Building a Care Management Model for Chronic Conditions:

Diabetes Intervention for Chicago's Medically Underserved

Revised From Presentation at American Public Health Association Annual Meeting, November 2006

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Overview

- **ACCESS**
- **Vision and Plan for Improvement**
- **Tools and Resources**
- **Case Study**
- **Lessons Learned, New Needs & Next Steps**

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Access Community Health Network (ACCESS) is the largest network of FQHCs in the nation.

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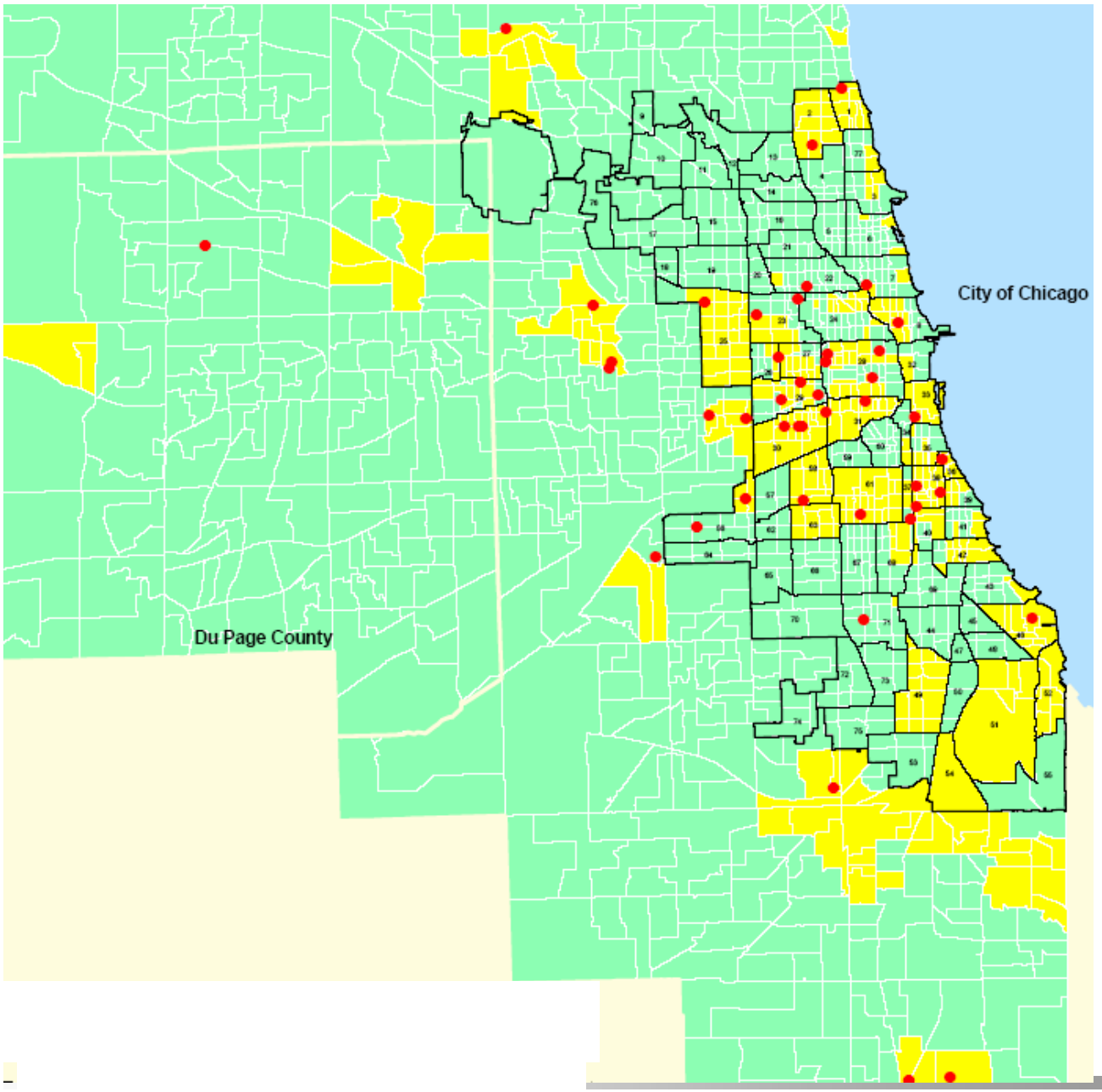

