Monthly Campaign Webinar

October 15, 2020

Today's Webinar

- Together 2 Goal® Updates
  - Webinar Reminders
  - *T2G Talk & Taste*
  - Final T2G Fall Survey
- Optimizing Diabetes Care in 4 High Volume Primary Care Clinics of Henry Ford Health System
  - Pamela Milan, MBA, RDN, CDCES
  - Denise White Perkins, M.D., Ph.D.
  - Kate Zenlea, MPH, CPH
- Q&A
  - Use Q&A or chat feature

Webinar Reminders

- Webinar will be recorded today and available the week of October 19th
  - www.Together2Goal.org

- Participants are encouraged to ask questions using the “Chat” and “Q&A” functions on the right side of your screen

T2G Talk & Taste

November 5, 2020

- Gather your team – in-person or virtually – for our final T2G Talk & Taste
- Download our Talk & Taste kit and watch the T2G Highlights video
- RSVP at together2goal.org/ndoa

Final T2G Fall Survey

Today's Featured Presenters

Pamela Milan
MBA, RDN, CDCES

Director, Diabetes Care Connection Services
Department of Population Health Management
Henry Ford Health System

Denise White Perkins
M.D., Ph.D.

Vice Chair, Academic Affairs Associate Residency Program Director,
Department of Family Medicine
Henry Ford Health System

Kate Zenlea
MPH, CPH

Managing Director,
Global Health Initiative
Henry Ford Health System

Optimizing Diabetes Care

Funded by Sanofi

Principal Investigators: Denise White Perkins, Vanita Pindolia, Pam Milan
Project Managers: Doreen Dankerlui, Kate Zenlea (QI)

Henry Ford Health System

- Founded in 1915 by auto pioneer, Henry Ford.
- Integrated health system
  - Provide health care delivery and health insurance, including acute, specialty, primary and preventive care services
  - backed by excellence in research and education.
- Six Regional Hospitals in four counties in SE Michigan.
- One of the nation's largest group practices, with more than **1,200 physicians** and researchers in more than **40 specialties**; **27 medical centers.**
- 18,520 full-time equivalent employees; **more than 30,000 total employees**.
- More than **4.24 million outpatient** visits annually.

Henry Ford Health System

Malcolm Baldrige National Quality Award
2011 Award Recipient

Diabetes Profile

- Type 2 Diabetes Population – approximately 36,000
  - Gender: 47% male; 53% female
  - Age: 78 and under 82%
  - Race: Caucasian 50%; African American 37%
- Physicians/ APP providing diabetes care:
  - Primary Care approximately 185
  - Endocrinology
- Diabetes Related practices:
  - Diabetes Care Connection Services embedded in primary care
  - Clinical Pharmacy programs

Project Overview

- Two-phase exploratory project
- Goal: identify and address key factors associated with uncontrolled diabetes among HFHS patients
- Phase I: quantitative and qualitative analysis of HFHS patients between 18-75 years with uncontrolled type 2 diabetes (as defined by last A1C result >8.0) with a primary care visit within 1 year
- Phase II: series of quality improvement processes in selected clinics to identify interventions that might address challenges identified in Phase I

Cohort Description

Primary Analysis:

