CARE OF THE PRE-DIABETIC AND DIABETIC PATIENT

March 25, 2020

CONFIDENTIAL

azara healthcare

Contact Information

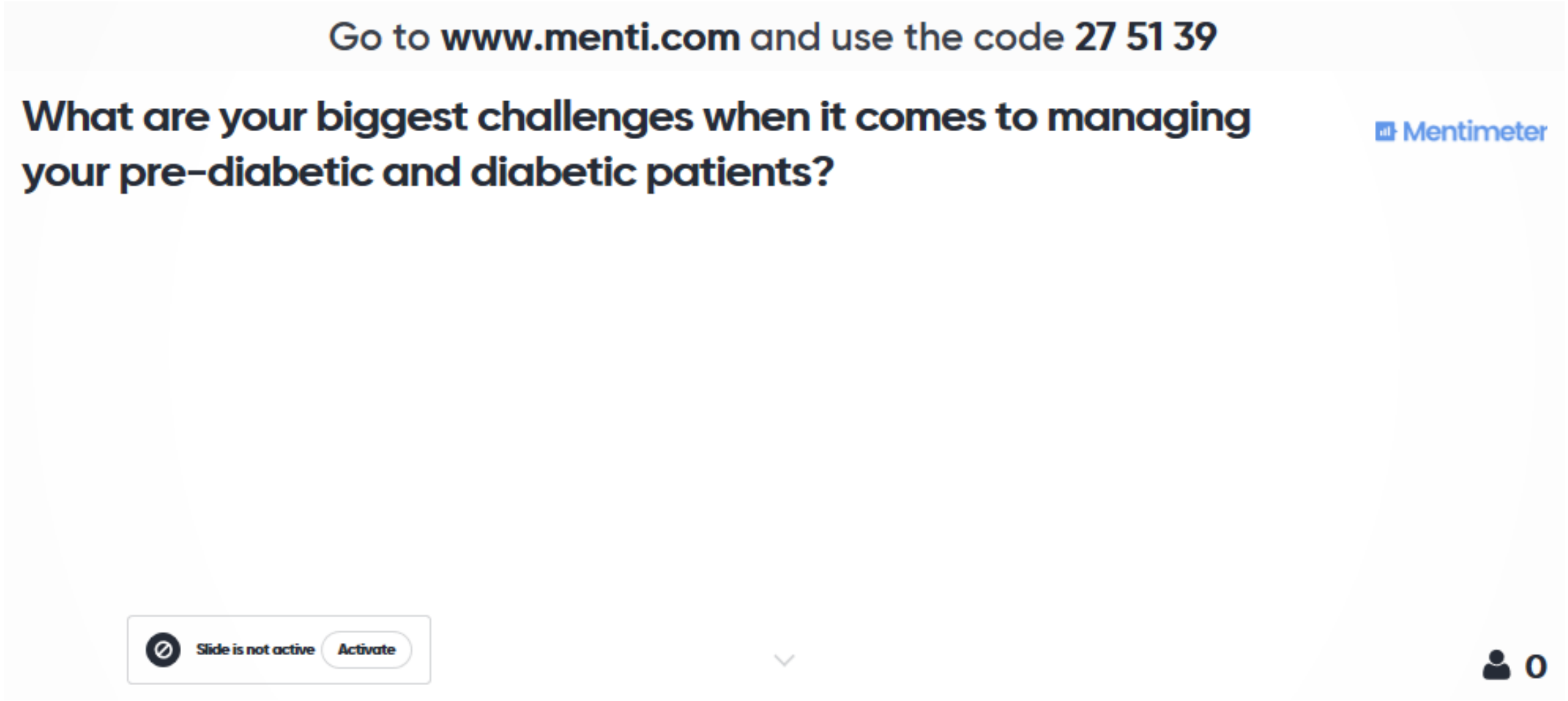
LuAnn Kimker, RN, MSN
Vice President of Clinical Innovation
Luann.Kimker@azarahealthcare.com