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Quick Facts:

- 200,000 Unique Patients served per year
- 47 Ambulatory Health Centers
- 10,500 Type 2 Diabetics
- 11,000 Asthmatics
- 45% Medicaid, 25% Uninsured (Self-Pay)

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Supporting Our Chronic Disease Initiatives:

- Centers for Disease Control
- Lloyd A. Fry Foundation
- Humana, Inc. Chicago Benefits
- Michael Reese Health Trust
- Washington Square Health Foundation

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Our Tools for Change

- Quality Models
- Focus on data to drive improvement
- New “Quality Procedures” to assess prevention and health promotion
- Financial model

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Quality Model: Chronic Care

Community

Resources And Policies

Health System

Self-Management Support

Delivery System Design

Decision Support

Clinical Information Systems

Health Care Organization

Informed, Activated Patient

Productive Interactions

Prepared, Proactive Practice Team

Improved Outcomes

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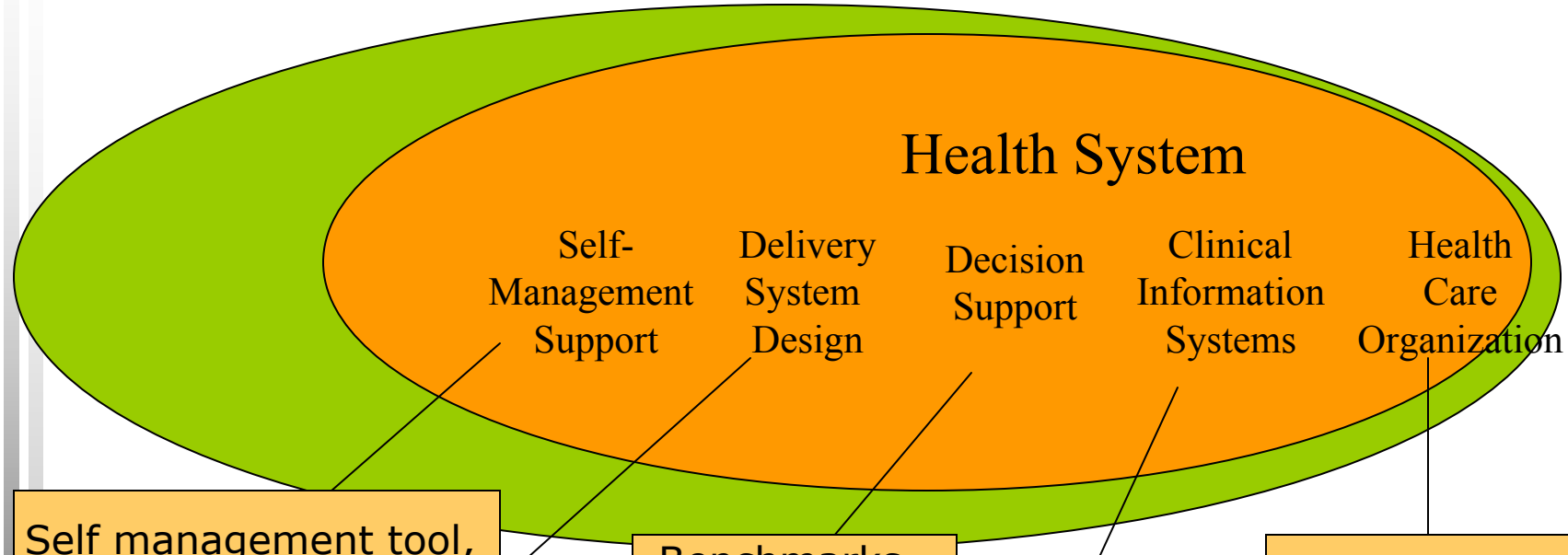
Adapted from the Chronic Care Model, EH Wagner, ACP-ASIM

