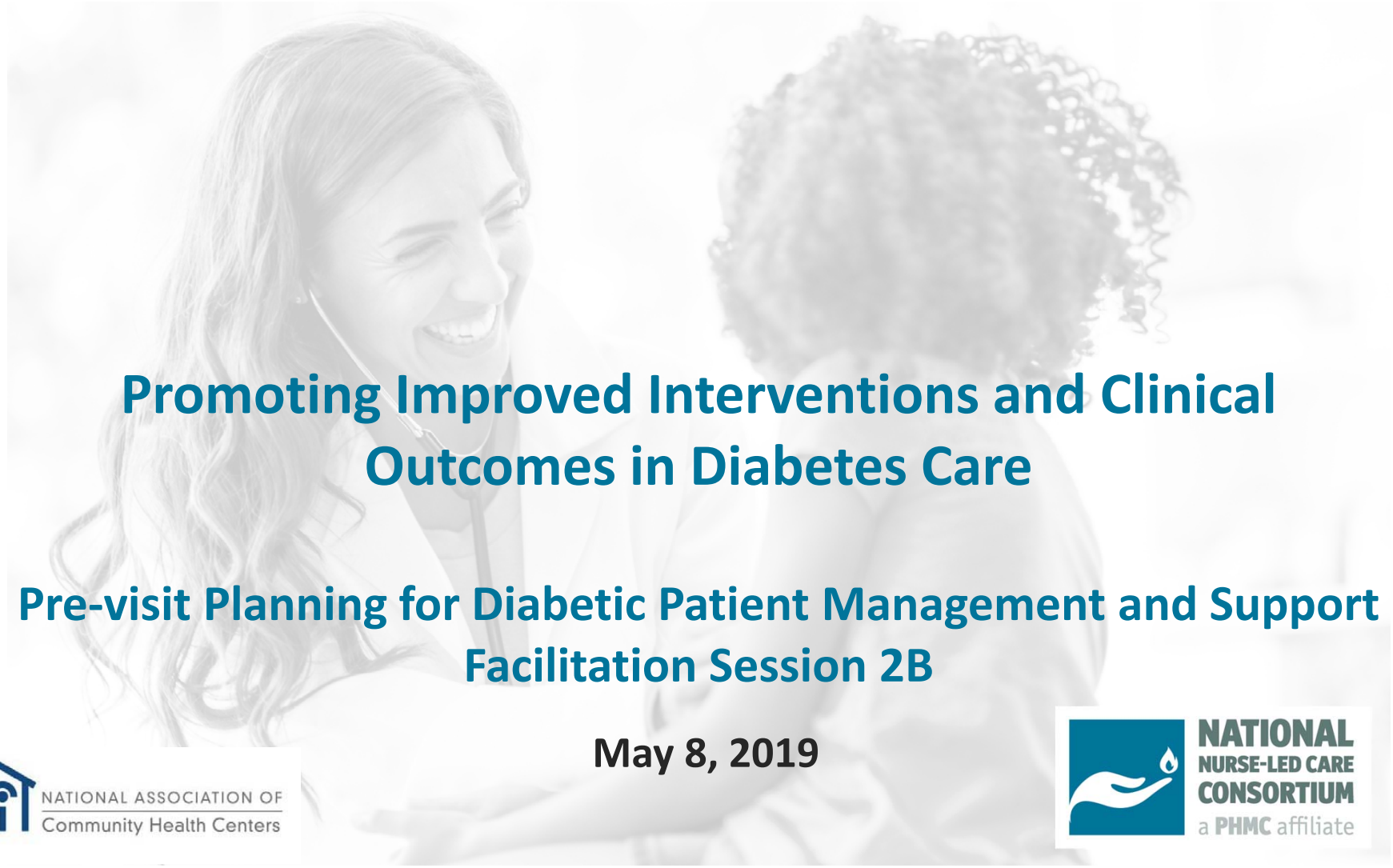

Promoting Improved Interventions and Clinical Outcomes in Diabetes Care

Pre-visit Planning for Diabetic Patient Management and Support Facilitation Session 2B

May 8, 2019

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Welcome & Regroup

Any new Attendees? Please introduce yourself in chat box

For tracking attendance: put email in chat box

All attendees use chat box to submit to group:

1 request for help or resource on a subject &

1 offer to help or a resource you have on a topic

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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
- **2B: Pre-Visit Planning Facilitation – TODAY**
- 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

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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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Learning Objectives

1. Attendees will be introduced to several tools to support the adoption and optimization of diabetic pre-visit planning.
2. Attendees will identify one request and one offer related to their efforts at diabetic care team formation and optimization.
3. Attendees will identify one next step they will take to further their efforts at diabetes care team formation/optimization.

