Achieving HEA1th Equity in Diabetes

AHEAD Kickoff

- Welcome!
- Please check-in and grab a boxed lunch in the lobby
- Restrooms are out the door and to the right
- We will start promptly at 12:30 pm
- Thank you for being here!
Achieving HEALth Equity in Diabetes

AHEAD Kickoff

Friday, October 20, 2023
12:30 – 4:00 pm
Welcome

Michael W. Konstan, MD
Principal Investigator
Case Western Reserve University
Goals of the NEO QI Hub AHEAD Initiative Kickoff

1. Understand the Northeast Ohio Quality Improvement Hub, Achieving HEAlth Equity in Diabetes initiative, and alignment with Medicaid priorities
2. Identify best practices for improving diabetes outcomes
3. Determine how to get started with initial quality improvement activities
4. Discuss ways to address health equity in quality improvement activities
5. Network with colleagues and other partners
<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Lead</th>
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<tbody>
<tr>
<td>12:00–12:30 pm</td>
<td>Check-in and Networking</td>
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<tr>
<td>12:30–12:35 pm</td>
<td>Welcome</td>
<td>Michael Konstan, MD</td>
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<tr>
<td>12:35–12:45 pm</td>
<td>Opening Remarks by Ohio Department of Medicaid (Video)</td>
<td>Mary Applegate, MD</td>
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<tr>
<td>12:45–1:20 pm</td>
<td>NEO QI Hub and AHEAD Initiative Overview</td>
<td>Shari Bolen, MD, MPH</td>
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<td>Rebecca Fischbein, PhD</td>
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<tr>
<td>1:20–1:40 pm</td>
<td>Health Equity and Partner Engagement</td>
<td>Anne Gaglioti, MD, MS</td>
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<td>Bode Adebambo, MD</td>
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<tr>
<td>1:40–2:05 pm</td>
<td>Dashboard Demonstration</td>
<td>Douglas Einstadter, MD, MPH</td>
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<td>Robert Ashmead, PhD</td>
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<tr>
<td>2:05–2:15 pm</td>
<td>Break and Networking</td>
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<tr>
<td>2:15–2:30 pm</td>
<td>Getting Started with Quality Improvement and Health Equity</td>
<td>Aleece Caron, PhD</td>
</tr>
<tr>
<td>2:30–3:50 pm</td>
<td>Tabletop Exercises</td>
<td>Aleece Caron, PhD, Mamta Singh, MD, MS</td>
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<td></td>
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<td>Deb Hrouda, PhD, LISW-S</td>
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<td></td>
<td></td>
<td>Caroline Carter, MS, LSW, LSW, BCC</td>
</tr>
<tr>
<td>3:50–4:00 pm</td>
<td>Evaluation Survey and Next Steps</td>
<td>Shari Bolen, MD, MPH</td>
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</table>
Disclosure Statements

The following speakers have no relevant financial interest or affiliation with any organizations that could be perceived as a real or apparent conflict of interest in the context of the subject of their presentation:

- Bode Adebambo, MD; Mary Applegate, MD, FACP; Robert Ashmead, PhD; Shari Bolen, MD, MPH; Aleece Caron, PhD; Caroline Carter, MS, LSW, BCC; Douglas Einstadter, MD, MPH; Anne Gaglioti, MD, MS; Deb Hrouda, PhD, LISW-S; Michael W. Konstan, MD; Mamta Singh, MD, MS

The following members of the planning committee do not have any disclosures or financial relationships from any ineligible companies:

- Bode Adebambo, MD; Kara Bloom, BA; Shari Bolen, MD, MPH; Aleece Caron, PhD; Kirstin Craciun, MPP, MSW; Caroline Carter, MS, LSW, BCC; Douglas Einstadter, MD, MPH; Rebecca Fischbein, PhD; Anne Gaglioti, MD, MS; Betul Hatipoglu, MD; Carolyn Henceroth; Deb Hrouda, PhD, LISW-S, PhD; PJ Kimmel, MPH; Elizabeth Littman; Chris Mundorf, PhD; Steven Ostrolencki; Ann Nevar, MPA; Mamta Singh, MD, MS; Cathy Sullivan, MS, RD

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the Ohio State Medical Association (OSMA) and The MetroHealth System. The Ohio State Medical Association (OSMA) is accredited by the ACCME to provide continuing medical education for physicians. The MetroHealth System designates this educational activity for a maximum of 3.25 AMA PRA Category 1 Credit(s)™. Physicians should only claim credit commensurate with the extent of their participation in the activity. Other Healthcare Professionals: check with your professional association as these credits might be applicable for hours towards licensure renewal.
CME Learning Objectives