Rollout Model: Diabetes



Self management tool, staff education, Group visit model

Benchmarks, Treatment Guidelines, QPs

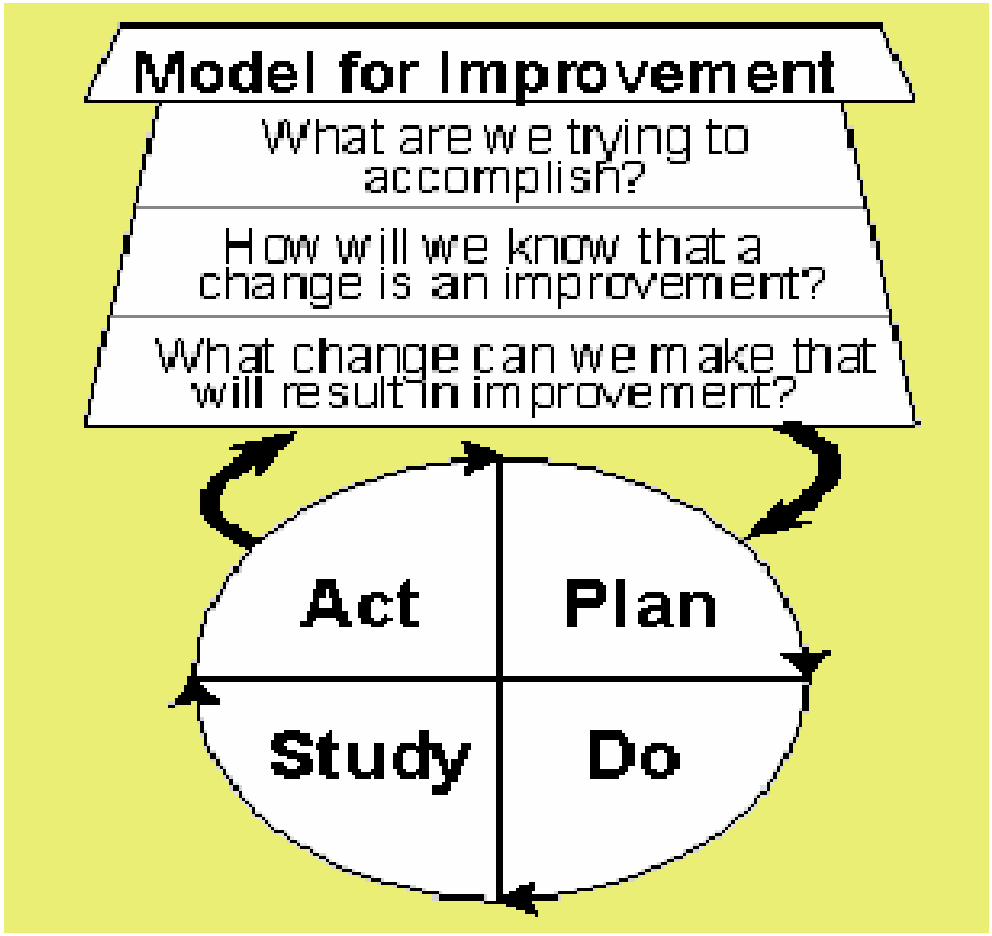
Financial model, data focus, Agency-wide progress reports

Care management flowsheet, In-office HbA1c, Automated callbacks

Patient registry with actionable data, Performance dashboard

Adapted from the Chronic Care Model, EH Wagner, ACP-ASIM

Quality Model: PDSA



Adapted from W. Edwards Deming www.improvingchroniccare.org

Quality Procedures (QPs)

- Counseling and screening interventions
- Based on USTF Guidelines for Preventive Care and Healthy People 2010
- Tailored to health and literacy needs
- Shift from acute to prevention & management
- Standard tools

