

**First Steps to Change
Premier Health Partners
Dayton, Ohio**

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Premier Health Partners

- Location: Dayton, Ohio
- System Information: Two hospital (1200+ beds including Miami Valley Hospital and Good Samaritan Hospital), 117 physician practice primary care network, Fidelity Home Health Care and Long Term Care Facility
- Aim: To develop a chronic diabetes management program to provide comprehensive, coordinated healthcare across the continuum.
- Pilot Population: 15 physician practices in the primary care network for a total of 1800+ with a diagnosis of Type I or Type II Diabetes.

Community

Resources and Policies

- Not a Diabetes treatment mandated state
- Discounted fee-for-service environment – no incentives for disease management
- External pressures to refocus approach to chronic care

Health System

Organization of Health Care

- Initiated as a PI strategy
- 1999 Momentum for Disease Management
- Shifting to Continuum integration – 1999
- Strong physician and management support
- Weak Disease Management structure

Informed,
Activated
Patient

Productive
Interactions

Prepared,
Proactive
Practice Team

Functional and Clinical Outcomes

Community

Resources and Policies

Health System

Organization of Health Care

Self-Management Support

- **Basic tool development: Blood sugar graph, wall posters**
- **Education of self-management concepts**
- **Focus on expansion and refinement of patient education**

Delivery System Design

- **System approach: Inpatient, Ambulatory and Education Committees**
- **Designation of 15 physician pilot sites**
- **Staff redesign**
- **Revitalized Disease Management focus**

Decision Support

- **ADA evidence based guideline**
- **Consistent patient ed. program**
- **Innovation Tool Kit**
- **Inpatient tools**

Clinical Information Systems

- **Attempt to develop registry without an IS system**
- **Paper/pencil chart review system**

Diabetes Initiative

- ◆ Delivery System Design:
 - System approach: inpatient, outpatient, etc.
 - Staff roles redesign in primary care sites
 - Focus on education of chronic disease model and disease management
 - Relook at all aspects of the continuum
 - Designation of pilot sites with spread to all sites after test period
 - Development of willingness to rapid test mentality

Diabetes Initiative

- Decision Support:
 - ADA evidence based guidelines implemented and educated
 - Innovation Tool Kit
 - Patient education materials
 - Inpatient tools
 - Documentation tools
 - Flow sheets

Self-Management

- Change: Fundamental philosophical shift to ambulatory arena for disease management
- Testing of the Change:
 - **What worked:**
 - Formation of work teams with key inpatient, outpatient and home care participants
 - Significant education on self-management concepts, proactive management and the role of primary care
 - Development of Innovation Tool Kit which allowed for the fostering of multiple innovation strategies rather than a “cookie cutter” approach

Self-Management

- Testing of the Change:
 - **What worked:**
 - Creation of enthusiastic pilot group through meetings and networking
 - Extensive communication plan of minutes, newsletters, meetings with senior leaders, fixed agenda items at Board and Leadership meetings
 - Demonstrating outcomes of existing methods of care
 - **What didn't work:**
 - IS system to support registry
 - Group visits (reimbursement issues)

Innovation Project Goals

- Reduce HbA1C's to < 8
- Implement self-management tools
- Implement smoking history
- Demonstrate urine protein testing
- Demonstrate ACE inhibitor utilization in patients with positive urine protein
- Demonstrate HbA1C tests twice a year
- Demonstrate annual Ophthalmologic exam
- Demonstrate annual foot exam
- Demonstrate annual Lipid measurement

Self-Management Innovations

- Physician and staff education on concepts
- Implementation of basic self-management assessment tools
- Implementation of Diabetes Innovation Tool Kit (office posters, chart documentation tools, patient education tools, self-management plans, etc.)
- Mental Health sub group innovations for improving compliance
- Coordination of Home Care service

Patient Education Innovations

- Movement of teaching program from central hospital location to offsites
- Implementation of “Survival Skills” education and annual assessment appointments as nurse visits in the physician network
- Successful negotiation with local HMO to increase reimbursement for local based education

Patient Education Innovations

- Promotion of ADA certification for entire system
- Coordination of teaching curriculum, patient education materials, data collection and documentation tools across the continuum
- 16 hour CEU course for system nursing staff