1. Understand the Northeast Ohio Quality Improvement Hub, Achieving Health Equity in Diabetes initiative, and alignment with Medicaid priorities

2. Identify best practices for improving diabetes outcomes and addressing health equity in diabetes care

3. Discuss how data can be used to inform your quality improvement activities
Opening Remarks (Video)
Ohio Department of Medicaid

Mary Applegate, MD
Medical Director
Ohio Department of Medicaid
NEO QI Hub Overview

Shari Bolen, MD, MPH
Co-Principal Investigator
Case Western Reserve University
The MetroHealth System
Quality Improvement Humor

Before doing quality improvement with someone you have never met, you should first make them use a computer with slow internet to see who they really are.

-Adapted from a joke by Will Ferrell
Coordinated Collaboratives Can Have a Strong Impact on Health Outcomes

- Regional and statewide efforts and quality improvement (QI) activities are often fragmented

- Coordinated primary care collaboratives can have a strong impact on outcomes
  - Especially if engaged in organized QI projects

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Background
About Cardi-OH

Founded in 2017, the mission of Cardi-OH is to improve cardiovascular and diabetes health outcomes and eliminate disparities in Ohio's Medicaid population.

WHO WE ARE: An initiative of health care professionals across Ohio’s seven medical schools.

WHAT WE DO: Identify, produce, and disseminate evidence-based cardiovascular and diabetes best practices to primary care teams.

HOW WE DO IT: Best practices resources are available via an online library at Cardi-OH.org, including monthly newsletters, podcasts, webinars, and virtual clinics using the Project ECHO® virtual training model.

Learn more at Cardi-OH.org
Diabetes Quality Improvement Project (QIP)

**SMART Aim**
- Reduce the % of adults with type 2 diabetes whose A1C > 9% by 15% from 24.96% to 21.22% by June 30, 2022.

**Strategies**
- IHI Model for Improvement
- Clinical and Patient Education Toolkit
- Monthly Action Period Calls
- Monthly QI Coaching
- Leverage EHR data for improvement
- Partner with Medicaid Managed Care Plans to address barriers
Percent of Patients With Diabetes Whose Most Recent A1C>9% for All Sites

Mean: 19.97% (Lower is Better)

Note: A1C is a measure of the average blood sugar over the last 3 months. A1C of 9% is an average blood sugar of 212 mg/dl
Interventions Tested in Statewide Efforts

1. **A1C Testing**: point of care testing, outreach to patients for lab work

2. **Monthly Follow-up in Team-based Care (if A1C >8 or >9)**: clinical pharmacists, diabetes self-management education, multidisciplinary diabetes team visit
   a. Patient input – reasons for no shows

3. **Outreach**: to patients 1-2 times a year who have A1C>8.5 or 9 and no scheduled follow-up within 1 month

4. **Social Drivers of Health (such as transportation challenges)**: referral to community resources, CHWs, telehealth
Regional QI Hub Timeline

Year 1
Build QI Infrastructure
Analyze current capacity & plan.

Year 2
Pilot & Test with infrastructure-ready CoMs
Continue scaling each CoM infrastructure to regional capacity/needs.

Year 3
College Spread
Within own/adjacent systems.

Year 4
Regional Spread
Start with large health systems & CoMs, progressing to smaller practices.

Year 5
Realize Population Health Improvements
In Partnership With
Executive Leadership Team Introductions

Executive Director
Elizabeth Littman

Director
Ann Nevar, MPA

Finance
Kristen Boyer, MEd

Informatics & Web
Rick Cornachione, MSIS

Marketing & Communications
Gillian Irwin, MA

Graphic Design
Devin O’Neill, BA
Steering Committee Introductions

Isaac Baez, MD, MPH
Summa Health

Betul Hatipoglu, MD
University Hospitals

Mamta Singh, MD, MS
VA Northeast Ohio Health Care System

Melanie Bortell, DO
AxessPointe

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Better Health Partnership

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MetroHealth Medical Center

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Better Health Partnership

Goutham Rao, MD
University Hospitals

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Cleveland Clinic

Mehul Danawala, MD
MetroHealth Medical Center

Patrick Runnels, MD, MBA
University Hospitals

Elisabeth Whipkey, MD
NEOMED Health Care

Chad Garven, MD, MPH
Neighborhood Family Practice
AHEAD Initiative Overview

Shari Bolen, MD, MPH
Co-Principal Investigator
Case Western Reserve University

Rebecca Fischbein, PhD
Principal Investigator
Northeast Ohio Medical University
Why Focus on Diabetes?

