

PRIME REQUIRED PROJECT IMPLEMENTATION WEBINAR

Webinar Series 2: Successful Approaches to Disease Management and Screening

Diabetes Control: Operational Practices and Resources

Thursday, February 16, 2017; 12:00-1:00pm

<u>Recording Link:</u> <u>https://safetynetinstitute.webex.com/safetynetinstitute/lsr.php?RCID=e107ecdca4164d1b98c3ba0fb8d00cd3</u>

Agenda

Time	Торіс	Lead(s)
12:00- 12:05	Opening PHS background on metric	David Lown, MD Chief Medical Officer, SNI
12:05- 12:55	Diabetes Control: Operational Practices and Resources Q&A	Theresa Cho, MD, Quality Medical Director for Ambulatory Care, Ventura County Medical Center Cassie Morn, MD, Medical Director, UCSD Scripps Ranch Clinic UCSD; DM Champion for UCSD Medi-Cal P4P Committee and UCSD Clinically Integrated Network
12:55- 1:00	Resources Closing	David Lown, MD



Housekeeping



Please mute locally



At any time, feel free to chat your question & we will read out

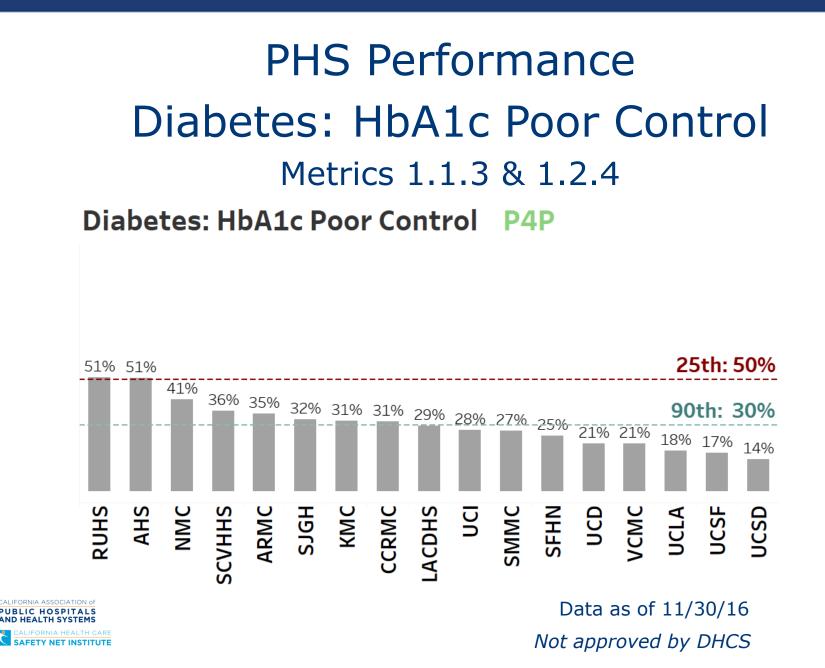


Webinar will be recorded



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Deck & tools will be saved on SNI Link





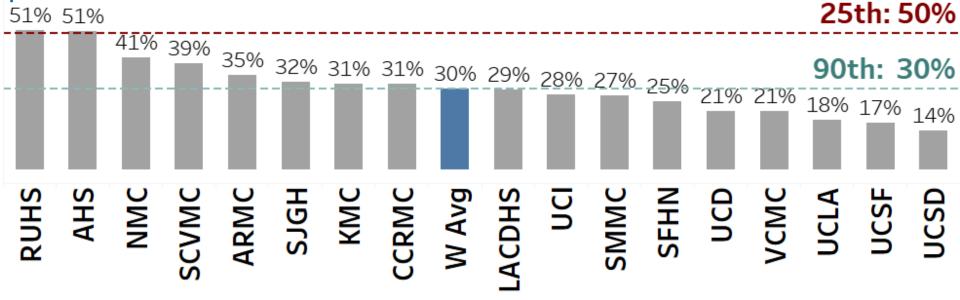
AMBULATORY CARE

DIABETES CONTROL: OPERATIONAL PRACTICES AND RESOURCES

Theresa Cho, MD Medical Director, Ambulatory Care Quality Director, Las Islas Diabetes Center February 16, 2017

PRIME 1.1.3 and 1.2.4: Diabetes HbA1c Poor Control

- **Numerator:** Patients whose most recent HbA1c level is greater than 9.0% or is missing a result, or for whom an HbA1c test was not done during the measurement period.
- **Denominator:** Patients 18-75 years of age by the end of the measurement period who had a diagnosis of diabetes (type 1 or type 2) during the measurement period or the year prior to the measurement period.



Road to Success

- 1. Development of a comprehensive diabetes center
- 2. Community outreach efforts
- 3. Performance improvement projects
- 4. Collaboration with colleagues



Diabetes and Population Health



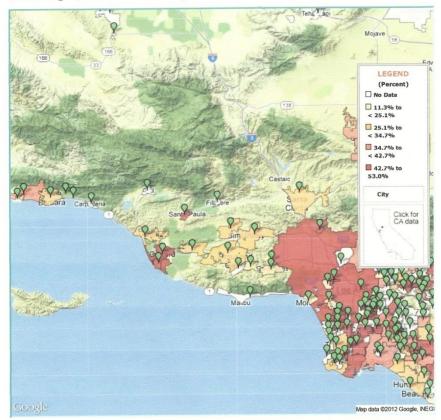
- According to a March 2016 study from the UCLA Center for Health Policy Research, 7% of Ventura County adults have diabetes.
- Additionally, 47% of Ventura County adults have pre-diabetes.