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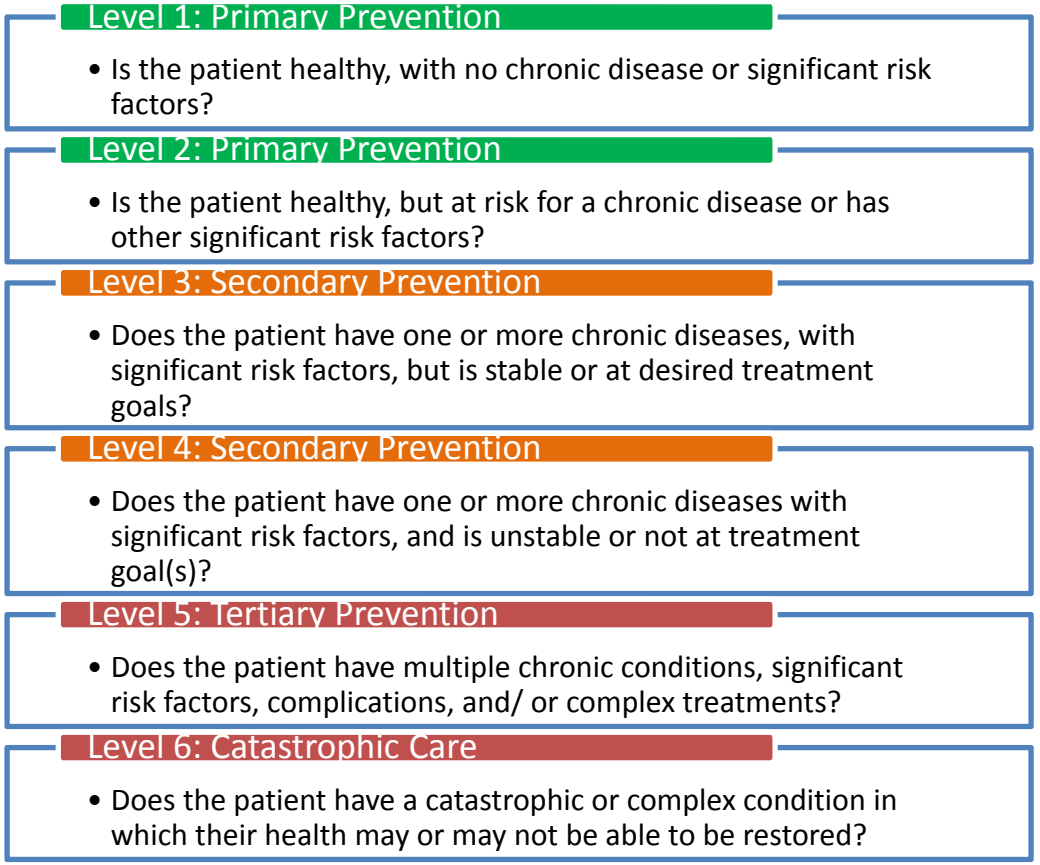
Today's Schedule

Time	Module	
5 minutes	Welcome and regroup	• New attendees
5-10 minutes	Data Management and Reporting for Pre-visit Planning- HITEQ with Jillian Maccini	• population health management • data integration technologies • registries and reports • risk stratification
10-15 minutes	Group Share on • Next Steps for PDSA or test of change • Resources to share • How data is being used currently	
5 minutes	Review and Discussion on Practice Transformation Work	
5 minutes	Conclusion/Wrap-Up	• Set goals for next 3 weeks • Share on Moodle as needed • Complete evaluation in Moodle for session


HEALTH INFORMATION TECHNOLOGY,
HITEQ
EVALUATION, AND QUALITY CENTER
NNCC | May 8, 2019

Creating a Team Based Risk Stratification Process

- Goals:
  - Assign a risk score to **every patient in the practice**
  - Divide into risk levels
  - Optimize care for patients and care teams
  - Monitor risk scores



