Diabetes Leadership Initiative

The Michigan Experience

Project Overview

- Approached summer, 2011 by NACDD
- Demonstration project to detect, delay, manage diabetes complications
- Implement health systems change
- Patient knowledge of kidney disease/health and provider education components

- 5 states accepted, 4 completed (MI, NC, NY, WI)
- Michigan addressed kidney disease (nephropathy) and eye disease (retinopathy)
- Designed simple protocol (DSME programs)
  - evaluate testing for kidney disease
  - referrals to registered dietitian (MNT)
  - nephrologist

Why Health Systems Change?

- Patients and populations have not reached their full health potential
- Need for new models that integrate clinical and population health
- DLI a model pilot to address collaboration of public health and primary care to address diabetes complications
- ACA and CDC requirements related to quality of care

Partner sites

- Henry Ford Health System's Diabetes Self-Management Education Program, Detroit MI (January, 2012)

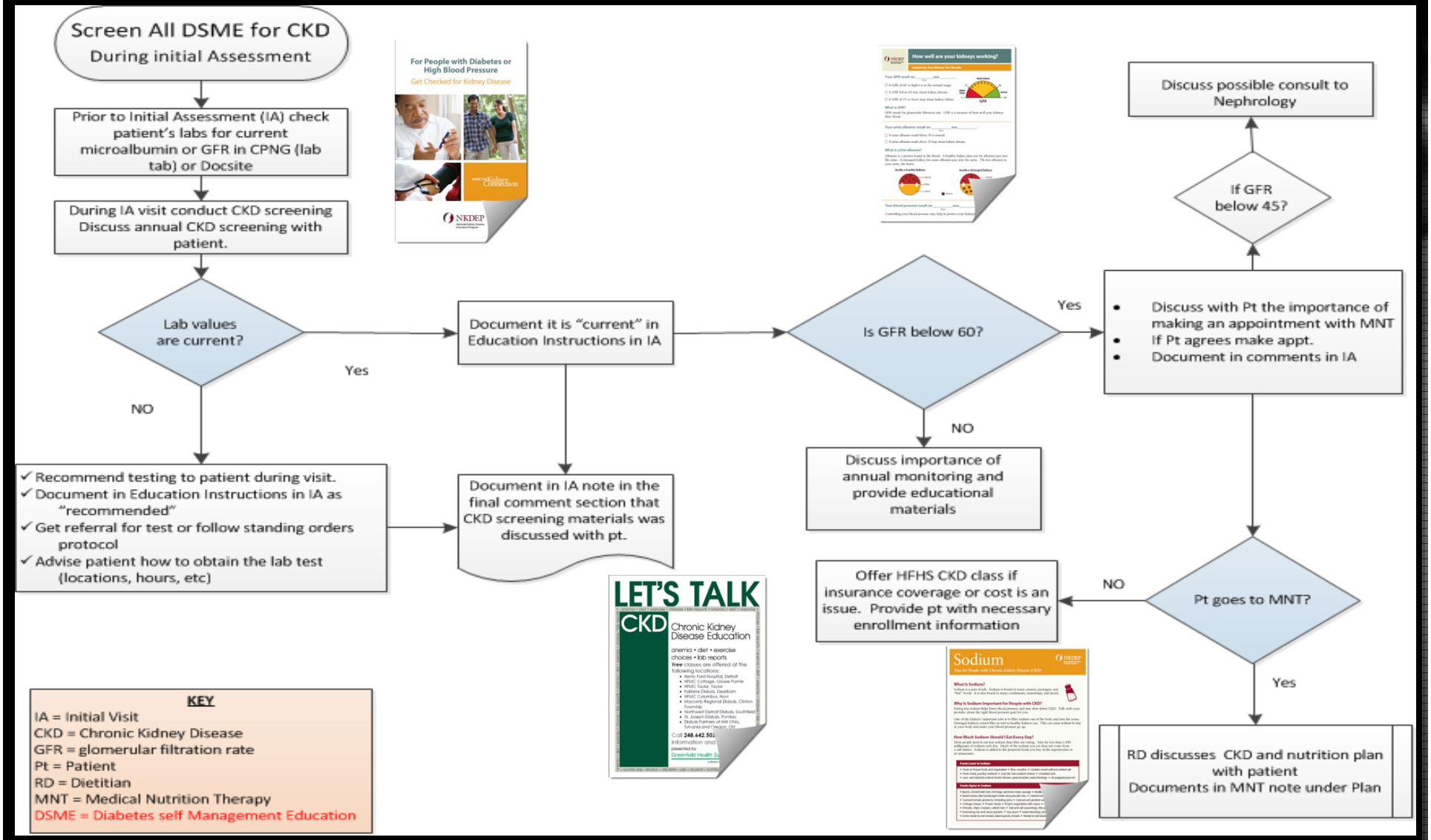
- Center for Family Health FQHC, Jackson, MI (February, 2012)

