NEO QI Hub

NORTHEAST OHIO QUALITY IMPROVEMENT HUB

CASE WESTERN RESERVE UNIVERSITY School of Medicine

Northeast Ohio MEDICAL UNIVERSITY

In partnership with

AxessPointe Community Health Centers · Better Health Partnership · Cleveland Clinic · Health Impact Ohio Equity. Access. Quality. · MetroHealth · Neighborhood Family Practice Community Health Centers · Summa Health · University Hospitals · U.S. Department of Veterans Affairs · Ohio Colleges of Medicine Government Resource Center · medtapp · Ohio Department of Medicaid

Achieving **HEA**lth Equity in **D**iabetes

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!

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Achieving **HEA**lth Equity in **D**iabetes

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

Agenda

Time	Activity	Lead
12:00–12:30 pm	**Check-in and Networking**	
12:30–12:35 pm	**Welcome**	Michael Konstan, MD
12:35–12:45 pm	**Opening Remarks by Ohio Department of Medicaid (Video)**	Mary Applegate, MD
12:45–1:20 pm	**NEO QI Hub and AHEAD Initiative Overview**	Shari Bolen, MD, MPH Rebecca Fischbein, PhD
1:20–1:40 pm	**Health Equity and Partner Engagement**	Anne Gaglioti, MD, MS Bode Adebambo, MD
1:40–2:05 pm	**Dashboard Demonstration**	Douglas Einstadter, MD, MPH Robert Ashmead, PhD
2:05–2:15 pm	**Break and Networking**	
2:15–2:30 pm	**Getting Started with Quality Improvement and Health Equity**	Aleece Caron, PhD
2:30–3:50 pm	**Tabletop Exercises**	Aleece Caron, PhD Mamta Singh, MD, MS Deb Hrouda, PhD, LISW-S Caroline Carter, MS, LSW, BCC
3:50–4:00 pm	**Evaluation Survey and Next Steps**	Shari Bolen, MD, MPH

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

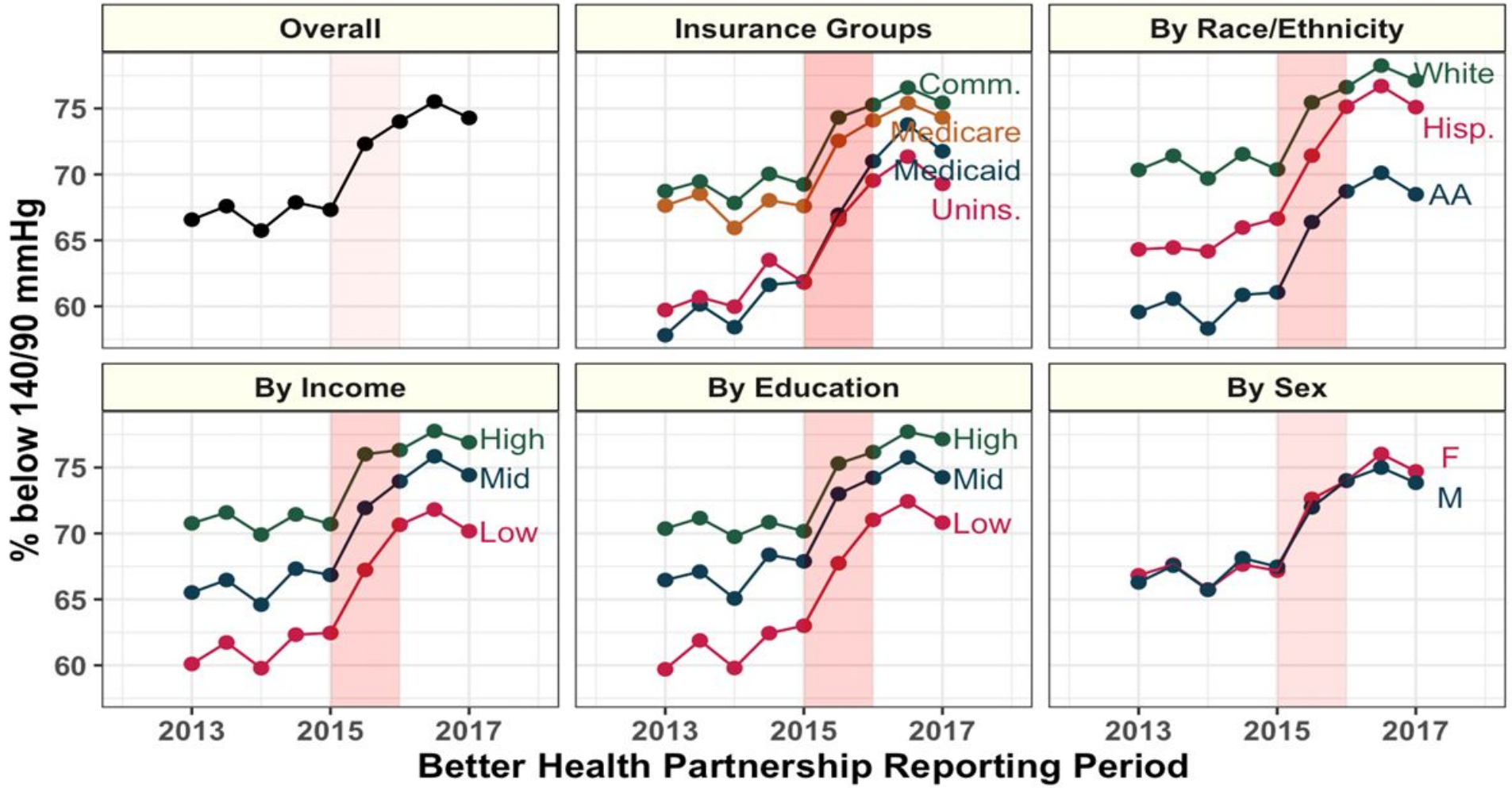
Before doing quality improvement with someone you have never met, you should first make them use a computer with slow internet to see who they really are.

-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

Background



Shaded red region indicates intervention period

CARDI·OH

Ohio Cardiovascular and Diabetes Health Collaborative

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)

Identification & Education of Best Practices and Processes

Testing, Modifying & Implementing Best Practices

Facilitating access to best practice, addressing non-clinical barriers

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.

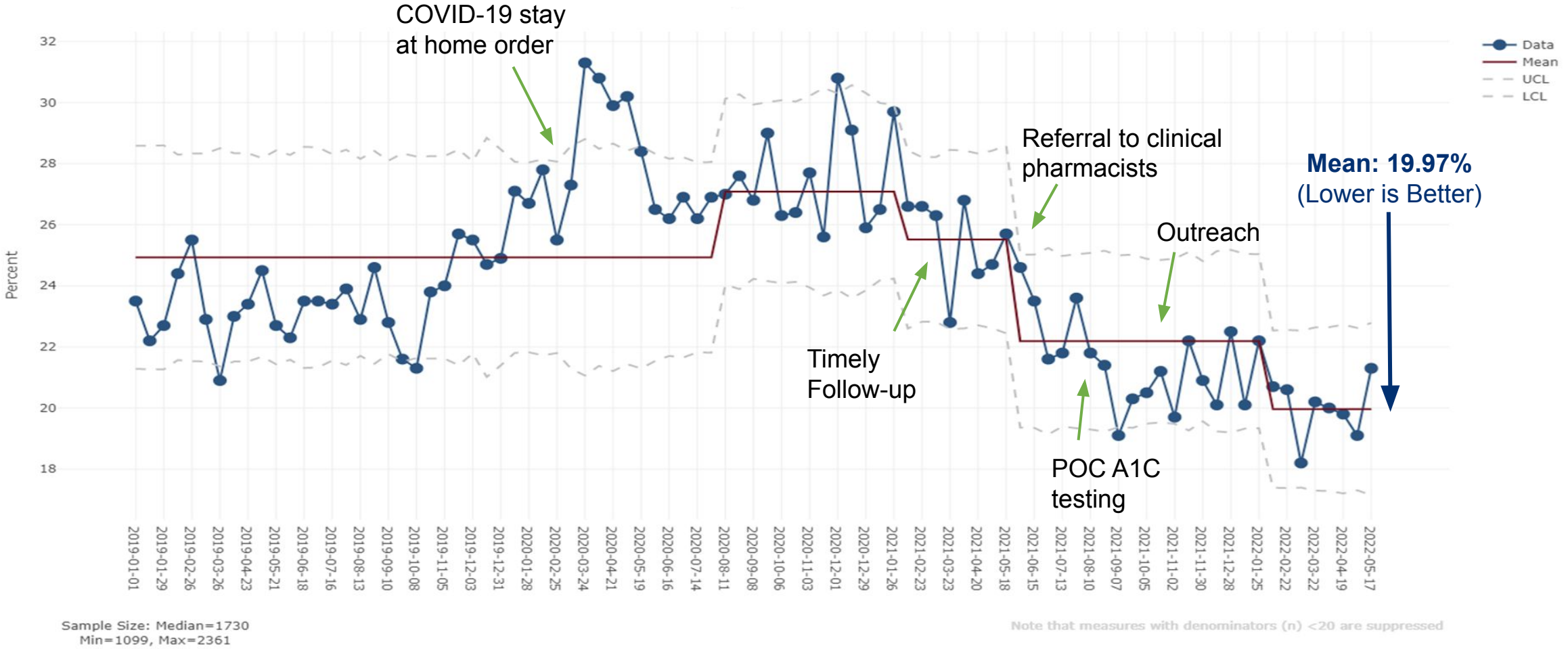
Strategies

- 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

Ohio Department of Medicaid

Percent of Patients With Diabetes Whose Most Recent A1C>9% for All Sites

Ohio Department of Medicaid

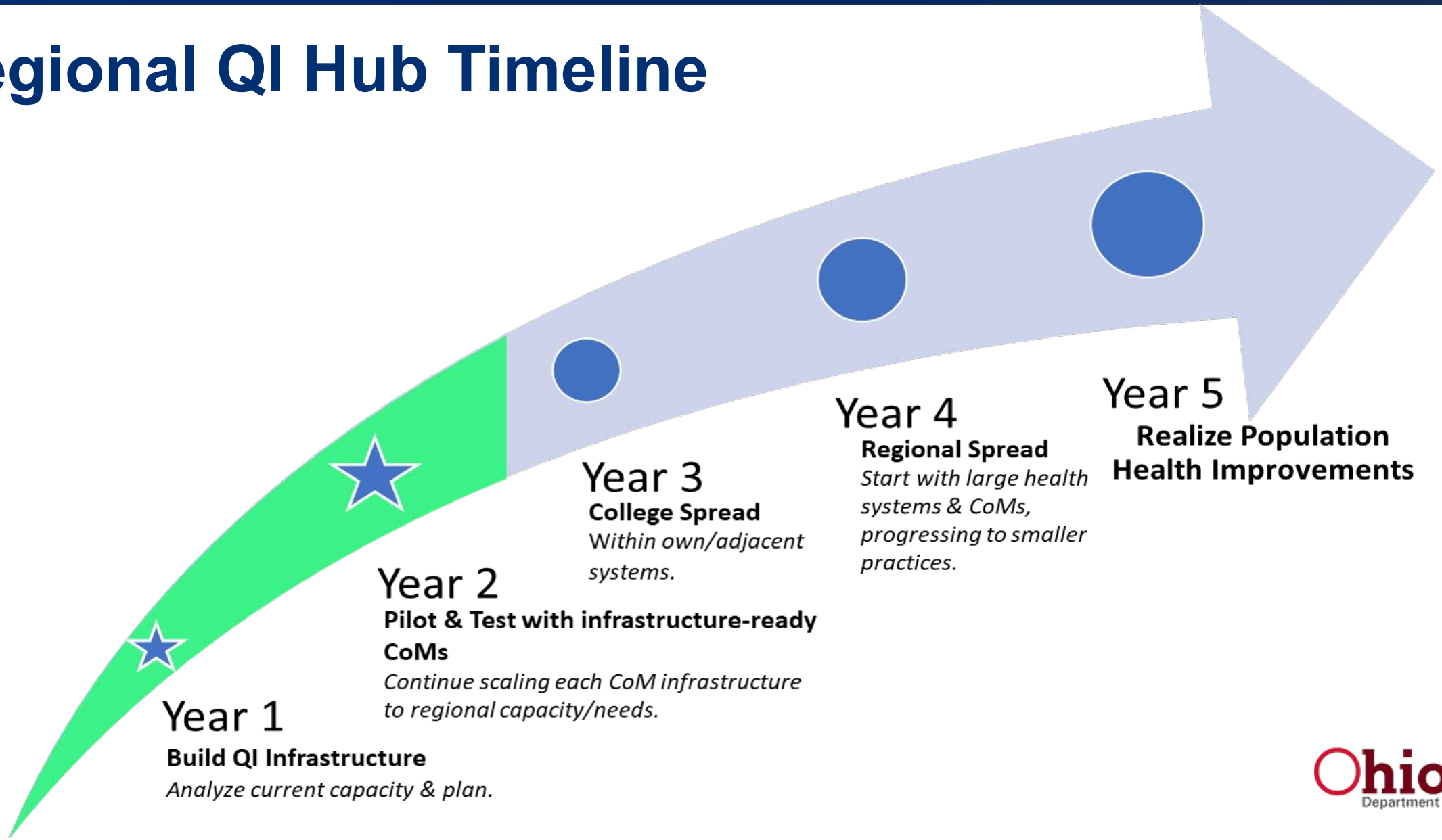


Note: A1C is a measure of the average blood sugar over the last 3 months. A1C of 9% is an average blood sugar of 212 mg/dl

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



Ohio Department of Medicaid

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Collaborating for a healthy community

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Neighborhood Family Practice
COMMUNITY HEALTH CENTERS

Summa Health™

University Hospitals

U.S. Department of Veterans Affairs
Veterans Health Administration
Office of Research & Development

