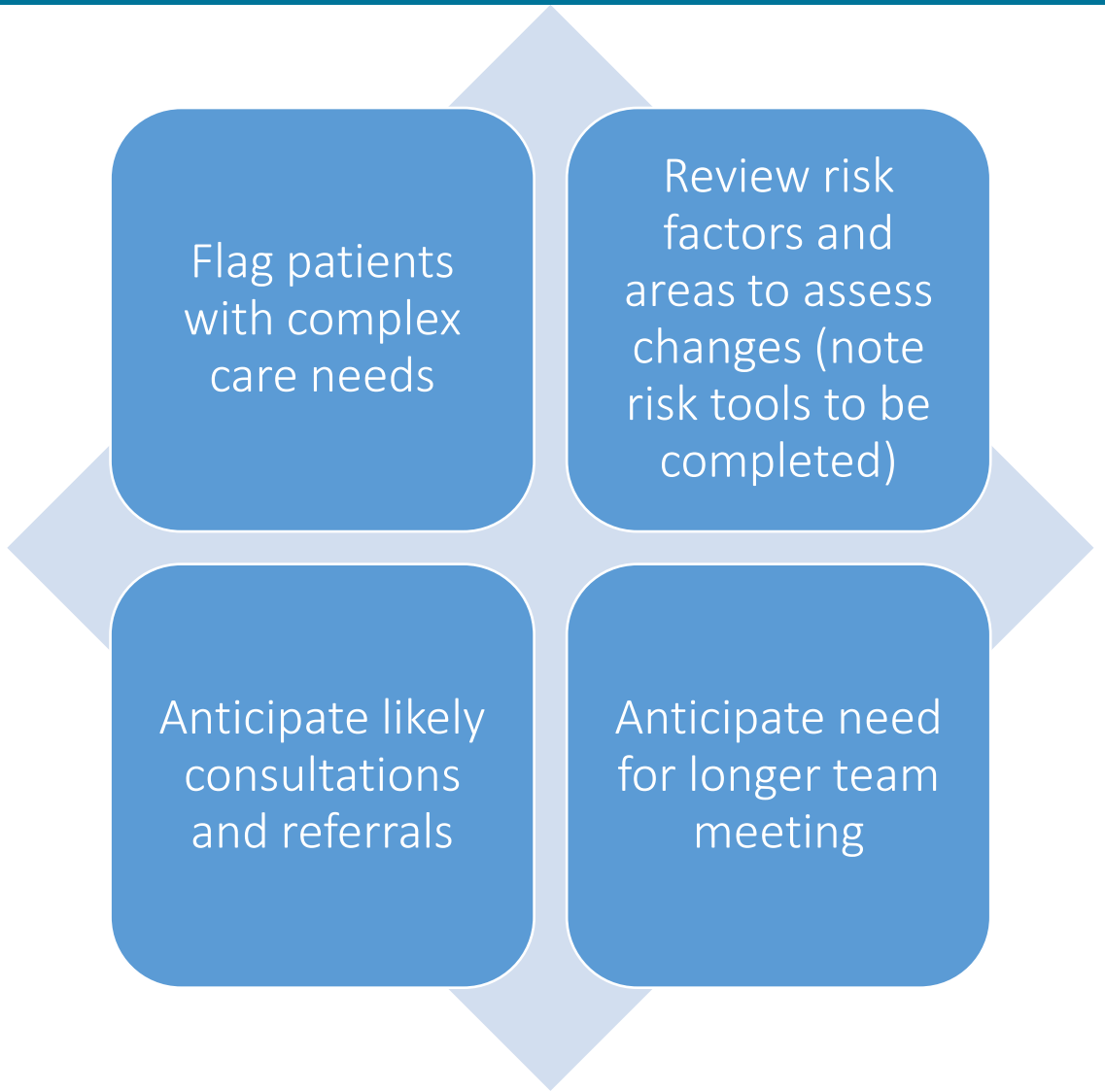
Goal

Help team organize the day and patient care delivery

Type of information shared

- Schedule for the day / changes
- Rapid review of patient needs
- Health maintenance
- Standing orders
- Referrals needed
- Chronic disease management
- Self-management
- Adherence
- Focus on scheduled patients / current emergent needs

Huddle Focus for Efficient Care Coordination



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More strategies for a Successful Team Huddles

1. Do a quick check in with everyone
   A. How is everyone feeling today?
   B. Is anyone leaving early?
   C. Is anyone out today?
   D. How can we support each other through the session?
2. Know the status of each team member because everyone is critical to the success of the team.