Janette Keddy, RN
Director of Client Success
Janette.Keddy@azarahealthcare.com

Agenda

1. Introductions
2. Population Health
3. Quality Improvement
4. Pre-Visit Planning
5. Point of Care
6. Questions

Poll #1


Go to www.menti.com and use the code 27 51 39
What are your biggest challenges when it comes to managing your pre-diabetic and diabetic patients?
Mentimeter
Slide is not active
Activate
0

Caring for Patients with Diabetes

azara healthcare

Focus Areas for Patient Care

azara healthcare

Population Health Management

- Outreach for appointments
- Coordinating care amongst various services

Quality Improvement

- Selecting improvement initiatives
- Implementing change
- Tracking improvement initiatives

Pre-Visit Planning

- Determining procedures/labs/etc. a patient is due for
- Preparing the team for the visit

Point of Care

- Accurately documenting the care provided
- Ordering the right tests/labs/referrals

Program 1815 Measures

azara healthcare

Pre-Diabetes & Diabetes 1815 Measures

azara healthcare

Undiagnosed diabetes prevalence

- Patients age 18-75 meeting clinical criteria for diabetes based on A1C, 2 hr OGTT, or FPG test who do not have a diagnosis of diabetes in the past 12 months.

Prediabetes prevalence

- Patients age 18-75 that have a diagnosis of prediabetes.

Prediabetes screening

- Patients screened using the American Diabetes Association (ADA)/Centers for Disease Control and Prevention (CDC) Prediabetes Risk Assessment.

Prediabetes diagnosis

- Patients diagnosed with prediabetes after using the ADA/CDC Prediabetes Risk Assessment.

Diabetic prevention program referral

- Patients with diagnosis of prediabetes who receive a referral to a CDC recognized/accredited DPP from their health care provider or have completed diabetes self management goals in the last 12 months.

Diabetes prevalence

- Patients age 18 to 75 who have a diagnosis of diabetes in the past 12 months.

Diabetes A1C >9 or untested

- Percentage of patients 18-75 years of age with diabetes who had most recent hemoglobin A1c > 9.0% during the measurement period.

DSME referral

- Patients with a diagnosis of Diabetes who receive a referral to a recognized/accredited DSME program from their health care provider or completed diabetes self management goals within the past 12 months.

Clinical pharmacy referral

- Patients with Diabetes, HTN, or HBC referred to Clinical Pharmacy Services in the last 12 months.

Structured Clinical Data | Required Mapping

Structured Clinical Data	Description	Corresponding Measure	Notes
SMBP Referral	A documented referral (includes e-referral) to a community program for Self-Measured Blood Pressure monitoring (SMBP). SMBP is defined as the regular measurement of blood pressure by the patient outside the clinical setting, either at home or elsewhere. It is sometimes known as “home blood pressure monitoring.”	Self Measured Blood Pressure Community Program Referral (NQF 0018 modified)	Patient can have this referral structured clinical data OR HTN Self Management goals (below) to satisfy the numerator criteria
HTN Self Management	Self Management goals/plan from EHR specifically for Hypertension. Indicates a patient-specific activity vs a medical recommendation. Requires date created or last updated.	Self Measured Blood Pressure Community Program Referral (NQF 0018 modified)	Patient can have this referral structured clinical data OR referral structured clinical data (above) to satisfy the numerator criteria
Prediabetes Risk Assessment	Total score of the American Diabetes Association (ADA)/Centers for Disease Control and Prevention (CDC) Prediabetes Risk Assessment.	Prediabetes Screening	
Diabetic Prevention Program	Documented referral to diabetic prevention program.	Diabetic Prevention Program Referral	
Diabetes Self Management	Self Management goals/plan from EHR specifically for Diabetes	• Diabetic Prevention Program Referral • DSME Referral	Either structured clinical data item can be used to qualify a patient for the numerator
DSMES Program	Referral to a recognized/accredited Diabetes self-management education and support (DSMES) program	DSME Referral	
Clinical Pharmacy Services Referral	Referral to Clinical Pharmacy Services	Clinical Pharmacy Referral	
Questionnaire Completed PRAPARE	The date that a social needs assessment was conducted e.g., PRAPARE or similar questionnaire of Social Determinants of Health. May include partial or complete answering of questions.	Social Determinants of Health Assessment Done (18+)	
Community Resource Referral	Referral to a community resource for social needs identified from SDOH screening.	Social Determinants of Health Referral	