OHIO COLLEGES OF MEDICINE
GOVERNMENT RESOURCE CENTER

medtapp

Ohio Department of Medicaid

Project Lead Introductions

NEO QI HUB

Executive PIs

Michael W. Konstan, MD
Case Western Reserve University

Shari Bolen, MD, MPH
Case Western Reserve University

Rebecca Fischbein, PhD
Northeast Ohio Medical University

Quality Improvement Leads

Aleece Caron, PhD
Case Western Reserve University

Mamta (Mimi) Singh, MD, MS
Case Western Reserve University

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

Caroline Carter, MS, LSW, BCC
Quality Improvement Coach

Health Equity Leads

Bode Adebambo, MD
Case Western Reserve University

Anne Gaglioti, MD, MS
Case Western Reserve University

Data and Evaluation Leads

Douglas Einstadter, MD, MPH
Case Western Reserve University

Chris Mundorf, PhD
Better Health Partnership

Endocrinologist Lead

Betul Hatipoglu, MD
University Hospitals

Project Management Leads

Cathy Sullivan, MS, RD
MetroHealth Medical Center

PJ Kimmel, MPH
Better Health Partnership

Kara Bloom, BA
Northeast Ohio Medical University

Executive Leadership Team Introductions

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Director

Ann Nevar, MPA

Finance

Kristen Boyer, MEd

Informatics & Web

Rick Cornachione, MSIS

Marketing & Communications

Gillian Irwin, MA

Graphic Design

Devin O'Neill, BA

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VA Northeast Ohio Health Care System

Cristina Sanders, APRN-CNP
MetroHealth Medical Center

James Thomascik, MHA, CPHQ
Cleveland Clinic

Elisabeth Whipkey, MD
NEOMED Health Care

AHEAD Initiative Overview

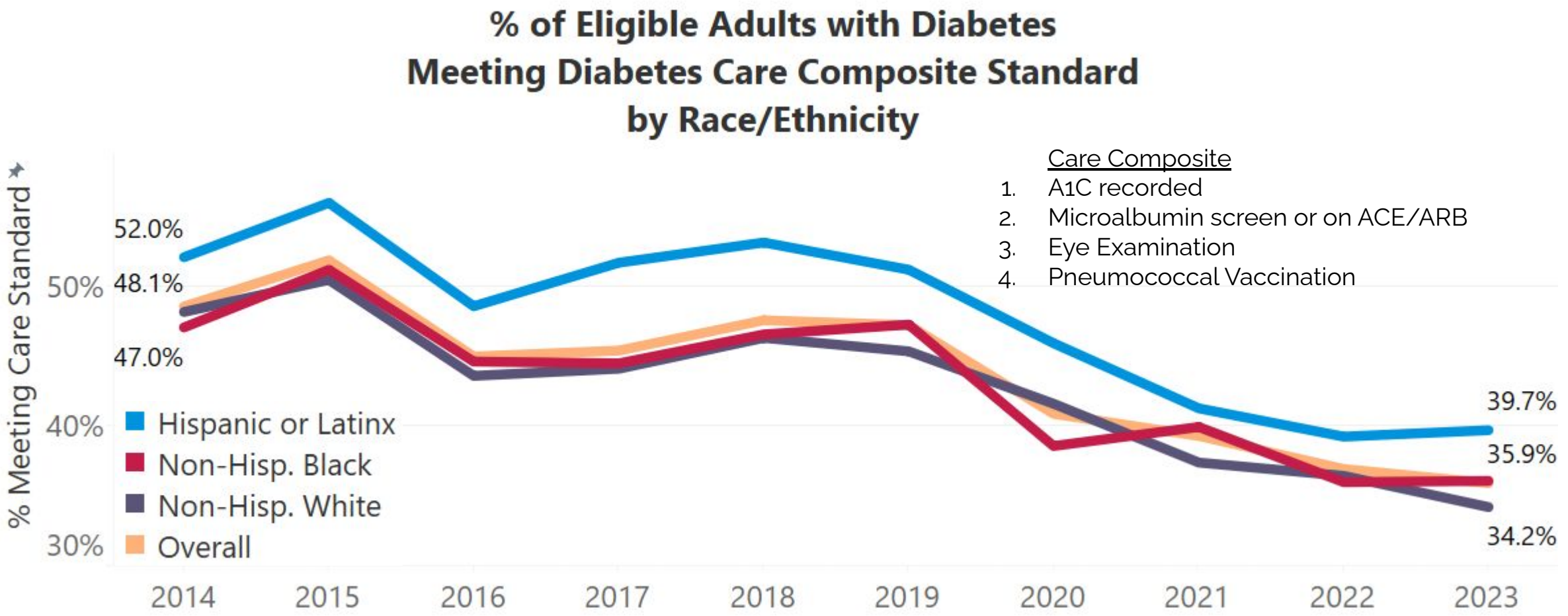
Shari Bolen, MD, MPH
Co-Principal Investigator
Case Western Reserve University

Rebecca Fischbein, PhD
Principal Investigator
Northeast Ohio Medical University

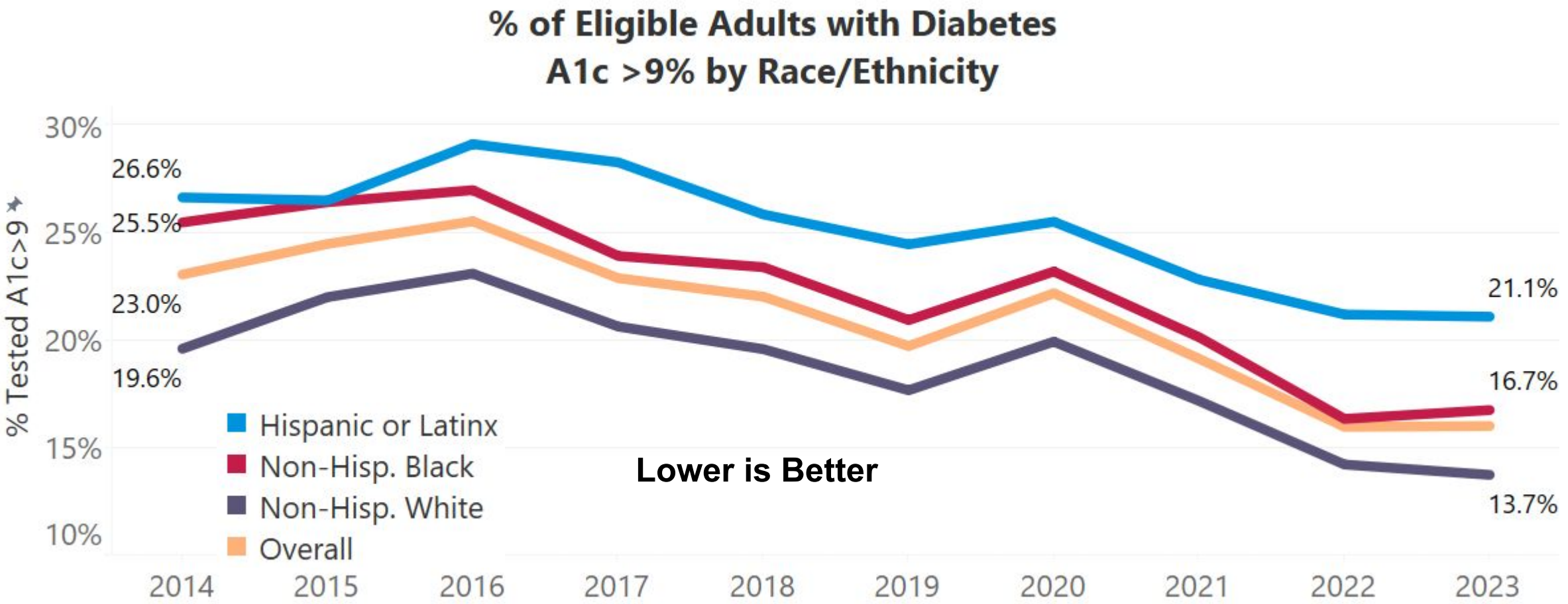
Why Focus on Diabetes?

- 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

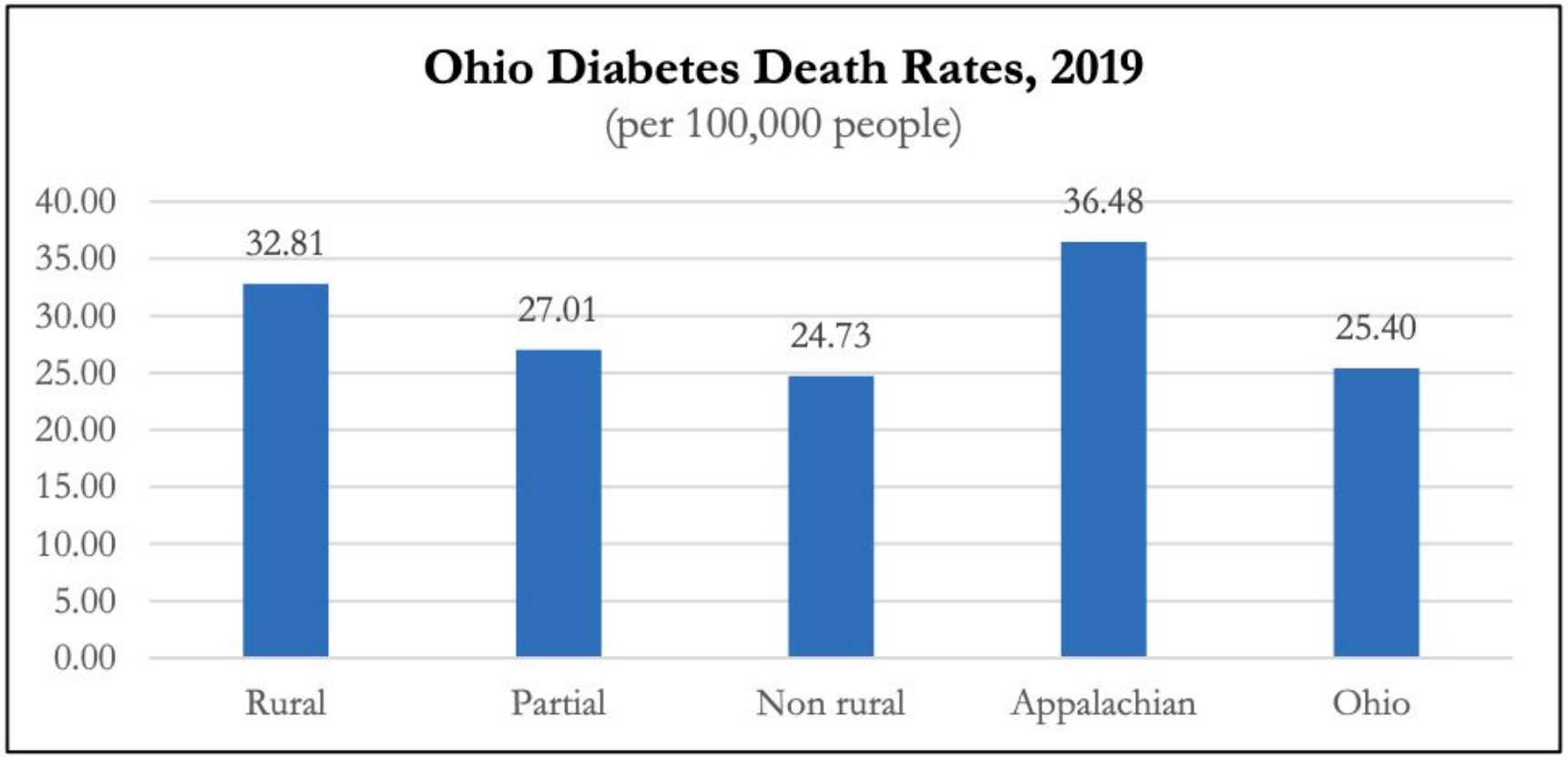


Better Health Partnership Glycemic Control Overall



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



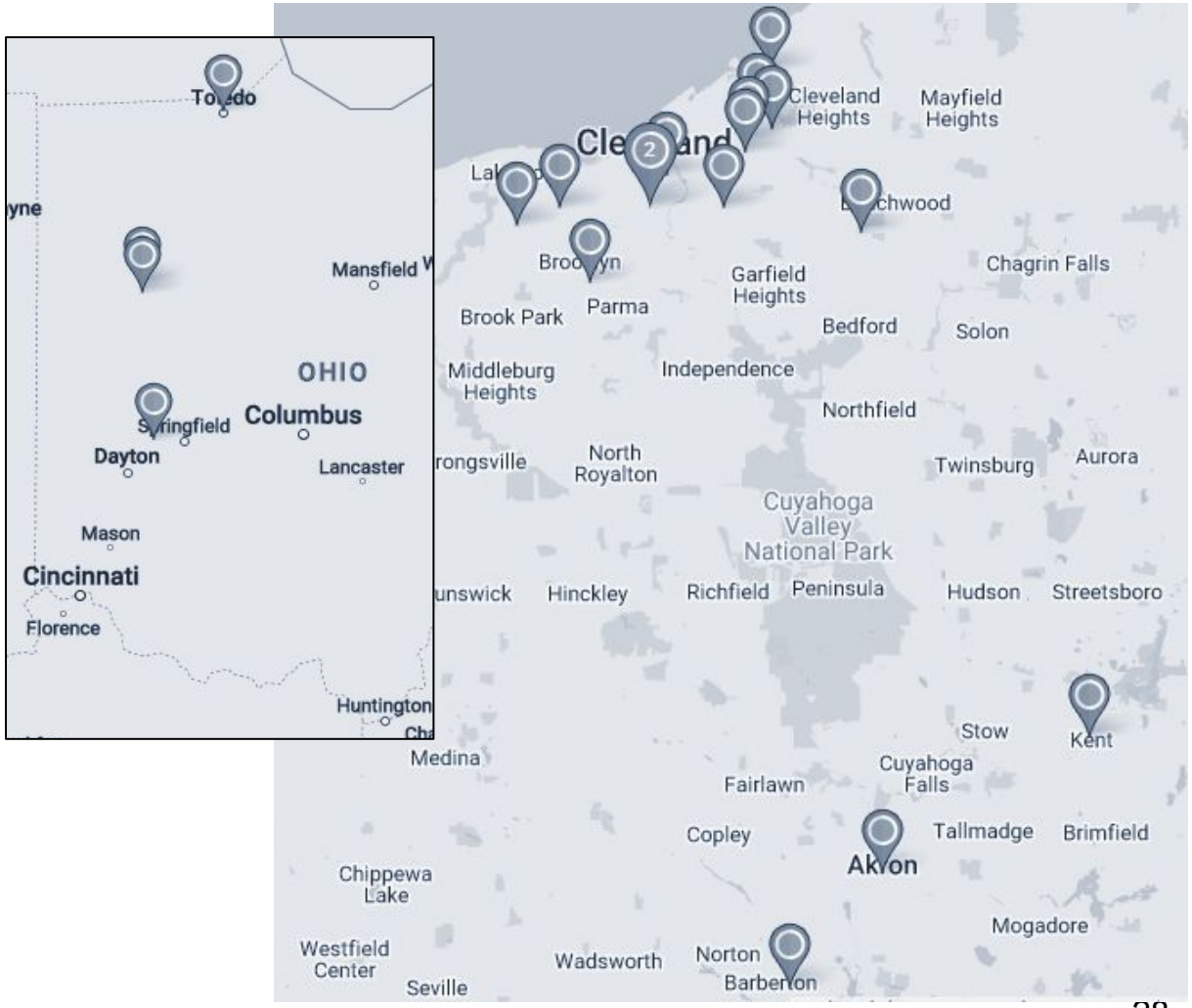
Ohio Department of Health. (2021, June). *Ohio Rural Health Improvement Plan*. https://www.ohioruralhealth.org/upload/documents/2021_rural_health_plan.pdf.