In Ventura County:

- Port Hueneme ranked 2nd highest in California for childhood obesity (52.6%).
- Oxnard ranked 21st (47.9%).
- Santa Paula ranked 22nd (47.9%).

Overweight/Obese Students (Federal Definition), by City: 2010 0



Definition: Percentage of public school students in grades 5, 7, and 9 with Body Mass Indices (BMIs) in the overweight or obese ranges of the 2000 Centers for Disease Control and Prevention sex-specific BMI-for-age growth charts.

Data Source: Babey S. H., et al. (2012). Overweight and obesity among children by California cities, 2010. UCLA Center for Health Policy Research and California Center for Public Health Advocacy. Funded by RWJF: California

Las Islas Diabetes Center



Opened in 2010 to address the needs of patients with diabetes in South Oxnard and throughout Ventura County.

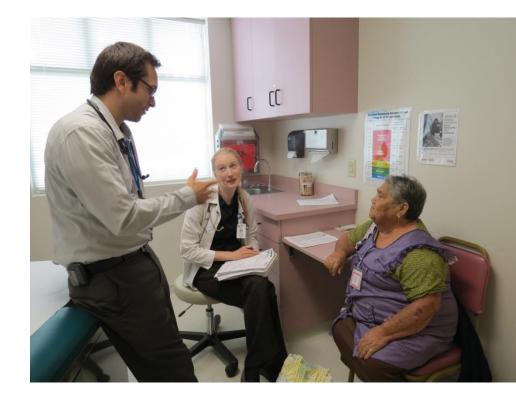
Our team includes:

- Physician
- Nurse Care Manager
- Registered Dietitian/Certified Diabetes Educator
- Psychologist
- Social worker
- Medical Assistant



Types of Care Provided

- Adult diabetes
- Pediatric diabetes
- Gestational diabetes
- Diabetic foot and wound care
- Retinal screening
- Nutrition and self-management education
- Peri-operative diabetes care



Types of Care Provided (continued)



- Group education and medical visits in Spanish and English
- Diabetes and depression group therapy
- Device management including insulin pumps and continuous glucose monitors
- Community outreach

Education Recognition Program: ADA

Dia Profess	betesP	TO sm Online		All types 🔹 Searc	h	Q	
ñ	Clinical Corner	Diabetes Educators	Research & Grants	Continuing Education	Membership	Scientific Sessions	
ERP Lis	sting						
Search	bgnized Education Progra h area and zip code and click a y from 93033	ms by zip code or filter by sta apply to search. Apply	ate. Reset	Healthy AE Conversal	ion Map [®] Tool En el camino l	hacia el mejor manejo de su diabetes	
Start) Site/Progr Program II Address: 3 City: Oxna State: Calif ZIP: 93033 Phone: 80 Spanish: Y Pediatric:	g Organization: Un Dulce am Name: Ventura Coun D: 6084 25 West Channel Islands rd fornia 5-486-2145 es No ance Learning: No 3.20 miles	ty Medical Center					

Community Outreach

WE'RE HERE FOR YOU!

The American Diabetes Association's Camp Prevent is a prevention camp for youth who are at high risk for developing type 2 diabetes. Camp will offer an educational and fun-filled environment and will focus on diabetes education, nutrition, physical activity and obesity prevention.

HELP MAKE CAMP POSSIBLE Visit www.diabetes.org or call 888-DIABETES to get involved locally. COMMUNITY PARTNERS





QUESTIONS? CONTACT Brett Griswold American Diabetes Association E-mail: bgriswold@diabetes.org Defensa 1.888 DIABETES - 7512 or 202.066.2890 v 7512





August 20-21, 2016 Held at Boys & Girls Club of Oxnard

American Diabetes Association (ADA)

Held at Boys & Girls Club of Oxnard Oxnard, CA

Mixteco Indígena Community Organizing Project (MICOP)



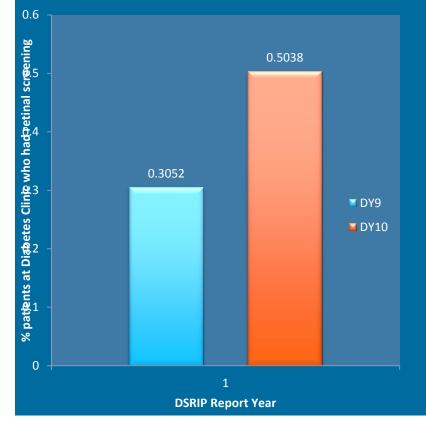
Lions Club



DSRIP Data: Retinal Screening



Retinal Screening Rate for Patients With Diabetes



Medical Team Engagement

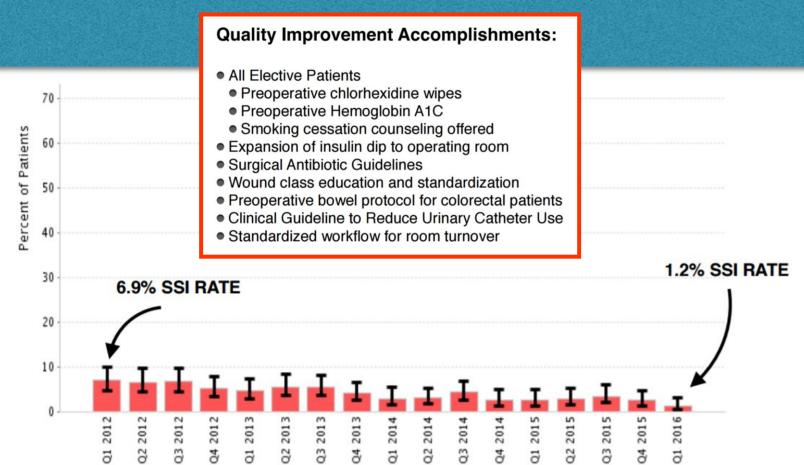
- 1. Partnerships with other primary care physicians and specialists
- 2. Transition of care between hospitals and clinics
- 3. Sharing a common goal to improve care
- 4. Leadership buy-in, specialist buy-in (poor outcomes, bad press, lost revenue)
- 5. Accountability
- 6. Sharing best practices: ACQA, CME lectures