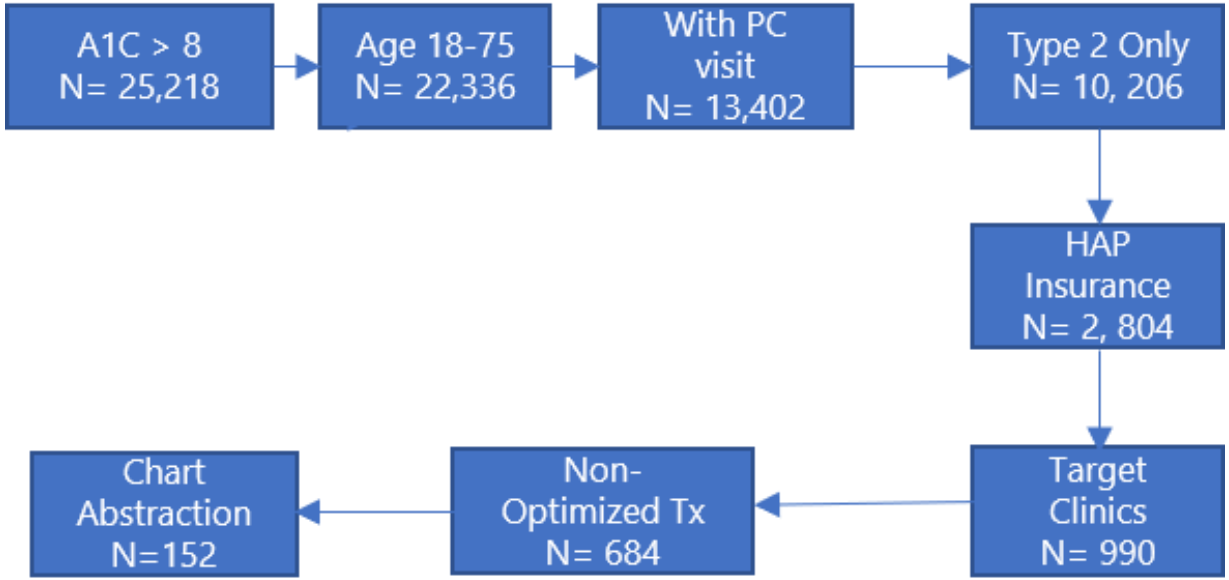
- All uncontrolled HFHS diabetes type 2 patients
  - Defined as A1C>8 result
  - Date of last A1C>8 result defined as **Index Date**
- Ages of 18-75 years
- Primary Care visit within past 1 year
- Study period: 7/1/2014 to 6/30/2017

Cohort Description

Secondary Analysis:

- HAP insured patients (Claims Data)
- Detroit Northwest, Harbortown, K15 or Fairlane clinics
- Non-optimized groups:
  - Patients with A1c>8 on ≥ 2 oral anti-diabetic medications but not prescribed insulin
  - Patients prescribed insulin but still have A1c ≥ 9
  - Patients with A1c>8 who are not prescribed Metformin

Cohort Flowchart



EMR Analysis - variables

Demographic characteristics	Age; Race; Ethnicity; Gender; Median Household Income; Insurance
Clinical characteristics	BMI (score); Depression (score, diagnosis); Hypertension (diagnosis)
Healthcare utilization rates	Primary Care visits (any provider); Primary Care Provider visits (assigned provider); Diabetes-related ER visits; Diabetes-related hospital admissions; Endocrinology visits; DCC visits
Provider treatment patterns	Endocrinology referrals; DCC referrals Oral meds; Metformin; Insulin

EMR Analysis - highlights

Demographic Characteristics		
Age	Median	57.9
Race	Black	40.8%
	White	45.3%
	Other	6.1%
Ethnicity	Hispanic/Latino	3.1%
	Not Hispanic/Latino	88.0%
Gender	Female	47.6%
	Male	52.4%
Median Household Income by Quintiles	[658-7628]	20.0%
	[7662-10320]	20.2%
	[10351-12479]	19.3%
	[12499-15262]	20.6%
	[16067-23742]	19.9%
Insurance	Medicaid	11.2%
	Medicare	15.0%
	Medicare Advantage	8.0%
	HAP Medicare Ad.	9.4%
	HAP	21.8%
	Blue Shield	27.1%
	Other	7.5%

EMR Analysis - highlights

Clinical characteristics	71.1% are obese 95.7% did not have depression at time of Index Visit; 13.4% had depression diagnosis in year prior to Index Date 73.2% had hypertension diagnosis in year prior
Healthcare utilization rates	~41% of patients had less than PC 6 visits in 3 years prior ~79% saw their assigned PCP at least 1 time in 3 years prior ~16% had 1 or more DM related ER visit ~11% had 1 or more DM related hospital admission ~17% had at least 1 DCC visit in year prior ~11% had DCC visit in year post