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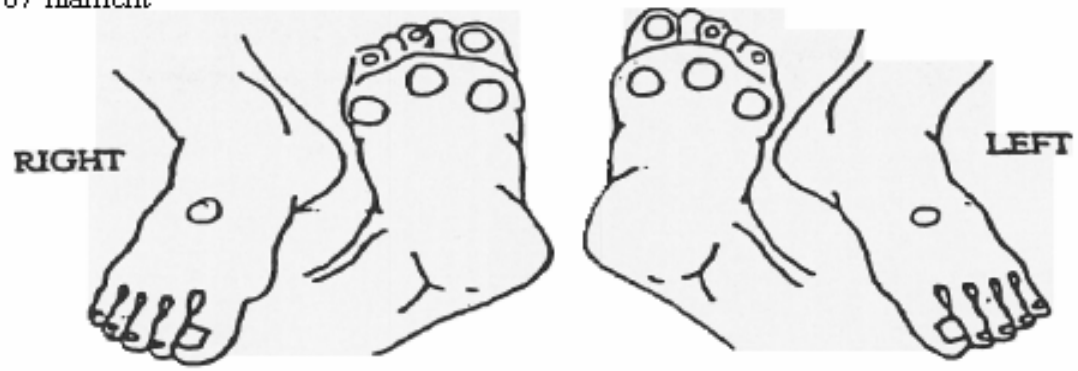
Sample Quality Procedure: Foot Exam

Can the patient see the bottom of their feet? _____ _____

Is the patient wearing improperly fitting footwear? _____ _____

***Note level of sensation in circles**

+ = Can feel 5.07 filament
- = Can't feel 5.07 filament



Draw in: Callus ___ Pre-Ulcer/Ulcer ____ (note width/depth in cm)
And Label: Skin Condition with **R-Redness** **D-Discoloration** **M-Maccration** **Y-Dryness**

Risk Category:		
_____	0	No loss of protective sensation
_____	1	Loss of protective sensation
_____	2	Loss of protective sensation with high pressure (callus/deformity) or poor circulation
_____	3	History of planar ulceration or neuropathic fracture (Charcot foot)

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Financial Model

- Increased revenue based on encounters
- Targeted grants to support program launch
- Providers have a base salary plus a credit for each outpatient visit
- Provider incentive for each Quality Procedure

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Data Feedback Dashboard

	Sample Health Center	ALL	Sample Health Center		QI Goal	Variance	
Diabetes Measures	Indicator	2005 Actual	n	%	2005 Goal		
	Annual lipid profile	95%	31	100%	95%	5%	
	Annual ophthalmology referral	64%	13	72%	75%	-3%	
	Completed ophthalmology referral in last 12 mo	56%	3	100%	50%	50%	★
	Diabetes:HbA1c: once in the past 6 months	88%	5	100%	85%	15%	★
	Diabetic flowchart	80%	5	100%	70%	30%	★
	Diabetic foot exam in last 12 months	58%	14	50%	65%	-15%	
	Diabetic self-management counseling in last 12 months	77%	14	83%	70%	13%	★

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RESULTS!