Source: AAFP Risk-Stratified Care Management Rubric; Presented in A Practical and Team-Based Approach to Risk Stratification for the Entire Patient Panel by Dr. James DomDera of NewHealth Collaborative in Akron, OH at PCMH Congress, Sept. 15, 2018

Two Step Risk Stratification Process

Step 1: OBJECTIVE

Use **objective** data and approaches to risk stratify your patient population. Two good examples:

- NACHC Risk Stratification
- AAFP Risk-Stratified Care Mgt Rubric

Three components to consider:

Pre-defined risk scoring: Payer-specific risk from claims, EHR calculated, CMS HCC scores, etc.

Clinical: BH diagnoses, chronic conditions, cancer diagnoses, clinical metrics out of bounds

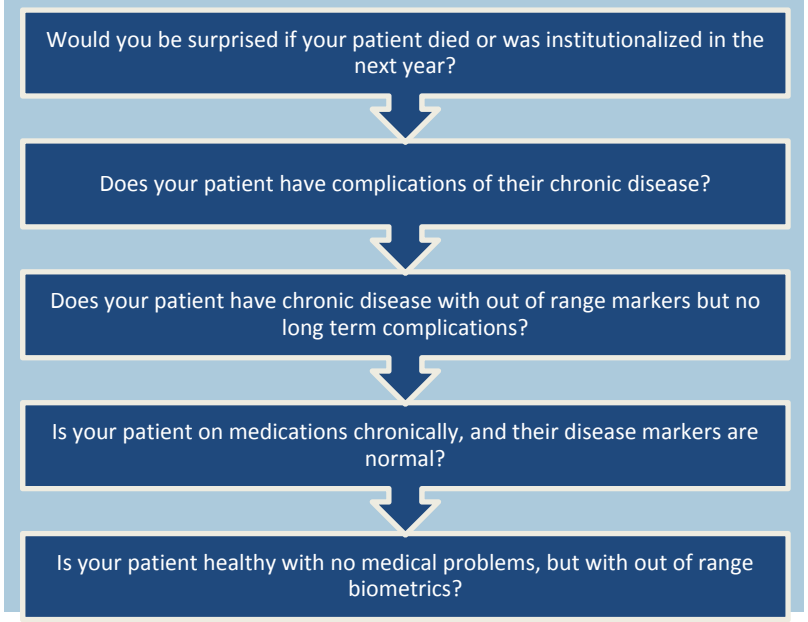
Utilization: ED visits, hospitalizations

Consider objective data: registry reports (e.g., pts with A1c>9%); gap reports

Step 2: SUBJECTIVE

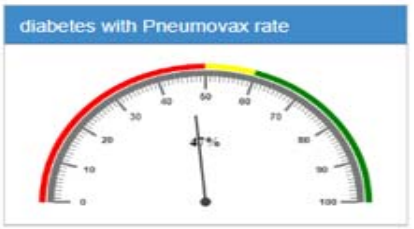
Apply **Subjective information** to risk scores identified through objective means. This may include:

- Care team perception
- Social Determinants of Health
- Gut Feeling



What is required to do this?