EMR Analysis - highlights

Provider referral/prescription patterns	Pre Index Date	Post Index Date
Referral to Endocrinology	~13%	~5%
Referral to DCC	~37%	~15%
Prescribed at least 1 oral medication	~88%	~70%
Prescribed Metformin	~65%	n/a
Prescribed insulin	~50%	~51%
Prescribed ≥2 oral meds and not prescribed insulin	~13%	~22%
Not prescribed Metformin (no allergy, GFR<30)	~28%	n/a
Not prescribed insulin with A1C ≥ 9	~30%	~13%

Provider referral/prescription patterns	A1C = 8-9	A1C = ≥ 9
Referral to DCC	~32% (~12%)	~39% (~17%)
Prescribed Insulin	~44% (~44%)	~53% (~55%)

HAP Claims Analysis - highlights

- Claims analysis for a subset of HAP-insured patients

Insulin Prescriptions Ordered	Number of Rx	Unique patients	Drop Off
	739	174	
Prescriptions Filled within 6 months	277	119	462 (62.5%)
Prescriptions Refilled within 3 months	72	70	205 (74.0%)
Prescriptions Refilled within 6 months	48	39	24 (35.1%)

Insulin Prescriptions filled (by clinic)					
# of patients	Total (2804)	K-15	Ford Rd.	DNW	HTWN
w/Rx ordered in year prior to Index Date*	967	109	135	81	42
w/Rx filled in year prior to Index Date	655 (68%)	81 (74%)	89 (66%)	49 (60%)	24 (57%)
w/Rx filled in year post Index Date	644 (67%)	84 (77%)	84 (62%)	53 (65%)	26 (62%)

Summary of Key Quantitative Analysis Findings

- Low referral rates to diabetes education services
- Low visit rates for diabetes education
- Under-prescribing of insulin
- Low insulin prescription fill and refill rates (existing and new Rx)

Qualitative Analysis

- Chart review
  - random samples of non-optimized patients from Detroit Northwest, Harbortown, K15 (AIM) and Ford Road clinics
- Key informant interviews - selected clinic staff
- Surveys - primary care providers in target clinics

Chart Review - highlights

Non-optimized groups:

- Patients with A1C>9 and not prescribed insulin:
  - Infrequent documentation of insulin start up discussion
- Patients with A1C>9 while having been prescribed insulin:
  - Very infrequent documentation of plan for adjusting or titrating insulin
- Patients who were prescribed insulin after Index Date (new starts)
  - Frequent documentation about use of insulin but limited mention of how patient is taking or dose patient is taking
  - Adherence noted for ~half of patients

Survey - Findings:

- Providers surveyed identified low health literacy, social and environmental factors and patient non-adherence as major issues

How much do you think the following issues attribute to the success or failure of patient control of diabetes?

	TO A GREAT EXTENT	SOMEWHAT	VERY LITTLE	NOT AT ALL
Patient Beliefs, Culture and Value	59.09%	36.36%	4.55%	0.00%
Low Health Literacy	81.82%	18.18%	0.00%	0.00%
Language Barriers	22.73%	50.00%	22.73%	4.55%
Patient Social/Environmental Factors	77.27%	18.18%	4.55%	0.00%
Provider-Patient Communication	45.45%	45.45%	9.09%	0.00%
Staffing/Clinic Set-up	36.36%	36.36%	27.27%	0.00%
Access to Appointments	45.45%	36.36%	18.18%	0.00%
Length of Visit Time	31.82%	54.55%	9.09%	4.55%
Insurance	45.45%	40.91%	13.64%	0.00%
Health Policy	50.00%	36.36%	4.55%	9.09%
Not Following Treatment Protocols	61.54%	30.77%	7.69%	0.00%

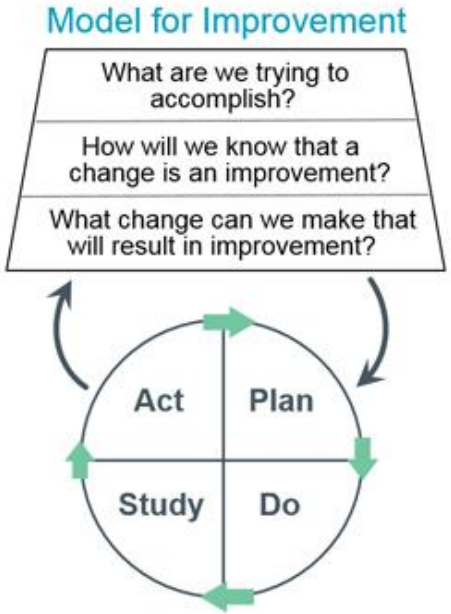
Main Opportunities Identified during Phase I

