SPREADING EFFECTIVE AND EFFICIENT DIABETES CARE IN CALIFORNIA'S PUBLIC HOSPITAL SYSTEMS 2007-2008

- ❖ **Affiliate of CAPH, established 1999**
- ❖ **Connects public hospitals with funding, partners, expertise, each other**
- ❖ **Promotes quality improvement, system efficiencies**
- ❖ **Priority areas:**
  - ❖ **1) Improving chronic disease management**
  - ❖ **2) Reducing disparities in health**
  - ❖ **3) Enhancing Systems Capabilities**

The SNI Staff for SEED

- **Angela Hovis, SEED Improvement Advisor**
- **Anne Peters, MD, Clinical Expert**
- **Erin Bowman, Program Coordinator**
- **Hunter Gatewood, Sr. Program Associate**
- **Nicole Griffin, Program Associate**
- **Norma Batongbacal, Admin. & Web Coordinator**
- **Wendy Jameson, SNI Director**

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CALIFORNIA ASSOCIATION OF
PUBLIC HOSPITALS AND HEALTH SYSTEMS

PURPOSE AND GOAL OF SEED

PURPOSE:

to improve the effectiveness of CAPH primary care clinics in caring for patients with diabetes, through the adoption of the Chronic Care Model and the use of chronic disease registry data at the point of care.

GOAL:

to spread chronic care improvements to at least two patient care teams in each of the participating CAPH systems in each of the program's 2 years, for a total of 48 additional CAPH adult primary care teams using improved practice by December 2008, compared to December 2006.

California Improvement Network

Better Ideas for Chronic Disease Care

- **CIN: Impacting care for approx 25 Million (of approx 36M Californians)**
- **Diabetes prevalence in state: Over 1.5 Million** (CHIS, 2001)
- **Estimated that 25% of DM is undiagnosed (nationwide)** (NHANES)

Diabetes, related health problems in LA County women
(LA Times, 5-24-07)

- DM incidence in women in LA County up 13%, from 1995 -2005
- Obesity rates: increase to 1 in 5 for women in LA County; Latinas: 1 in 4, almost 1 in 3 for African-American women
- Leading causes of death for LA County women: heart disease and stroke
- Majority (> ½) of Af-Am women at risk of developing heart disease, as were almost 2 out of 5 Latinas and whites, and more than 1 in 4 of API women.

SEED STATEWIDE:
10 CAPH systems, 9 counties

Organization	Site Names
1. Alameda County Medical Center	Winton Wellness Center Highland Hospital Adult Medicine Clinic
2. Contra Costa Health Services	Richmond Health Center Pittsburg Health Center North Richmond Health Center
3. Kern Medical Center	Family Care Center (Medicine Clinic)
4. Harbor-UCLA Medical Center	Harbor-UCLA Family Health Center Long Beach Comp. Health Center
5. LAC+USC Medical Center	Roybal Comprehensive Health Center El Monte Comprehensive Health Center
6. Riverside County	Medicine Clinic Family Care Clinic
7. Arrowhead Regional Medical Center (San Bernardino County)	McKee Family Health Center Fontana Family Health Center
8. San Francisco Department of Public Health (Community Health Network)	Maxine Hall Health Center Castro-Mission Health Center
9. San Mateo Medical Center	Daly City Clinic Fair Oaks Adult Clinic
10. Ventura County Medical Center	Magnolia Family Health Center Santa Paula

SEED: the What

1) Two learning collaboratives on diabetes
   a) NorCal/Bay Area: Spreading from Pilot sites
   b) SoCal: Pilot teams + Spread from ACCC sites

2) Spread Leaders: identified leaders to build QI capacity, support system-level capacity for change

3) IT planning and registry support
   a) $40,000 challenge grants, 4 each year
   b) IT consultants to provide systems with minds and momentum

Team Member Role in a Collaborative

- **Meet weekly with your team**
- **Test changes (Plan, Do, Study, Act) and implement what works for your patients and your team**

SEED focus areas

1) **Clinical Information Systems (electronic disease registries)**
2) **Self-Management Support (engage patient in their own care)**
3) **Delivery System Design (team care)**

Action Period 1
How are we doing?

May Reporting - Off to a Good Start!

- 10 teams submitted narrative reports
- 8 teams submitted data, BUT
  - Few teams missing optional measures
  - Few teams missing some required measures
  - Some patient documentation data is difficult to capture in excel template
- All teams busy getting up to speed.

Popular Changes

- Self-Management Tool
- Identify Population of Focus for Registry
- Populate Registry with Patient Data
- Registry Form to Guide Visit
- Flow Sheet/Data tracking forms

Other Noteworthy Testing

- Clerks assist with Self-Mgt Support and Follow-Up
- Generate Report Card for Patients
- Train Residents
- Meet with leadership to Problem Solve

Required Measures Summary

A look at numbers for May

Based on data submitted by 8 team on a total of 722 patients.

Measures Summary

Measure Name	# Teams Tracking	Average (all pts)	Team High	Team Low
Ave. HbA1c	6	8.1 n=504	9.8 n=38	7.5 n=100
2 HbA1c's	8	54.8% n=122	90.5% n=21	11.3% n=133
SM Goal	8	12.7% n=722	100% n=41	0% n=104
ACE/ARB	5	60.9% n=297	92.9% n=99	33% n=57
Statins	4	62% n=313	75.5% n=163	42.4% n=99

Measures Summary

Measure Name	# Teams Tracking	Average (all pts)	Team High	Team Low
BP Control	8	44.3 n=526	100% n=36	22.2% n=45
LDL Control	5	60.7% n=236	74.4% n=122	43.4% n=36
Optional: Foot Exam	7	28.3% n=554	49.5% n=109	1% n=104

And Now:
Learning Session 2

- ❖Have a fun day with supportive learning community
- ❖Review work so far: celebrate, troubleshoot; get new ideas, new resources
- ❖Use time away from clinic to make plans
- ❖Go to Action Period 2 and continue to test changes, improve diabetes care

And finally:

SNI has some rapid tests of change to do ourselves.

By next Tuesday, we will . . .

A PDSA for SNI: Team Communications

- **PLAN:** Erin at SNI will send a Word doc newsletter to two SEED clinic team leaders, by email, to print and post for team members every two weeks
- **DO:**
- **STUDY:**
- **ACT:**