Measure Relationships

MEASURE	RESULT	NUMERATOR	DENOMINATOR
Undiagnosed Diabetes Prevalence	16.5%	120	725
PreDiabetes Prevalence	74.5%	540	725
PreDiabetes Screening	85.7%	600	700
PreDiabetes Diagnosis	50.0%	300	600
Diabetic Prevention Program Referral	27.3%	150	550
Diabetes Prevalence	63.4%	460	725
Diabetes A1c > 9 or Untested (NQF 0059)	28.0%	200	715
DSME Referral	41.7%	300	720
Clinical Pharmacy Referral			

Denominator for DSME Referral is essentially the same as Diabetes Prevalence, PreDiabetes Prevalence, and Undiagnosed Diabetes Prevalence with minor variances in the exclusion criteria, which is why they do not match exactly.

Population Health

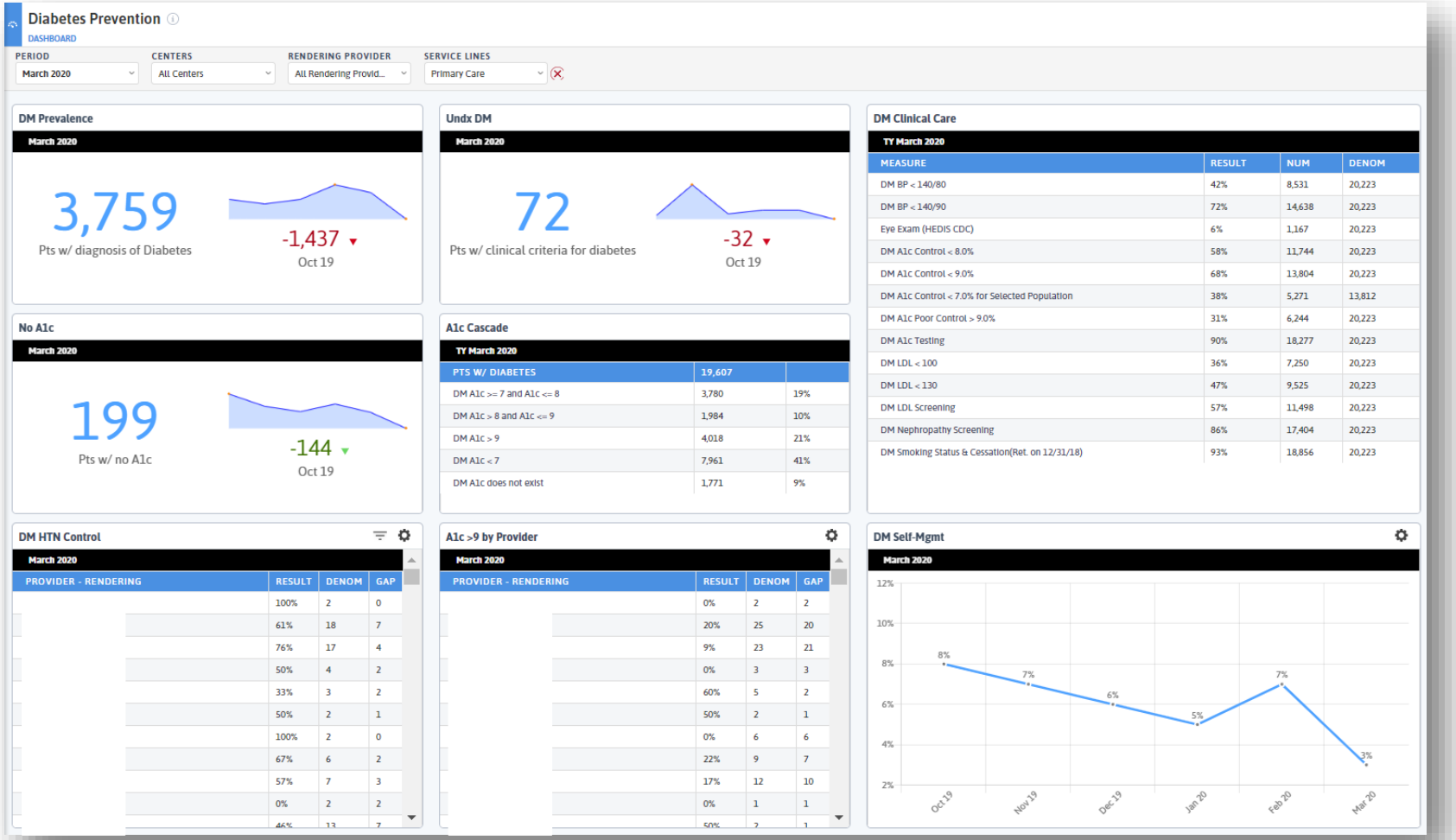
azara healthcare

Population Health Management

- The work that goes into managing patients outside of an office visit.
- Population Health Management can include:
  - Outreach
  - Engagement
  - Care coordination
  - Referral management
  - Hospital/ED follow up
- Data hygiene and EHR updates

Population View

- Snapshot of measures related to patient care, coding, and outreach.
- Should tell a story of your population.
- Can be utilized operationally or as an executive overview.



Diabetes Prevention

DASHBOARD