- Under-prescribing of insulin by providers (initiation and titration)
- Under-referral to diabetes education services by providers
- Insufficient initiation of insulin treatment, even when prescribed by providers
- Abandonment of insulin therapy by patients after initiation

PHASE II – TESTS OF CHANGE INTERVENTIONS

Continuous Quality Improvement

- Series of Plan Do Study Act (PDSA) cycles in target clinics
- Goal: identify process improvements to address primary drivers identified in Phase I
- Repeated small cycles of testing a theory
  - First gain confidence that a change is an improvement, then run larger tests under a variety of conditions



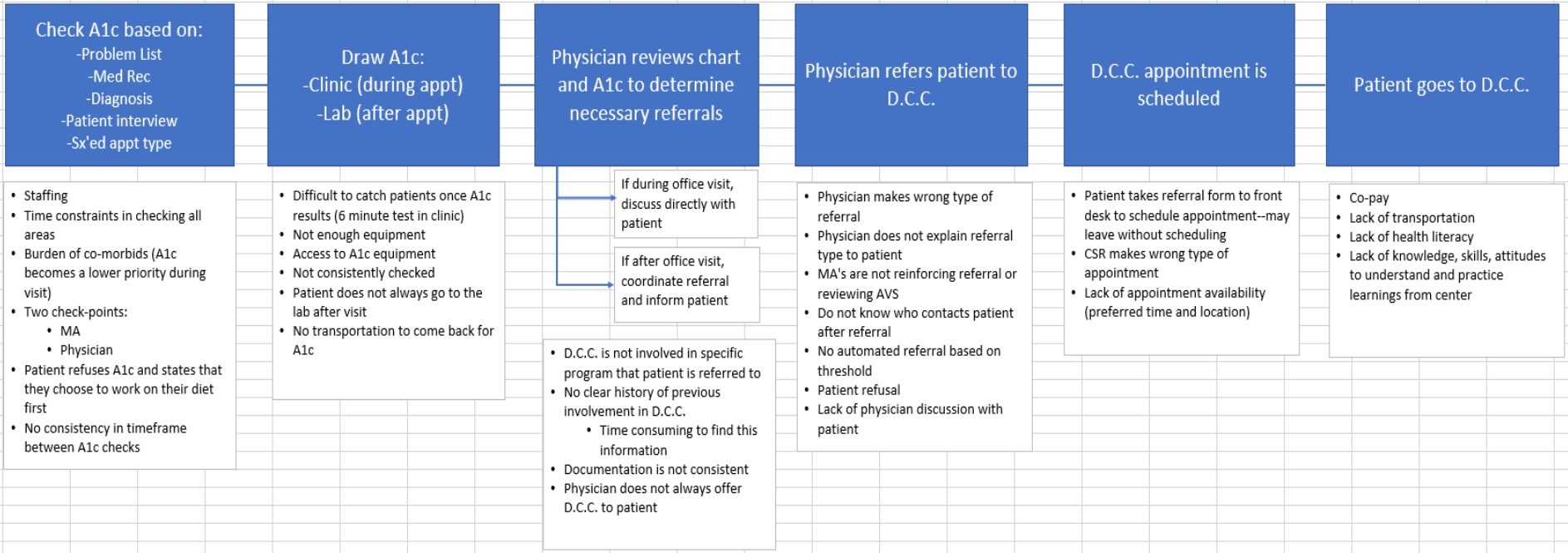
Process

- PDSAs developed and implemented in collaboration with the project team, HFHS providers/clinic team, diabetes educators and additional diabetes care management staff based in target clinics
  - Meetings held with clinic operational leads to review Phase I key findings and to better understand their perspective of challenges
  - Each clinic was assigned one of the identified challenges to address
  - Key persons were identified to participate in CQI Design Teams
  - Teams developed block diagram focused on clarifying current process for diabetes care at their specific site in detail
  - Teams then generated change ideas to test and measure using PDSA cycles