- Approximately 37 million Americans have diabetes and an additional 96 million have prediabetes.
- Rates of those diagnosed have doubled in the past 20 years; models suggest 1 out of 3 people will develop diabetes in their lifetime.
- In the United States, diabetes is the primary cause of blindness, leg amputation, and kidney failure and the 8th leading cause of death.
- Diabetes costs a total estimated $327 billion in medical costs and lost work and wages.
- In fact, people with diagnosed diabetes have more than twice the average medical costs that people without diabetes have.
Better Health Partnership Diabetes Care Measure

% of Eligible Adults with Diabetes
Meeting Diabetes Care Composite Standard
by Race/Ethnicity

Care Composite
1. A1C recorded
2. Microalbumin screen or on ACE/ARB
3. Eye Examination
4. Pneumococcal Vaccination

% Meeting Care Standard

<table>
<thead>
<tr>
<th>Year</th>
<th>Hispanic or Latinx</th>
<th>Non-Hisp. Black</th>
<th>Non-Hisp. White</th>
<th>Overall</th>
</tr>
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<tbody>
<tr>
<td>2014</td>
<td>52.0%</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2015</td>
<td>50.0%</td>
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<tr>
<td>2016</td>
<td>48.1%</td>
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<tr>
<td>2017</td>
<td>47.0%</td>
<td></td>
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<tr>
<td>2018</td>
<td>46.0%</td>
<td></td>
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<td>2019</td>
<td>45.0%</td>
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<td>2020</td>
<td>44.0%</td>
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<td>2022</td>
<td>42.0%</td>
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<tr>
<td>2023</td>
<td>41.0%</td>
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</tbody>
</table>

Care Composite:
1. A1C recorded
2. Microalbumin screen or on ACE/ARB
3. Eye Examination
4. Pneumococcal Vaccination

2023 Data:
- Hispanic or Latinx: 39.7%
- Non-Hisp. Black: 35.9%
- Non-Hisp. White: 34.2%
- Overall: 34.2%
Better Health Partnership Glycemic Control Overall

% of Eligible Adults with Diabetes
A1c >9% by Race/Ethnicity

Note: A1c is a measure of your average sugar over the last 3 months. An A1C of 9% is a blood sugar of around 212 mg/dl
Rural Diabetes Care and Outcomes in Ohio

Ohio Diabetes Death Rates, 2019
(per 100,000 people)

<table>
<thead>
<tr>
<th>Region</th>
<th>Rate</th>
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<tbody>
<tr>
<td>Rural</td>
<td>32.81</td>
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<tr>
<td>Partial</td>
<td>27.01</td>
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<tr>
<td>Non rural</td>
<td>24.73</td>
</tr>
<tr>
<td>Appalachian</td>
<td>36.48</td>
</tr>
<tr>
<td>Ohio</td>
<td>25.40</td>
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Appreciative Inquiry

- Pair up with someone you don’t know
- Introduce yourself
- Share a story about how you, your organization, or your practice has improved the life of someone living with diabetes, OR
- If you or a family member have diabetes, share a story about how you or your primary care team has improved your quality of life
Meet our 20 Participating Practices

- **AxessPointe Community Health Centers**
  - Barberton, Kent, Portage Path

- **Cleveland Clinic**
  - Main Campus Internal Medicine, South Pointe Family Medicine

- **Health Partners of Western Ohio**
  - New Carlisle Community Health Center, Dr. Gene Wright
  - Community Health Center, Old West End Community Health Center, Quick Care

- **MetroHealth System**
  - Broadway Health Center, Main Campus Internal Medicine Faculty Clinic, Main Campus Internal Medicine Resident Clinic, Glenville Community Health Center, West Park Health Center

- **Neighborhood Family Practice**
  - Tremont, West 117th Street

- **University Hospitals**
  - Bolwell Family Medicine, Otis Moss Jr. Health Center

- **VA Northeast Ohio Healthcare System**
  - Parma, Wade Park
AHEAD Timeline

<table>
<thead>
<tr>
<th>2023</th>
<th>2024</th>
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<tr>
<td>Oct</td>
<td>Nov</td>
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**Kickoff**

- Bi-Weekly EHR Data Submission
- Monthly Quality Improvement Coaching
- Monthly Action Period Webinar
- Sustainability Planning