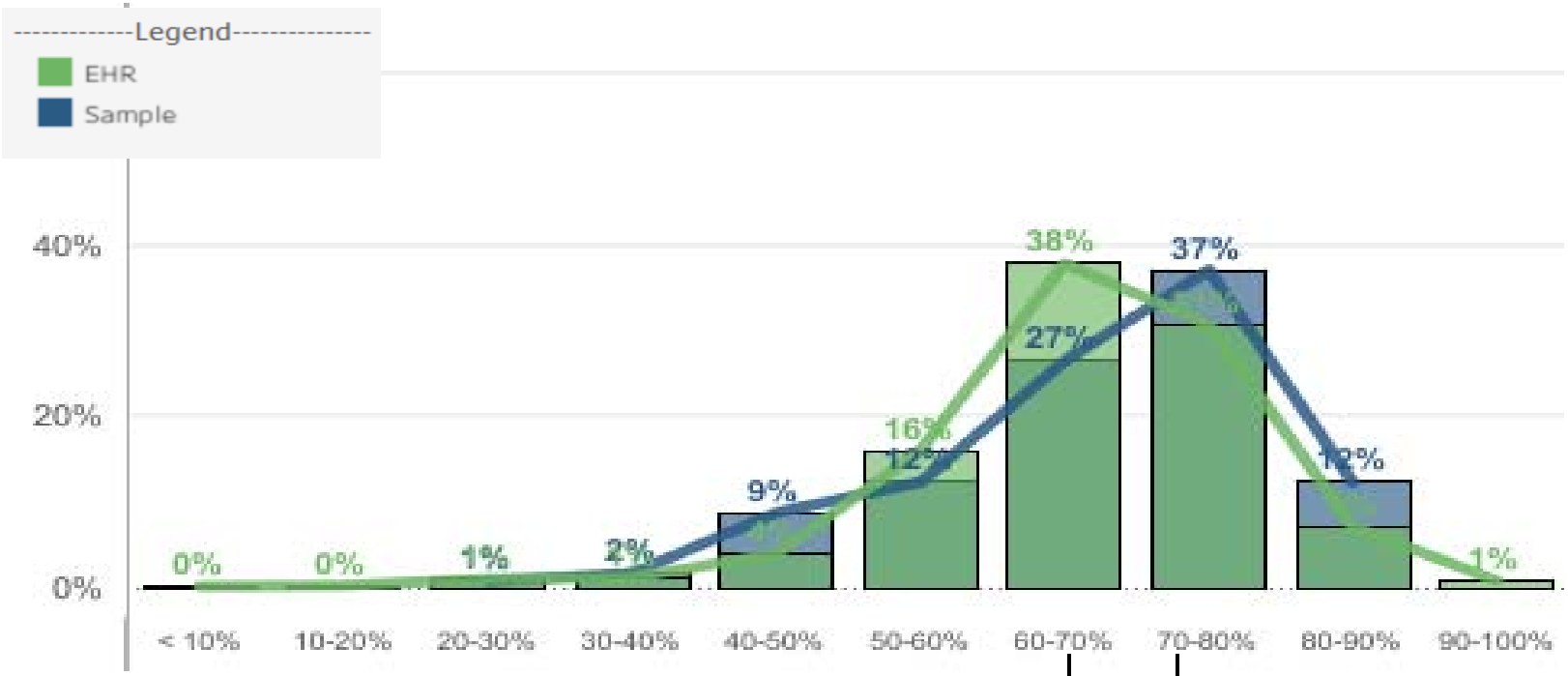
- Objective data should come from existing data and reports.
  - Registry reports by diagnosis
  - Dashboards or gap reports (with drill down lists)
  - **Accurate documentation to feed into these!**



Subjective assessment is optimally done in care team meetings or huddles.

If objective assessment cannot be automated, then you can take objective information for patients on the schedule that day, assign score (document in EHR) and **then move to subjective discussion, and finalize score**. Use huddle forms!

There is evidence that documentation in the EHR isn't where we need it to be!



Most health centers reporting from an **EHR** report diabetes control in the range of 60-70%.

Most health centers reporting from a **Sample** report diabetes control in the range of 70-80%.