Appreciative Inquiry

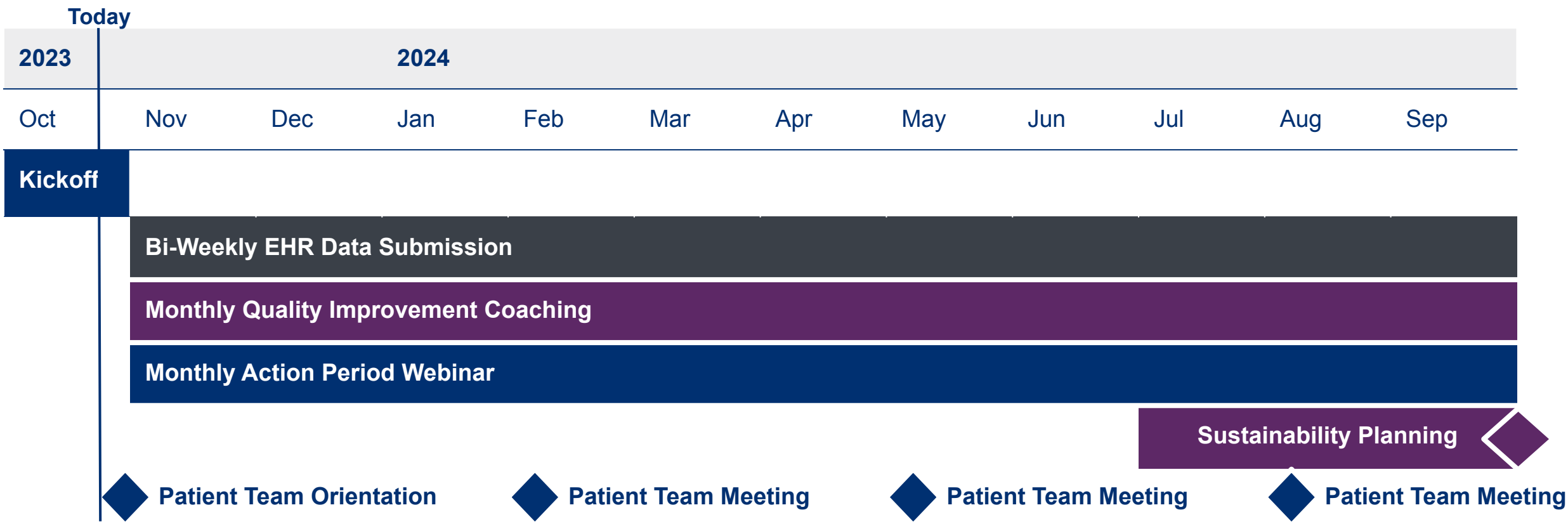
- Pair up with someone you don’t know
- Introduce yourself
- Share a story about how you, your organization, or your practice has improved the life of someone living with diabetes, OR
- If you or a family member have diabetes, share a story about how you or your primary care team has improved your quality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



Abbreviations: **EHR** = electronic health record

Key Driver Diagram

NEO QI HUB

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.

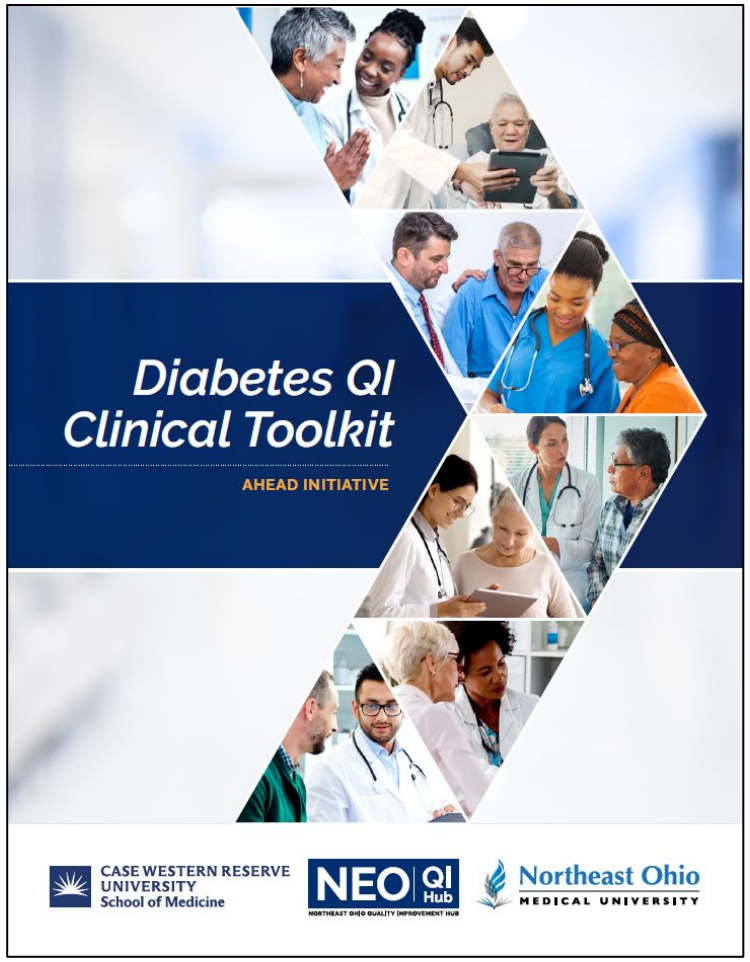
Population

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

Key Drivers	Interventions
A: Appropriate and Timely Treatment	Optimize medication regimen across conditions (A, B, E, F)
B: Access to High Quality Coordinated Care	Consistent Access to Medication/Supplies/ Equipment/Technology (A, B, D, F)
C: Screened and Well Managed Behavioral Health	Diabetes self-management education (A, B, C, D, E, F)
	Coordinated comprehensive individualized medical treatment plan (B, C, D, E, F)
D: Patient Engagement, Healthy Lifestyle and Self-Efficacy	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)
E: Effective Supportive Relationships	Screening for social drivers of health and linkage to community resources and or CHWs (C, E, F)
F: Healthy Equitable Environment for Care	Engaging patients in quality improvement (D, E, F)

Clinical Drivers

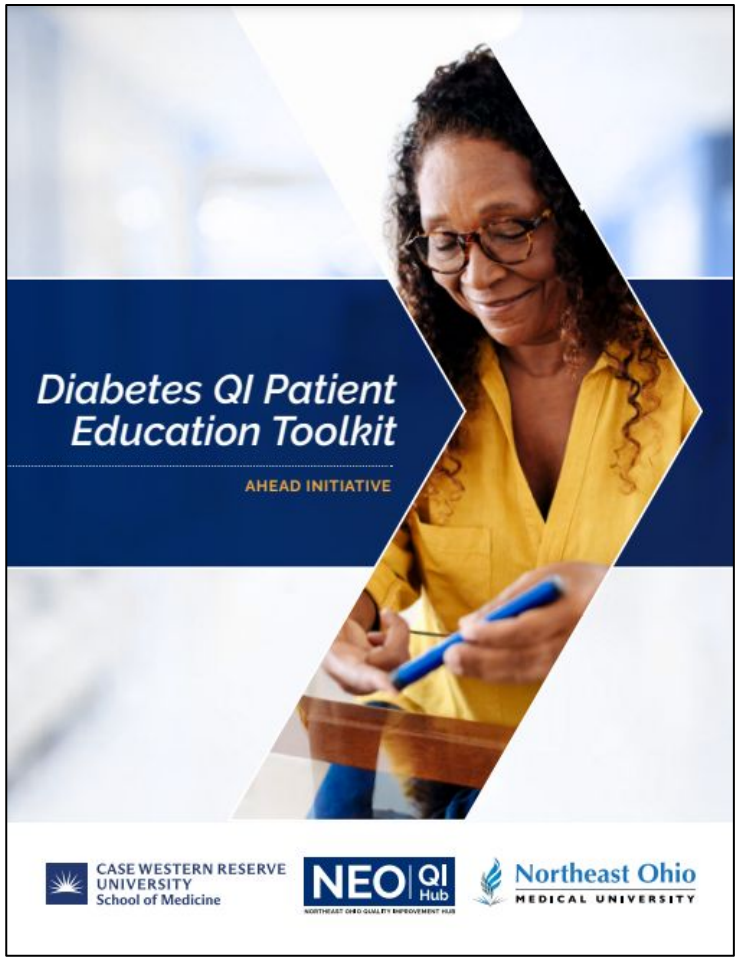
Diabetes QI Clinical Toolkit



- 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**

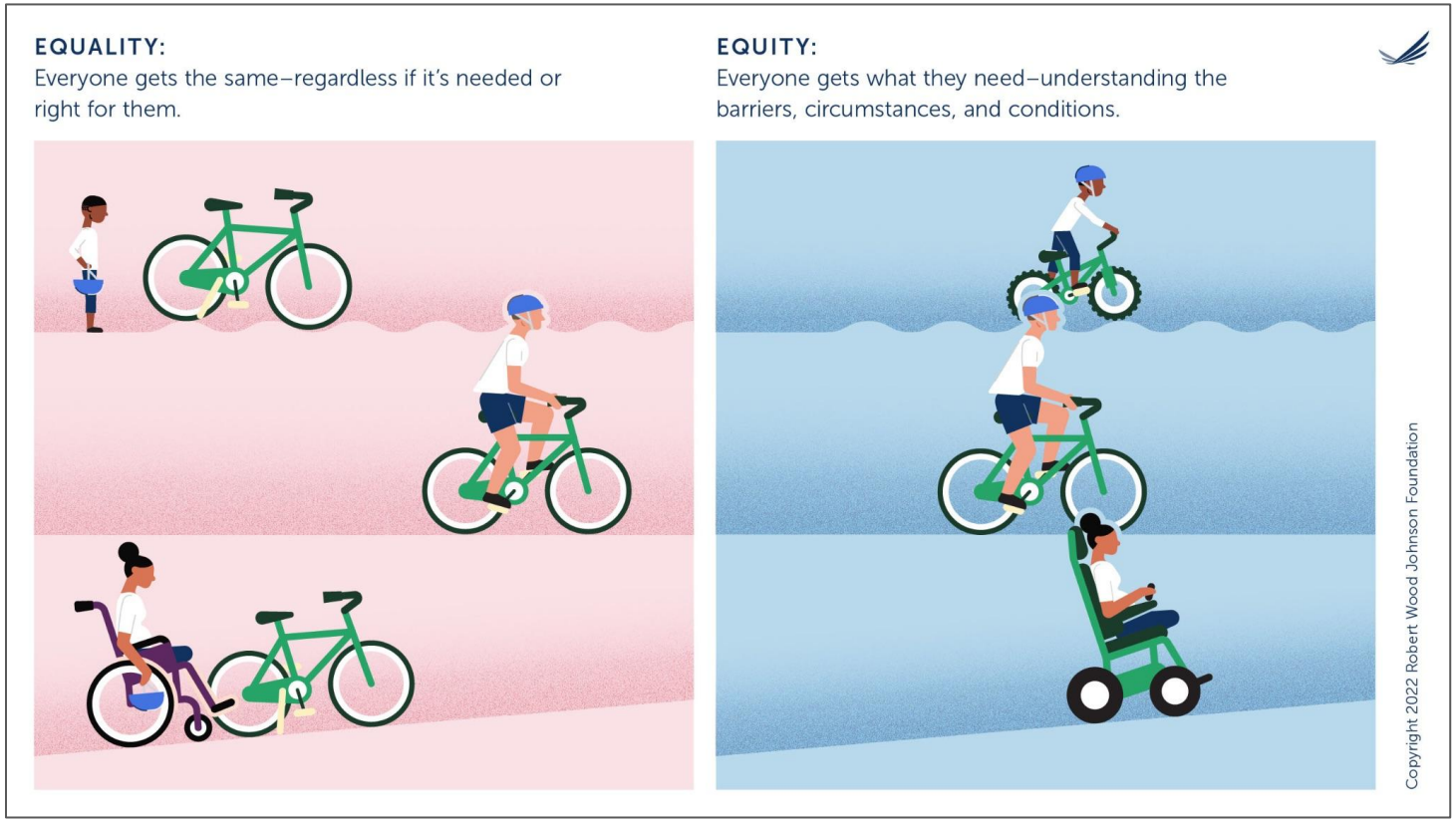
Health Equity and Partner Engagement

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)

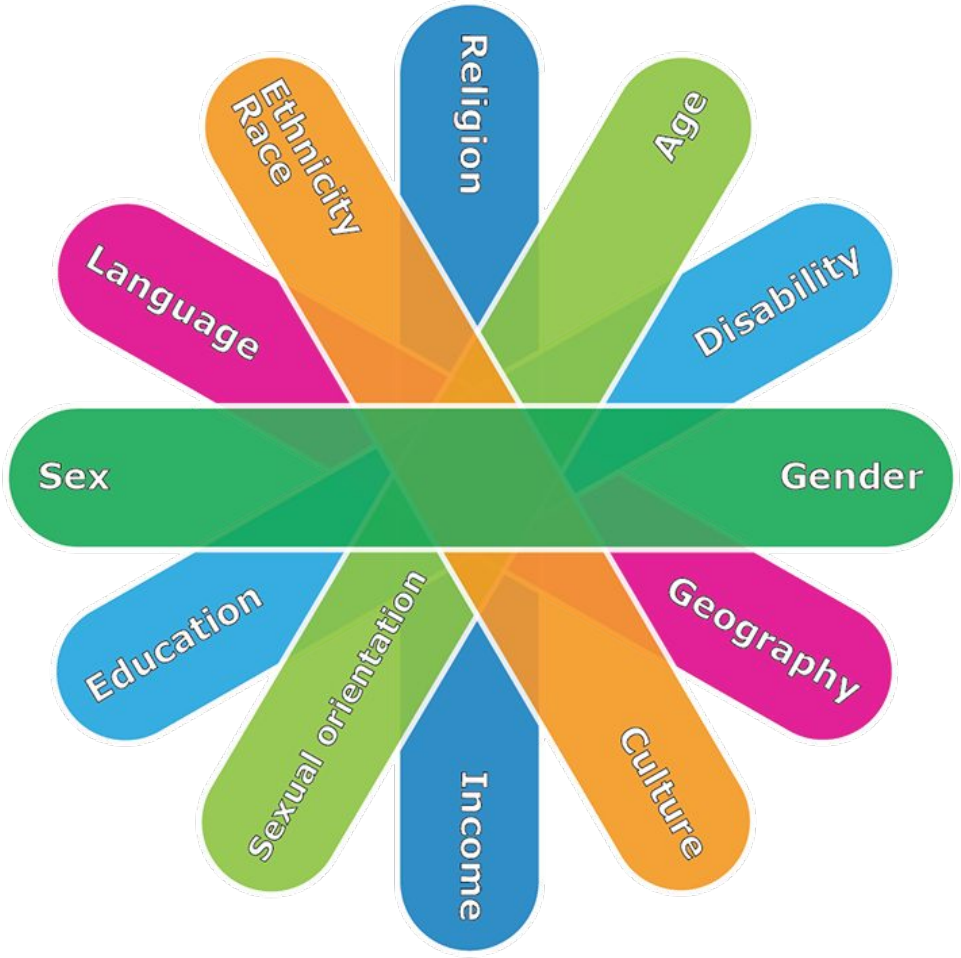


Office of Health Equity. (2022, July). *What is Health Equity?* Centers for Disease Control and Prevention. https://www.cdc.gov/healthequity/whatis/index.html#:~:text=Health%20equity%20is%20the%20state,health%20and%20health%20care%3B%20and.