Patient Team Meeting

Patient Team Orientation

Patient Team Meeting

Patient Team Meeting

Patient Team Meeting

Patient Team Meeting

**Abbreviations:** EHR = electronic health record
Key Driver Diagram

Global Aim

- Reduce complications associated with uncontrolled type 2 diabetes while addressing health equity

SMART Aim

- Reduce the percentage of adult patients enrolled in Medicaid with type 2 diabetes whose hemoglobin A1C (HbA1C) was uncontrolled (>9%) by XX% from XX% to XX% by XX.
- Reduce the percentage of uncontrolled A1C (>9%) in the Hispanic and NHB populations by XX% from XX% to XX% by XX.

Population

- Adult (18-older) Medicaid patients diagnosed with type 2 diabetes at participating practices

Key Drivers

- A: Appropriate and Timely Treatment
- B: Access to High Quality Coordinated Care
- C: Screened and Well Managed Behavioral Health
- D: Patient Engagement, Healthy Lifestyle and Self-Efficacy
- E: Effective Supportive Relationships
- F: Healthy Equitable Environment for Care

Interventions

- Optimize medication regimen across conditions (A, B, E, F)
- Consistent Access to Medication/Supplies/Equipment/Technology (A, B, D, F)
- Diabetes self-management education (A, B, C, D, E, F)
- Coordinated comprehensive individualized medical treatment plan (B, C, D, E, F)
- Standardized office processes for the healthcare delivery system (B, D, E, F)
- Screening and integration of behavioral health services within primary care (C, E, F)
- Screening for social drivers of health and linkage to community resources and or CHWs (C, E, F)
- Engaging patients in quality improvement (D, E, F)
Diabetes QI Clinical Toolkit

- Appropriate and Timely Treatment
- Access to High Quality Coordinated Care
- Screened and Well Managed Behavioral Health
- Patient Engagement, Healthy Lifestyle, and Self-Efficacy
- Effective Supportive Relationships
- Healthy Environment for Care

⇒ Access the toolkit at NEOQIHub.org
Diabetes QI Patient Education Toolkit

- What is Diabetes
- Taking Medications
- Monitoring
- Healthy Eating
- Problem Solving
- Being Active
- Hypoglycemia and Hyperglycemia
- Prevention of Long-Term Complications
- Continuous Glucose Monitoring
- Healthy Coping

Access the toolkit at NEOQIHub.org
Health Equity and Partner Engagement

Anne Gaglioti, MD, MS
Health Disparities Co-Lead
Case Western Reserve University
The MetroHealth System

Bode Adebambo, MD
Health Disparities Co-Lead
Case Western Reserve University
The MetroHealth System
Addressing Health Equity

- **Health Equity** is the state in which everyone has a fair and just opportunity to attain their highest level of health (**CDC Definition**)

- **Health Disparities** are preventable differences in the burden of disease and opportunities to achieve optimal health that are experienced by populations that have been disadvantaged by their social or economic status, geographic location, and environment (**CDC Definition**)

Addressing Health Equity

What Health Disparities will we focus on?

While our collaborative is focused on eliminating disparities in diabetes outcomes across racial and ethnic minoritized groups, and among rural communities, we acknowledge the complexity and intersectionality embedded in framing disparities in this way.

Addressing Health Equity

How will we approach advancing health equity?

A practical framework to advance health equity within our Hub: **The PETAL Framework**

1. Prioritize Health Equity
2. Engage the Community
3. Target Health Disparities
4. Act on the Data
5. Learn and Improve

---

Engagement is Critical to Addressing Health Equity: The Assessing Community Engagement (ACE) Conceptual Model

How the Toolkit Addresses Health Equity

- Health equity frameworks that center equity measurement and activities
- Standardized protocols to reduce implicit bias
- Identifying and addressing social drivers of health, anti-racism, and inclusion
- Treatment algorithms prioritizing medications which can improve diabetes morbidity and mortality
- Consistently identifying and addressing barriers to medication and visit adherence
- Continuous glucose monitoring and remote home blood sugar monitoring to overcome access to care and provide data to facilitate appropriate treatment and follow up
- Outreach to patients using tailored approaches and team-based care
- Leveraging telehealth to address transportation barriers/access
- Communication skills to build trusting relationships between patients and primary care teams, including cultural humility, health literacy, and implicit bias
Engaging Patients in Quality Improvement