Henry Ford Health System's Diabetes Self-Management Education (DSME) Program

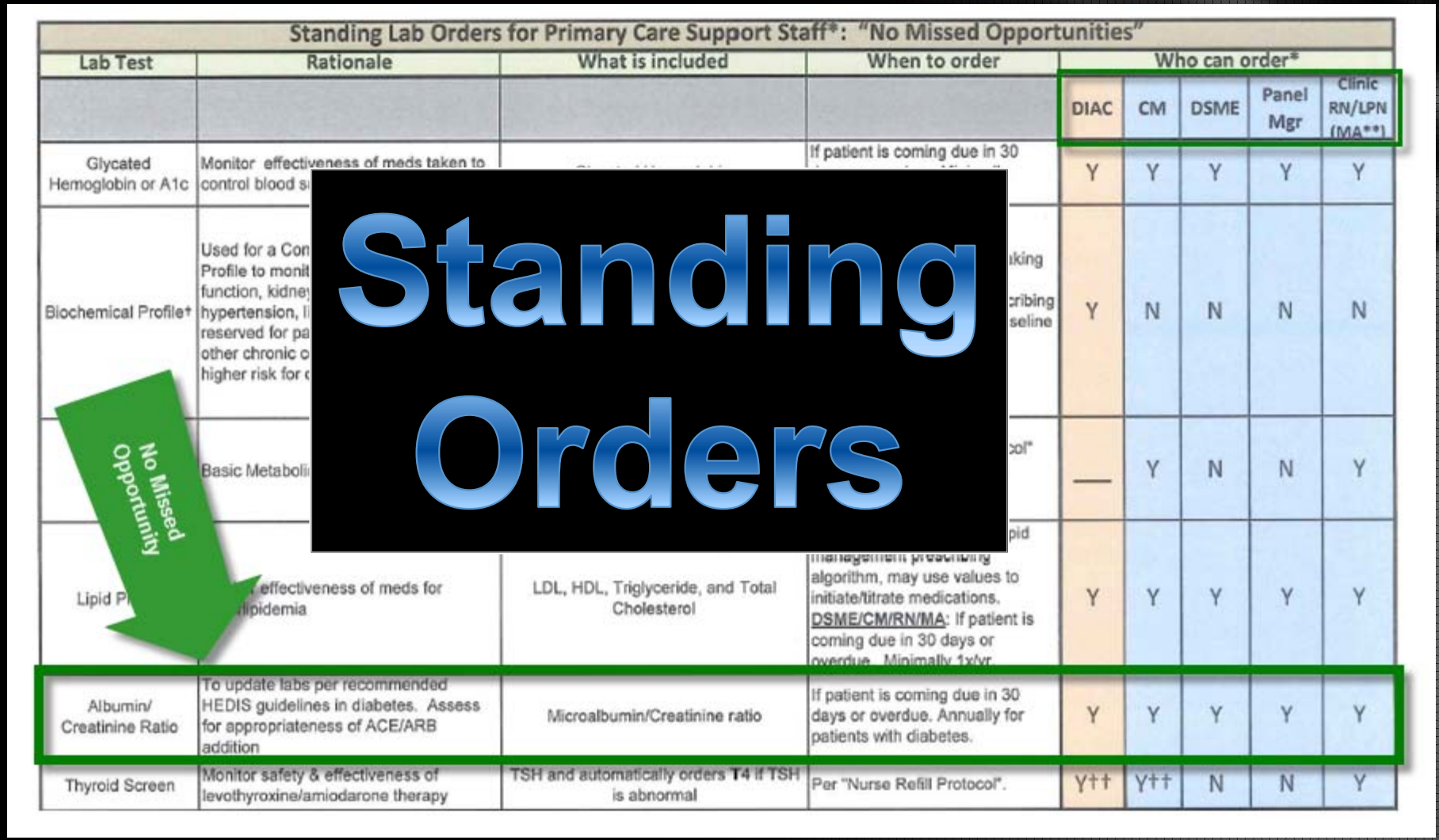
- Educators in DSME Program added screening for chronic kidney disease along with depression screening to initial visit in program.
- DSME Program flow chart was developed for screening & referral process.
- DSME Program collaborated with Greenfield Health System a division of Henry Ford Health System to refer patient without Medical Nutrition Therapy benefits to the free chronic kidney disease classes.
- DSME Program dietitians received additional training in kidney disease.
- This is testimonial from a patient's satisfaction survey we have seen since we started the DLL study.