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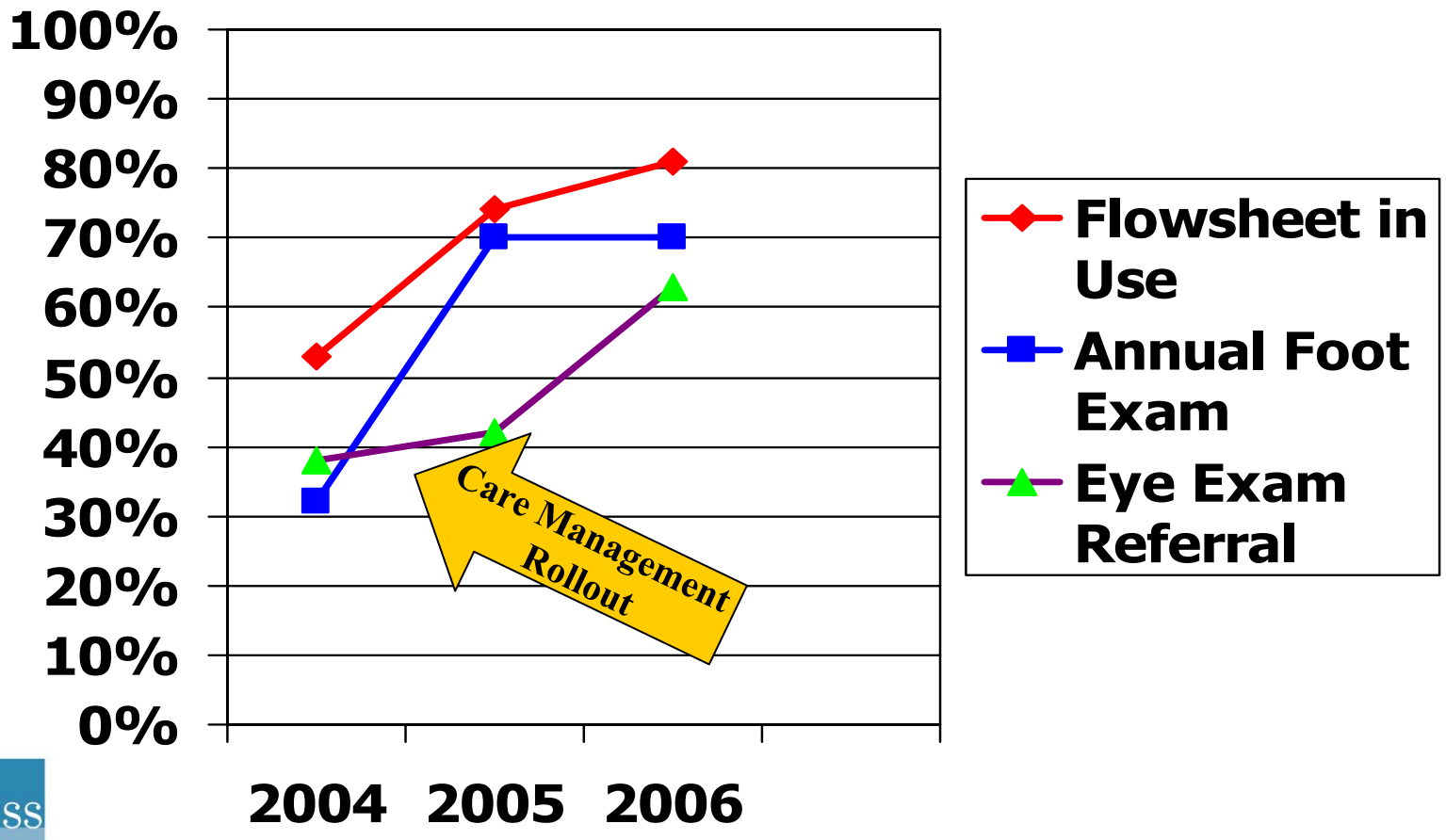
Diabetes: Selected Results