Strategy #3:
Risk Assessment

Risk assessments allow for targeted care to improve outcomes and reduce costs.

- Create a baseline response
- Optimize staff to work with designated risk levels

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Risk Assessment

- Why am I assessing for risk?
  - Hospital admission / readmission
  - High service use / expense for practice
  - Adverse outcomes, e.g., medication errors, functional decline, failure to thrive
  - Meeting quality/incentive payment guidelines
  - Responding to community/patient need
  - Panel management

Risk Screening

Identifies patients at risk and in need of more intense care coordination.

Risk Stratification

The process of grouping patients and targeting interventions according to their level of risk.

Risk Adjustment

A statistical technique used in quality measurement to allow for comparability across patient populations.

Risk Screening Results

Stratagem Health

Diabetes Desktop

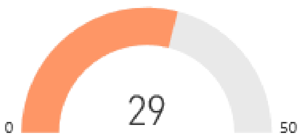
User : **Florence Nightingale, RN**
Role: Case Manager II
Unit: 3-North, 5- South

Orange County Hospital System

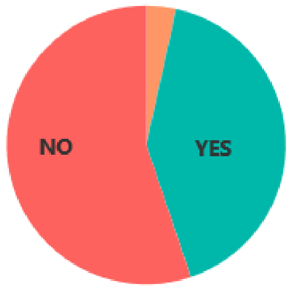
Patients with Diabetes

First	Last	Patient ID	S...	DOB	Phone numb...	On correct Treatment	CHF	Risk Stratificati...	Stratagem Risk Score
Angela	Bowman	4190538	F	Monday, June 14, 1926	9979535996	2	0	High	7
Anthony	Hunt	9924284	M	Saturday, December 3, 1966	1971230804	0	0	Medium	3
Brandon	Dixon	6672311	M	Thursday, July 18, 1929	2555858849		0	Medium	4
Bruce	Hughes	1157079	M	Wednesday, February 24, 1954	5793606742	0	0	Medium	2
Christi...	Rivera	7973382	F	Thursday, December 4, 1947	2297896306	2	1	High	11
Craig	Bell	8170000	M	Friday, January 6, 1939	8129905719	0	0	Medium	4
Cynthia	Moreno	4073328	F	Sunday, January 26, 1941	4788129249	2	1	High	10
Debra	Chapman	6898450	F	Sunday, June 27, 1971	4385133567	2	0	High	7
Donald	Lynch	2407489	M	Tuesday, February 8, 1944	5055141916	0	0	High	5
Eric	Webb	5973548	M	Thursday, April 13, 1950	1526200036	2	0	High	6
Fred	Ryan	3750537	M	Saturday, January 30, 1943	7276223555	2	0	High	6
Gregory	Ellis	9103680	M	Thursday, June 18, 1942	2645116296	0	0	Medium	4