Transitions

	Diagnoses & Problems	Search	n Contains 🗸 Adva	anced Options 👻 Type: 🗖	Ambulatory (Meds as Rx)
	Diagnosis (Problem) being Addressed this Visit		🔏 🚖 🕶 🐚 Folder: Search wit		
	🕂 Add 笃 Convert Display: All 🗸	1	La 🐹 🛀 🛁 Folder: Search wit	thin:	•
	Add Convert Display: All Annotated Display: Code Annotated Display Code Annotated Display Code Annotated Display E11.3399 HLD (hyperlipidemia) E78.5 HLD (hyperlipidemia) E78.5 Problems Add Convert No Chronic Problems	₽ RE	F Referral to HEMATOLOGY-ONCOLOGY Referral to Abnormal Pap Referral to Abnormal Pap Referral to Allergy Referral to Allergy/Immunology Referral to Ambulatory Care Clinics Referral to Ambulatory Care Clinics Referral to Candiocogy Referral to CardiacElectrophysiology Referral to CardiacElectrophysiology Referral to CardiacElectrophysiology Referral to Cardiothoracic Transplant Referral to Cardiovascular Surgery Referral to Cardiotoxacular Surgery Referral to Caeda Sinai Genetics Referral to Chest X-Ray Referral to Chest X-Ray Referral to Children's Hospital		Referral to Diabetes Group Education Classes at Las Islas Referral to Diabetes Group Education Classes at Las Islas Referral to DM Nurse Educator Referral to Durable Medical Equipment Referral to Endodontist Referral to Family Planning Referral to Field Nursing Referral to Field Nursing Referral to General Surgery Referral to General Surgery Referral to Genetics Referral to Genetics Referral to Genetogy Referral to Genetogy Referral to Hand Surgery Referral to Hando Surgery Referral to Hando Surgery Referral to Hando Surgery Referral to Hando JCLA Referral to Hearing/Speech
	Display: All MO Annotated Display ▲ Name of Problem Code ▲ Benign hypertension Benign hypertension 18632012 Chronic depression Dysthymia 130532011 ■		Referral to Chiropractic Referral to City of Hope Referral to Comprehensive Perinatal Services Referral to Counseling Referral to Craniofacial Referral to Dental Referral to Developmental Vision Specialist Referral to Diabetes Center at Las Islas		Referral to Hematology Referral to HIV/Aids Specialist Referral to Home Care/Companion Referral to Home Health Referral to Home Nursing Agency Referral to Hospice Referral to Imaging Referral to Infusion
	M Chronic lower back pain ODE16707- DM Diabetes mellitus DM - Diabetes mellitus S02372015 M Hyperlipidemia 92826017 + Image: Comparison of the state of		Referral to Diabetes Clinic at Anacapa Referral to Diabetes Education Class at Las Islas (educa Referral to Diabetes Education Class at Las Islas (educa		Referral to Insurance Referral to Internal Medicine Referral to Laboratory
		•	Diabetes		\rightarrow
H	OSPITAL -	- [Center	•	

Engagement and Collaboration

VCMC SURGICAL SITE INFECTION REDUCTION



Diabetes and SSI improvement



- 1. Clear incentive
- 2. Clinically actionable
- 3. Measurable outcome
- 4. Consistent evidence-based goal
- 5. Data

Collaboration with Stakeholders

April 7, 2014

Dear Colleague,

In collaboration with the Armstrong Institute for Patient Safety, our performance improvement and surgical departments have launched an initiative to reduce the incidence of surgical site infections (SSI) in colorectal surgery patients at VCMC and SPH. Our collaborative has identified opportunities for improvement in two major risk factors: poor glycemic control and tobacco use. We are writing to solicit your help in reducing our patients' preoperative risk of SSI.

Prior to referring a patient to Anacapa Surgery for an elective operation, please complete the following:

- For patients with diabetes, ensure documentation of the patient's glycohemoglobin within the last 3 months.
- For adult patients without diabetes, ensure documentation of the patient's glycohemoglobin within the last 12 months (to confirm that the patient has been screened to rule out diabetes).
- Document the most recent date that the physician counseled the patient regarding tobacco cessation.
 Counseling should have been done within the last 3 months for patients who smoke. Please enter the counseling date under Histories, in the Social History tab, by double-clicking the Tobacco category.

Prior to the patient's pre-operative appointment, the office staff at Anacapa will review the patient's record to confirm that the referring provider has addressed the above issues. A communication will be sent to the PCP regarding missing glycohemoglobin and tobacco information, and if these remain incomplete at the pre-operative visit, the surgeon will order the glycohemoglobin and tobacco counseling at Anacapa.

Please keep in mind that a patient with poorly-controlled diabetes and a glycohemoglobin ≥8% has a significantly higher risk for SSI and other surgical complications. When possible, surgery referral should be delayed until glycernic management has improved. If you feel that a multi-disciplinary approach to DM management (including diabetes physician, dietitian, psychologist, and nurse educator) would benefit your patient, please make a referral to the Las Islas Diabetes Center.