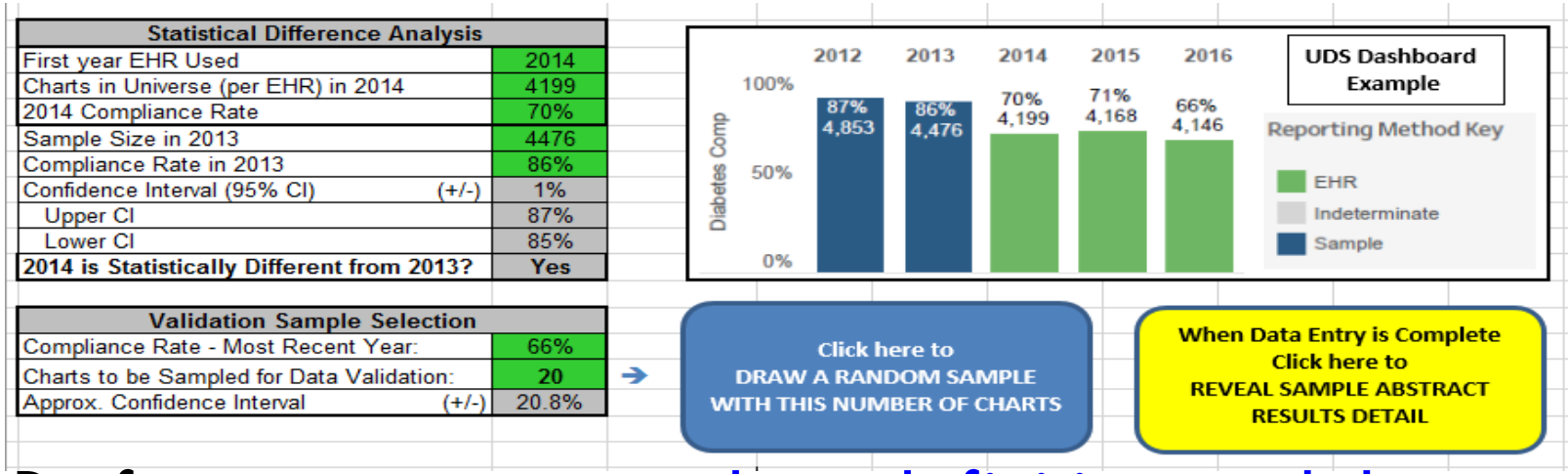
Ensuring Accuracy in Reports

- Documentation needs to include diagnosis codes to the highest degree of specificity and be captured on an ongoing basis.
  - Value Sets for CQMs, including for lab tests
  - ICD-10 Coding for Diabetes

- Depending on what is used for risk scoring or reports, diagnostic data may not carry over year over year or may not be considered active after a set period, and therefore diagnoses should be documented at least annually.

Data Hygiene Tools

- Excel-based resource to work through the data validation issues and identify underlying causes.



Statistical Difference Analysis	
First year EHR Used	2014
Charts in Universe (per EHR) in 2014	4199
2014 Compliance Rate	70%
Sample Size in 2013	4476
Compliance Rate in 2013	86%
Confidence Interval (95% CI) (+/-)	1%
Upper CI	87%
Lower CI	85%
2014 is Statistically Different from 2013?	**Yes**

Validation Sample Selection	
Compliance Rate - Most Recent Year:	66%
Charts to be Sampled for Data Validation:	20
Approx. Confidence Interval (+/-)	20.8%

- Performance measure data definition worksheet; part of EHR optimization series.

