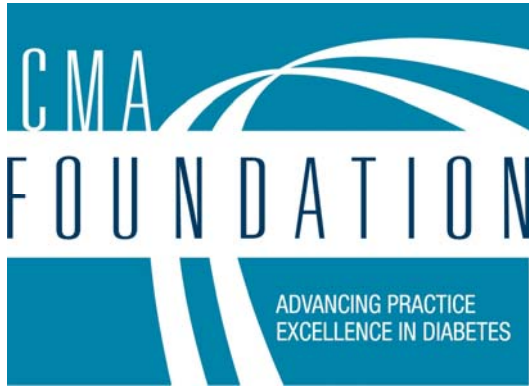




Advancing Practice Excellence in Diabetes Executive Summary

Quality Collaborative
March 2006 -
December 2008





Overview

In 2006, the California Medical Association (CMA) Foundation began *Advancing Practice Excellence in Diabetes*, initiating its Quality Collaborative to help improve the quality of diabetes care provided in solo and small group practices. In California, these healthcare providers represent approximately 60% of all primary care physicians, who, in 2007, provided care to over 800,000 adult patients with type 2 diabetes. Because of the high rates of diabetes in ethnic communities, elimination of healthcare disparities was also a key focus of the collaborative. At the completion of the Quality Collaborative, participating practices achieved

both systems improvement and improved patient outcome among their patients with diabetes.

Quality Collaborative Organization

The *Advancing Practice Excellence in Diabetes* Quality Collaborative was designed to answer the following two questions:

- Is practice & patient improvement possible in smaller primary care practices?
- What does it take to make & sustain these improvements?

Regional Model

The collaborative was conducted in three regions: 1] Butte/Glenn Counties, 2] San Joaquin County and 3] Riverside/San Bernardino Counties [Inland Empire]. We chose a regional model because medical practice is greatly influenced by local health care culture. 24 solo/small group practices started in the collaborative, with 16 of these primarily safety-net practices. Each committed to a two year cycle. Regional partners [Table 1] assisted in practice recruitment and provided support for physician and staff training. Working with these organizations enabled the Foundation to conduct regional training sessions and expand communications to facilitate the sharing of best practices with a broader audience.

Table 2 provides a breakdown of the racial and ethnic make-up of patients served by participating practices, derived from demographic information provided by the physicians. In San Joaquin County and Inland Empire regions, all participating practices were considered safety-net providers. This played a critical role in the patients' ability to follow through with their diabetes self-management and medication adherence, as well account for additional time and effort spent by office staff assisting patients to complete lab tests and referrals for diabetes complications.

Table 1 - Regional Partners
Local Medical Societies
Medi-Cal & Commercial Health Plans
Ethnic Physician Organizations
California Diabetes Program
Provider Organizations

Table 2 - Patient Ethnicity by Region					
Ethnicity by Region	Latino	African American	Asian American	Native American	White
Butte/Glenn Counties	10%	3%	4%	6%	77%
San Joaquin County	40%	10%	21%	1%	28%
Inland Empire	58%	18%	7%	2%	15%

Establishing Benchmarks

At the start of the Quality Collaborative, each practice completed an extensive practice assessment to evaluate diabetes care and the systems in the office that would support practice improvements. They received a set of worksheets and assessments [Table 3] which were completed by office staff and physicians.

Table 3 - Assessment Components	
Team Roster	Team Satisfaction Survey
Physician Questionnaire	Self Assessment on Care of Patients with Diabetes
HIT Survey	Handling Everyday Processes

Project staff tabulated assessment results and returned the completed assessment to each practice. Practices also pulled 35 benchmark charts from which data was extracted to track a set of measures to evaluate practice and patient improvements. [Table 4] Results from the data extraction were inputted by practice staff into the DocSite registry, along with other diabetes patient data during the collaborative time frame.