- AHEAD aims to eliminate disparities in A1C control by integrating the lived experience and needs of patients and family members in QI interventions.
- The Patient Team has 9 members and many have joined us today for the kickoff!
- An orientation meeting will be hosted on Thursday, October 26 to further discuss how patients will advise the project and to create a shared vision and governance.
Patient Engagement

- The Patient Team will meet quarterly, but there will be lots of opportunities for dialogue between the patient advisors, AHEAD practices, and steering committee:
  - Toolkit Recommendations
  - Standing agenda item at Action Period Webinars
  - Standing agenda time at Steering Committee Meetings
  - Submission of items for patient advisor team review at quarterly meetings or asynchronously
  - Specific practice feedback shared through monthly practice coaching
  - Dashboard data trends, practice-level interventions and progress, and initiate their own feedback and suggestions

- Evaluation Process
  - The NEO QI Hub will track the patient advisor experience and empowerment
  - Patient Team recommendations will be tracked and followed for outcomes
Community Engagement

- All hubs are required to engage patients and community based organizations
- The long-term goal of community engagement is to establish linkages to social care for Medicaid beneficiaries through partnerships
  - Ohio Department of Medicaid (ODM), Colleges of Medicine (CoM), Community-Based Organizations (CBOs)
- We are working to better understand ODM’s vision for structuring partnerships, existing and desired partnerships among the CoM, health systems, and CBOs
  - Identify and align priorities on areas of focus that have high potential to advance health equity in diabetes outcomes
  - This early work will inform our collaborative activities for year 2
Payer Engagement

- Medicaid Managed Care Plan representatives have joined us today!

- The NEO QI Hub will be working closely with them to determine ways we can collaborate together.

- This will include working with practices and patients to understand and address barriers to diabetes care.

- Examples from prior statewide efforts include:
  - Removal of prior authorization for continuous glucose monitoring (CGM)
  - Payment for and assistance with diabetes self-management education and support (DSMES)
  - Outreach to patients with uncontrolled diabetes
  - Addressing social needs
Dashboard Data

Douglas Einstadter, MD, MPH
Data and Evaluation Co-Lead
Case Western Reserve University

Robert Ashmead, PhD
Ohio Colleges of Medicine
Government Resource Center
Dashboard Data Logistics

- Dashboard login
  - There will be a unique username/password for each site that will allow access to individual site data and aggregates by health system and overall
  - The logins have been distributed by email. Contact Katie Jenkins (katherine.jenkins@osumc.edu) if you have questions

- We anticipate receiving data from practices every two weeks after the baseline data are submitted

- Dashboard will be updated every 2 weeks on Wednesday

- Dashboard demonstration
Congratulations on Baseline Data Submission!
Core Measures

- Diabetes Control (A1C >9%)
- Timely follow-up (scheduled) for elevated HbA1C
- Adherence to timely follow-up (attended visit)
- Screening for Social Drivers of Health (SDoH) (in progress - dashboard data not validated)
- SDoH need addressed (in progress – data not currently available)
- Depression screening (in progress - dashboard data not validated)
- Diabetes medication optimization (number and type of diabetes medications)
- Referral to services to improve blood sugar control (diabetes self-management education, group visit, nutrition, weight management, pharmacy, Endocrinology)
Control Chart: Percent HbA1C > 9 at Baseline
Percent With HbA1C > 9 by Race/Ethnicity
Percent With Timely Follow-up Scheduled
Percent With Timely Follow-up Attended
Number of Diabetes Medications

![Bar chart displaying the number of diabetes medications for different HbA1c levels.](chart.png)

- HbA1c <= 9
- HbA1c > 9
Type of Diabetes Medications

Diabetes Medication Category

- INSULIN
- GLP1-A
- DPP4
- SULFONYLUREA
- METFORMIN
- SGLT2
- TZD

Percent on Medication

HbA1c <= 9  HbA1c > 9
Additional Measures Planned for the Dashboard

- Continuous Glucose Monitor (CGM) use.
- Attention to foot exam.
- Attention to eye exam.
- Attention to kidney disease.
- Low density lipoprotein cholesterol controlled (<100 mg/dl) or on statin.
- Blood pressure control (<140/90 and <130/80 mm Hg).
- Flu vaccine in the last year.
- Pneumonia vaccine.
- Smoking screening.
- Smoking status.
- Attention to depression.
- Medication adherence (Medicaid).
Summary

- Many opportunities for improving HbA1C, including:
  - Increasing monthly follow-up until blood sugar is controlled,
  - Expanding the use of newer diabetes medications and insulin where appropriate,
  - Increasing the number of medication classes used.