Patients who use tobacco may call (805) 201-STOP (201-7867) for Ventura County Public Heath's free "Call it Quits" classes. They may also get assistance with a tobacco cessation plan by calling the California Smoker's Helpline at 1-800-NO-BUTTS (English) or 1-800-45-NO-FUME (Spanish). In addition, the surgery clinic will reinforce your efforts by offering smoking cessation counseling by trained staff at the time of initial surgical consultation.

Thank you for your efforts to help us improve patient care by reducing surgical site infection rates at VCMC and SPH.

Respectfully,

Jeremy Schweitzer, MD Anacapa Surgical Associates Theresa Cho, MD Las Islas Diabetes Center

Rick Rutherford, MD Director, Performance Improvement Bryan Wong, MD VCMC/SPH Medical Director



Surgery and Diabetes

- Referrals to surgery screened by surgery staff
- Automatic referral into Diabetes Clinic
- Diabetes Clinic within Surgery Clinic



EHR Tools to Improve Care: Automated Reminders

Costoine Aduspood Options	🗸 🗸 Type: 🧱 Ambulatory (Meds as Rx) 🗸
Discern: (1 of 1)	
	▼
Please Order HbA1c	
Flease Order HDATC	Referral to Children's Hospital
Cerner	Referral to Chiropractic
A1c result is not available or is too old for a surgical consult.	Referral to City of Hope
A1c result is not available or is too old for a surgical consult.	Referral to Comprehensive Perinatal Services
Ve	Referral to Counseling
	Referral to Craniofacial
Patients with DM need A1c within last 60 days.	Referral to Dental
	Referral to Developmental Vision Specialist
	Referral to Diabetes Center at Las Islas
Patients without known DM need A1c screening within last 12 months.	Referral to Diabetes Clinic at Anacapa
I dionis milliot klown DM need Are selecting milling to 2 menus.	Referral to Diabetes Education Class (educator only) - English
	Referral to Diabetes Education Class (educator only) - Spanish
Add Order for:	Referral to Diabetes Group Education Classes at Las Islas - English
	Referral to Diabetes Group Education Classes at Las Islas - Spanish
Hemoglobin A1c -> Blood, Routine collect, reporting: RT - Routine, T;N, Order for future	Referral to DM Nurse Educator
	Referral to Durable Medical Equipment
	Referral to Endodontist
	Referral to Family Planning
ОК	Referral to Family Practice
	Referral to Field Nursing
	Referral to General Surgery
▶ I IIII TRANSPORT	Referral to Genetice
■ REF Referral to Pain Management	Referral to Geriatr.
■ REF Referral to PM&R	Referral to Gynecology
■ REF Referral to Podiatry	Referral to Hand Surgery
REF Referral to Pulmonary	Referral to Harbor UCLA
■ REF Referral to Rheumatology	Referral to Hearing/Speech
REF Referral to HEMATOLOGY-ONCOLOGY	Referral to Hematology
REFERRAL - Endo (hyperparathyroidism) 9/30/2014	Referral to HIV/Aids Specialist
PReferral - ENDO - pituitary mass 9/29/2014	Referral to Home Care/Companion
	B Z 16 11 11 10

EHR Tools to Improve Care: Diabetes Flowsheet

Menu 7	< 👻 🕈 Results Review 🗇 🖓 Full screen	🛱 Print 🛛 🍣 0 minutes ago
Dashboard		
Quick Orders		
Since Last Time This Visit	Physician Office/Clinic Recent Results Vital Signs Lab Microbiology Radiology Assessments Delivery Record Respiratory Therapy	
Acute Workflow	Flowsheet: Diabetes Outpatient Flowsheet Level: Diabetes Outpatient Flowsheet - Table O Group	
Results Review	Howsheet, bible both and housineed in the bible	
Diagnoses and Problems	← February 13, 2014 0:28 PST - February 13, 2018 0:28 PST (Clinical Range)	4 Þ.
Orders 🕂 Add	Navigator	
Medication List 🕂 🕂 Add	WEIGHT AND BMI: norm	
Health Maintenance	BLOOD PRESSURE: goal Diabetes Outpatient Flowsheet	A
Physician Documentation	GLUCOSE: goal HbA1c <=7.0 (eval q3-6mo.) Glycohemog Hgb A1c Est Ave Gluco	
Form Browser	Image: NEPHROPATHY PREVEN Im	
Notes	CV DISEASE PREVENTION 8/26/2016 10:50 PDT 8.3 (H)	
Tabliat	Retinopathy Evaluation (8/20/2016 9:02 PDT 8.1 (H) 186 *	
Task List	7/12/2016 9:40 PDT 9.1 (H)	
Allergies 🕂 Add	Vacc: flu q1y (>6mo), pr 4/19/2016 14:46 PDT 9.7 (H)	
Advanced Growth Chart	T1DM and Pediatric Flov 🚽 3/12/2016 9:05 PST 10.2 (H) 246 *	
	8.7.7.7015 Stop PDT S 6.1H) 200 *	· · · · · · · · · · · · · · · · · · ·
Histories 🗸 🗸		

EHR Tools to Improve Care: Importing Select Data into Note

General: Well-developed, well-nourished woman, in NAD HEENT: NCAT, PERRL, EOMI, conjunctiva clear, intact dentition, oral mucous membranes moist Cardiovascular: RRR, normal S1 and S2, no murmurs, rubs, or gallops Lungs: clear to auscultation bilaterally, no wheezes, rales, or rhonchi Abdomen: NABS, soft, NT, ND, no organomegaly, no masses Extremities: no CCE