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.

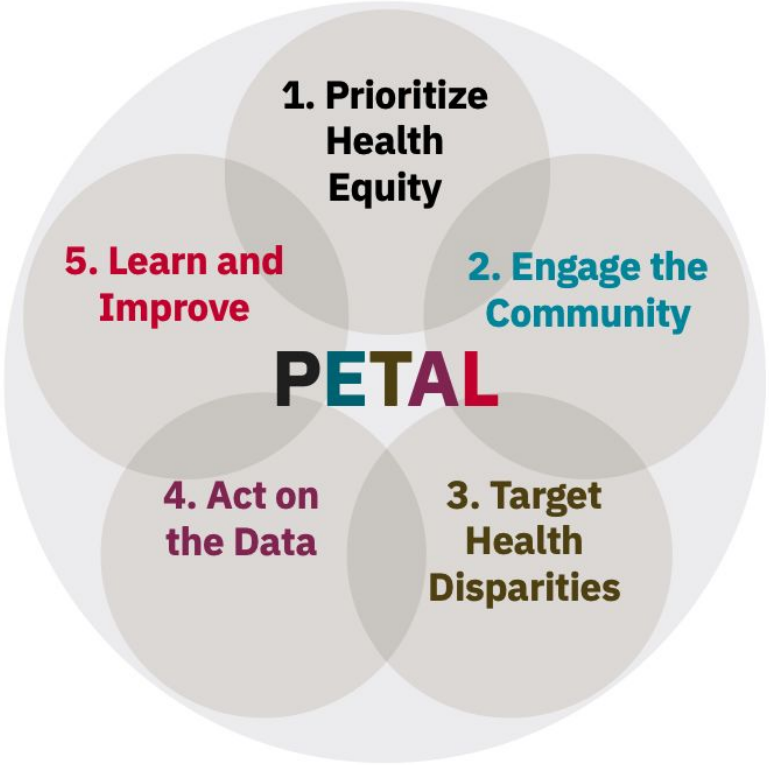


Government of Canada. (2022, April). *Introduction to Intersectionality*. https://women-gender-equality.canada.ca/gbaplus-course-cours-acsplus/eng/mod02/mod02_03_01a.html.

Addressing Health Equity

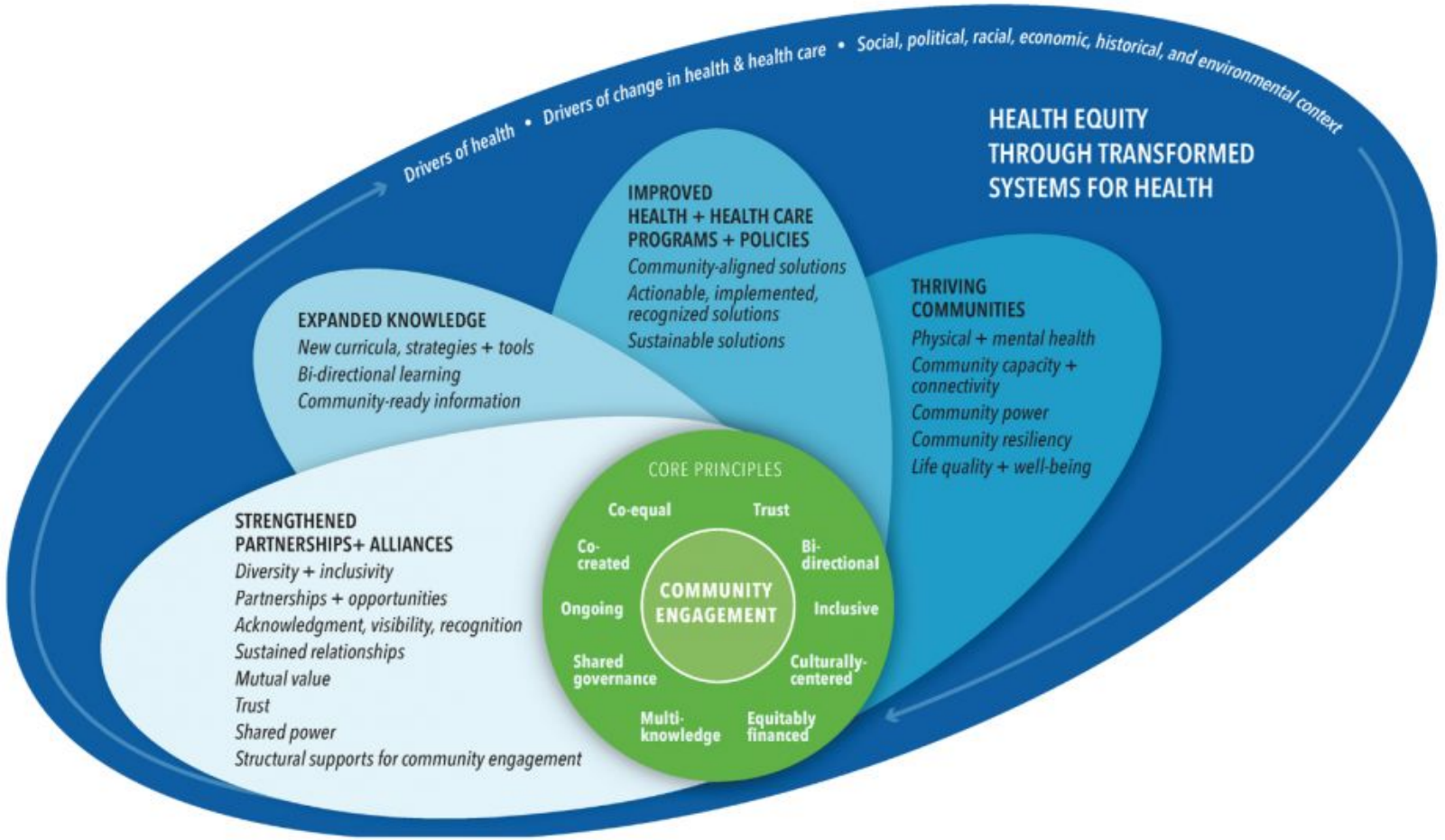
How will we approach advancing health equity?

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



Brooks, D, Douglas, M, Aggarwal, N, Prabhakaran, S, Holden, K, Mack, D. Developing a framework for integrating health equity into the learning health system. *Learn Health Sys*. 2017; 1:e10029.

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



Organizing Committee for Assessing Meaningful Community Engagement in Health & Health Care Programs & Policies. 2022. Assessing Meaningful Community Engagement: A Conceptual Model to Advance Health Equity through Transformed Systems for Health. *NAM Perspectives.* Commentary, National Academy of Medicine, Washington, DC. https://doi.org/10.31478/202202c.

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

Q&A

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!

Health Partners of Western Ohio

MetroHealth

Devoted to Hope, Health, and Humanity

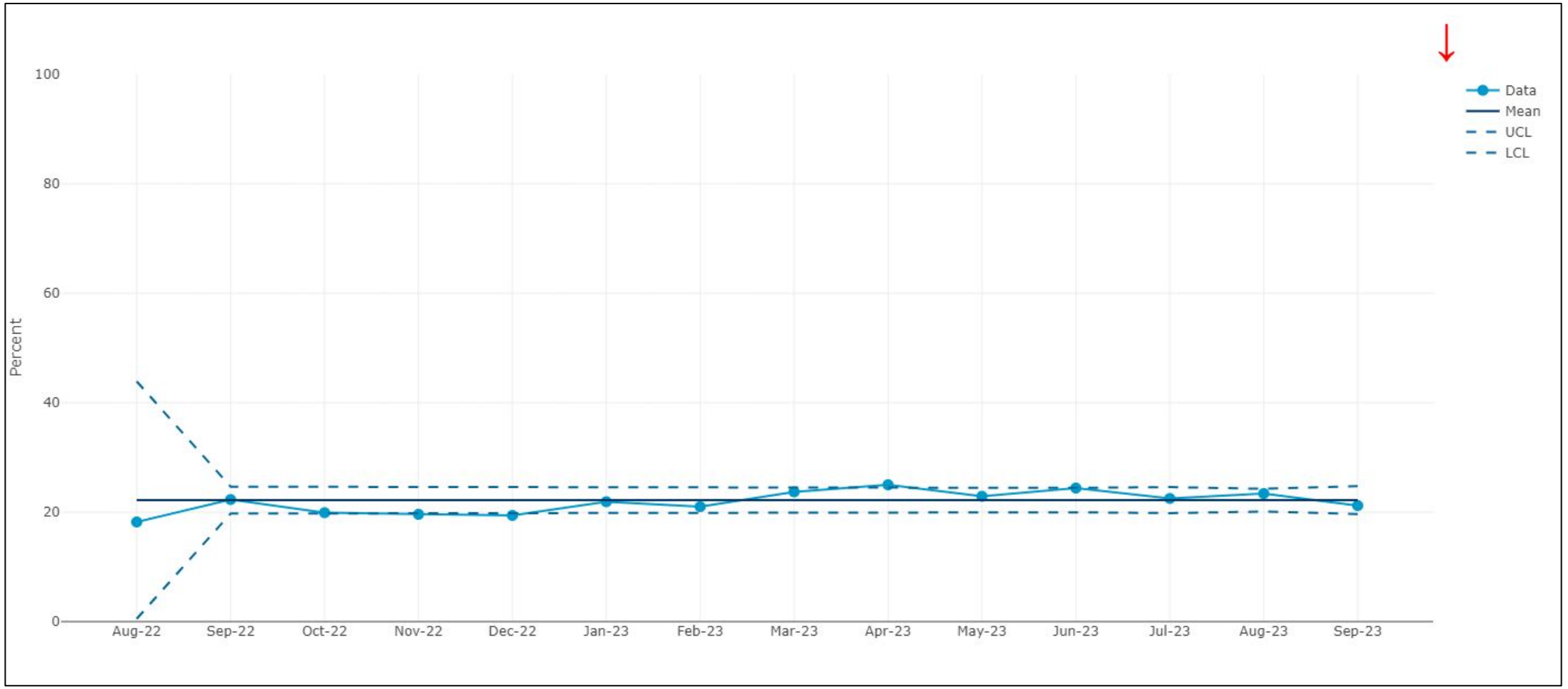
Neighborhood Family Practice

COMMUNITY HEALTH CENTERS

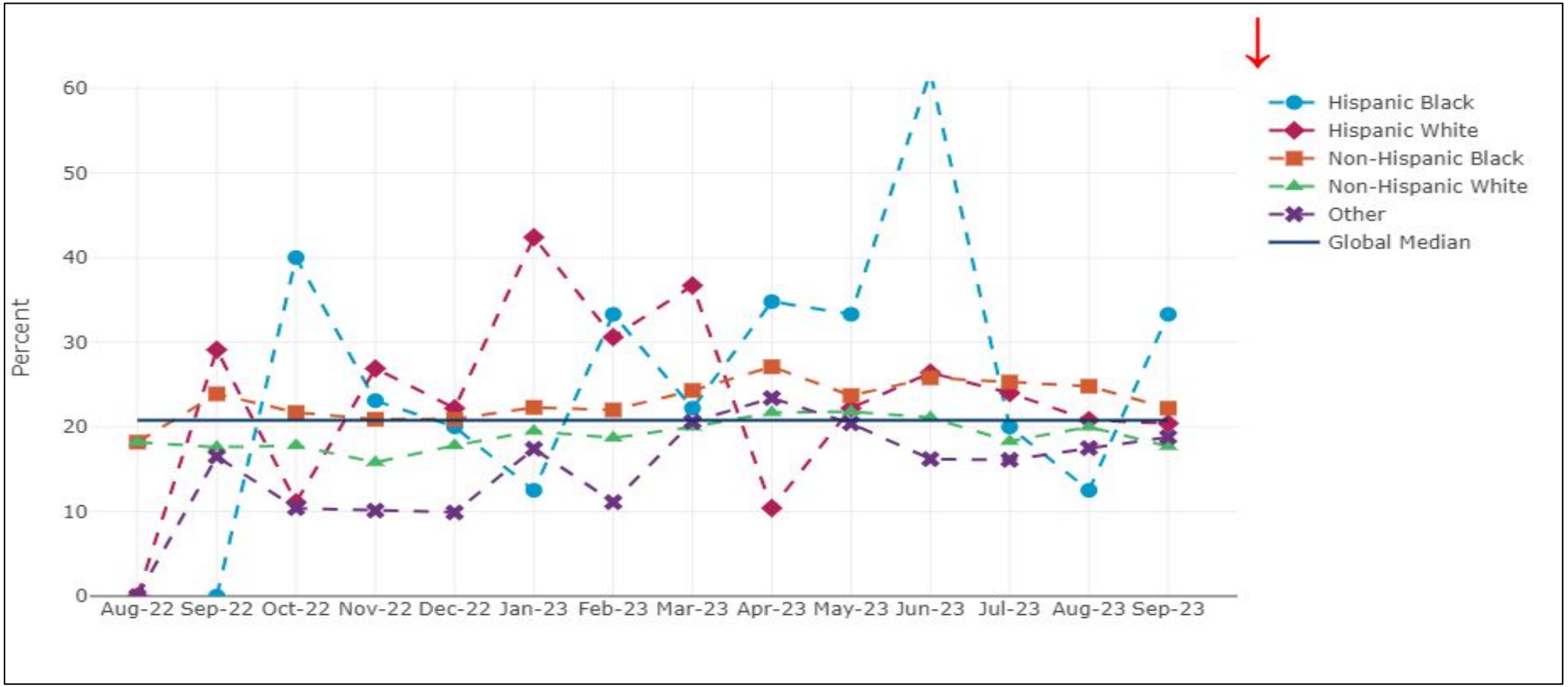
Core Measures

- 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)