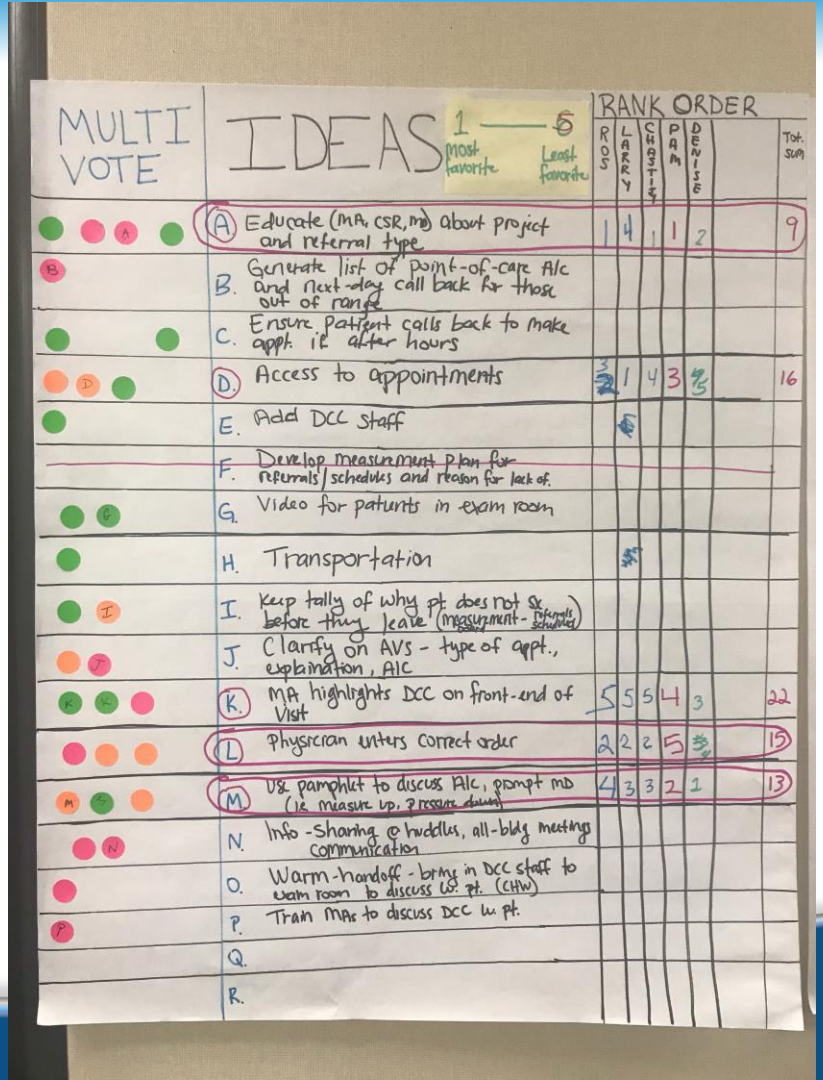
Focus Areas

- Detroit Northwest
  - Increase number of patients being referred to DCC
  - Increase number of referrals turned into scheduled appointments
- Academic Internal Medicine (K-15)
  - Reduce the number of no-shows at DIAC
  - Improve retention of patients referred to insulin titration program
- Ford/Fairlane
  - Increase number of insulin prescriptions written by providers
  - Increase number of patients who successfully fill their new prescription and adhere to insulin therapy