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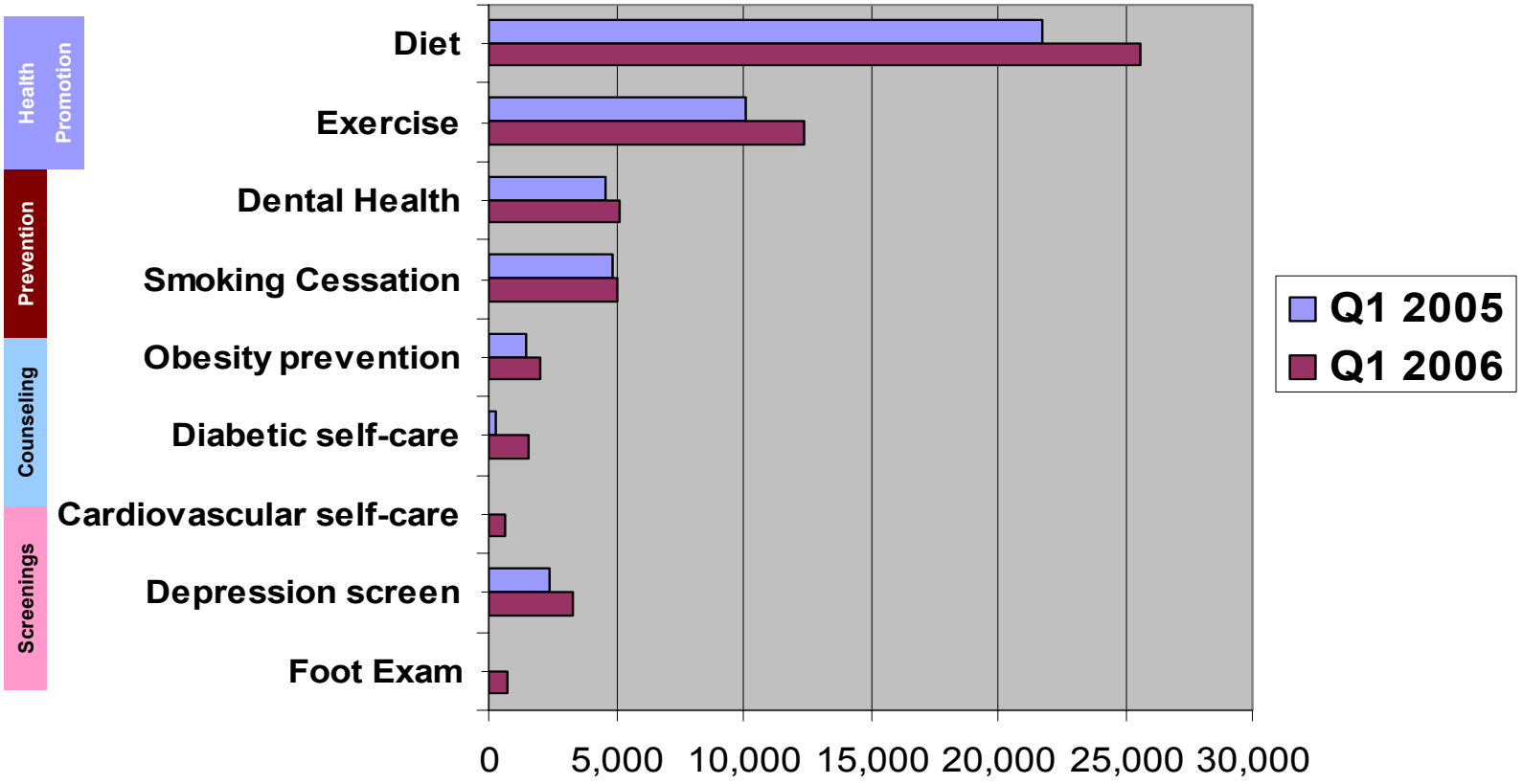
Tracking and Analysis: Quality Procedures



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Revenue Model

	Year 1	Year 2
Revenue		
Increased visits	168,500	114,750
Start-up Grants	200,000	75,000
Expense		
Personnel	125,000	75,000
Supplies	34,000	35,700
Net Income-Expense	209,500	79,050

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Key Learnings

- Demonstrated improvement
- Engage staff and patient as part of the team
- Embrace simple solutions
- Data feedback to point of care

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Replicating Success: Key Elements

- The right tools
- Buy-in and rewards
- Timely data feedback
- Staff participation, orientation and support
- Support of decision-makers

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Lessons Learned: Other Impacts

- Improved screening = more patients identified
- Infrastructure for care is critical
- Focus on diabetes is not enough