Lab Results		
Diabetes Results (Last charted value.)		
A1c H 8.1 (08/20/16)		
A1c-POC H 7.7 (02/10/17)		
GluPOC 103 (02/10/17)		
Cr 0.98 (08/20/16)		
mAlb/Cr H 87.8 (01/10/14)		
GFR >60.0 (08/20/16)		
TSH 1.901 (08/20/16)		
Trig 153 (08/20/16)		
Chol 136 (08/20/16)		
HDL L 25 (08/20/16)		
LDL 95 (08/20/16)		
Eval Retinopathy Yes - Retinal scan done ONLY (03/30/16)		
Retin Date 03/12/16 (03/30/16)		
Retinopathy Results No Apparent Diabetic Retinopathy	(03/30/16)	
Influenza 0 (09/01/16)		
PCV-23 0.5 mL (08/09/16)		

Assessment/Plan

BMI 45.0-49.9, adult

Elevated BMI noted. I reviewed BMI goal with patient and advised lifestyle changes, including dietary modification and increased physical activity, for weight management.

Diabetes type 2, uncontrolled

I spent over 25 minutes with the patient today, with over 50% of that time counseling the patient about diabetes management, reviewing medications, discussing weight management, and diminished libido.

1. Continue metformin at her 500 mg XR once a day. Unable to increase dose due to history of GI intolerance.

Continue Victoza 1.8 mg subcutaneous daily

3. Continue Touieo 25 units subcutaneous nightly



Information for Patients and Health Care Providers

http://diabetes.org/

 American Diabetes Association Standards of Medical Care in Diabetes—2017

http://professional.diabetes.org/sites/professional.diabetes.org/files/media/dc_40_s 1_final.pdf

Group Education Material

http://healthyinteractions.com/assets/files/HI_PositionPaper_v01_16_102715.pdf

Ventura County Preoperative Management Policy
 <u>https://safetynetinstitute.org/wp-content/uploads/2016/05/preop-management-of-elective-surgery-patients-policy-0916.pdf</u>

Implementing Diabetes Quality Care

CASSIE MORN, MD

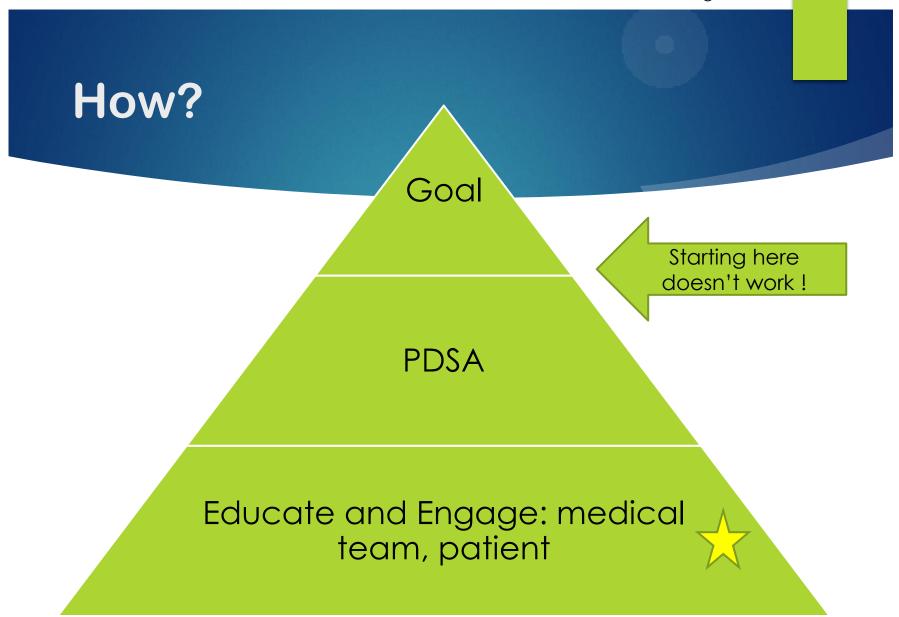
UCSD DEPARTMENT OF FAMILY MEDICINE



Provide high quality care to all patients diagnosed with Diabetes -ADA Standards of Care (EBM)

-Integrated Healthcare Association (IHA) 90th percentile

Two A1cs per yearA1c A1c control <8.0



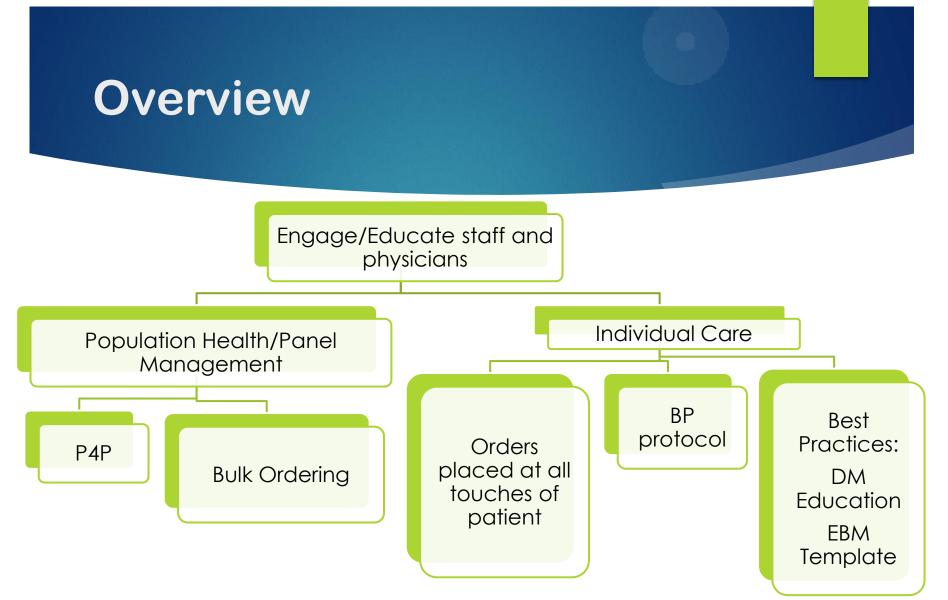
Engage

Staff

- Team approach/patient ownership
- Staff committee
- Incentive payments
- Team competition