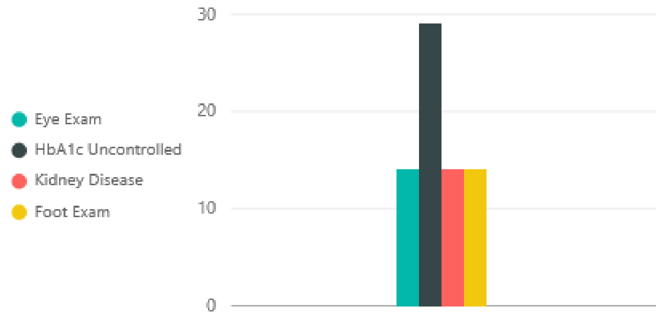
Number of Diabetic Patients



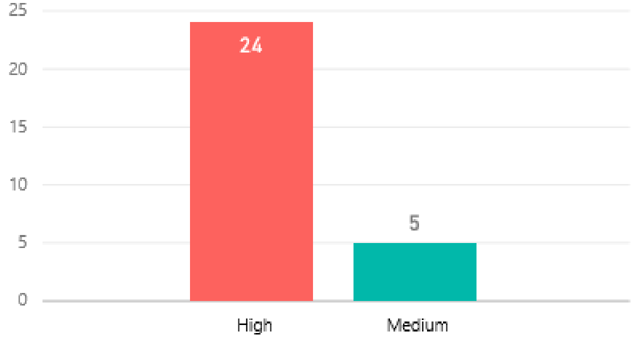
On correct Diabetic treatment



Diabetes Report Card



Diabetic Patients - Risk Stratification



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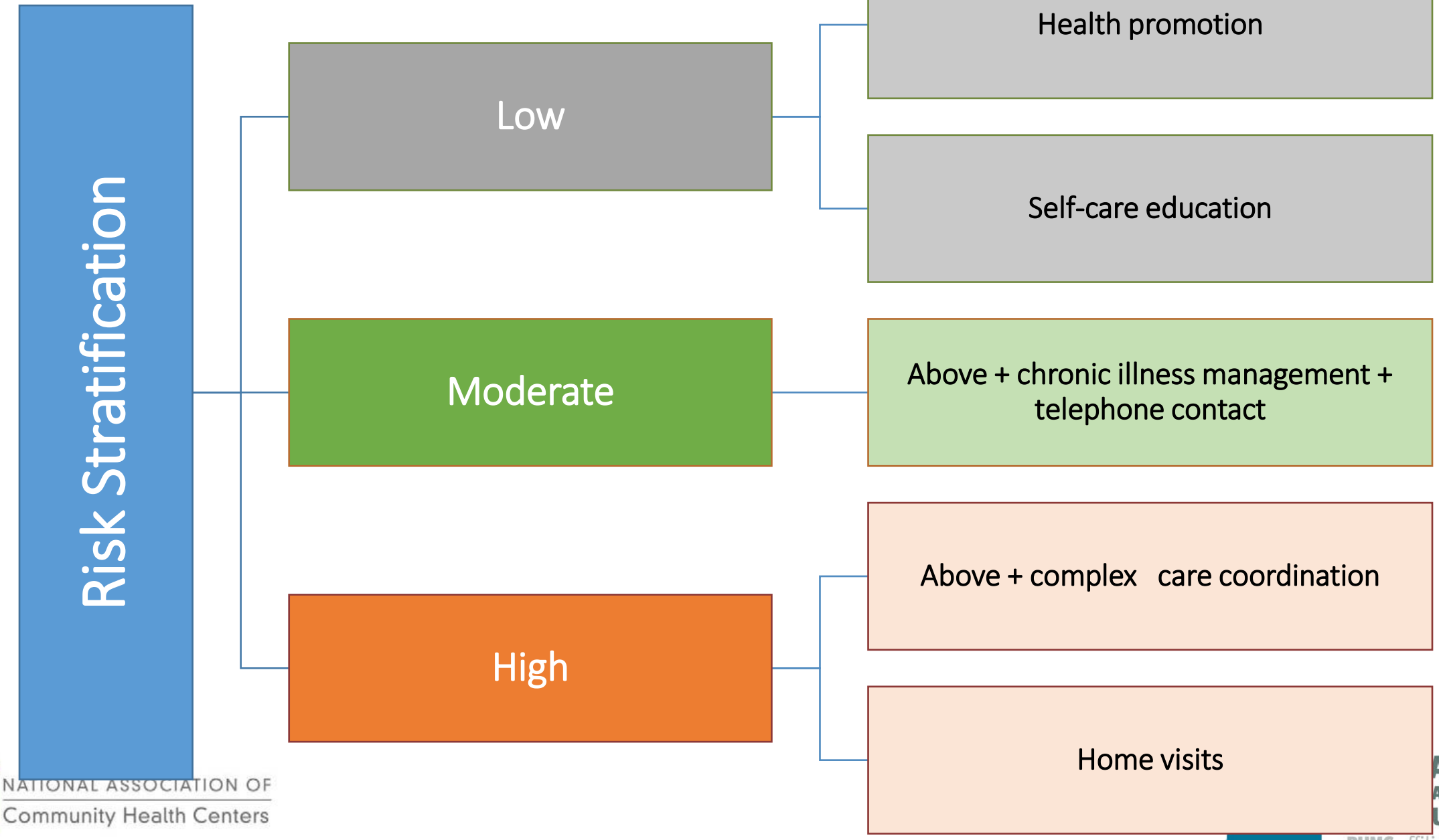