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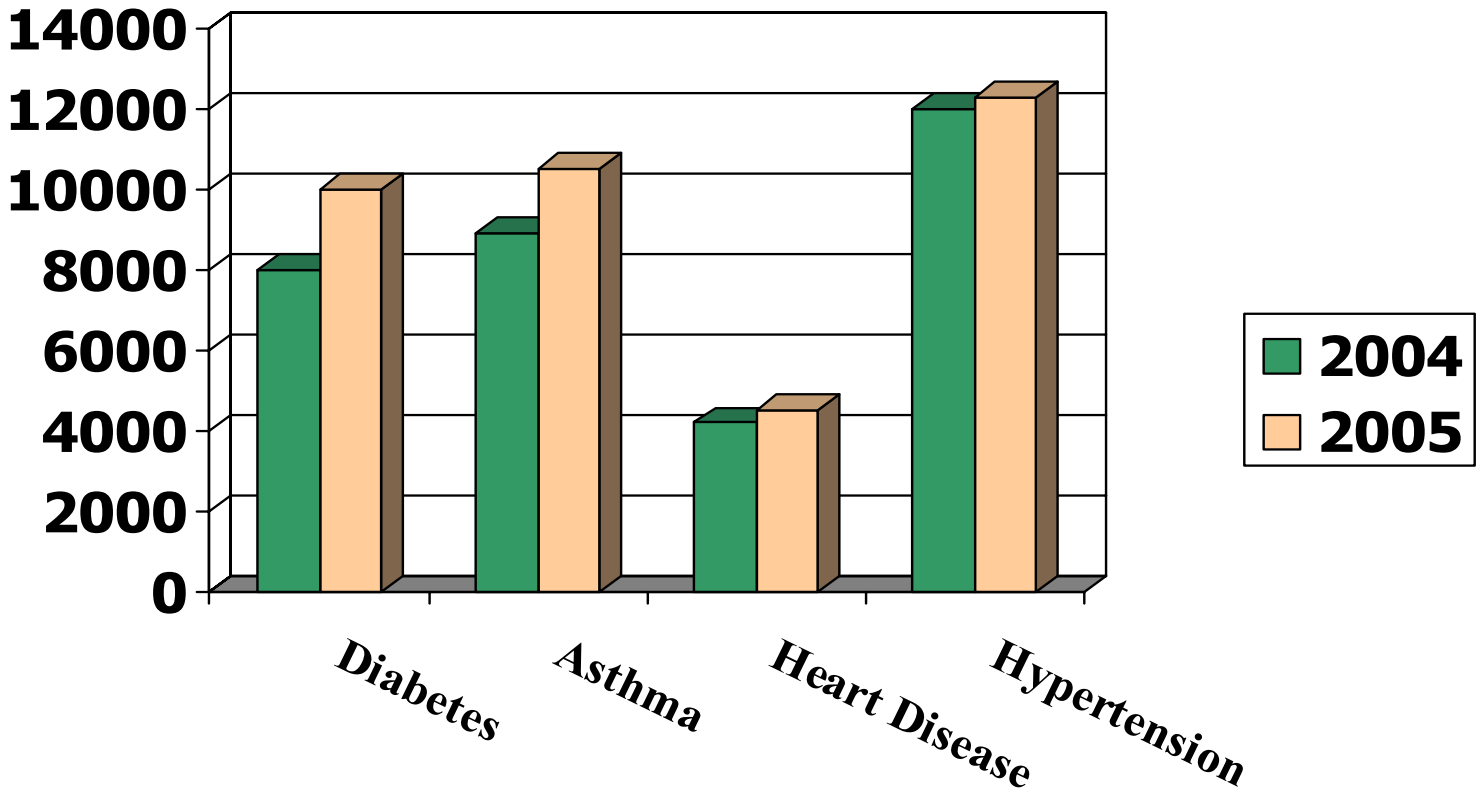
Where Are We Now: More Patients With Chronic Illness



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Thinking Ahead: the next strategic plan

Focus Areas:

- Quality Processes
- Infrastructure
- Continuum of High Quality Care

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Thank you

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