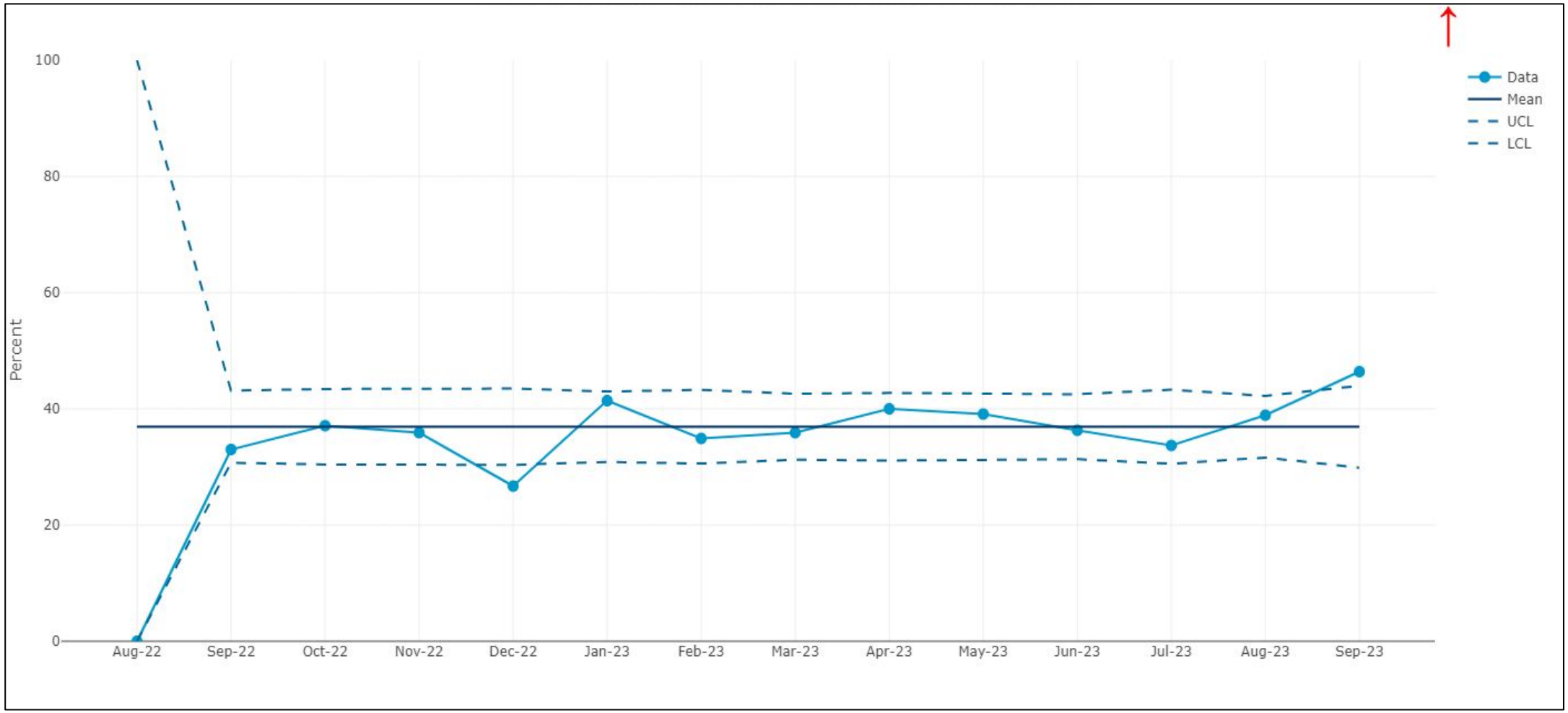
Control Chart: Percent HbA1C > 9 at Baseline



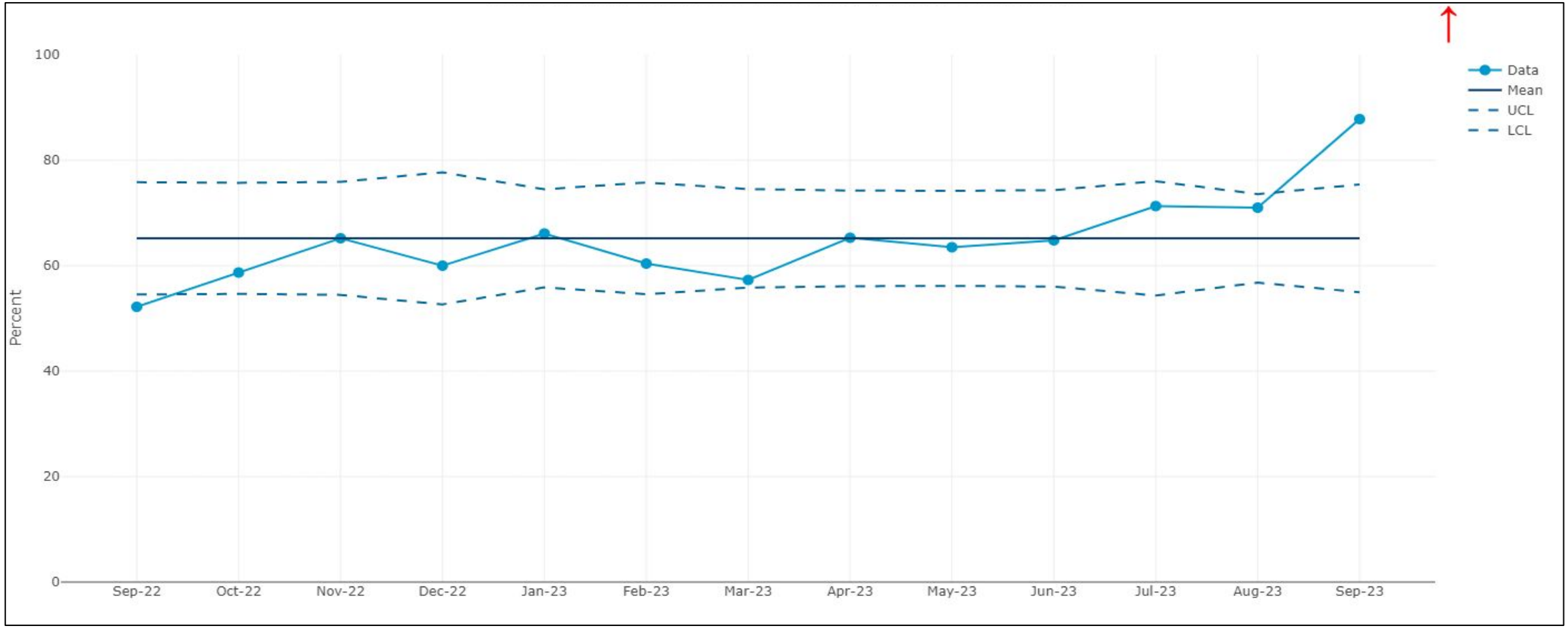
Percent With HbA1C > 9 by Race/Ethnicity



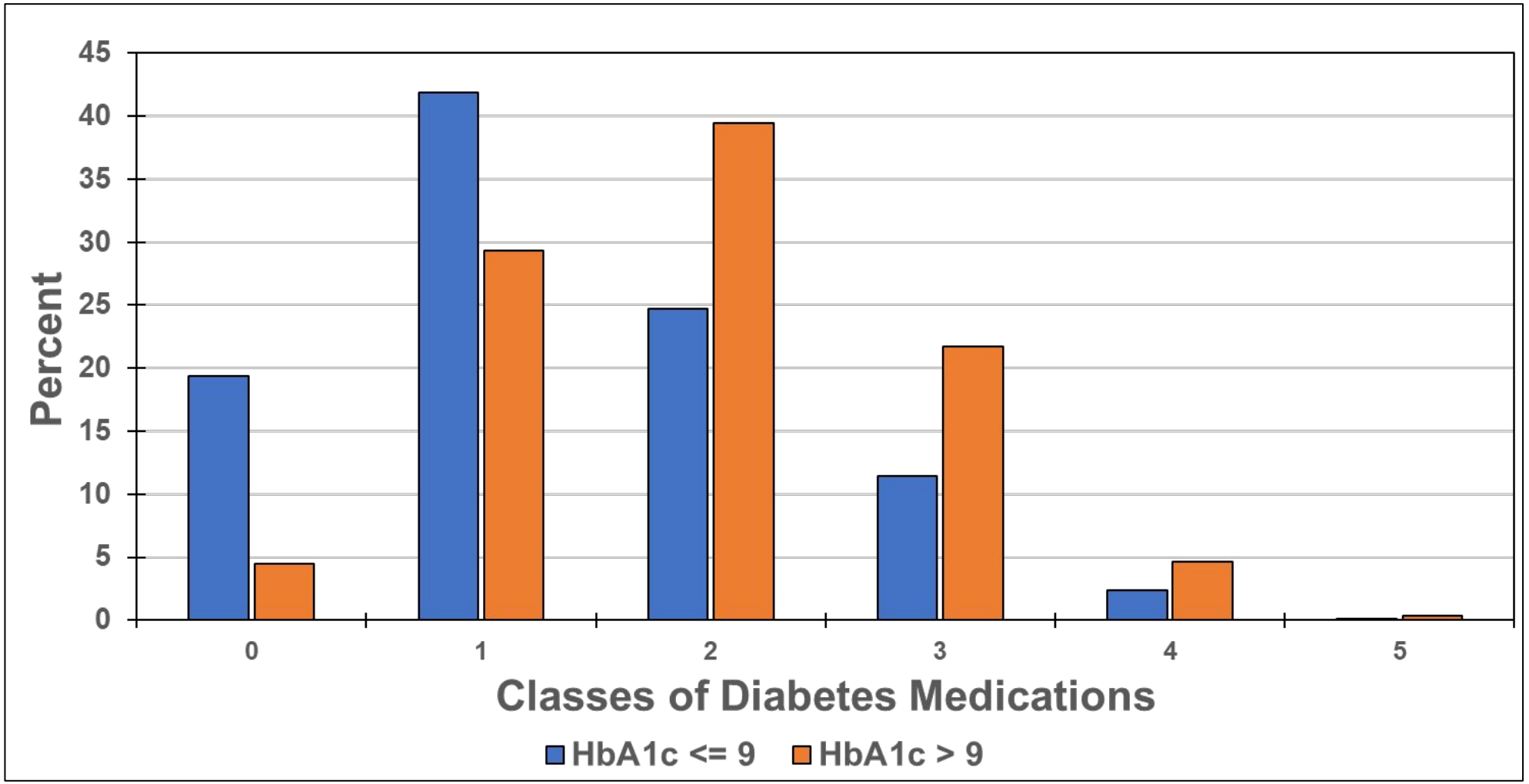
Percent With Timely Follow-up Scheduled



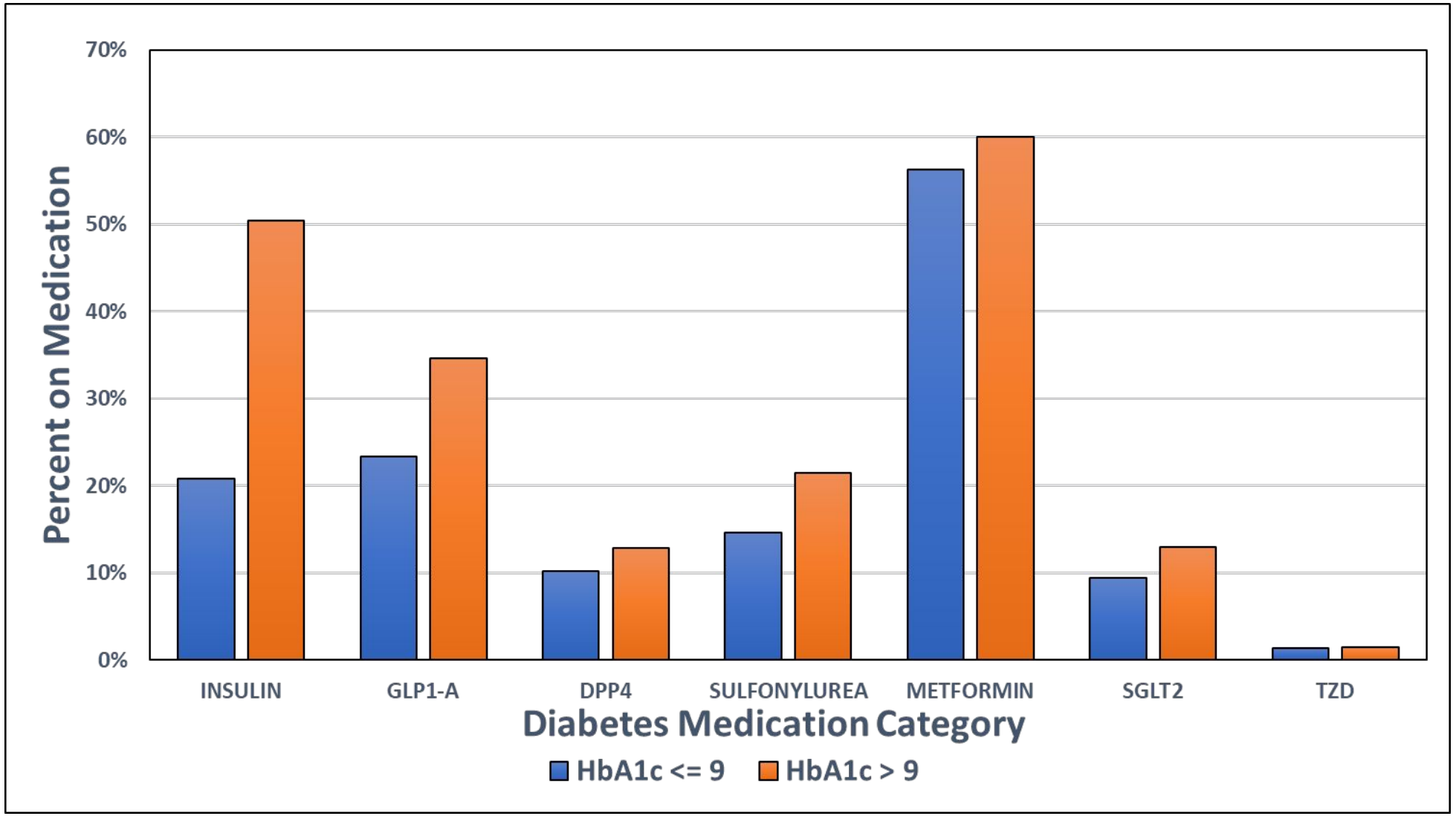
Percent With Timely Follow-up Attended



Number of Diabetes Medications



Type of Diabetes Medications



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

Aleece Caron, PhD
Quality Improvement Co-Lead
Case Western Reserve University

CME Objectives

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…

Source: Sue Butts Dion

Oh… Hmmm… then we need even BIGGER resources!

