This Forum was recorded; click HERE to view it!

In-Person Meeting Planning

At the January meeting, we decided to pursue Friday, May 3 for the spring in-person Forum. Unfortunately, Community Care is hosting an Emergency Preparedness training in Topeka on that day. Due to the potential conflict for health center staff who may want to attend both events, Terri Kennedy suggested Thursday, May 2 in Topeka as an alternate date for the Forum. After some discussion, Terri committed to sending out a poll or survey to determine participants' plans for attending the Emergency Preparedness training and availability for alternate Forum dates.

Update: The poll was sent the afternoon of 3/25.

Measures and Targets

Of the 10 measures we are tracking, DRVS users have reached or exceeded 4 Silver targets (Breast Cancer Screening, Adult Weight Screening, Dental Sealants, and Child Weight Screening). 2 Gold targets have been met/exceeded as well (Dental Sealants, and Child Weight Screening). Refer to slide 4 for a list of the Forum measures, current DRVS performance, and targets. Refer to slide 5 for a screen shot of the DRVS Quality Forum Measures scorecard showing March 2019 trailing year performance.

UDS Diabetes Measure

Refer to slides 7-14 for the Diabetes A1c Poor Control measure breakdown, workflow, and best practices. Treatment best practices on slide 12 are evidence-based from providers. Heather Budd shared the following key information during her review of this information.

- Use a automated tool to help you determine a patient's care caps.
- Use standing orders to allow the MA/LPN/RN to perform an A1c finger stick, if overdue.
- Use standing orders to allow the MA/LPN/RN to order an A1c lab, if warranted.
- Point of care testing is really important due to the high rate of lab no-shows.
- If the A1c is overdue and the patient is in-house, do the test regardless of the visit type.
- Community Health Workers and lay care managers can help patients monitor glucose levels.

Diabetes Member Best Practice Spotlight

- KU Pharmacy Partnership at GraceMed – Heather Sell shared that their pharmacy partnership with KU ended last year after their PharmD consultant moved out of state. During the partnership, the pharmacist met with patients and provided patient education. She also provided recommendations to their providers. GraceMed intends to restart the partnership in 2019.
- Diabetes Program at GraceMed – Heather Sell shared the following about how GraceMed helps their patients manage diabetes.
    - GraceMed focuses on 5-8 measures each year. They've assigned subcommittees to each CQM to break down barriers and determine process changes that may be needed. Some subcommittees include patients.

- HRSA was in-house to perform a Diabetes measure analysis. While in-house, they set 3 goals which they will follow throughout the year.
- GraceMed staff review reports to determine no-shows, then call patients to get them back in-house. They also run reports on non-compliant patients, then call and offer appointments to them. Their call center has staff that only do outbound quality calls.
- They had 2 different provider training on diabetes.
- They added an appointment type for "quality care gap visit status".
- They stress chart preps and services needed during morning huddles.
- MAs walk the patients up to schedule follow-up appointments while they are still in-house.
- They've added machines in each clinic that allow them to test A1cs while the patient is in the clinic.

- Diabetes Program at PrairieStar – Mona Broomfield shared the following information about the diabetes control strategies in place at PrairieStar. ***Mona's compiled list of PrairieStar's diabetic strategies is included as an attachment to these notes.***
  - PrairieStar uses many of the same strategies as GraceMed. Their primary strategy is that it takes everyone to actively work with the patient to bring down their A1c levels.
  - She stressed starting with the basics – getting medications, assessing SDOH like housing, refrigeration, diet, etc.
  - Sometimes you have to go back to the basics in education and teach patients what a carbohydrate is, etc. Their volunteer Internal Medicine doctor conducts 3-hour classes with patients focused on basics. BH staff work with patients on changes needed to improve.
  - PrairieStar's case workers get involved to help patients overcome barriers.
  - Mona stressed using a trained interpreter when needed instead of relying on children or relatives to translate.
  - They conduct peer reviews for providers and nurses to ensure they're completing the tasks they're supposed to complete with patients.
  - Their educator will refer patients to an exercise group held on-site and/or to a nutritional cooking class. The educator may also refer patients to behavioral health. The patients can enter a program and actually graduate. Graduates can be a mentor within the group.
  - Other strategies in place:
    - Use flow sheets to ensure consistency
    - Ensure there is an oral assessment done
    - Limit the number of refills that are given so the patient is seen every 3 months
    - Review ER visits every day and follow up with patients that visited the ER
    - Have standing orders in place to allow delegation
    - Review dashboards regularly

Cherie Singletary shared in **Chat**, "I wanted to echo that in starting our CCM Program; one of the foundational aspects that we are working on is Standing Actions/Orders for Medication Refills & Monitoring Diagnostic Orders that our Care Coordinators are able to do for the patients in the CCM Program."

Diabetes Control Brainstorming for Improvement

Amy Lurken stated that Heartland is employing many of the same strategies to controlling diabetes. She's interested in what other health centers are doing with group visits.

Cohorts

Creating a filtered patient grouping, or cohort, helps to track outcomes for patients with similar conditions. DRVS and many EHRs have the ability to create cohorts. For DRVS users, click HERE for the Cohort User Guide.

Cohort Member Best Practice Spotlight

Heartland's Use of Cohorts – Amy Lurken shared that after Heartland and Healthcare Access merged, they had an influx of new patients with uncontrolled diabetes and hypertension. Using DRVS, Amy created cohorts of diabetic and hypertensive patients. The uncontrolled diabetic cohort includes patients from that merger diagnosed with diabetes and treated for that condition for at least one year. This cohort allows them to look at how long-term, integrated care has affected those patients. By monitoring this cohort, they've found that patients aged 20-34 are the hardest to control. They're looking at care continuity and care gaps for this cohort.