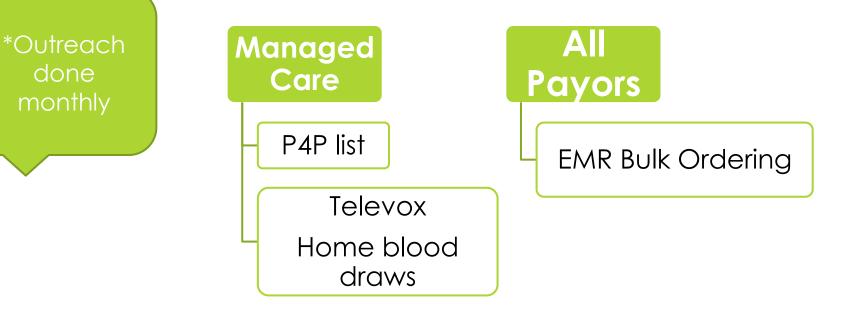
Physician

- Decreased work load
- Incentive payments
- Transparency of data/feedback
- Educational



Do...Population Outreach





Bulk Ordering

Place Orders			>
Authorizing Provider:	MORN, CASSANDRA BROOKE	Use PCP as Authorizing P	rovider
	Search	Browse (F4) Preference List (F	5) Clear Selected
			Selected Orders
 ♥ Bulk Orders Diabetes Cvd Osteoporosis Chlamydia/gc Colon Cancer Breast Cancer Protocol Orders (for Pr 		Urine microalbumin/creatinine ratio Consult/Referral to Retina Clinic	 Procedures A1C Lipid Panel Urine microalbumin/creatinine ratio Consult/Referral to Retina Clinic
< <u> </u>			<u>.</u>
he orders can take several	minutes to process. An In Basket mes	sage will be sent once done.	
	→ Add Communication	✓ Sign Without Communication	X <u>C</u> ancel All



Don't miss opportunities

- Pre-visit encounter (huddle)
- all patient touches
 - For all refills, telephone encounters, mychart messages and acute visits: HM button reviewed and orders placed

Guideline based care

• BP protocol

Plan

- EMR template
 - Note prompts for ADA guideline based care
 - Orders accessible

WEB REF UpToDate SEA Schedule In Basket	ind Me 📆 Chart 🔐 Encounter 🐗 Doc/Order:	Temp: None	Height: None				EpicCare
9/1992, Male PCR: None Coverage: None (Allergies: Unknown: Not CVG Type: None Infection: None MyUCSDChart: Ina Code: Not on file Snap Shot	Pt In Basket Msg Pref Language: No tive FYIs: None		Last Wt: None Last BMI: None Last BSA: None				
Recurring Treatments					Report:	inapShot	ىكى 🔍
Pentamidine Inhalation - Every 28 Days for 6 Months 5	Type ONCOLOGY SUPPORTIVE CARE 1 (OUTPT)	Current Treatme Every 28 Days,		Planned For Thu 8/18/2016	\$	√ 0/1	♦ 0/1
Test Patient 24 year old male 9/19/1992 000-000-0000 (H) Comm Pref: None Problem List ਨ Colorectal cancer (CMS-HCC) ✓ Mark as Reviewed Never Reviewed			MM_TD/TDAP=>11 YO HPV Vaccine <= 26 Yrs (INFLUENZA VACCINE	9/19/2003 1) 9/19/2003 8/1/2016	Last Comm	unication	
Allergies 5 Not on File Mark as: Verified Never Reviewed Medications 5		Nor	rgical History 5				
Outpatient Medications None Patient Reminders and In Basket Results 5 None		Not	cial History 5 yet reviewed ne mily Comments				Ec

All Touches...Refill request (smartphrase: .rxr)

Patient is requesting refill of Metformin 1,000 mg Last refill: 11/3/15 Pharmacy: CVS Westview Pkway Last visit in this department 11/7/2016 Next visit in this department Visit date not found

Last labs:

Lab Results Component Value Date CHOL 182 11/07/2016 HDL 43 11/07/2016 LDLCALC 118 11/07/2016 **TRIG** 106 11/07/2016 LDLDIRECT 125 03/01/2010 TSH 1.93 03/29/2011 TSH 2.64 01/10/2006 A1C 10/17/2016 8.4

-staff driven phrase -Decreased work load

Blood Pressure

11/07/16	120/80
06/06/16	151/87
05/09/16	139/82

HM Items that are overdue or due soon include:

Health Maintenance Due

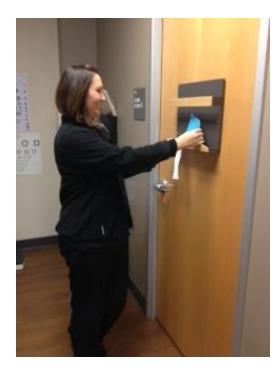
Topic Date Due

DM_RETINA EXAM 12/17/2015

Blood Pressure Protocol

BP Control: Blue Card Protocol

- All BP readings >139/89 blue card put on door
 - Alerts doctor
 - Reminds MA to repeat
- Repeat BP at end of visit
 - MA/nurse competency completed
- Nurse visit 1 week for BP check



A1c Control

-A1c controlled (< 8.0)-A1c poorly controlled (> 9.0)