Source: Sue Butts Dion

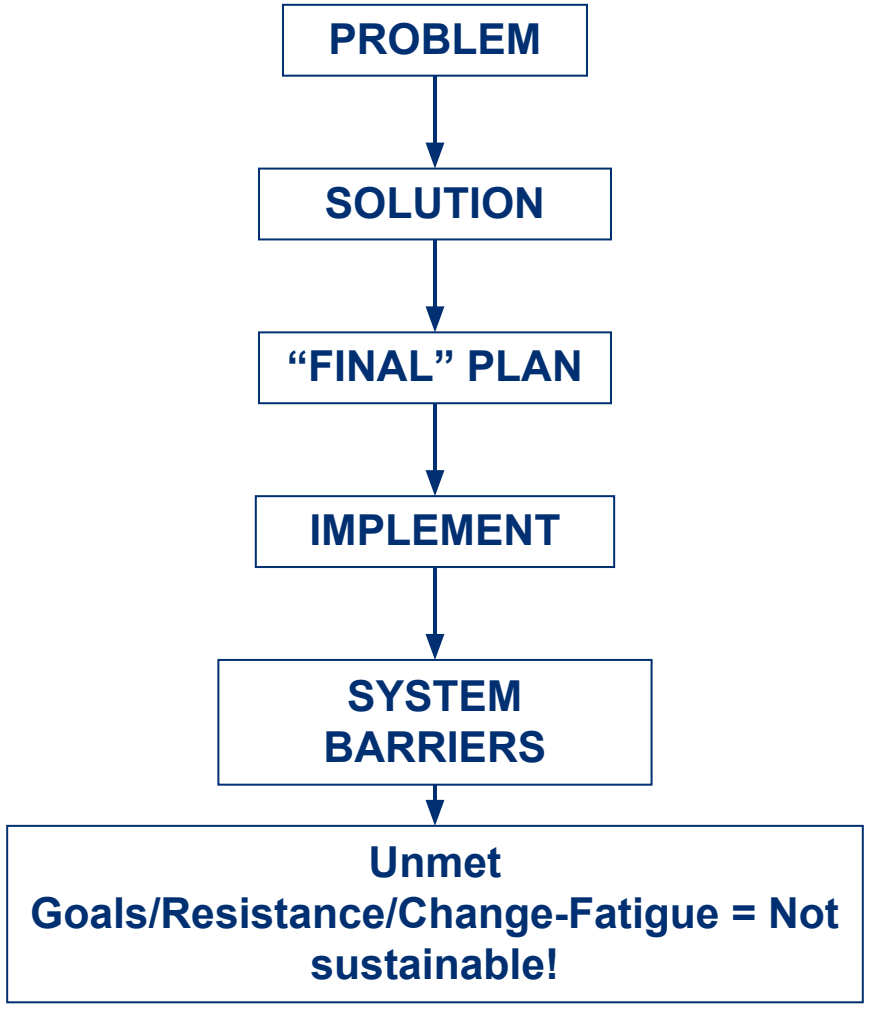
Source: Sue Butts Dion

Source: Sue Butts Dion

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



Adapted from: Jean Vukoson’s Bright Futures Presentation

QI Approach to Change

PROBLEM

↓

ASSESS CURRENT CONDITION

↓

DEFINE POSSIBLE SOLUTIONS

↓

CONDUCT

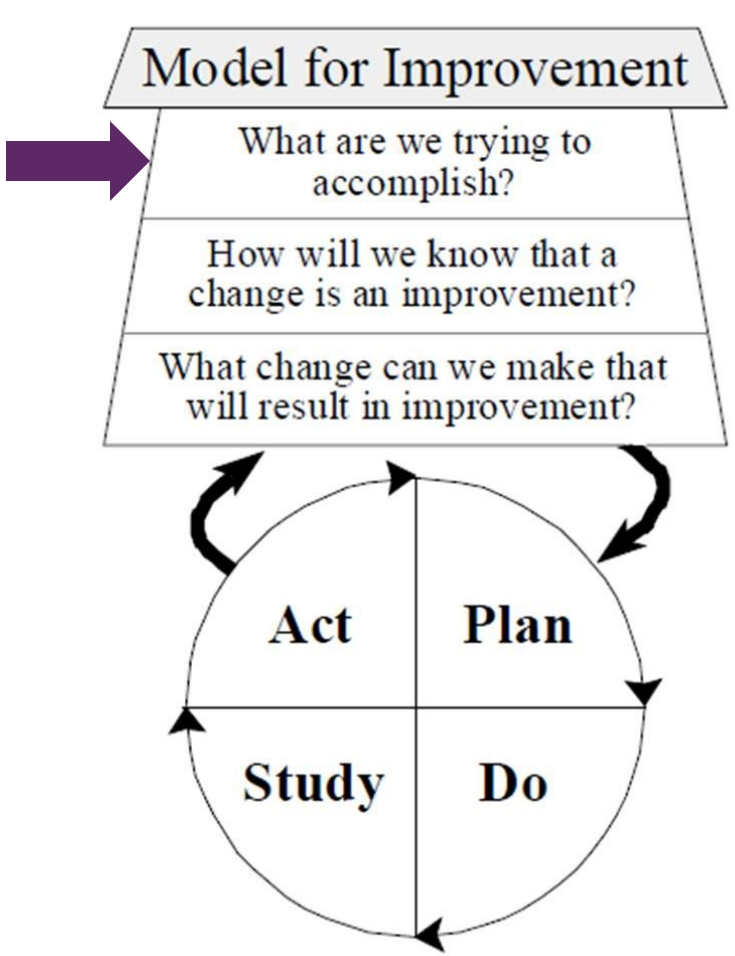
Plan-Do-Study-Act cycles

Designed by a team that does the work – "Ownership"