Example of Lab results
Presentation in stratified manner for patient education

Area of Risk	Blood Sugar Control	Cardiovascular					Kidney Status		Nerve Status
Risk Level									
Lab Test	$HbA1_c$	Chol.	Trig.	LDL	HDL	Blood Pressure	Creatinine	MAU	Mono-filament
Lab Test	$HbA1_c$	Chol.	Trig.	LDL	HDL	Blood Pressure	Creatinine	MAU	Mono-filament
Result	**9.9**	**199**	**2076**	**60**	**27**	**152/82**	**0.9**	**100**	**Insensate**
Units	%	mg/dL	Mg/dL	mg/dL	mg/dL	mmHg	mg/dL	mg/L	
High Risk Ref. Range	> 8	> 240	> 500	> 130	< 35	>130/ > 85	> 1.5	> 100	Insensate

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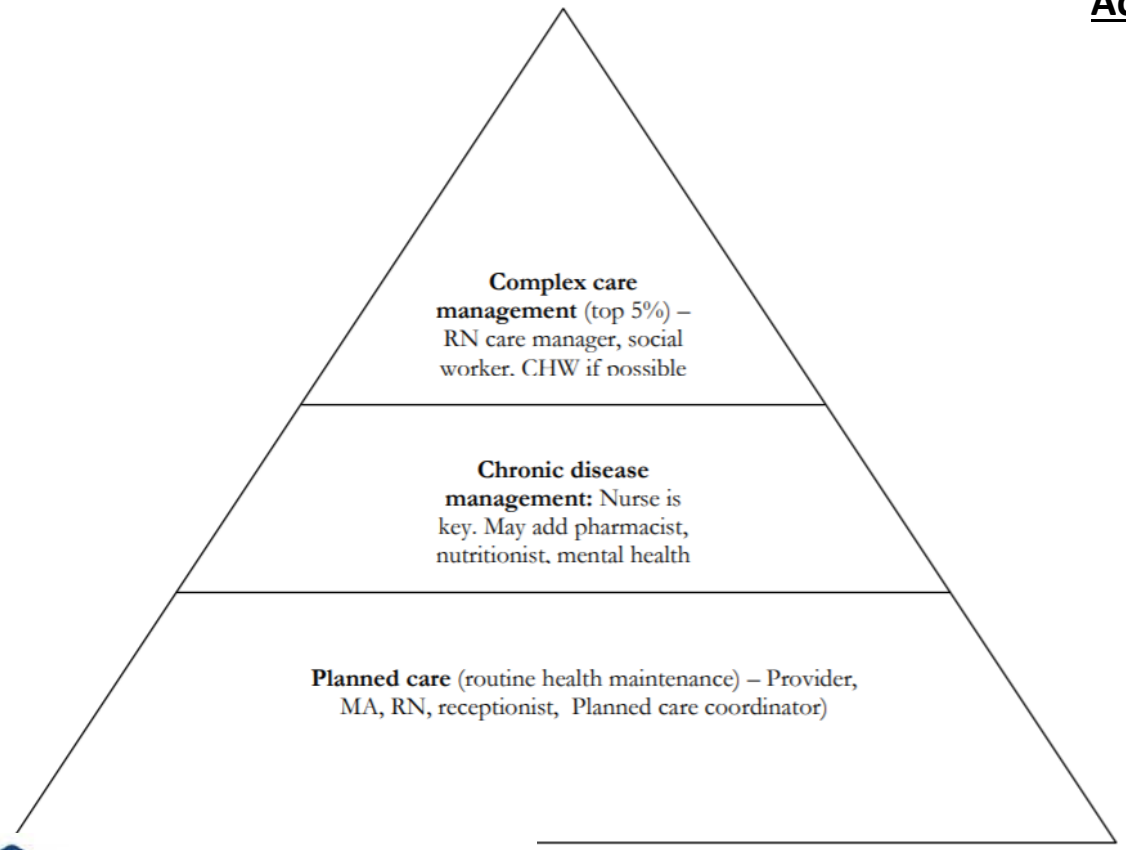
Risk Stratification Activity



Activity:

1. Consider the case scenario on the next slide
   - What information might you need to better understand this patient's risks?
2. Consider the stratification tool provided
   - What indicators of risk would you include at the top?
   - What management steps or sieves do you think are missing from the bottom?
3. What score would you use to stratify risk? This tool uses
   0-3 care management
   4-7 moderate
   8< high risk
4. Consider your own scale for risk, how would it be different/
5. Consider your care team and designate the team for each stratification level:

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Risk Stratification Activity

RED ZONE
Maximum support needed.
Overall Stratification Score > 6

YELLOW ZONE
Moderate support needed.
Overall Stratification Score 3 to 6

GREEN ZONE
Minimal support needed.
Overall Stratification Score < 3

Patient #1 - Chuck

- **Age: 72**
- **Gender: Male**
- **Race: White, Non-Hispanic Male**
- **Insurance Coverage: Medicare**
- **Blood Pressure: 198/90**
- **Maintenance Meds: 5**
- Blood Sugar: Over 300
- Diagnoses: Diabetes, Hypertension
- Patient has history of Renal Failure
- Patient is a lifelong smoker
- Patient is overweight

Topic 2: Pre-visit, Intra-visit and Post-visit check lists

Strategy #4:
Standardized Check Lists

Previsit

The time of recognized need or risk by system or time of patient contact to check-in

Care team plans for the encounter

Visit

Time of check-in to departure from health center

Patient's encounter with clinician and care team

Between visit

Completion of visit plans/actions to previsit

Care management

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1. Scrub charts check list
2. Patient visit check list
3. Huddles check list
4. Risk stratification check list

1. Shared decision making
2. Goals check list
3. Office visit check list (standing orders)
4. Patient education check-list, risk based

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1. MA checklist/follow up
2. Referral follow up check list
3. Routine care management check list
4. Ensure labs are done

Diabetes Check-list Example

Type of diabetes: ☐ Type 1 ☐ Type 2 ☐ Other **Date Diagnosed:**			**Patient Name:**	
Comorbidities: ☐ Hypertension ☐ Coronary artery disease ☐ Stroke/TIA ☐ Dyslipidemia ☐ Peripheral arterial disease ☐ Depression/Anxiety ☐ CKD – stage _____ ☐ Other(s):			**Date of Birth:**	
		Date:	**Date:**	**Date:**
Healthy behaviour interventions	**Weight** (kg) **Height** (cm) **BMI** **Waist circumference** (cm)	Wt _____ Ht _____ BMI _____ WC _____	Wt _____ Ht _____ BMI _____ WC _____	Wt _____ Ht _____ BMI _____ WC _____
	Nutrition			
	Physical Activity (Aerobic 150 mins/week, Resistance 2–3x/week)			
	Smoking Status	☐ Non-smoker ☐ Ex-smoker ☐ Smoker	☐ Non-smoker ☐ Ex-smoker ☐ Smoker	☐ Non-smoker ☐ Ex-smoker ☐ Smoker
Glycemic control	**A1C** (target: ≤7% or _____ %) (Individualize based on patient characteristics and antihyperglycemic medication(s) – see CPG) (q3 months. If at target and stable – q6 months)	Test Date: Result:	Test Date: Result:	Test Date: Result:
	Antihyperglycemic Medication(s) **Drug Name(s)/Dose(s):**			
	Therapy Adherence/Concerns			
	BG Record (targets: premeal: 4–7 mmol/L or _____ mmol/L; 2hr postmeal: 5–10 mmol/L or _____ mmol/L) (Individualize based on ability to achieve A1C target + risk of hypoglycemia)			