- We encourage practices to focus initially on key drivers of improved HbA1C control, including timely follow-up and tailoring to subpopulations

- As data become available, we encourage you to view your data on the dashboard and discuss with your practice coach to determine the best opportunities for your practice.
Q&A
Break

When you return, please sit at your assigned table listed in your event folder
Getting Started With Quality Improvement and Health Equity

Aleeece Caron, PhD
Quality Improvement Co-Lead
Case Western Reserve University
1. Describe the Model of Improvement and basic quality improvement tools
2. Explain how quality improvement can advance health equity
3. Identify ways to address health equity in quality improvement
4. Practice developing a project that uses quality improvement steps
“Eighty five percent of the reasons for failure and deficiencies are in the systems and process rather than the employee.”

➔ W. Edward Deming
If there’s a really BIG problem....

Source: Sue Butts Dion
...We just have to put BIG resources into it...
Oh... Hmmm... then we need even BIGGER resources!
The measure of success is not whether you have a tough problem to deal with, but whether it is the same problem you had last year.
- John Foster Dulles
Changing the System: What Usually Happens?

Traditional model for introducing change

- PROBLEM
- SOLUTION
- “FINAL” PLAN
- IMPLEMENT
- SYSTEM BARRIERS
- Unmet Goals/Resistance/Change-Fatigue = Not sustainable!

Adapted from: Jean Vukoson’s Bright Futures Presentation
QI Approach to Change

**Act**
- What changes are to be made
- Next cycle

**Plan**
- Objective
- Questions / Predictions
- Plan to carry out cycle (who, what, where and when)

**Study**
- Compare Analysis of data
- Compare data to predictions
- Summarise what was learned

**Do**
- Carry out plan
- Document problems and observations
- Begin analysis

**PROBLEM**

**ASSESS CURRENT CONDITION**

**DEFINE POSSIBLE SOLUTIONS**

**CONDUCT**
- Plan-Do-Study-Act cycles

Designed by a team that does the work – “Ownership”
Quality Improvement

A roadmap to improve population based outcomes

Model for Improvement

- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?
Improvement Strategy

Problems are solved one step at a time

EACH ATTEMPT GETS YOU CLOSER TO SUCCESS
Aim: To improve the care of patients with diabetes by creating self-management goals with each patient.

Cycle 1: Develop a self-management tool for patients with diabetes.
Cycle 2: Test the tool with 2 patients tomorrow.
Cycle 3: Redesign the tool and retest.
Cycle 4: Standardize the tool in policy and procedure.
Cycle 5: Educate all in use of the new tool.

Establishment of self-management goals with patients will improve outcomes.
Linear Fallacy of Research and QI: Widely-held assumption that social and biological systems can be largely understood by dissecting out micro-components and analyzing them in isolation.

***DANGER****

The journey up the ramp of complexity is NOT linear.
Conceptual Model of Rapid Cycle Change

Legend:
P=Plan       D= Do                                         = Barrier
S=Study      A= Act                                      = Lingering background impact
                        = Direct flow of impact
Arrowhead = Feedback or feedforward
Different Sizes of letters and cycles and bolding of letters = denotes differences in importance/impact

Engineering Change: PDSA

Principles for Success:

- Start new changes on the smallest possible scale, e.g. one patient, one nurse, one doctor
- Run just as many PDSA cycles as necessary to gain confidence in your change – then expand
- Expand incrementally to more patients
- Expand to involve more nurses, more doctors, more departments
- Balance changes within system to ensure other processes not adversely stressed
Engineering Change: PDSA

- Increases belief that change will result in improvement
- Allows opportunities for “failures” without impacting performance
- Provides documentation of improvement
- Adapts to meet changing environment
- Evaluates costs and side-effects of the change
- Minimizes resistance upon implementation
# Plan-Do-Study-Act Worksheet

**Overall project aim:** To Improve Diabetes Control in eligible Type 2 DM patients

**Objective of test:** Reduce the percentage of poorly controlled DM (HgBA1C>9%) in adult patients enrolled in Medicaid by 20% by August 31, 2024 by standardizing timely follow up.

**Test start date:** 10/1/23

**Test end date:** 8/31/24

## Plan:

**What is the test?** Developing a standard care pathway for patients with poorly controlled Type 2 DM which includes diabetes education, pharmacy, social work or behavioral health visits depending on the needs of the patient to ensure appropriate timely follow up.