Adapted from: Jean Vukoson's Bright Futures Presentation

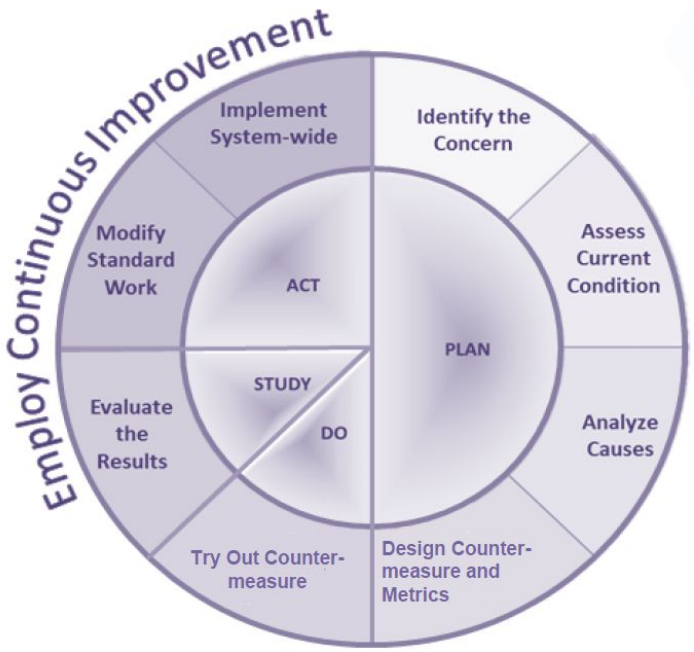
Quality Improvement

A roadmap to improve population based outcomes

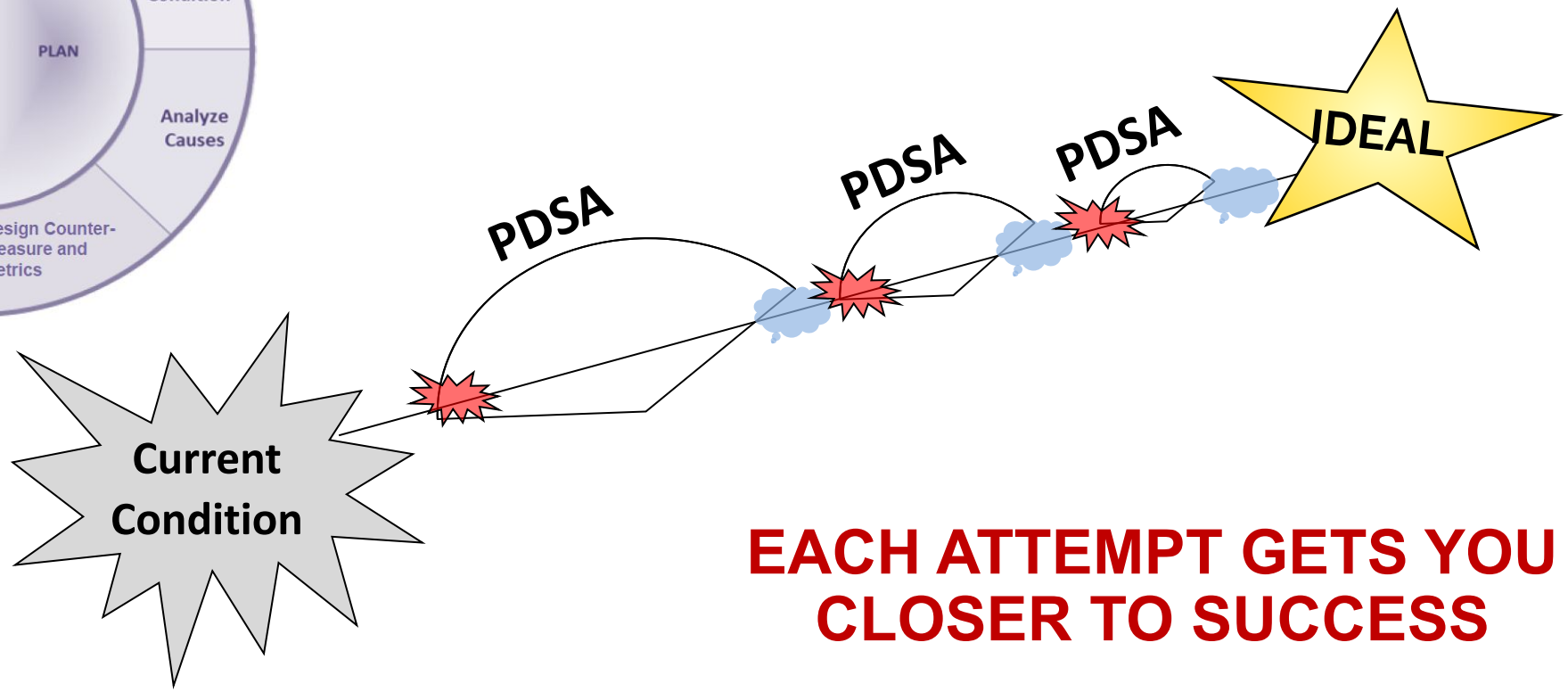


Model for Improvement

Improvement Strategy



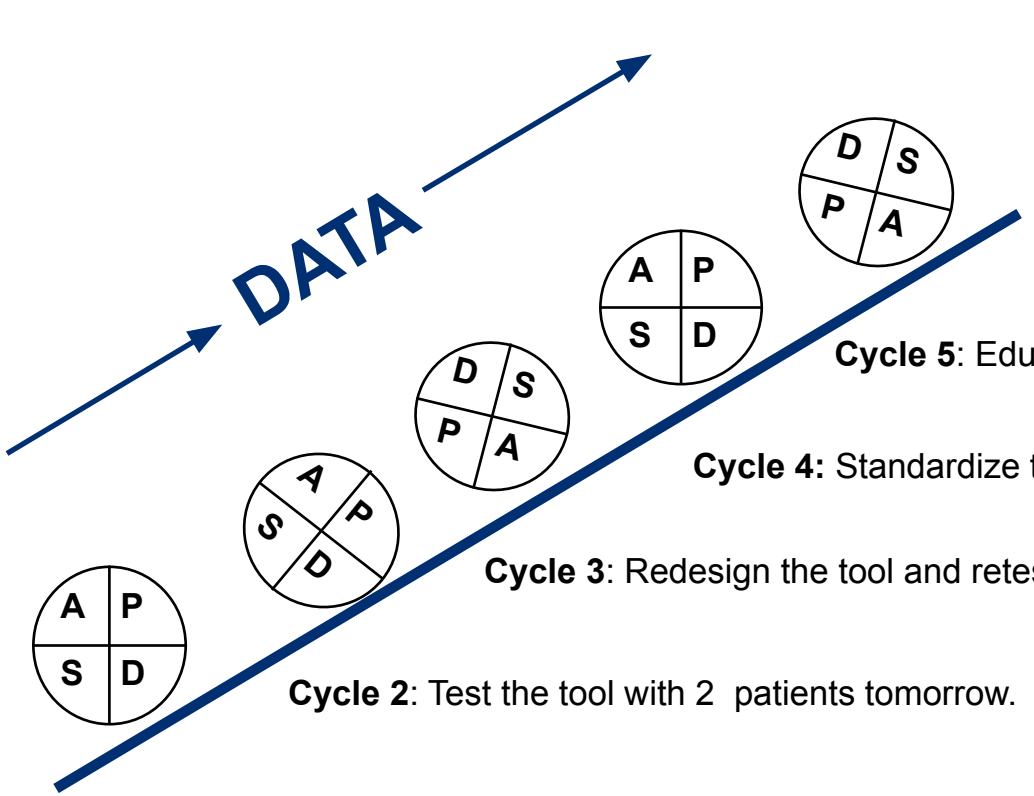
Problems are solved one step at a time



EACH ATTEMPT GETS YOU CLOSER TO SUCCESS

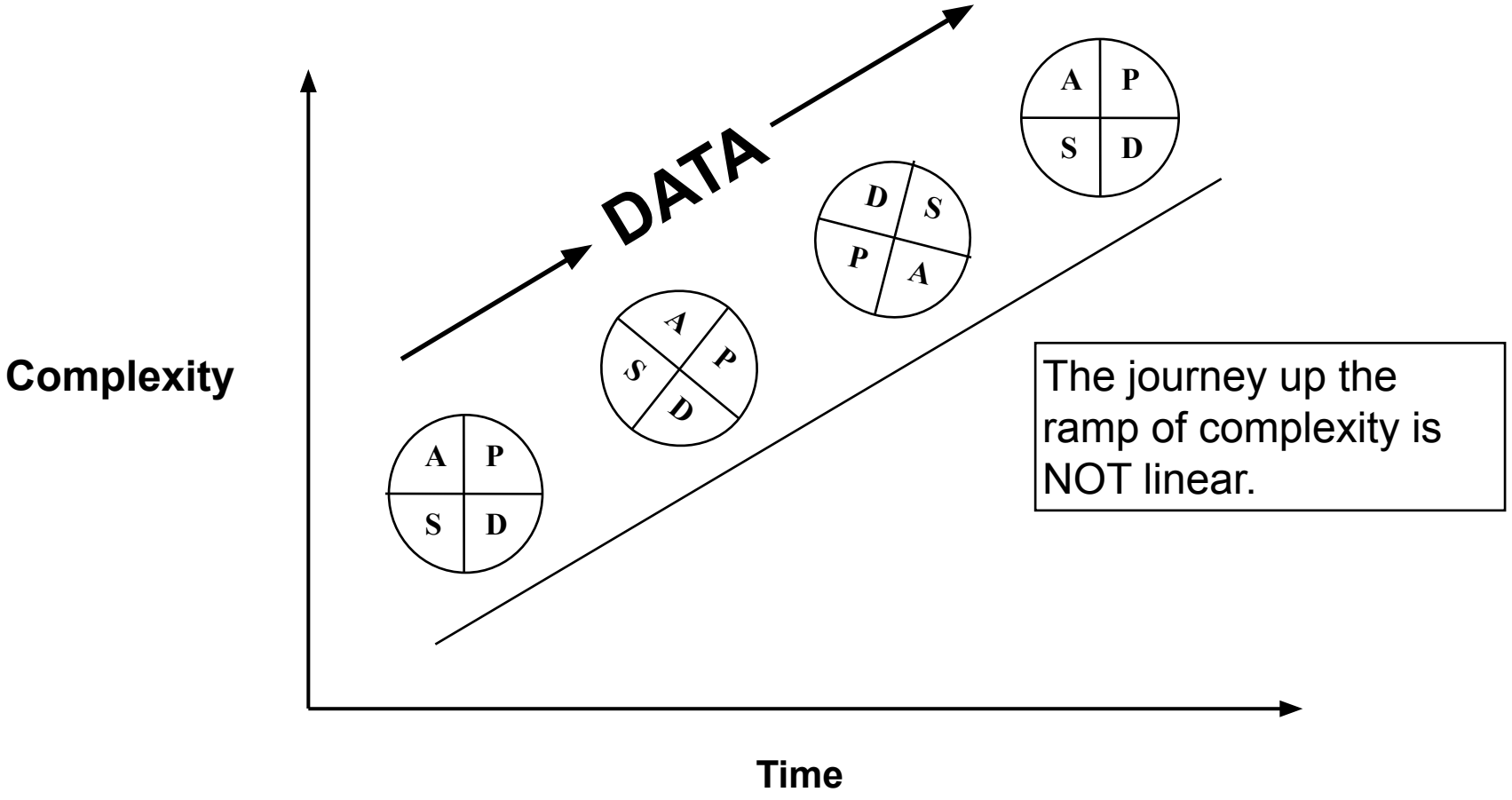
Aim: To improve the care of patients with diabetes by creating self-management goals with each patient

Establishment of self-management goals with patients will improve outcomes

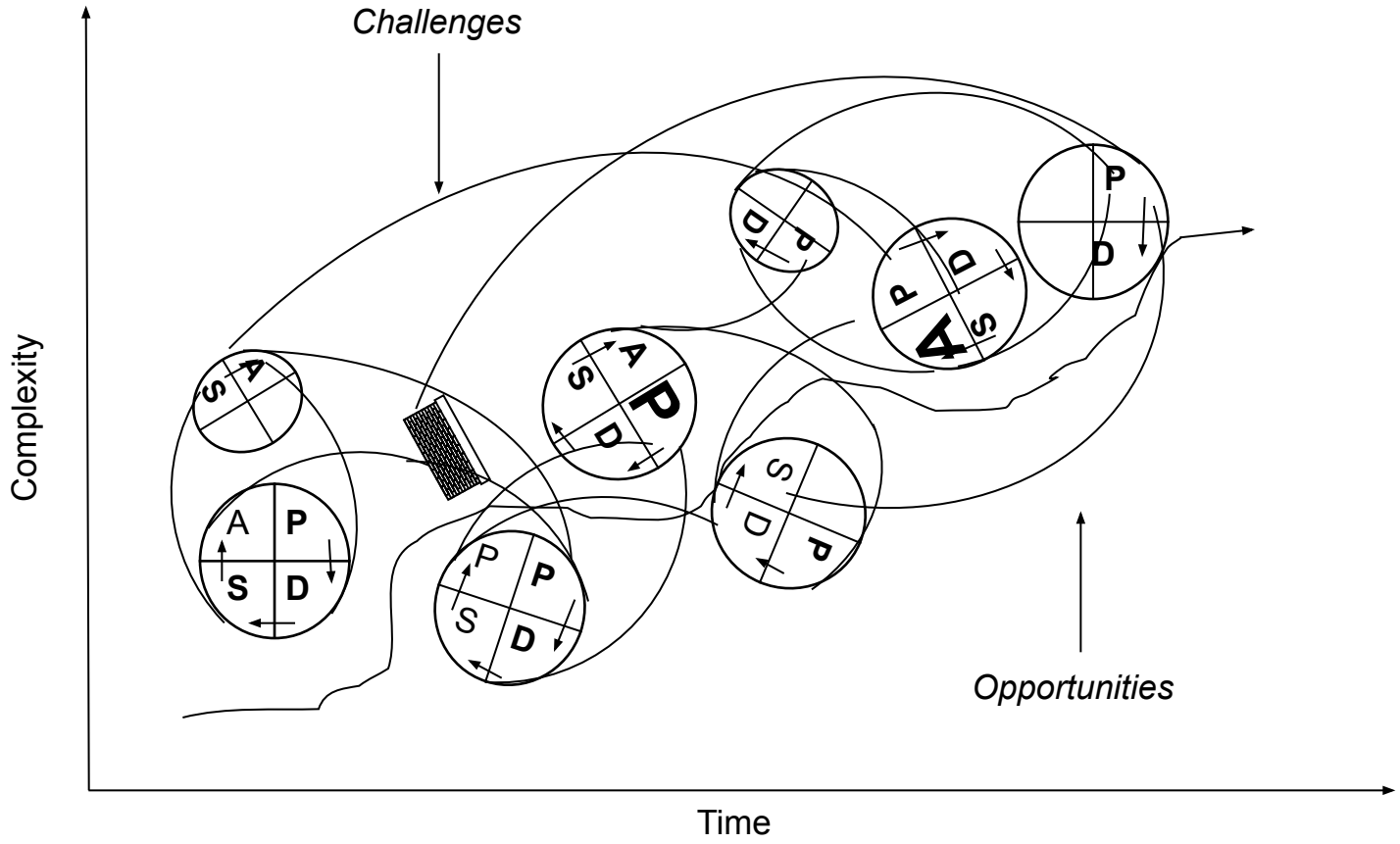


DANGER*

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.



Conceptual Model of Rapid Cycle Change



Legend:

P=Plan D= Do = Barrier = Direct flow of impact

S=Study A=Act = Lingering background impact Arrowhead = Feedback or feedforward

Different Sizes of letters and cycles and bolding of letters = denotes differences in importance/impact

Tomolo AM, Lawrence RH, Watts B, Augustine S, Aron DC, Singh MK. Pilot study evaluating a practice-based learning and improvement curriculum focusing on the development of system-level quality improvement skills. J Grad Med Educ. 2011 Mar;3(1):49-58.

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

Template Created by: UC Health, 2019

Plan-Do-Study-Act Worksheet

Updated 12/7/2021

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

Test start date:10/1/23

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

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 Plan: Continue to standardize care pathway

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

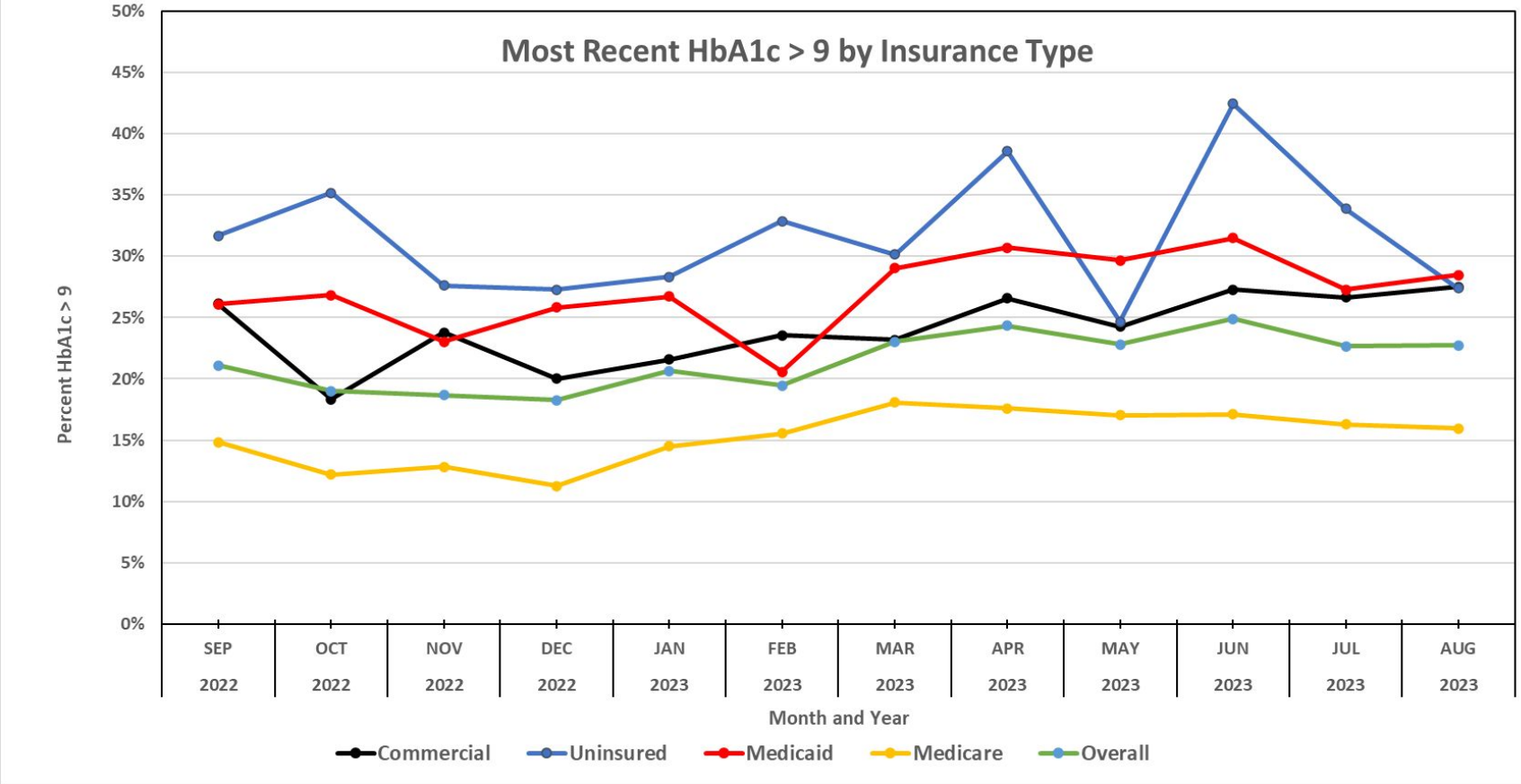
Exercise 1:

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



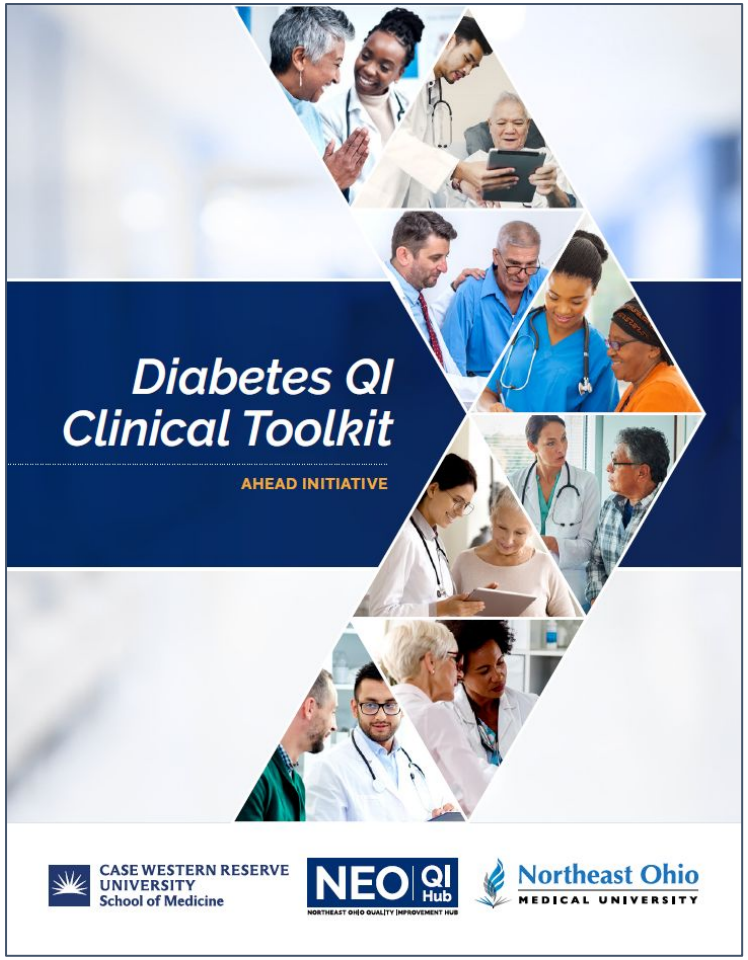
Question 2: Who would you want on your project team?