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Final Questions

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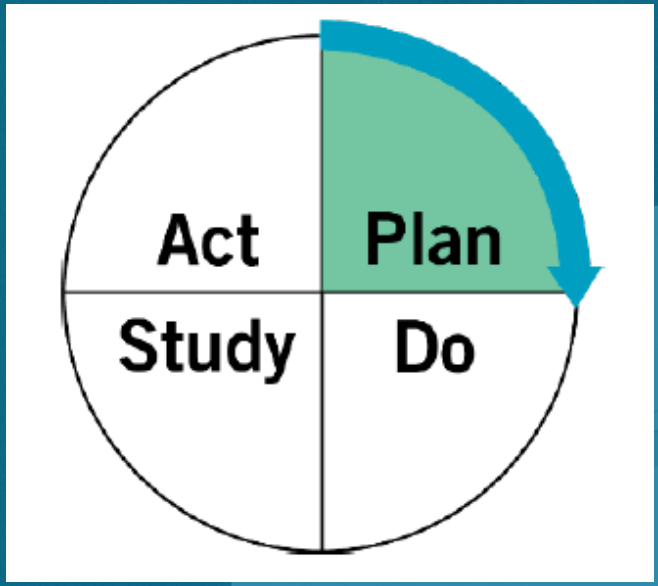
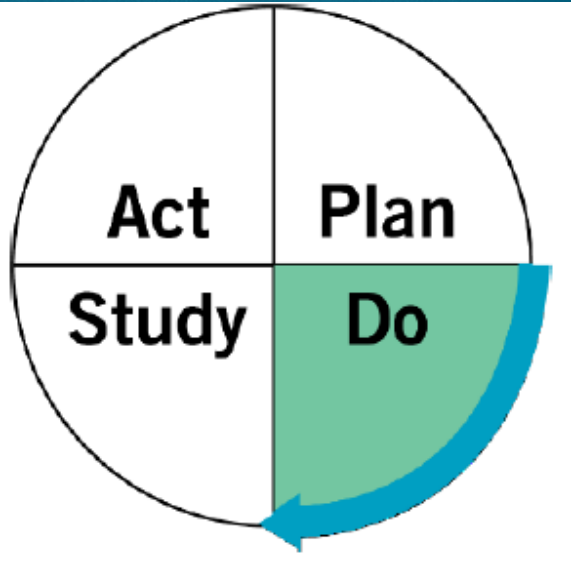
Final Reminder!

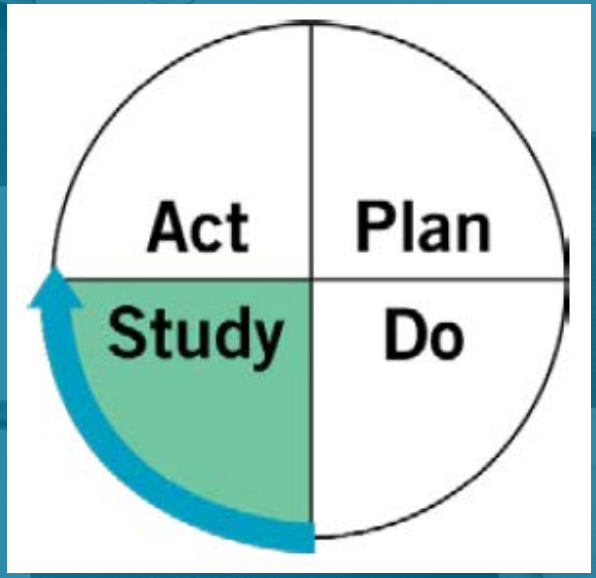
Practice Transformation Work

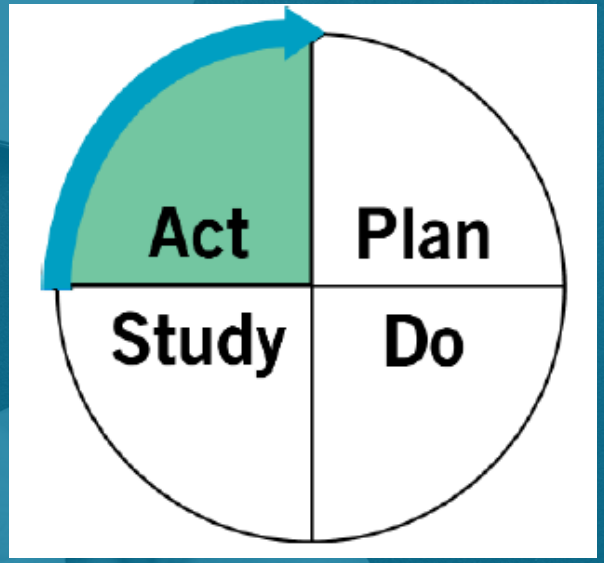
1. Use a PDSA cycle to implement one tool into the pre-visit planning period.
   a) Identify and draft one diabetic standing order
   b) Pilot test diabetic team huddle
   c) Review current risk profile of diabetics in your EHR
   d) Create consensus check lists with diabetic care team
2. Resources available in session 2B on Moodle
   a. Forum for sharing tools/ideas in Moodle
3. Session 2B: check in to share progress & feedback

Test of Change: Decide a pre-visit tool you would like to try over the next few week









The steps in the PDSA cycle are:
Step 1: Plan—Plan the test or observation, including a plan for collecting data
Step 2: Do—Try out the test on a small scale
Step 3: Study—Set aside time to analyze the data and study the results
Step 4: Act—Refine the change, based on what was learned from the test

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