Care Management

Care management involves the provision of care coordination services that are intended to intervene in a positive way with patients who have various barriers including health and social determinants. Care management requires personal engagement with those patients to affect change. Clinical, non-clinical and business staff are involved in the care management process. Refer to slides 31-43 for more information about care management.

Care Management Discussion

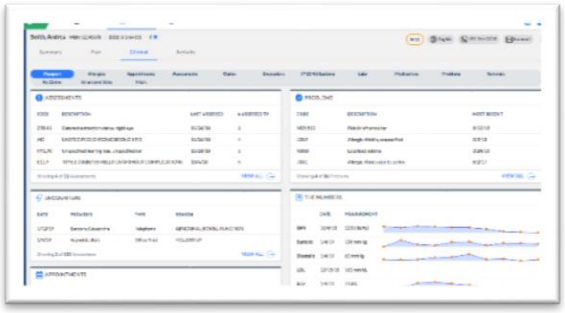
Via **Chat**, Amy Lurken stated, "I was curious as to how everyone staffs care management if they have designated care managers (or if it is rolled up into parts of nursing team roles)". Kalicia Wilson responded in **Chat**, "At our clinic in Salina, two of us provide Chronic Care Management and Transitional Care Management to our patients. We have a Kancare Rep in Clinic and one of our Pharmacists is also a CDE." She also responded, "Also, our role as Care Coordinators is separate from Nursing staff. I am a RN and the other Care Coordinator is a RRT."

Amy shared that at Heartland they have had a few iterations of care management staffing. They've had AmeriCorps Case Management for case management and care coordination, both internally and with community organizations. After a reduction in AmeriCorps staff, their behavioral health consultants have taken on some of the care management tasks.

Beginning in August 2019, the HCCN will begin a Care Management Community of Practice for care managers. Trish Harkness will lead the Community. This Community will be similar to the Quality Forum, but will focus on tasks and tools for care managers.

Azara Care Management (ACM)

Azara will release Azara Care Management (ACM) on April 1. ACM is a product separate from DRVS, but is powered by the health center's data in DRVS. ACM supports the organization of patients into cohorts and then allows care managers to manage and monitor the panel of patients by tracking tasks and follow-up activities related to their care.



Refer to slides 46-81 for an ACM overview and screen shots. Click HERE for a recorded demonstration of ACM.

Next Steps

Terri Kennedy will send out a survey or poll to determine the date of the spring in-person Forum, then work toward scheduling that meeting.

PDSA Reminder

Submit a PDSA on diabetes or care management that was started or completed within the last 12 months to Terri by April 12th!

Meeting Participation

Connections Health Center	**Attendee(s)**
Atchison CHC	Dorothy Gibson
CHC in Cowley County	David Brazil, Tiffany Swanson, Melody Vaden
First Care Clinic	Rhiannon Maier
Genesis Family Health	Jim Perkins
GraceMed Health Clinic	Sherry Clark, Lashawn Johnson, Diane Moore, Jocelyn Moreno, Heather Sell
Health Ministries Clinic	Kaely Burgess, Matthew Ediger, Bethany Gormley, Nancy Salas
Health Partnership Clinic	Maria Hensley
Heart of Kansas	Heather Hicks
Heartland CHC	Amy Lurken
Hoxie Medical Clinic	Whitney Zerr
Hunter Health Clinic	Joanna Sabally
Konza Prairie CH&DC	Cherie Singletary
PrairieStar Health Center	Mona Broomfield, Tad Ramage
Salina Family Healthcare	Melodie Reich, Kalicia Wilson
Other Organization	**Attendee(s)**
Community Care / Health Center Connections	Terri Kennedy, Trish Harkness
Azara Healthcare	Heather Budd

Next Forum

May 2, 2019 (tentative) – Depression Screening and Adult BMI

DIABETES STRATEGIES – IT TAKES EVERYONE

1) Team work & standing orders – Nurse will have A1c completed before the Provider comes to the exam room. Set the standards so nursing knows when to get an A1c.
2) Always use a flow sheet so nothing is missed. This would include all labs, eye exams, foot exams, etc..
3) Education – Nursing, know the level the patient requires to understand, start at basics. Provide additional education by Provider or DM Educator.
4) Screening – Always ensure screens for depression, alcohol, drugs.
5) Get Behavioral Health involved for positive screening or even issues of non-compliance or making changes.
6) Have classes available – Exercise, Nutrition, Basics (what is a protein/carb), have an end goal for class so the patient can graduate.
7) Compliance – Providers, address this early on in the relationship, let patient know expectations as well as risks every time.
8) Ask the patient if they are having difficulties getting meds, don't assume they are filling all prescriptions. Refer to PAP, 340B, etc…
9) Refer non-compliant patients to a Case Worker for increased one on ones for frequent interactions and assistance.
10) Ensure proper translation is taking place by using trained interpreter vs family member/child.
11) Consistently call no-shows to get the patient back in sooner than later.
12) Monitor ER/Hospital usage by diabetics. Was it a DM need or other?
13) Limit the number of refills for an uncontrolled diabetic to assist in getting patient to come for a visit.
14) Include financial assistance if patient is having difficulty with payments/co-pays.
15) Include oral assessments and refer to dental as needed.
16) Be aware of any cultural issues that may be occurring.
17) Social determinants of health are frequently the main cause for patient outcomes and non-compliance.
18) Providers – Latest guidelines
19) Peer Review – CMO to ensure Providers are treating appropriately, make suggestions, provide education.
20) Continuous eye on the A1c measure, where/who/why.
21) Don't miss an opportunity, patient may not be in again for a year.