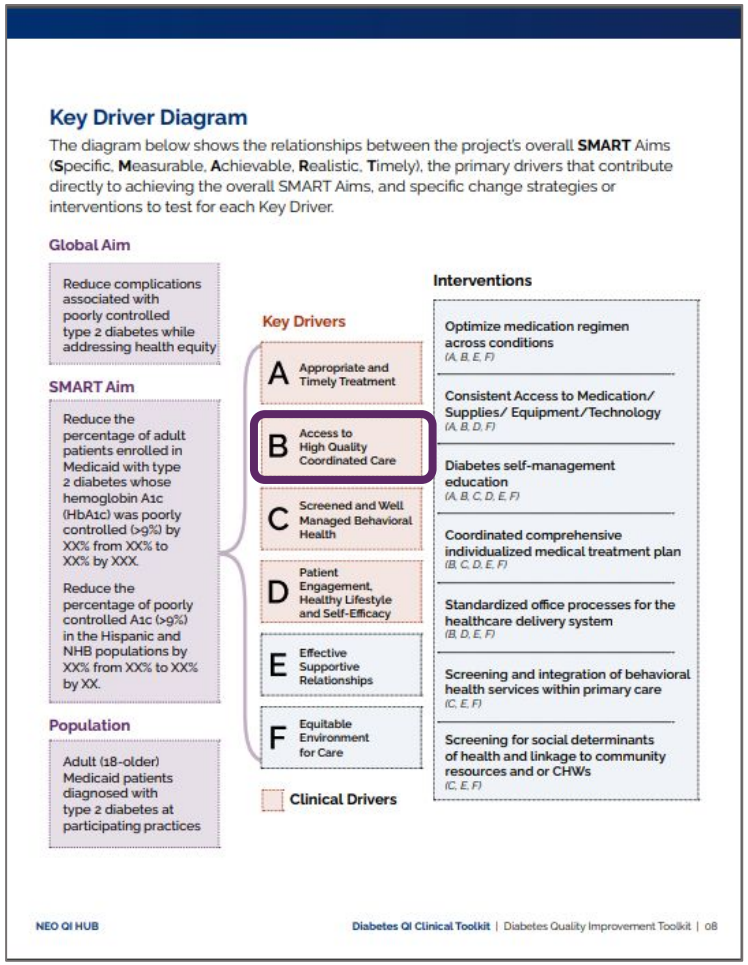
- Physician
- Medical Assistant
- Community Health Worker
- Patient Team
- Nurse Care Manager
- Pharmacist
- Medicaid Managed Care Payers
- Diabetes Educator
- Community Partner

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





Key Driver Diagram

The diagram below shows the relationships between the project's overall **SMART** Aims (**S**pecific, **M**easurable, **A**chievable, **R**ealistic, **T**imely), the primary drivers that contribute directly to achieving the overall SMART Aims, and specific change strategies or interventions to test for each Key Driver.

Global Aim

Reduce complications associated with poorly controlled 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 poorly controlled (>9%) by XX% from XX% to XX% by XXX.

Reduce the percentage of poorly controlled 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

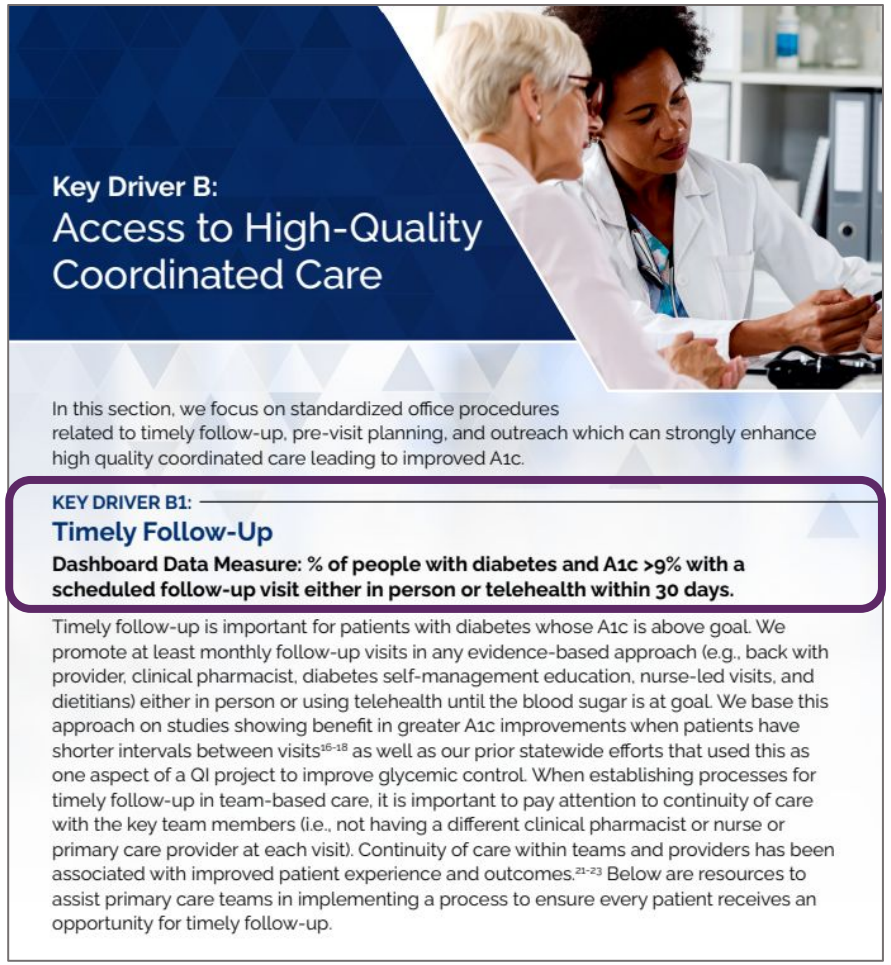
Key Drivers

- 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 — Equitable Environment for Care

Clinical Drivers

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 determinants of health and linkage to community resources and or CHWs (C, E, F)



Key Driver B: Access to High-Quality Coordinated Care

In this section, we focus on standardized office procedures related to timely follow-up, pre-visit planning, and outreach which can strongly enhance high quality coordinated care leading to improved A1c.

KEY DRIVER B1:

Timely Follow-Up

Dashboard Data Measure: % of people with diabetes and A1c >9% with a scheduled follow-up visit either in person or telehealth within 30 days.

Timely follow-up is important for patients with diabetes whose A1c is above goal. We promote at least monthly follow-up visits in any evidence-based approach (e.g., back with provider, clinical pharmacist, diabetes self-management education, nurse-led visits, and dietitians) either in person or using telehealth until the blood sugar is at goal. We base this approach on studies showing benefit in greater A1c improvements when patients have shorter intervals between visits[16-18] as well as our prior statewide efforts that used this as one aspect of a QI project to improve glycemic control. When establishing processes for timely follow-up in team-based care, it is important to pay attention to continuity of care with the key team members (i.e., not having a different clinical pharmacist or nurse or primary care provider at each visit). Continuity of care within teams and providers has been associated with improved patient experience and outcomes.[21-23] Below are resources to assist primary care teams in implementing a process to ensure every patient receives an opportunity for timely follow-up.

Exercise 2:

Drafting an Aim Statement

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

SMART Aim Statement

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

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.

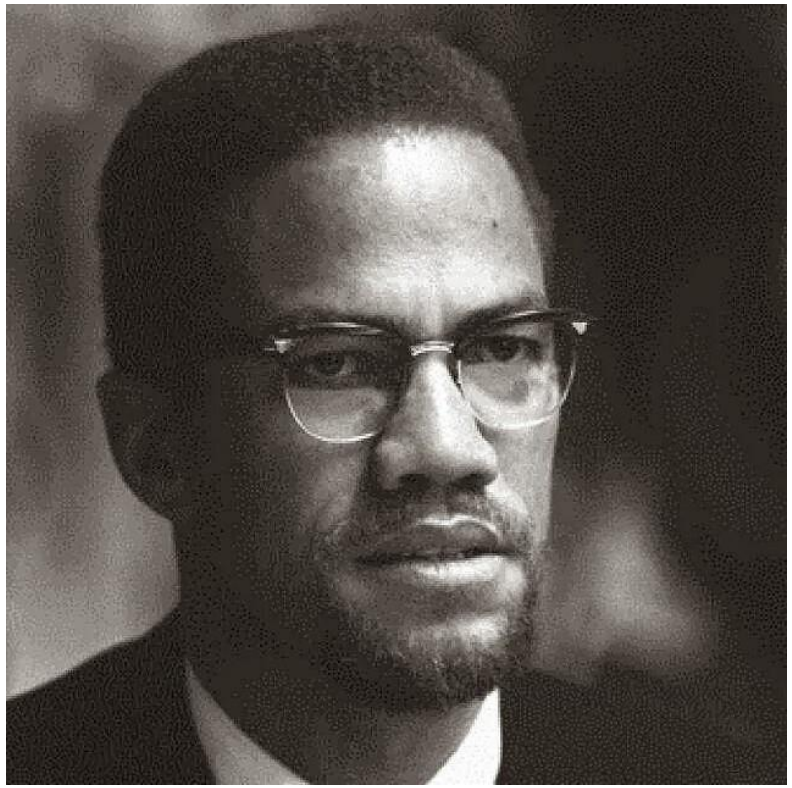
Next Steps

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

CASE WESTERN RESERVE UNIVERSITY
School of Medicine

NEO QI Hub
NORTHEAST OHIO QUALITY IMPROVEMENT HUB

Northeast Ohio
MEDICAL UNIVERSITY

Thank You!

AxessPointe Community Health Centers

Better Health Partnership
Collaborating for a healthy community

Cleveland Clinic

Health Impact Ohio
Equity. Access. Quality.

MetroHealth
Devoted to Hope, Health, and Humanity

Neighborhood Family Practice
COMMUNITY HEALTH CENTERS

Summa Health

University Hospitals

U.S. Department of Veterans Affairs
Veterans Health Administration
Office of Research & Development

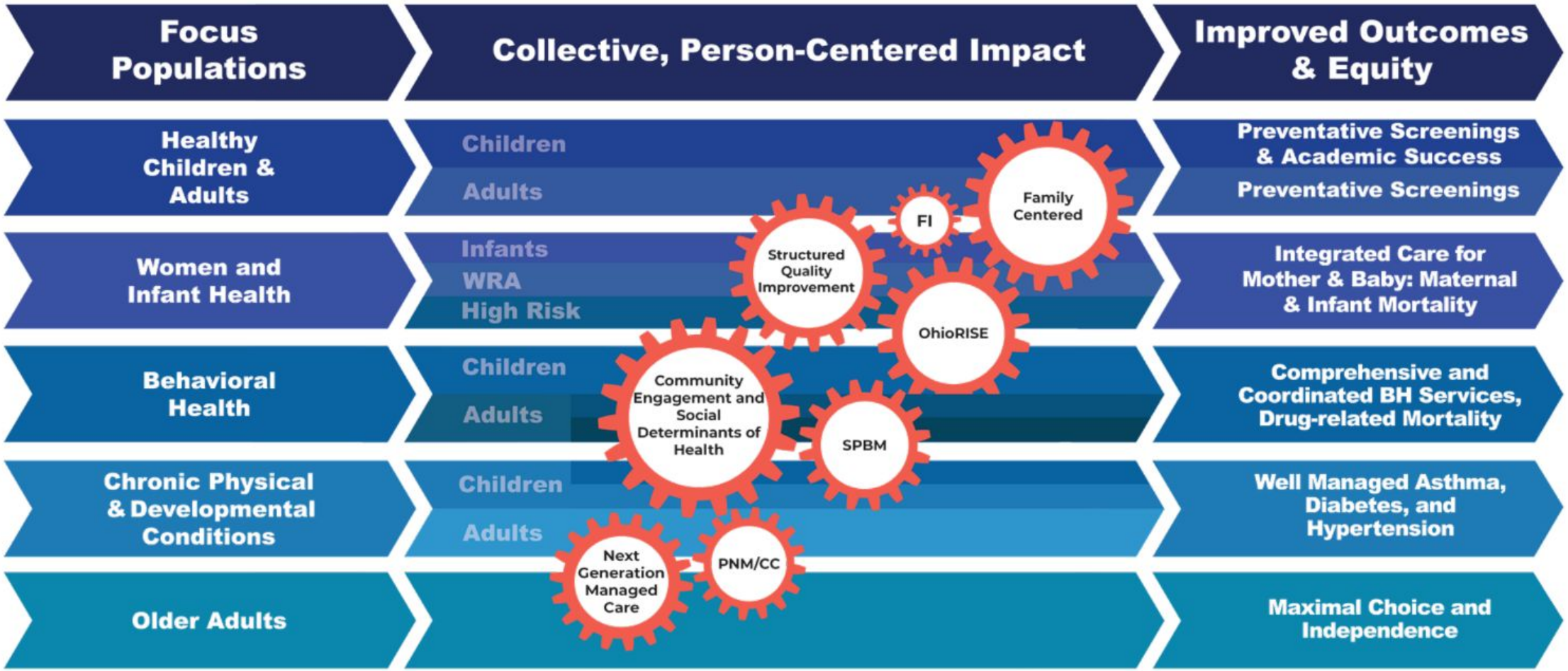
OHIO COLLEGES OF MEDICINE
GOVERNMENT RESOURCE CENTER

medtapp

Ohio Department of Medicaid

Appendix

Ohio Medicaid's Population Health and Quality Strategy



Project Timeline