**How will data/measure be tracked?**
- How many poorly controlled DM patients were scheduled for an appointment with Pharmacist, Nutritionist or for Diabetes Education Vists.
- How many patients came in for HgBA1C measurement
- Hemoglobin A1C measurements at appropriate intervals.

**What is the prediction for the test outcome?** Patients may have concerns related to frequency of visits and may prefer virtual visits if available.

## Tasks needed to complete the test

<table>
<thead>
<tr>
<th>Tasks needed to complete the test</th>
<th>Person Responsible</th>
<th>Details / How</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure education materials and resources are available</td>
<td>Care Manager-Melanie</td>
<td>Review online and clinic resources to include in pathway</td>
</tr>
<tr>
<td>Develop care pathway to include DSME and pharmacy follow up</td>
<td>Melanie with Diabetes Educator and Pharmacist</td>
<td>Flow diagram of appropriate follow up intervals</td>
</tr>
<tr>
<td>Comprehensive DM education</td>
<td>Diabetes educator</td>
<td>Education information with literacy and cultural issues in mind</td>
</tr>
<tr>
<td>Medication management using ADA guidelines</td>
<td>Pharm D</td>
<td>Develop protocols for patient to help with complex drug regimen</td>
</tr>
<tr>
<td>Diet education</td>
<td>Nutritionist</td>
<td>Follow up plan for diet education with cultural issues in mind</td>
</tr>
</tbody>
</table>

## Do:

**What the test carried out as planned? Yes / No**

**Test data/observations:**
- Increase in DSME and shared medical appt referrals
- Increase in Pharm D follow up of eligible patients
- Improve DM control in 20% of eligible patients

**Unexpected events/observations:**
- Balancing measures: additional time or staff resources?
- More virtual visits and staff resources for follow up.
- Increase in no show rates initially

## Study:

**Did the results match predictions? Yes / No**

**How are the results different than past tests/previous system?**
- Much more consistent follow up in motivated patients who did not have transportation issues

**New learning from the test:**
- Virtual visits can be helpful but need to address broadband issues

## Act:

**ADAPT:** Improve / edit the intervention and continue testing
**ADOPT:** Select changes for larger test or implementation
**ABANDON:** Discard this change and try a different idea
Q&A
Tabletop Exercises

Aleece Caron, PhD
Case Western Reserve University

Mamta Singh, MD, MS
Case Western Reserve University

Deb Hrouda, PhD, LISW-S
Northeast Ohio Medical University

Caroline Carter, MS, LSW, BCC
Health Impact Ohio
Tabletop Instructions

- **Objective:** prepare an improvement project by applying quality improvement principles

- **Introductions** (10 minutes)
  - Introduce yourself (name, role, and organization if applicable)
  - Why are you excited to be involved in this project?

- **Case Scenario** (5 minutes)
  - Read the case scenario on pages 1-2 of the worksheet included in your folder
Exercise 1:

Initiating a Quality Improvement Project

- **Objective**: prepare an improvement project by applying quality improvement principles.

- **Exercise 1** (5 minutes)
  - Work with the team at your table to answer questions 1 on page 2 of the worksheet.
  - Pick someone to take notes and pick another person to share your discussion with the other groups.
Question 1: What is the long-term goal of the project?

- **Goal:** Improve A1C (or average blood sugar) and eliminate gaps by insurance type
Question 2: Who would you want on your project team?

- Physician
- Medical Assistant
- Community Health Worker
- Patient Team
- Nurse Care Manager
- Pharmacist
- Medicaid Managed Care Payers
- Diabetes Educator
- Community Partner
Question 3: What is the problem and what data would you need to support the problem statement?

- 3a. Why might A1C differ by insurance type?
- 3b. What barriers may prevent scheduling and attending a timely follow up visit?
- 3c. How could the team you identified in question 2 develop potential strategies to overcome the barriers listed in 3b?
Benchmarking and Current Evidence
Exercise 2:

Drafting an Aim Statement

- **Objective**: prepare an improvement project by applying quality improvement principles.
SMART Aim Statement

Specific  Measurable  Attainable  Relevant  Time-bound

SMART GOALS
Principles of an Effective Specific Aim Statement

- State aim clearly
- Use numerical goals
- Set stretch goals
- Set target date to achieve
- Avoid aim drift—but be prepared to shift aim if you discover this is wrong focus
- Don’t need permission to improve
- Can work on NOW
Example: Evaluate Based on SMART Criteria

- Our **goal** is to improve the care of our patients with diabetes within the next 12 months.