" I have learned about tests I should have GFR and how stress can push my B/G levels higher. Thank you Henry Ford for this wonderful program! "

DSME Process for Screening



“No Missed Opportunities”



Standing Lab Orders for Primary Care Support Staff*: “No Missed Opportunities”

Lab Test	Rationale	What is included	When to order	Who can order*				
				DIAC	CM	DSME	Panel Mgr	Clinic RN/LPN (MA**)
Glycated Hemoglobin or A1c	Monitor effectiveness of meds taken to control blood s		If patient is coming due in 30	Y	Y	Y	Y	Y
Biochemical Profile†	Used for a Con Profile to monit function, kidne hypertension, l reserved for pa other chronic c higher risk for		king cribing seline	Y	N	N	N	N
	Basic Metaboli		col*	—	Y	N	N	Y
Lipid P	effectiveness of meds for lipidemia	LDL, HDL, Triglyceride, and Total Cholesterol	pid algorithm, may use values to initiate/titrate medications. DSME/CM/RN/MA: If patient is coming due in 30 days or overdue. Minimally 1x/yr	Y	Y	Y	Y	Y
Albumin/ Creatinine Ratio	To update labs per recommended HEDIS guidelines in diabetes. Assess for appropriateness of ACE/ARB addition	Microalbumin/Creatinine ratio	If patient is coming due in 30 days or overdue. Annually for patients with diabetes.	Y	Y	Y	Y	Y
Thyroid Screen	Monitor safety & effectiveness of levothyroxine/amiodarone therapy	TSH and automatically orders T4 if TSH is abnormal	Per “Nurse Refill Protocol”.	Y††	Y††	N	N	Y

Standing Orders

No Missed Opportunity

Medical Nutritional Therapy

- National Kidney Disease Education Program (NKDEP) offers in depth training on Kidney Disease for free without credit.
- Diabetes Care Center Dietitians took the NKDEP education modules on kidney disease and received Academy of Nutrition and Dietetic certification of training
- http://nkdep.nih.gov/identify-manage/ckd-nutrition/training-modules.shtml

National Campaign

- **AMGF National Campaign** launched in November 2012, HFMG kickoff March 2013
- **Campaign Goal:**

  Engage and empower patients to actively manage blood pressure

  Achieve control for 80% of patients with HTN per National JNC 8 standards by 2016