Decision Support Innovations

- Implementation of Treatment Guidelines across the system
- Implementation of multiple documentation and teaching tools
- Implementation of monofilament foot exams
- Rollout of Innovation Strategies to 15 physician beta sites

Community Linkages

- Mental Health sub group work to develop stronger linkages to community resources
- Linkage with pharmaceutical groups for free monitors, monofilaments, educational materials
- Strengthening of relationships with local HMO's to promote disease management efforts

Spread Strategies

- Continue to work with ambulatory beta sites through 12/99
- Spread to entire physician network in early 2000
- Implementation of education innovations continuing through 2000
- Continued refinement of inpatient innovations through 2000

Clinical Information Systems

- ◆ Not available in primary care
- ◆ Need to develop registries, spread sheets, for ongoing monitoring
- ◆ Only paper and pencil tools currently available

Understanding Spread

- ◆ The real value of the project is not so much what you were able to do in your small test sample, but in your ability to spread your learnings to a larger system
- ◆ 10% will embrace anything
- ◆ 10% will never embrace anything
- ◆ 80% are workable with a lot of effort

Keys to Creating a Spread Environment

- ◆ Pick your most interested and dynamic “superstars” as your alpha site – if they can’t articulate how great it is to their peers they are not helpful
- ◆ Start advertising your successes from day one of the project – build a “success” expectation for your project
- ◆ Communicate: Meeting agendas, brief presentations, newsletters: everyone needs to know what you are doing and how well

Spread Strategies

- ◆ If you have created a “success” environment, by the time you spread, everyone will want to play
- ◆ Take volunteers but also draftees
- ◆ Approach not only the most innovative, but especially the most influential (whether they are on board or not)
- ◆ Be overtly manipulative

Spread Strategies

- ◆ Time intensive, hands on approach in their “home”
- ◆ Encourage spread site networking – meetings, sharing new ideas (tool kit updates, etc.)
- ◆ Promote strong leadership support – even if it is not present in the beginning, you can build it over time

Spread Strategies

- ◆ Visible support for the effort and the successes: awards, stories in newsletters, verbal praising in key meetings, etc.
- ◆ Don't do the project if you don't have the time to commit to hands on mentoring
- ◆ By the end of initial spread, most will be on board in some fashion

“Self-Management Training is Not Traditional Patient Education”

- Goal and emphasis is on behavior change not on increasing knowledge
- Patients must be actively involved – set their own goals – not doctor, ADA, etc.
- Self-management is: ongoing, active, requires support, and continuous feedback



Attention Patients with Diabetes

Please remove your shoes and socks/hose so your feet can be examined for the following conditions:

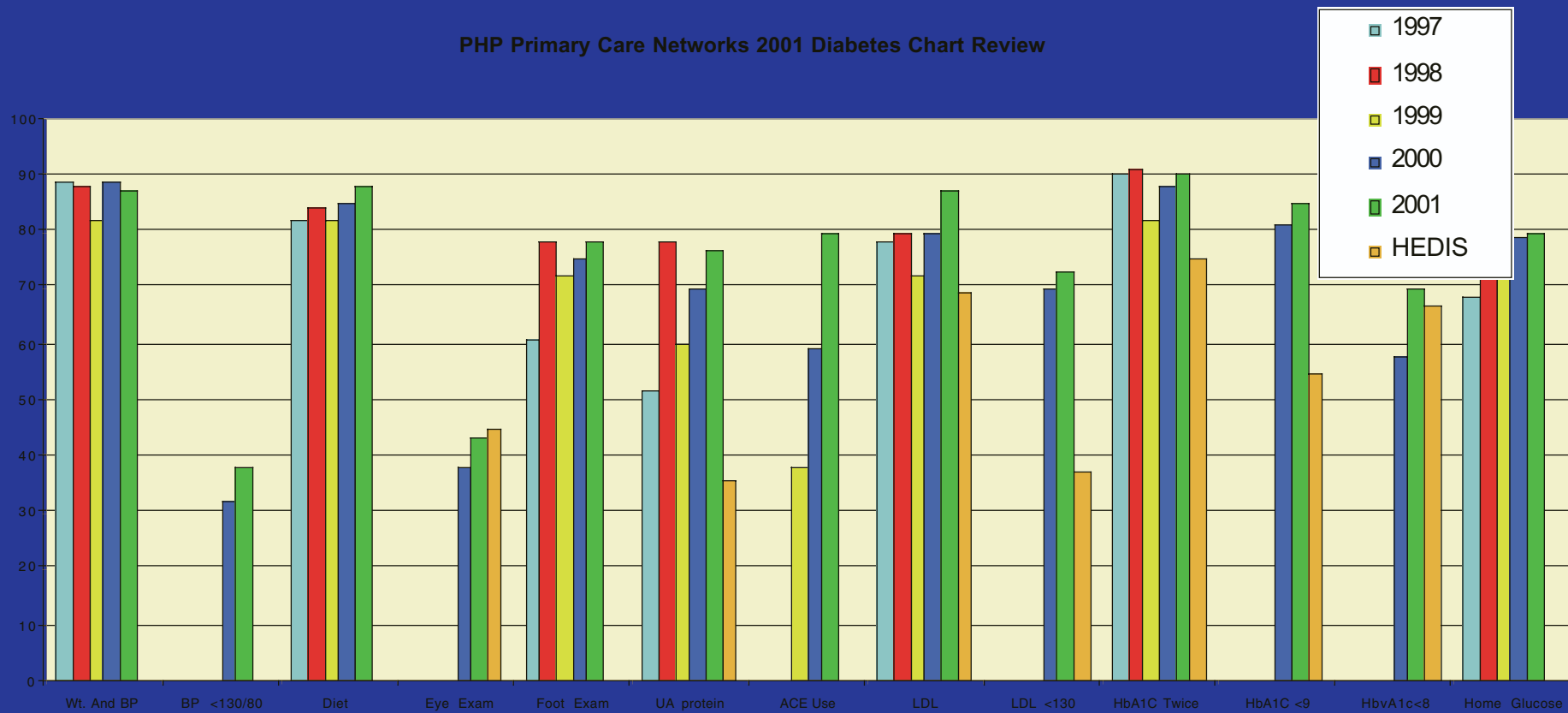
- Hair loss
- Thickened nails
 - Cold feet
- Foot and leg ulcers



Results

- 1800 plus patients enrolled in program
- 69% patients with HbA1C < 8
- 95% with twice yearly HbA1C measure
- 100% with height and weight on every visit
- 96% with documented smoking status
- 56% with documented annual retinal exam
- 78% documented annual foot exam (monofilament)
- 67% annual Microalbumin
- 72% ACE Inhibitor use with positive Microalbumin
- 85% annual Lipid measurement

PHP Primary Care Networks 2001 Diabetes Chart Review



Keys to Implementation Success

- ◆ Accepting there is no quick fix – forget what you read or heard at a CME
- ◆ Deal openly with attitudes, ownership issues from the beginning – you may be the physician but are you actually “the leader”
- ◆ Use data to support change and monitor religiously over time
- ◆ Allow for choice with strategies – there is never only one perfect strategy

Keys to Success

- System's support for initiative even though it was not present at start of project
- Use of outcomes data to drive change
- Allowing for choice with innovation strategies
- PI Attitude – This project is never over
- Building an enthusiastic team in spite of resource limitations
- Frequent and visible communication

Keys to Success

- ◆ Significant and ongoing staff education
- ◆ Be willing to admit your “perfect” idea is not working
- ◆ Don’t waste your time on ideas that are not working – don’t force it
- ◆ It is your team – LEAD IT and SUPPORT IT

Keys to Success

- ◆ Lower your expectations, the team is not always ready for the most innovative concept
- ◆ Waiting for the office or team to “be on board” before change occurs takes too much time and never happens
- ◆ Model embracing change
- ◆ Success breeds interest – they will get there and so will you

Barriers

- Lack of information systems
- Reimbursement
- Staffing resources
- State legislation
- Need for a significant paradigm shift from reactive to proactive delivery of care
- Need for ongoing strategic focus to support gains and continue to move forward