- The **aim** of this project is to decrease the percentage of patients who refuse a flu vaccine (by 6%) from 56% to 50% from 10/1/19 - 2/28/20 in my adult Family Medicine patients at my clinic.
Writing a SMART Aim Statement

Specific
Measurable
Achievable
Realistic
Time Bound

I believe that this Nation should commit itself to achieving the goal, before this decade is out, of landing a man on the moon and returning him safely to earth.
Exercise 2:

Drafting an Aim Statement

- **Objective**: prepare an improvement project by applying quality improvement principles.

- **Exercise 2** (10 minutes)
  - Work with the team at your table to answer question 4 on page 3 of the worksheet.
  - Pick someone to take notes and pick another person to share your discussion with the other groups.
Question 4: Create a SMART aim statement to improve timely follow up for patients with diabetes enrolled in Medicaid

The aim of this project is to reduce the percentage of adult patients with diabetes and high sugars (hemoglobin A1C > 9%) who are enrolled in Medicaid by 20% by August 31, 2024.

Note: hemoglobin A1C > 9% is equal to average blood sugars above 212
Wrap Up

▪ Your primary care clinic will be supported through monthly quality improvement coaching, monthly action period webinars, and input from the Patient Team.

▪ The next steps that you should begin to think about include:
  ▪ Identify measures that will provide evidence that you accomplished what you intended to or demonstrate effectiveness of a process change.
  ▪ Determine methods to study the current process and identify potential process changes.
  ▪ Evaluate one potential change of the process under consideration.

▪ The NEO QI Hub can answer any questions you have and we will meet regularly with your practice coach to address any barriers related to your QI project.
Next Steps

Shari Bolen, MD, MPH
Case Western Reserve University
The MetroHealth System
Next Steps

- Complete CME Evaluation and claim credits by December 1 if applicable
  - Attendees who indicated they would like to receive CME credit during registration will receive an email from myevaluations.com next week with more information
  - Contact cme@metrohealth.org if you do not receive an email or need assistance
- Submit EHR data (next due October 31)
- The Patient Team will meet on Thursday, October 26, from 1:00-3:00 pm
- Attend your first quality improvement coaching session in November
- Look for dashboard login email and review data with your coach
- Attend the first action period webinar on Thursday, November 16, 12:00-1:00 pm
  - Topics: A1C Testing, Timely Follow-up, and Run and Control Charts
Collaborative Quote

When ‘I’ is replaced with ‘We’, even ‘Illness’ becomes ‘Wellness’

- Malcolm X
Kickoff Evaluation Survey

- Please complete the kickoff evaluation survey before you leave!
  - Scan the QR code below using your mobile phone camera, or request a print version

tinyurl.com/AHEADKickoff
Thank You!
# Ohio Medicaid’s Population Health and Quality Strategy

## Focus Populations

<table>
<thead>
<tr>
<th>Healthy Children &amp; Adults</th>
<th>Collective, Person-Centered Impact</th>
<th>Improved Outcomes &amp; Equity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children</td>
<td><a href="#">Structured Quality Improvement</a></td>
<td>Preventative Screenings &amp; Academic Success</td>
</tr>
<tr>
<td>Adults</td>
<td></td>
<td>Preventative Screenings</td>
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<table>
<thead>
<tr>
<th>Women and Infant Health</th>
<th></th>
<th>Integrated Care for Mother &amp; Baby; Maternal &amp; Infant Mortality</th>
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<tbody>
<tr>
<td>Infants</td>
<td><a href="#">Community Engagement and Social Determinants of Health</a></td>
<td>Comprehensive and Coordinated BH Services, Drug-related Mortality</td>
</tr>
<tr>
<td>WRA</td>
<td></td>
<td>Well Managed Asthma, Diabetes, and Hypertension</td>
</tr>
<tr>
<td>High Risk</td>
<td></td>
<td>Maximal Choice and Independence</td>
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<table>
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<th><a href="#">Structured Quality Improvement</a></th>
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<tr>
<th>Older Adults</th>
<th><a href="#">Structured Quality Improvement</a></th>
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Project Timeline

Year 1
Build NEO QI Hub infrastructure, assess regional needs, and plan
SFY2023

Year 2
Test and pilot NEO QI Hub with select health system primary care practices
SFY2024

Year 3
Scale NEO QI Hub capacity to adjacent regional health systems
SFY2025

Year 4
Sustain regional engagement and scale NEO QI Hub capacity to local practices
SFY2026

Year 5
Realize equitable population health improvement in diabetes control
SFY2027

SFY2028