QI Process: Block Diagrams



QI Process: Structured Brainstorming



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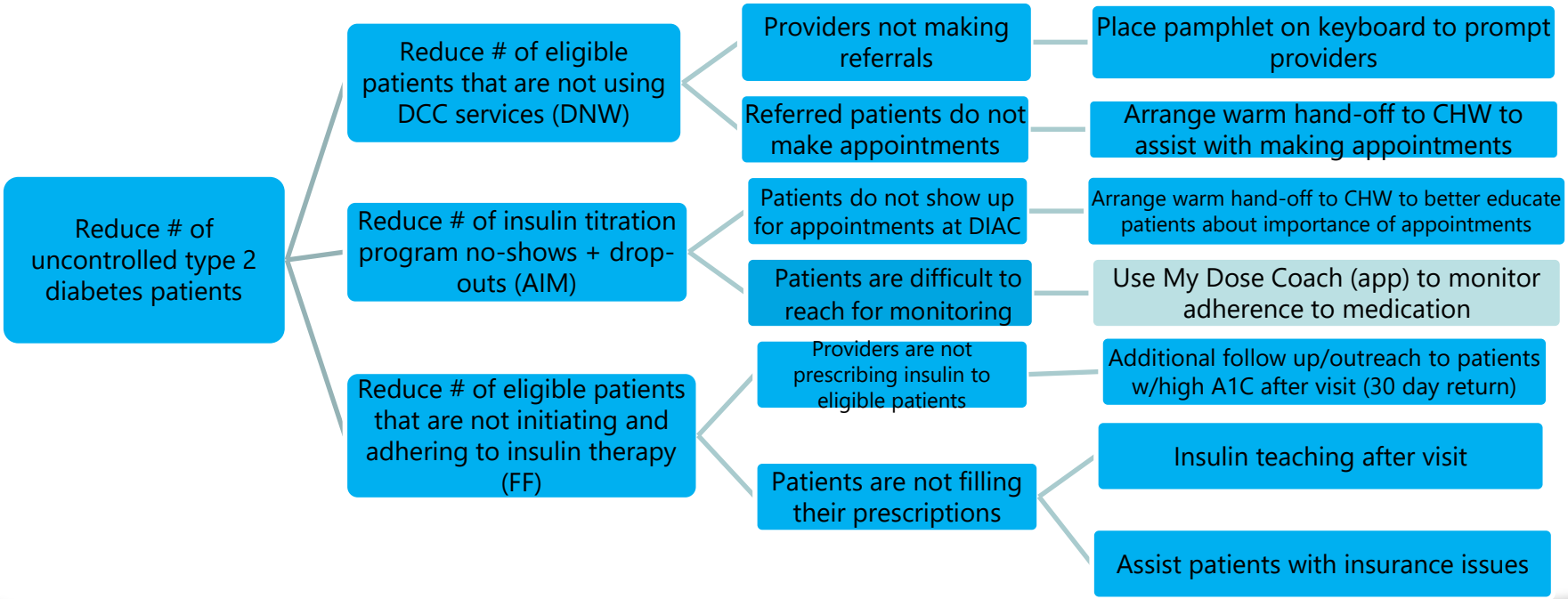
Intervention Mapping



AIM PDSAs

Aim Statement	By March 2019, the AIM team will decrease the number of type 2 diabetic patient “no-shows” who are on insulin at the DIAC program by 10% from baseline (60%).

Description	Warm-handoff process to the DIAC RN during a patient clinic visit
Status	Abandoned – DIAC RN left position during PDSA. Clinic Lead decided to focus on My Dose Coach pilot instead.
Results	No-shows=25%

Ford Rd PDSAs (1)

Aim Statement	By February 2019, we will increase the number of type 2 diabetic patients with an A1c>9% who are prescribed to start insulin. We will also increase the number of eligible patients who have successfully filled and adhered to their new insulin prescription at the Ford Fairlane clinic in Dearborn, Michigan.

Description	Outreach to eligible patients to schedule f/u appt within 30 days for disease management and insulin teaching
Status	On Hold; transitions within clinical team
Results	Total 30-day return visits scheduled of eligible patients=92%

Ford Rd PDSAs (2)

Description	Introduce tracking tool for provider to complete after visit to provide necessary info for RN to initiate teaching
Status	Completed
Results	Satisfaction Survey Pre-test: 12% indicated they were very satisfied with the current process Satisfaction Post-test: 93% indicated they were very satisfied with the new process Tracking tools received= 87% All necessary info received=85%

Description	Distribute new 'Insulin RX Fill Handout' to patients during insulin teaching
Status	In process
Results	Filled insulin prescriptions=83%