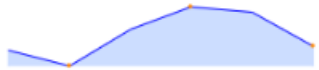
PERIOD: March 2020 | RENDERING PROVIDER: All Rendering Provid... | SERVICE LINES: Primary Care

DM Prevalence

March 2020

312

Pts w/ diagnosis of Diabetes



+31 ▲

Oct 19

Undx DM

March 2020

11

Pts w/ clinical criteria for diabetes

+1 ▲

Oct 19

DM Clinical Care

TY March 2020

MEASURE	RESULT	NUM	DENOM
DM BP < 140/80	41%	809	1,967
DM BP < 140/90	72%	1,411	1,967
Eye Exam (HEDIS CDC)	1%	15	1,967
DM A1c Control < 8.0%	54%	1,064	1,967
DM A1c Control < 9.0%	65%	1,269	1,967
DM A1c Control < 7.0% for Selected Population	34%	472	1,380
DM A1c Poor Control > 9.0%	34%	672	1,967
DM A1c Testing	92%	1,813	1,967
DM LDL < 100	46%	909	1,967
DM LDL < 130	63%	1,247	1,967
DM LDL Screening	80%	1,582	1,967
DM Nephropathy Screening	85%	1,673	1,967
DM Smoking Status & Cessation(Ret. on 12/31/18)	93%	1,832	1,967

No A1c

March 2020

9

Pts w/ no A1c

+2 ▲

Oct 19

A1c Cascade

TY March 2020

PTS W/ DIABETES	1,893	
DM A1c >= 7 and A1c <= 8	373	20%
DM A1c > 8 and A1c <= 9	200	11%
DM A1c > 9	521	28%
DM A1c < 7	686	36%
DM A1c does not exist	111	6%

DM HTN Control

March 2020

PROVIDER - RENDERING	RESULT	DENOM	GAP
	68%	19	6
	67%	9	3
	75%	16	4
	80%	5	1
	75%	12	3
	50%	2	1
	67%	3	1
	73%	11	3
	79%	14	3
	61%	18	7
	100%	1	0