Table 4 - Benchmark Measures	
Clinical Measure	Process Measure
HbA1c - % of patients <7	HbA1c Recorded Annually
Dilated Eye Exam [DEE]	DEE Completed or Scheduled
LDL - % of patients ≤100	LDL Completed
HDL - % of patients ≥35	HDL Completed
Triglycerides - % of patients ≤200	Triglycerides Completed
Total Cholesterol - % of patients <200	Cholesterol Completed
Routine Foot Exam (Routine) Completed or Scheduled	
Monofilament Foot Exam Completed or Scheduled	
Blood Pressure DPP (mmHg) - % of patients <130/80	Blood Pressure Taken

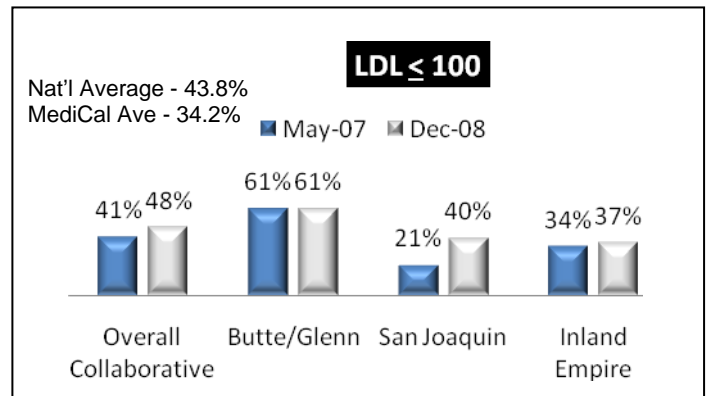
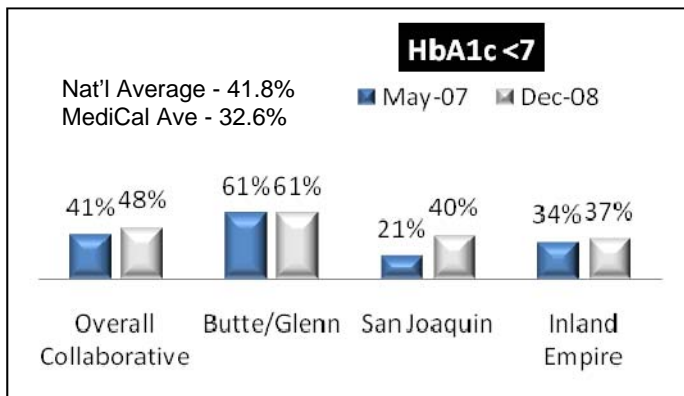
Based on each practice's assessment and benchmark data, a practice action plan was developed to address areas for improvement. Practices reported on fourteen clinical measures at the beginning and end of the two year collaborative. Blood pressure measures were added mid cycle and only reported at the end of the collaborative.

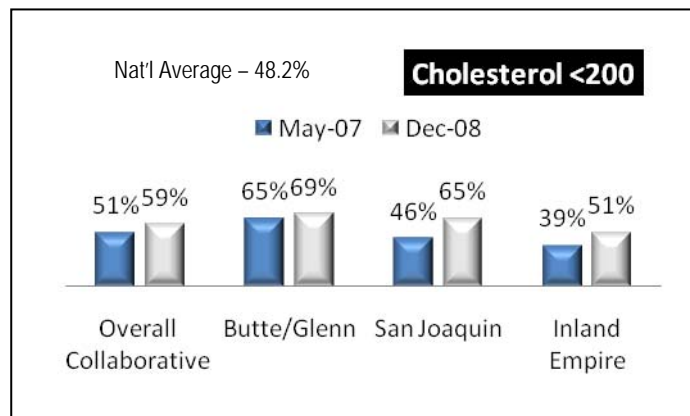
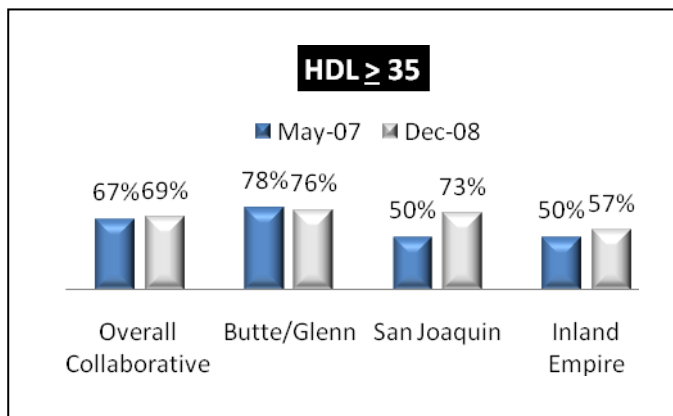
Collaborative Results

At the conclusion of the Quality Collaborative, 14 of the original 24 practices, roughly 60% remained involved, continuing to implement quality improvement changes and best practice strategies. The 11 physicians who withdrew experienced a number of challenges, including physician relocation and a practice merger requiring time to be spent on restructuring practices and building a new office. All 14 practices that completed the collaborative successfully implemented their practice action plans and improved on at least one of the measures.