DNW PDSAs

Aim Statement	By May 2019, we will increase the number of active type 2 diabetic patients referred to the DCC by 10% from baseline (51%). We will also increase the number of diabetes service referrals that turn into scheduled appointments by 10% from baseline.
Description	Leave card w/A1C result on provider desktop to prompt diabetes referral
Status	Abandoned; determination made that intervention must start further upstream (outside scope of work)
Results	Referrals made=67%

Description	Introduce warm hand-off to Community Health Worker to address barriers to making DCC appointment
Status	Completed/in-testing
Results	Referrals made=61% Scheduled appointments=100%

Successes PDSA Approach

- Opportunity for teams to experiment and test out new change ideas
- Increased staff enthusiasm
- Tests completed with minimal expenditure of resources and without taking great risks
- Development of new clinical materials
  - Insulin teaching checklist
  - Insulin prescription handout
  - Standardized CHW warm-handoff workflow

Challenges PDSA Approach

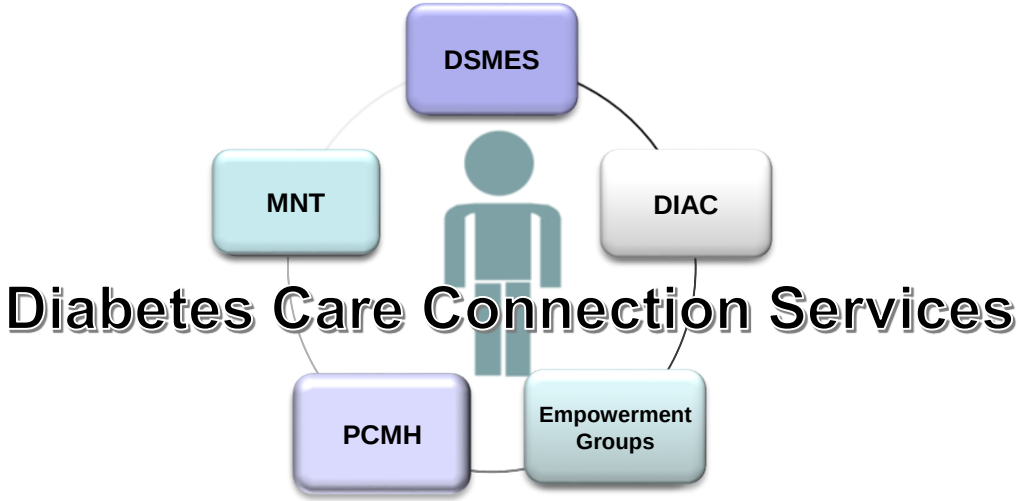
- Identification of workflow problems beginning further upstream
- Ownership – no assigned QI team leads in all settings
- Communication with teams difficult
  - Knowledge/sharing of pre-existing workflows/protocols
  - Successfully inform/equip all staff directly involved in test
    - Rotating Medical Assistants
- Time
  - Development/design prep necessary before launch of test
  - Difficulty getting large enough sample sizes
  - Limited time for teams to dedicate to tests

Lessons Learned from Interventions

- Clinical inertia not just a provider issue; need to identify gaps in team workflow/communication
- Patient centered warm hand-off to team member is important for engaging patient in treatment or referral plan
- Anticipate barriers to medication adherence and provide information/resources and teaching in advance
- Need to monitor for treatment abandonment and nonadherence