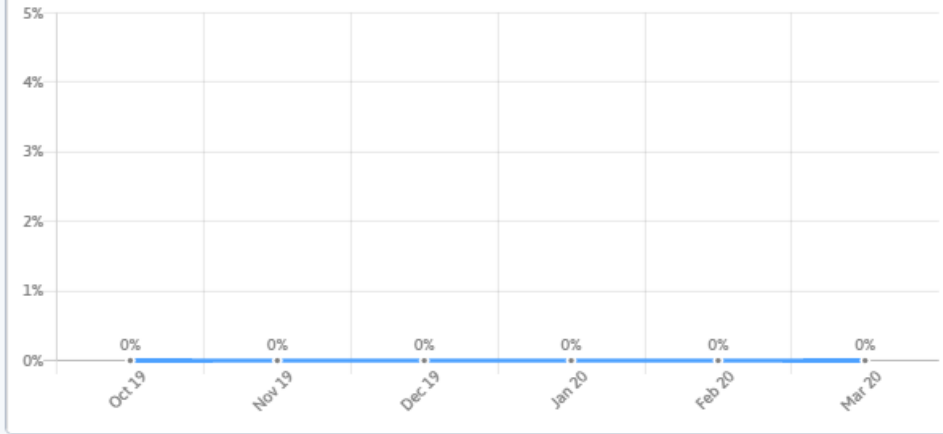
A1c >9 by Provider

March 2020

PROVIDER - RENDERING	RESULT	DENOM	GAP
	22%	32	25
	35%	26	17
	32%	28	19
	40%	5	3
	0%	1	1
	40%	5	3
	42%	24	14
	25%	4	3
	33%	3	2
	25%	20	15
	19%	27	22

DM Self-Mgmt

March 2020



Pre-Diabetes

DASHBOARD

PERIOD: March 2020 | CENTERS: All Centers | RENDERING PROVIDER: All Rendering Provid...

Pre-DM Prevalence

March 2020

1,519

Pts w/ diagnosis of PreDiabetes

0

Oct 19

Pre-DM Dx

January 2020

0

Numerator

0

Aug 19

Pre-DM Screening

January 2020

0

Numerator

0

Aug 19

DM Prevention Program Referral

January 2020

0

Numerator

0

Aug 19

Provider Pre-DM Dx

TY March 2020

PROVIDER - USUAL	RESULT	NUM	DENOM
	0%	0	1
	0%	0	1
	0%	0	9
	0%	0	14
	0%	0	1
	13%	123	956
	0%	0	13
	11%	42	379
	6%	50	783
	0%	0	4
	0%	0	1
	11%	21	198
	0%	0	79
	0%	0	16
	0%	0	1

Cohorts

- A cohort is a group of patients with a certain set of characteristics.
- Important to track cohorts when measuring success.
  - Are the people you're outreaching to coming in?
  - Are they getting their A1C?
  - Are those being managed by the CDE improving their A1C?
- Example:
  - TY December 2019
  - Diabetes A1C does not exist (NQF 0059 Modified)

Diabetes Prevention

DASHBOARD

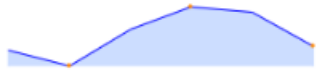
PERIOD: March 2020 | RENDERING PROVIDER: All Rendering Provid... | SERVICE LINES: Primary Care

DM Prevalence

March 2020

312

Pts w/ diagnosis of Diabetes



+31 ▲

Oct 19

Undx DM

March 2020

11

Pts w/ clinical criteria for diabetes

+1 ▲

Oct 19

DM Clinical Care

TY March 2020

MEASURE	RESULT	NUM	DENOM
DM BP < 140/80	41%	809	1,967
DM BP < 140/90	72%	1,411	1,967
Eye Exam (HEDIS CDC)	1%	15	1,967
DM A1c Control < 8.0%	54%	1,064	1,967
DM A1c Control < 9.0%	65%	1,269	1,967
DM A1c Control < 7.0% for Selected Population	34%	472	1,380
DM A1c Poor Control > 9.0%	34%	672	1,967
DM A1c Testing	92%	1,813	1,967
DM LDL < 100	46%	909	1,967
DM LDL < 130	63%	1,247	1,967
DM LDL Screening	80%	1,582	1,967
DM Nephropathy Screening	85%	1,673	1,967
DM Smoking Status & Cessation(Ret. on 12/31/18)	93%	1,832	1,967