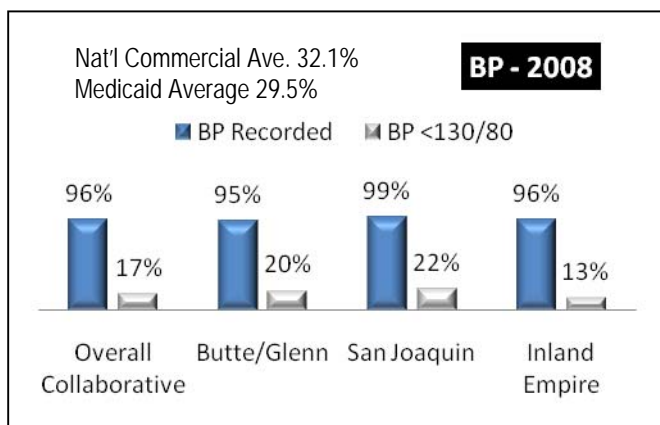
Clinical Benchmark Data

What follows is selection of collaborative results highlighting diabetes and cardiovascular measures.





At the beginning of the pilot project, blood pressure was not designated as a measure to be reported. Therefore, the project only had complete results for this measure in 2008.



As the Collaborative progressed, many of the physicians expressed concern that the Quality Collaborative needed to expand its focus to address cardiovascular complications. As a result, measures for blood pressure were recorded and reported only in December 2008.

While the practices were consistently recording their diabetic patient's blood pressure, these patients were far from goal. Additional focus needs to be placed on strengthening partnerships with diabetic patients to lower their blood pressure rates.

Practice Improvement

All practices that completed the Collaborative made changes in their office systems and demonstrated practice improvements. Examples of the practice improvements include:

- Implementation of regular staff meetings, supporting the team care approach.
- Adoption of a morning/pre-visit 'huddle' to review the care measures for the patients with diabetes.
- Medical assistants assisting the physician in reaching all points of care by performing routine visual foot exams and/or having patients remove shoes and socks upon entry into the exam room.
- Aggressive screening of all patients for diabetes.
- Staff preparing charts with diabetes flow sheets and pre-filled lab slips to assist physician.
- Use of in language patient education posters and materials to improve patient knowledge of foot care and other preventive care needs.
- Development of a combined diabetes and cardiovascular disease visit flow sheet.

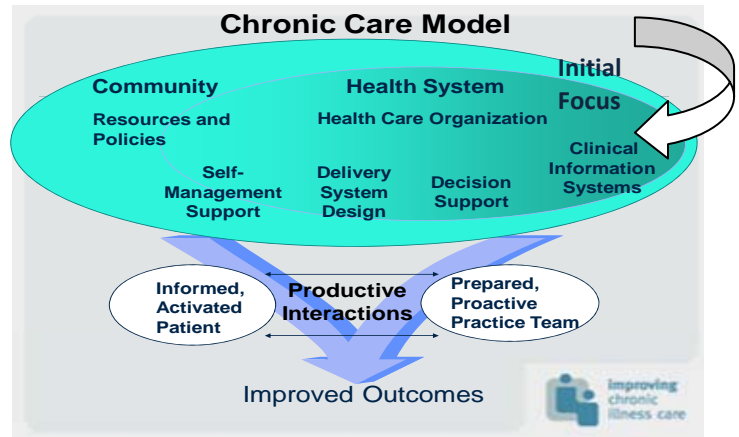
"Working with the project helped by giving my staff a better understanding of the disease. I feel like they are more invested in their role in caring for the patients. As a result, the MA's are more involved in brainstorming ways to improve how we care for them."

Inland Empire Physician

Chronic Care Model & Plans of Action

The *Advancing Practice Excellence in Diabetes* Quality Collaborative was built on the Chronic Care Model. Given the limitations within smaller practices, including fewer staff, fewer levels of staff training, and only one practice with an electronic health record [EHR], the decision was made to focus the Quality Collaborative on the Model’s Health Systems components and building a Prepared, Proactive Team. By focusing only on these components of the model, we hoped to present a less overwhelming scope of work.