  Select and focus on **“Plank” activities** to achieve goals

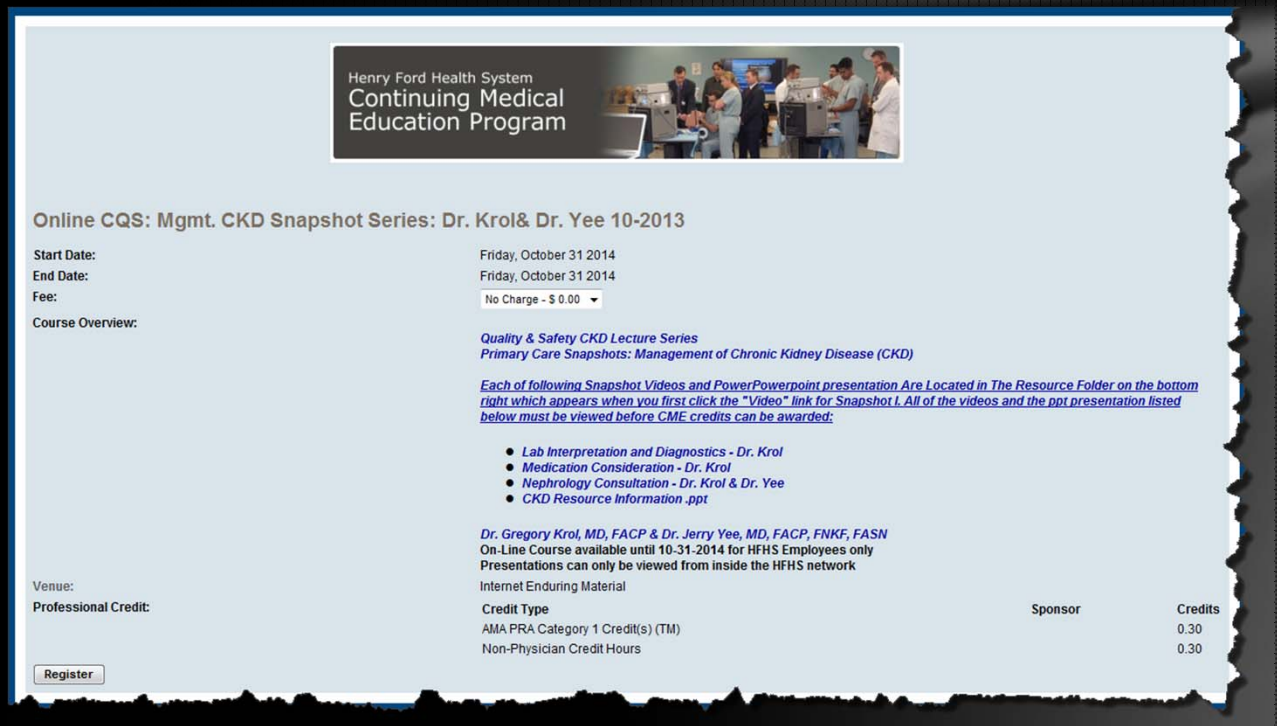
Quality Initiatives for HTN guidelines/ BP at every visit

Planks 2 & 3

- DKD video vignettes by HTN/Nephrology on You Tube (available on CME Multimedia site)
- Team care focus on lifestyle as well as medication initiation/titration
- Standing Orders for labs
- Universal Medication algorithm *in development*
- Follow up within 7 days for at risk patients transitioning from hospital to home
- ↑ Access- 30% Same Day plus Extended Hours, Acute Care & Weekend Care
- EMR reports- real time data to close gaps pilot

Educating Primary Care Providers

- Primary Care Snapshots: Management of Chronic Kidney Disease (CKD) was add to the HFHS Continuing Medical Education Program
- Providers can receive .3 CME at their convenience.



Center for Family Health (FQHC)

- Patient care coordinator (PCC) role integral to success of project
- Systems' change: PCC provides education to patients with diabetes on preventing and managing CKD
- PCC roles related to self-management support and change in care management of patients with diabetes

Patient Care Coordinator Roles

- **Before the patient visit:**

1. Identify and call patients with diabetes who have not been seen for over 6 months
2. Review charts prior to patient appointments (A1c, foot screen)

- **During the patient visit:**

1. Provide patient education and initiate referrals
2. Provide a copy of “How Well are My Kidneys Working”

- **Routinely:** Flag charts of patients for lab tests, referrals and education

Center for Family Health

Success of this project - Spread of this protocol and these system changes are now being implemented with hypertension

Primary Care Snapshots

- Addressed provider awareness component of DLI
- Series of 5 videos: 3-4.5 minutes in length
- Quick reference
- Based on “Chronic Kidney Disease: Clinical Practice Recommendations for Primary care Physicians and Healthcare Providers,” edited by Drs. Gregory Krol and Jerry Yee at Henry Ford
- www.youtube.com/PrimaryCareSnapshots

Results (preliminary)

- Among patients with diabetes and those with CKD, all kidney disease screen measures increased
  - Medical nutrition therapy
  - Referral to nephrologist
- Eye exams unchanged, modest improvement in BP control, large improvement in foot exams
- For patients with CKD, modest improvements in A1c, BP, LDL cholesterol and non-smoking status
- Explanation of results: DLI population different in racial/ethnic composition and insurance status and too early to see the results of the interventions

Lessons Learned

- Institute of Medicine: "It will not be easy for the healthcare delivery system to learn and change." What would help:
- Establish a functional multidisciplinary team
- Do an initial assessment of the health system's readiness for sustaining change
- Align health system QI projects with reporting requirements & meaningful use measures
- Ensure data collection and periodic review

Questions?

Thank you

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