

Together2Goal[®]

AMGA Foundation
National Diabetes Campaign

October 2020 Webinar at Work

"Putting T2G webinars into practice"

Webinar: ["Optimizing Diabetes Care: 4 High Volume Primary Care Clinics of Henry Ford Health System"](#)

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Summary:

In this webinar, the team from Henry Ford Health System (HFHS) provides an overview of their project designed to identify and address key factors associated with uncontrolled diabetes among HFHS patients. The project was split into two phases: Phase 1) 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 one year; and Phase 2) series of quality improvement processes in selected clinics to identify interventions that might address challenges identified in Phase I.

In Phase 1 after their quantitative analysis, HFHS discovered patients with uncontrolled Type 2 diabetes had:

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

In their qualitative analysis, they used chart reviews of random samples of non-optimized patients, key informant interviews in selected clinic staff, and surveys of primary care providers in target clinics.

In their chart review of non-optimized patients, they found:

- Patients with A1C>9 and not prescribed insulin had infrequent documentation of insulin start-up discussion
- Patients with A1C>9 while having been prescribed insulin had very infrequent documentation of plan for adjusting or titrating insulin
- Patients who were prescribed insulin after Index Date (new starts) had frequent documentation about use of insulin, but limited mention of how patient is taking or dose patient is taking. Additionally, adherence was noted for only half of patients.

Their survey asked providers to identify issues that impact the success or failure of patient diabetes control. The survey respondents identified low health literacy, social and environmental factors, and patient non-adherence as major issues.

Based on these findings from Phase I, the team identified the following as the main opportunities for improvement:

- 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

After identifying and implementing interventions in Phase 2, HFHS recognized the following lessons learned:

- Identify gaps in team workflow/communication because clinical inertia not just a provider issue
- Engage patient in treatment or referral plan by incorporating a patient-centered warm hand-off to team member
- Anticipate barriers to medication adherence and provide information/resources and teaching in advance
- Monitor for treatment abandonment and non-adherence

Implementation Tips:

Henry Ford Health System implemented a series of “Plan-Do-Study-Act” (PDSA) cycles in target clinics to identify process improvements to address the primary drivers established in Phase I. The PDSA model is comprised of repeated small cycles of testing a theory. The purpose is to first gain confidence that a change is an improvement, and then run large tests under a variety of conditions. PDSAs are developed and implemented in collaboration with the project team, providers/clinic team, diabetes educators and additional diabetes care management staff based in target clinics.

The PDSA model for improvement asks:

- 1) What are we trying to accomplish?
- 2) How will we know that a change is an improvement?
- 3) What change can we make that will result in improvement?

To implement PDSAs:

- Hold meetings with key stakeholders to review key findings and to better understand their perspective of challenges
- Assign one of the identified challenges to each clinic to address
- Identify key individuals to participate in continuous quality improvement design teams
- Develop block diagrams focused on clarifying current process for diabetes care at each team’s specific site in detail

- Describe the current process by identifying major blocks of activity
- Narrow the project boundaries to focus on a manageable slice (typically 2-4 blocks of activity)
- Generate change ideas to test and measure using PDSA cycles
 - Utilize Nominal Group Technique by encouraging contributions from everyone on the team. Ask team members to present an idea, and then discuss and prioritize suggestions as a group.

The PDSA approach creates opportunities for teams to experiment and test out new change ideas, increase staff enthusiasm, complete tests with minimal resources and minimal risks, and develop new clinical materials. Challenges can arise with time, communication among various teams, ownership of projects, and workflow issues that begin further upstream.

Team Discussion:

1. What are we currently doing from a system perspective to identify and address our patients with uncontrolled Type 2 diabetes?

2. What is one change we like to see to improve our current process for addressing patients with uncontrolled Type 2 diabetes? How will we know when that change marks an improvement?

3. What are our current referral rates to diabetes educator services? What are our visit rates to diabetes education services? How can we improve these rates?

Additional Notes:

Next Steps:

- _____
- _____
- _____
- _____

Resources:

- [Minnesota Department of Health Plan-Do-Study-Act overview](#)