No A1c

March 2020

9

Pts w/ no A1c

+2 ▲

Oct 19

A1c Cascade

TY March 2020

PTS W/ DIABETES	1,893	
DM A1c >= 7 and A1c <= 8	373	20%
DM A1c > 8 and A1c <= 9	200	11%
DM A1c > 9	521	28%
DM A1c < 7	686	36%
DM A1c does not exist	111	6%

DM HTN Control

March 2020

PROVIDER - RENDERING	RESULT	DENOM	GAP
	68%	19	6
	67%	9	3
	75%	16	4
	80%	5	1
	75%	12	3
	50%	2	1
	67%	3	1
	73%	11	3
	79%	14	3
	61%	18	7
	100%	1	0

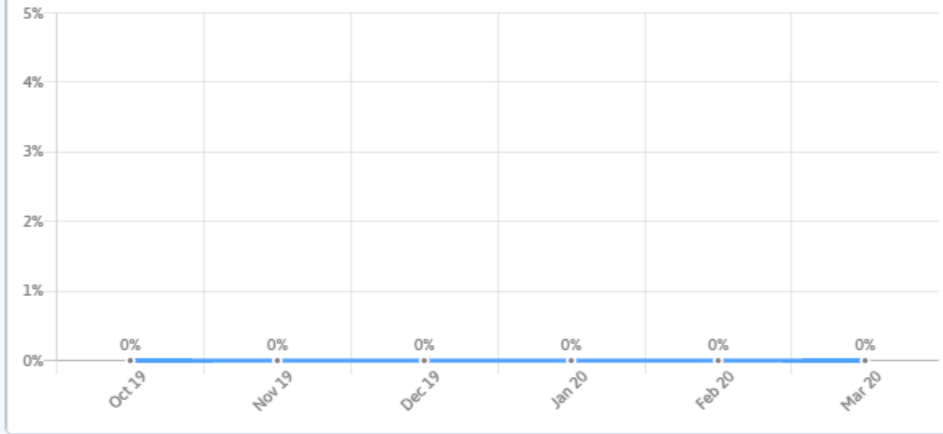
A1c >9 by Provider

March 2020

PROVIDER - RENDERING	RESULT	DENOM	GAP
	22%	32	25
	35%	26	17
	32%	28	19
	40%	5	3
	0%	1	1
	40%	5	3
	42%	24	14
	25%	4	3
	33%	3	2
	25%	20	15
	19%	27	22

DM Self-Mgmt

March 2020



Diabetes Prevention

DASHBOARD

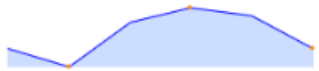
PERIOD: March 2020 | RENDERING PROVIDER: All Rendering Provid... | SERVICE LINES: Primary Care | COHORT: DM No A1C TY Dec 19

DM Prevalence

March 2020

276

Pts w/ diagnosis of Diabetes



-4 ▼

Oct 19

Undx DM

March 2020

0

Pts w/ clinical criteria for diabetes

-2 ▼

Oct 19

DM Clinical Care

TY March 2020

MEASURE	RESULT	NUM	DENOM
DM BP < 140/80	41%	719	1,746
DM BP < 140/90	72%	1,256	1,746
Eye Exam (HEDIS CDC)	1%	14	1,746
DM A1c Control < 8.0%	55%	960	1,746
DM A1c Control < 9.0%	66%	1,150	1,746
DM A1c Control < 7.0% for Selected Population	34%	408	1,210
DM A1c Poor Control > 9.0%	33%	571	1,746
DM A1c Testing	94%	1,643	1,746
DM LDL < 100	49%	856	1,746
DM LDL < 130	66%	1,143	1,746
DM LDL Screening	82%	1,433	1,746
DM Nephropathy Screening	87%	1,516	1,746
DM Smoking Status & Cessation(Ret. on 12/31/18)	94%	1,639	1,746