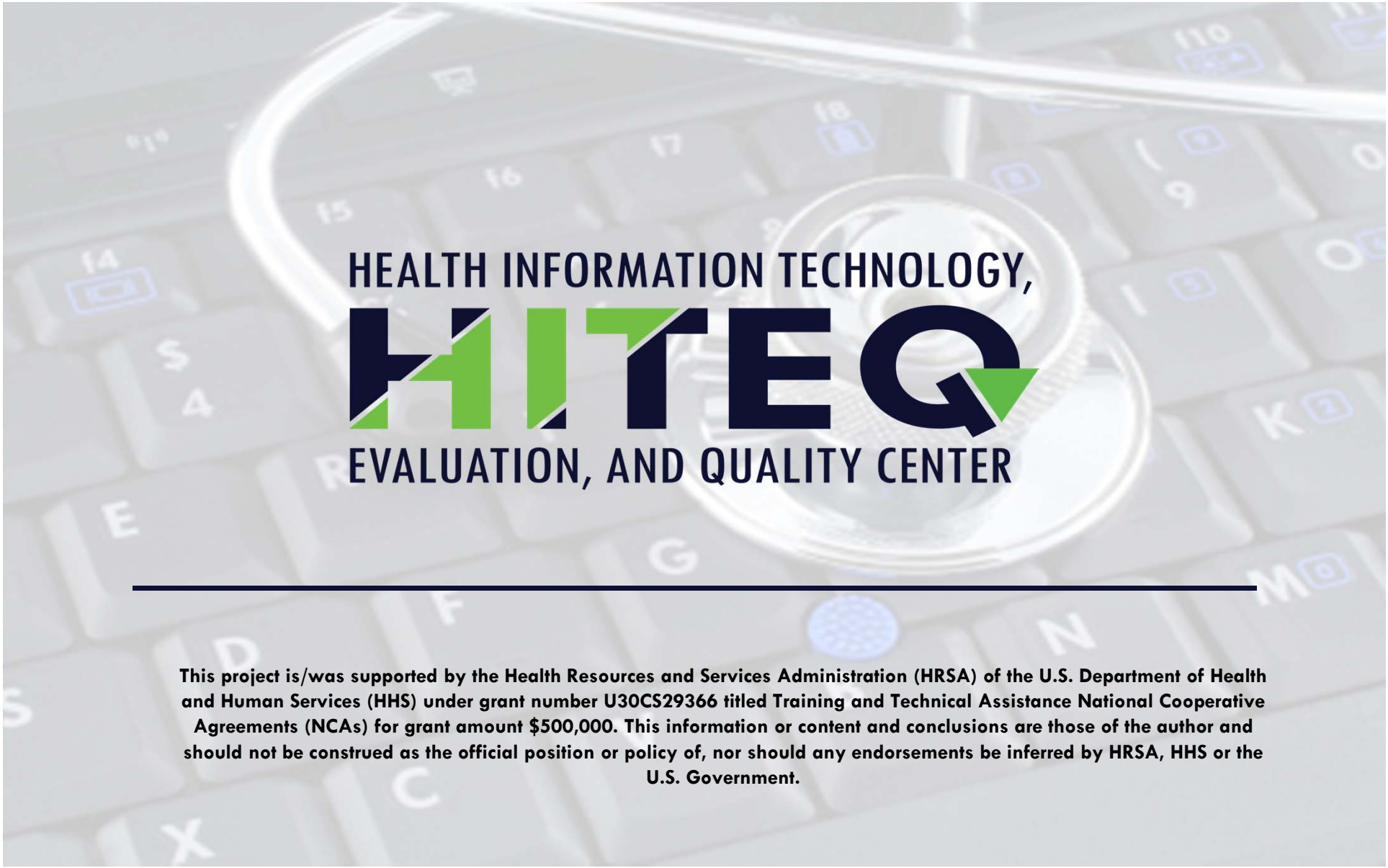
Optimizing Care

Level 1: Primary Prevention	• Is the patient healthy, with no chronic disease or significant risk factors? • Access: Annual F2F, alternative appt types as needed; Goal: Prevent disease
Level 2: Primary Prevention	• Is the patient healthy, but at risk for a chronic disease or has other significant risk factors? • Access: Annual F2F, alternative appt types as needed, health coaching; Goal: Prevent disease
Level 3: Secondary Prevention	• Does the patient have one or more chronic diseases, with significant risk factors, but is stable or at desired treatment goals? • Access: Twice yearly F2F, asynchronous access; Goal: Treatment of existing disease reduce more serious complications, decrease rising risk
Level 4: Secondary Prevention	• Does the patient have one or more chronic diseases with significant risk factors, and is unstable or not at treatment goal(s)? • Access: Quarterly F2F, asynchronous access; Goal: Treatment of existing disease reduce more serious complications, decrease rising risk
Level 5: Tertiary Prevention	• Does the patient have multiple chronic conditions, significant risk factors, complications, and/ or complex treatments? • Access: At least quarterly F2F, intensive care coordination; Goal: Treat late stage disease and minimize disability
Level 6: Catastrophic Care	• Does the patient have a catastrophic or complex condition in which their health may or may not be able to be restored? • Access: function of patient's level of function and level of morbidity; Goal: to provide palliative and comfort level care, and mitigate the effects of disability

HITEQ Center

- In addition the Health IT QI tools and guide discussed, HITEQ has several other resource sets on health center priority topics.
- For additional information see http://hiteqcenter.org or contact HITEQ at hiteqinfo@jsi.com.
- If you are interested in hosting a workshop or training with your health centers around these tools, please reach out to us!

Reach out: hiteqinfo@jsi.com



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Group Share

Pre-visit Work:

Standing Orders, Check-lists, Data Utilization

Open share- Risk Stratification

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Discussion
Practice Transformation Work for next 3 weeks

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Practice Transformation Work ideas

1. Identify area of interest to try the next few weeks.
2. Does not have to be new, can be the same you have been working on so far.
3. Recognize the areas you are needing support.
4. Report on Moodle in a thread or email us here and we can start a thread for support from your peers.

THANK YOU!

PLEASE COMPLETE EVALUATION IN MOODLE

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Final Questions
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