Practice Action Plans were developed to identify the goals and processes that practices would take to improve care, based on the results of their practice assessments and initial clinical benchmarks. Practices were asked to reflect on the systems and operations that worked well and those needing improvement and then identify patient outcomes, office procedures, and staff/team development areas they wanted to improve.



DocSite Disease Registry

To encourage documentation and management of the practice’s patients with diabetes, the CMA Foundation provided each office with the DocSite Disease Registry, training and technical support in registry use. One of the most positive aspects of registry use was the feedback received from pulling reports from the system. This provided practices with results regarding what areas needed better recording and which measures were not up-to-date. These features supported the practice’s ability to self-monitor their patient care. There were also downsides to the registry. Because it was not interoperable, when practices inputted data into the registry, it resulted in duplicate entry and fewer patients entered into the registry. Although the registry provided a tool to rank and prioritize disease risks for patients, it did not integrate well into office work flow. Recording patient race/ethnicity and language was also somewhat cumbersome and therefore not routinely recorded. At the end of the collaborative, 1,941 patients with diabetes were included in the registry.

Training & Technical Assistance

Multiple approaches were used to provide training and technical assistance to the pilot practices. [Table 5] Regional Training sessions were used to present the majority of the content, allowing faculty to tailor the discussion to local factors that might influence patient care and patient follow through. Practice staff also attended training sessions with their physicians. Content areas clinical in nature, such as Medication Management and Diabetes as a Cardiovascular Disease were conducted using a statewide webinar format. Training included:

Table 5 - Training Programs	
Diabetes & the Chronic Care Model	Doc Site Registry Use
Practice Action Plans	Conducting Small Tests of Change
Group Visits in Small Practices	Planned Care
Medication Management	Diabetes as a Cardiovascular Disease

Also provided to the practices were –

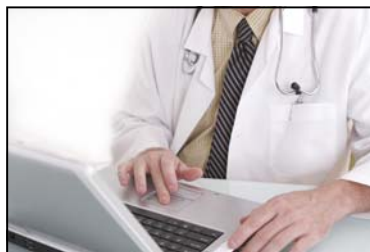
- **Diabetes Care Coordinator Training** - conducted in partnership with the California Diabetes Program.
- **Office Hours** – Collaborative faculty was available during the lunch hour to answer questions raised by the practices and share resources.
- **Site Visits & Office Check in Calls** – Staff was in contact bimonthly with each participating practice.

Scaling the Model

In working on the Health System and Prepared, Proactive Team components of the Chronic Care Model in the Collaborative, three areas of work were essential to bringing about practice improvement:



Delivery System Design



Decision Support



Prepared/Proactive Team

What follows is a summary of the practice improvements adopted in each of these areas:

Delivery System Design - Use of in-language patient education posters and materials to improve patient knowledge of foot care and other preventive care needs for patients with diabetes was adopted in practices throughout the three regions. Aggressive screening of all patients for diabetes was also initiated where the medical assistant took the lead in organizing patient outreach and follow up communications. A key take away from the Collaborative is that for sustainable change, small practices must be allowed to anchor down one change before moving forward to try to make another. There is the critical time factor that must be understood for small practices in their efforts to improve quality.

Decision Support - Without health information technology [HIT] of some sort in these practices it would have been impossible to identify patients with diabetes and other chronic diseases, respond to their risk factors and language needs and track the care provided and its outcome on the patient's health. The use of HIT is still a relatively new concept for many small practices. Learning and using new software takes commitment, time and sustained effort. While the registry provided a tool for practices to better manage their patients with diabetes, keeping the registry up-to-date required staff time that was often seen to be in direct competition with other, more basic needs, such as maintaining scheduling and billing.

Prepared/Proactive Team - Communication between the physician and office staff plays a critical role in the adoption of diabetes workflow changes. Implementation of regular staff meetings, and daily huddles to review the schedule were initiated in a number of the practices. Posting reminders in the front and back office to provide a visual reminder of what the staff members should do to best support diabetic patient care was also a doable change to increase staff involvement in coordinating diabetes care. Practices must have both a physician and staff champion to achieve success and sustain diabetes care quality improvement changes in the solo and small group practice setting.

Quality Improvement is possible in small practices. Physicians and staff in these practices want to provide the best care for their patients. They are often stretched for time, with fewer resources available to initiate some of these needed changes. Staff members will take on new responsibilities to strengthen team care. And, physicians can grow in their understanding and support for a stronger role for staff in coordinating chronic disease care.