- Refer to DM education classes
 - At diagnosis
 - Poorly controlled
 - Consider annually
- Refer to PharmD intensive medication management
 - Pro-active calling patients with A1c>9.0
- Increase frequency of physician visits
- Use of DM template to assist with standard of care
- Econsults to Endocrinology



Study: P4P Report

			Attair	nment	Improvement	October 2015	24	October	2016		
Measure	Measure Abbrv	Clinic	75th	IHA 2015 95th Percentile	UCSD 2015 Final Rate (%)	Last Year at This Time (%)		Num	Denom	Score	Add To Num For Max Score
Blood Pressure: In Control (Non-Diabetic w/ HTN): Ages 18-85	CBPH_1885	Scripps Ranch	66.64	83.81	64.07	No Data	73.86	65	88	5	8
Patients on Persistent Medications: Annual Monitoring Overall	MPMOV	Scripps Ranch	86.19	90.54	79.25	No Data	73.17	120	164	0	28
Diabetes: Blood Pressure Control (<140/90 mm Hg)**	CBPD4	Scripps Ranch	70.94	84.09	68.06	68.10	66.13	41	62	0	11
Diabetes: HbA1c Control < 8.0%	HBAC8	Scripps Ranch	65.42	71.18	69.84	66.80	74.19	46	62	10	0
Diabetes: HbA1c Poor Control > 9.0%***	HBACON	Scripps Ranch	22.91	15.87	10.12	No Data	4.84	3	62	10	0
Diabetes: One HbA1c Test	HBASCR1X	Scripps Ranch	Info Only	Info Only	Info Only	Info Only	85.48	53	62	Info Only	Info Only
Diabetes: Two HbA1c Tests	HBASCR2X	Scripps Ranch	67.24	83.37	63.49	49.00	53.23	33	62	0	19
Diabetes: Medical Attention for Nephropathy	NEPHSCR	Scripps Ranch	93.31	95.16	96.43	88.40	93.55	58	62	2	1
Diabetes: Optimal Care - Combination	ODCCOMBO	Scripps Ranch	34.61	43.85	49.21	No Data	37.10	23	62	3	4
Low Back Pain: Use of Imaging Studies ^t	LBP	Scripps Ranch	13.54	10.09	17.78	No Data	4.55	1	22	10	0
Children With Pharyngitis: Appropriate Testing	CWP	Scripps Ranch	92.58	96.27	SD	No Data	No Data	0	0	0	0
Upper Respiratory Infection: Appropriate Treatment for Children	URI	Scripps Ranch	98.24	99.3	96.20	No Data	No Data	0	0	0	0
Immunizations for Children: Combination 10	CISCOMBO10	Scripps Ranch	58.96	67.92	50.00	No Data	28.57	2	7	0	3
Immunizations for Adolescents: HPV (Female)	HPV	Scripps Ranch	34.09	41.85	28.57	25.50	44.44	4	9	10	0
Immunizations for Adolescents: HPV (Male)	HPVM	Scripps Ranch	29.83	39.56	22.22	8.50	33.33	1	3	6	1
Immunizations for Adolescents: Tdap	IMATDAP	Scripps Ranch	90.12	94.22	88.07	83.10	91.67	11	12	6	1
Immunizations for Adolescents: Combo2 (Meni & Tdap & HPV)*	ІМАСОМВО2	Scripps Ranch	NEW	NEW	NEW	NEW	33.33	4	12	NEW	0
Colorectal Cancer Screening: Ages 50-75	COL	Scripps Ranch	74.56	80.69	79.15	75.40	81.61	355	435	10	0
Breast Cancer Screening: Ages 50-74	BCS	Scripps Ranch	85.14	89.36	86.50	83.10	87.18	204	234	5	5
Chlamydia Screening: Ages 16-24	CHLAMSCR	Scripps Ranch	66.8	74.59	77.66	84.20	90.00	54	60	10	0
Cervical Cancer Screening	CCS	Scripps Ranch	82.51	91.19	80.77	No Data	83.36	471	565	2	42
Cervical Cancer Overscreening***	ссо	Scripps Ranch	15.23	6.98	6.99	No Data	11.19	60	536	5	-23
								Acquire	ed Points	94	



190

49.5%

-

-

-

Total Possible Points

Tier 1 Incentive (≥39%)

Tier 2 Incentive (≥43%)

Tier 3 Incentive (≥47%)