CURRENT INITIATIVES IN DIABETES CARE

Diabetes Care Connection (DCC) Overview

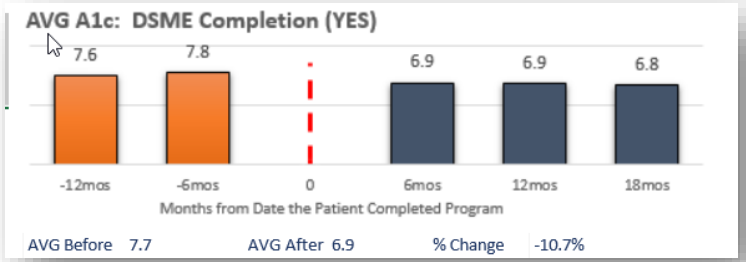


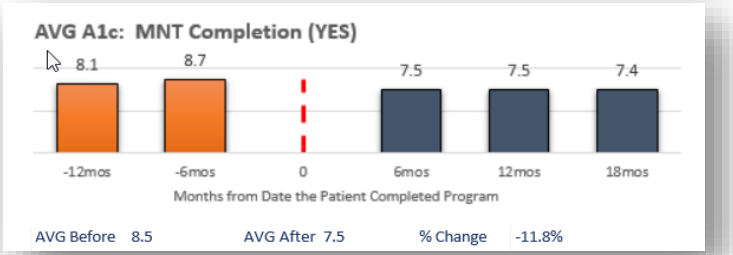
KEY
Medical Nutritional Therapy – MNT
Diabetes in Active Control – DIAC
Patient Center Medical Home – PCMH
Diabetes Self-Management Education & Support – DSMES

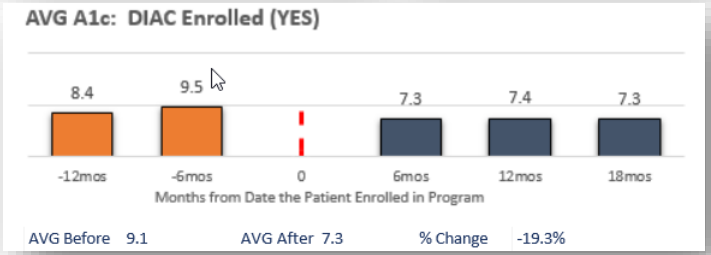
Lifestyle Modification – Behavior Change

DCC Management Success

Services work if we can engage the patient







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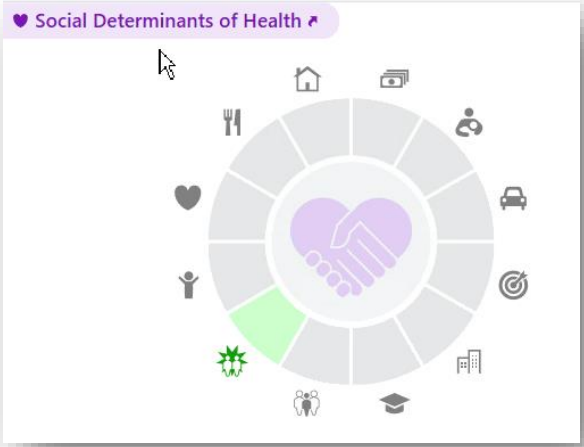
Leslie Grijalva
Community Health Worker (CHW)

DN W

Warm Handoff

- DNW site has a CHW in DCC program
- Warm Handoff :
  - PCP identifies potential patient for services.
  - Leslie meets patients and explains program
  - Screens for barriers of engagement
- Launching social determinants of health screening in Epic within DCC and case management



MDHHS Study to Profile: DCC Referrals, Engagement, Enrollment

- Look at DCC referrals October 1, 2018 and September 30, 2019 was N = 3,769 subjects
- Comparing to those who completed, we then examine demographic characteristic of three groups:
  - participants that are never contacted or decline to make appointment **(no contact)**
  - participants that were contacted but never completed a session **("no show")**
  - participants that were contacted and completed at least one session **(Incompletes)**

Key Findings

- **"No contact"** group were likely to be under 50 years old.
- **"No show"** group were likely to have Medicaid insurance or be younger and Black/AA.
- **"Incompletes"** group were likely to be under 62 years old and/or have higher A1c.

Next Steps and Planned Interventions

- Outreach for referrals to include texting patients
- Program culture change to “individual plan & coaching” approach
- Social determinants of health screening (SDOH) initiative
  - CHW to screen “no shows” for SDOH

Lessons Learned

- Key elements to optimize diabetes care:
  - Personalized patient touch
  - Team Communication and coordination
  - Address patient barriers to care and self management

November Webinar

- **Date/Time**: November 19, 2020 from 2-3pm Eastern
- **Topic**: Addressing Kidney Health in Type 2 Diabetes: Gaps between Guidelines and Clinical Practice
- **Presenters**: AMGA Analytics

Questions