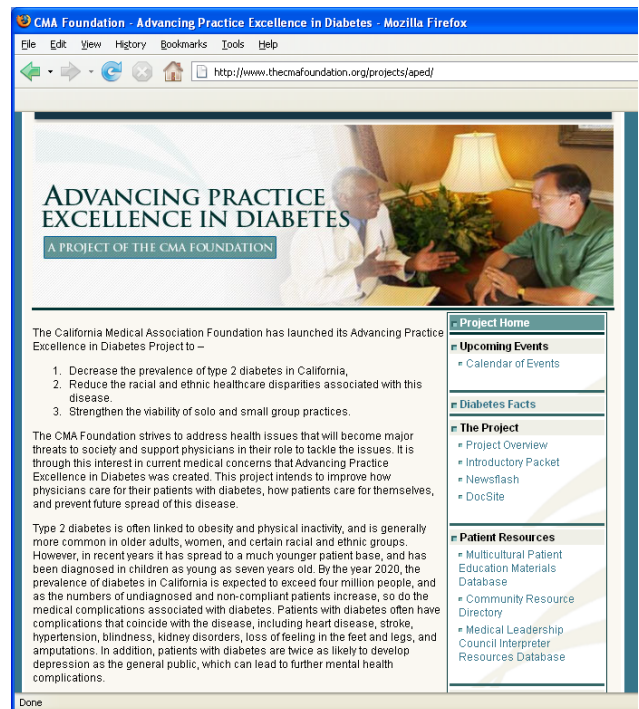
"To shoulder the responsibility to change healthcare...requires one final element of trust – trust in the workforce...Our premise is this: to achieve the healthcare we want, we will have to re-envision, and largely retrain, the health care workforce, so that they can become citizens in the improvement of their own work."

Don Berwick 2003

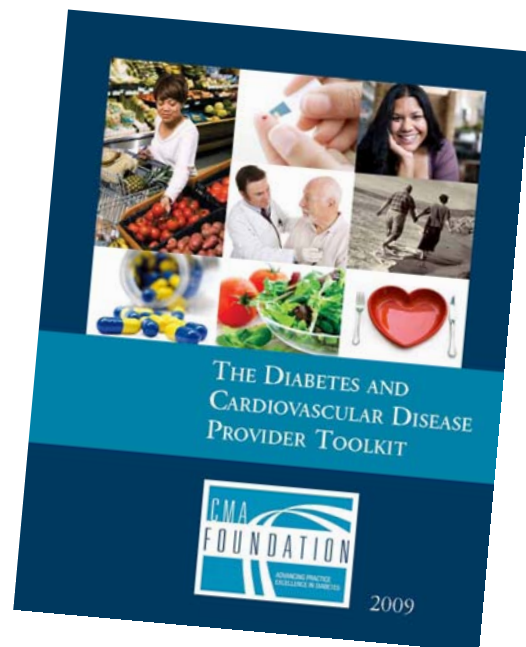
Moving Forward

Advancing Practice Excellence in Diabetes will expand its scope and take on a statewide focus. Key elements of the next phase of the project include :

- Dissemination of the Quality Collaborative learnings and best practices.
- Distribution of a Diabetes Practice Monograph highlighting the successes of several of the pilot project's physicians and staff. The monograph will be posted on the Foundation's website and disseminated with the help of our project partners and the Network of Ethnic Physician Organizations.
- Development of resources for medical office staff to strengthen their role in practice and system change to improve diabetes care and management of cardiovascular complications.
- Establishment of a partnership with the California Department of Health Care Services Medi-Cal Managed Care Division and commercial health plans on a statewide diabetes quality improvement project.



- Expand the CMA Foundation website to include web based resources on culturally responsive diabetes care, create a medication assistance clearinghouse and post a best practices section on the site with practical tips to improve patient care.
- Distribute the project's Diabetes as a Cardiovascular Disease Toolkit and expand the project's focus to include a greater emphasis on cardiovascular disease complications.
- Broaden the project's focus to include patient self management and medication adherence, engaging in new strategies to improve patient outcome and reduce the impact of diabetes and its cardiovascular complications.



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Inland Empire Health Plan	Lifescan
Molina Healthcare	Network of Ethnic Physician Organizations
Novo Nordisk	Roche Diagnostics
San Bernardino County Medical Society	San Joaquin Medical Society
Sanofi~Aventis	Takeda



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