Scripps Ranch

Grade

Study: EMR Reports

Desktop 🕺 🗸 🐨 📮 🗐

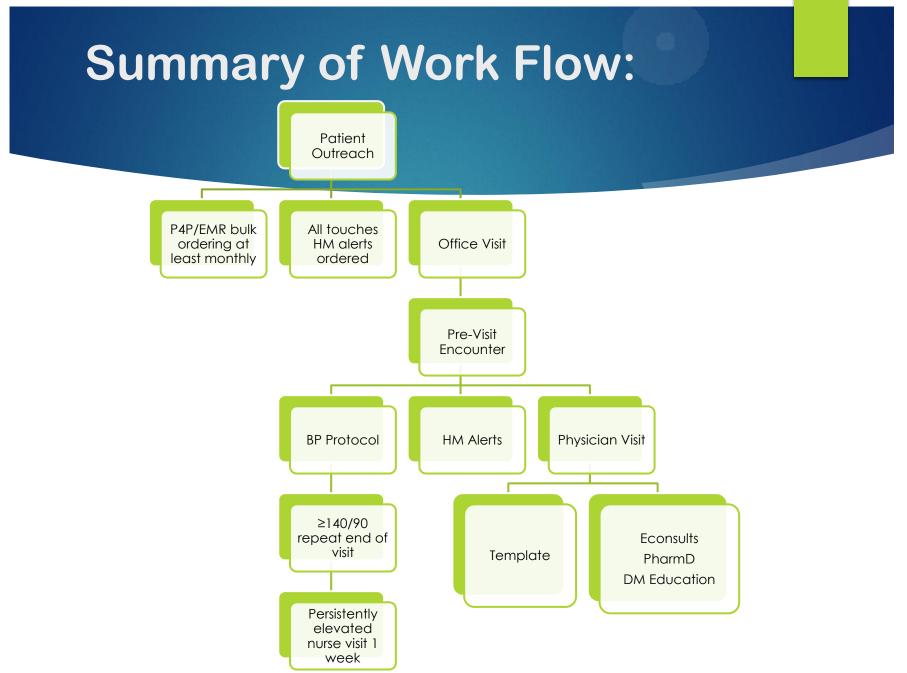
Dependent: SPC FAMILY NEDCONE P Diabetes: Statis Nov 33 Det 31 In Feb Mar Apr May Mail Aug MD Run and Saved Reput Hemoglobin Vm 72358 72468 72238 72488 72438 72488 72438 72489 72499 72499 72499 72499 72499 72499 72499 72499 72499 72499 72499																	Sate	is Default
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Hemoglobin A1c Control	74.24%	71.21%	71.21%	70.31%	72.06%	71.21%	75.38%	78.13%	78.46%	82.81%	82.54%	78.13%	78.13%	Reports 5 - Just now
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Blood Pressure	72.73%	69.70%	69.70%	68.75%	75.00%	77.27%	75.38%	75.00%	78.46%	84.38%	69.84%	79.69%	79.69%	
LDL Control	48.48%	48.48%	53.03%	51.56%	50.00%	51.52%	49.23%	50.00%	49.23%	54.69%	60.32%	59.38%	56.25%	
LDL Testing	81.82%	75.76%	80.30%	78.13%	79.41%	78.79%	73.85%	73.44%	72.31%	81.25%	87.30%	89.06%	89.05%	
Nephropathy Screening	<i>.</i> .				90.57%	92.31%	93.62%	88.64%	79.07%	71,43%	78.72%	86.27%	90.38%	
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+ LDL Control 🗸	J~ 64	1.29% 62.0	07% 60.0	62.0	7% 64.52	96 60.7	1% 60.7	1% 62.0	7% 65.52	96 68.97%	66.67%	68.97%	68.97%	
🔸 LDL Testing 💦 🔪	96	i.43% 93.3	10% 83.3	3% 82.7	87.10	85.7	1% 82.1	4% 82.7	6% 79.31	% 75.86%	73.33%	68.97%	72.41%	
						_								





- Feedback at clinic level
- Feedback to teams (MA/LVN/Physician)
- Incentives
- Assess Barriers
- Share Best Practices

Lessons Learned

Barriers

- Engaging medical team
- Ownership of population health
- Discrepancies across primary care clinics
- Time

Solutions

- Educate, incentives, ownership
- Team leaders that own patient outreach
- Standardize protocol and share best practices
- Implementation saves time

Resources

- UCSD CIN Protocol for Diabetes Management (word document) <u>https://safetynetinstitute.org/wp-content/uploads/2016/05/1.2-cin-dm-protocol.docx</u>
- PA Nutting et al. Journey to the Patient-Centered Medical Home: A Qualitative Analysis of the Experiences of Practices in the National Demonstration Project <u>Ann Fam Med 2010 8:S45-S56; doi:10.1370/afm.1075</u>
- T Markova et al. Implementing Teams in a Patient-Centered Medical Home Residency Practice: Lessons Learned. J Am Board Fam Med 2012;25:224 –231
- WK Bleser et al. Strategies for Achieving Whole-Practice Engagement and Buy-in to the Patient-Centered Medical Home <u>Ann Fam Med</u> <u>January/February 2014 12:37-45; doi:10.1370/afm.1564</u>

QUESTIONS?

Resources on SNI Link

Posted on Project 1.2 page

Diabetes

- Information for Patients and Health Care Providers (American Diabetes Association)
- Standards of Medical Care in Diabetes—2017 (American Diabetes Association)
- Group Education Model (Healthy Interactions)
- Preoperative Management Policy (Ventura County)
- Protocol for Diabetes Management (UCSD CIN)
- Journey to the Patient-Centered Medical Home: A Qualitative Analysis of the Experiences of Practices in the National Demonstration Project (PA Nutting et al.; Ann Fam Med 2010 8:S45-S56; doi:10.1370/afm.1075)
- Implementing Teams in a Patient-Centered Medical Home Residency Practice: Lessons Learned. (*T Markova et al.; J* Am Board Fam Med 2012;25:224 –231)
- Strategies for Achieving Whole-Practice Engagement and Buy-in to the Patient-Centered Medical Home (WK Bleser et al. Ann Fam Med January/February 2014 12:37-45;

doi:10.1370/afm.1564)

SNI LINK



Project Leads on SNI Link 1.2 Contact list posted on PRIME Member Information



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PRIME Project Implementation Webinars

 Controlling Blood Pressure (Metric 1.2.5) – Thursday, February 23, 2017 12-1pm (Register Here)

 Colorectal Cancer Screening: Operational Practices and Resources (Metric 1.2.3) – Wednesday, March 1, 12:00-1:00pm (<u>Register Here</u>)





Information on all these webinars, including presentations and recording links, will be posted on SNI link <u>here</u>.

CLOSING

Take 2-3 minutes to let us know how we did in the post-event pop-up!

Thank you for joining us, and to our speaker!