No A1c

March 2020

5

Pts w/ no A1c

-2 ▼

Oct 19

A1c Cascade

TY March 2020

PTS W/ DIABETES	1,747	
DM A1c >= 7 and A1c <= 8	345	20%
DM A1c > 8 and A1c <= 9	188	11%
DM A1c > 9	470	27%
DM A1c < 7	646	37%
DM A1c does not exist	96	6%

DM HTN Control

March 2020

PROVIDER - RENDERING	RESULT	DENOM	GAP
	68%	19	6
	67%	9	3
	73%	15	4
	75%	4	1
	73%	11	3
	50%	2	1
	67%	3	1
	80%	10	2
	75%	12	3
	59%	17	7
	100%	1	0

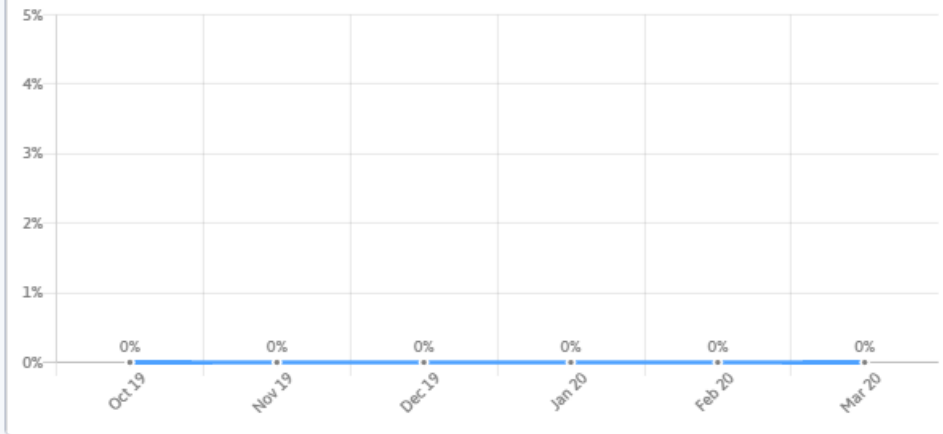
A1c >9 by Provider

March 2020

PROVIDER - RENDERING	RESULT	DENOM	GAP
	19%	27	22
	36%	25	16
	28%	25	18
	40%	5	3
	50%	4	2
	30%	20	14
	25%	4	3
	33%	3	2
	27%	15	11
	19%	27	22
	26%	27	20

DM Self-Mgmt

March 2020



Patient Lists

azara healthcare

Registry of patient details

Filterable to patient traits

Used for care coordination

Diabetic Registry Features

- Contains patient demographics and information related to diabetes management.
  - ✓ Insurance
  - ✓ Most recent and next encounter
  - ✓ Diagnosis date
  - ✓ A1c
  - ✓ LDL
  - ✓ BP
  - ✓ BMI
  - ✓ Eye exam
  - ✓ Urine protein
  - ✓ Flu
  - ✓ PCV
- Filterable by patient traits
  - ✓ Diagnosis
  - ✓ SDOH
  - ✓ Provider
  - ✓ Race/Ethnicity
  - ✓ Care Manager
  - ✓ Risk level

Diabetic Registry Uses

- Outreach for appointment scheduling
- Ad hoc patient list creation
- Care manager patient assignment
- Data analysis of a population
- Cohort creation for tracking a group of patients
- Data hygiene review

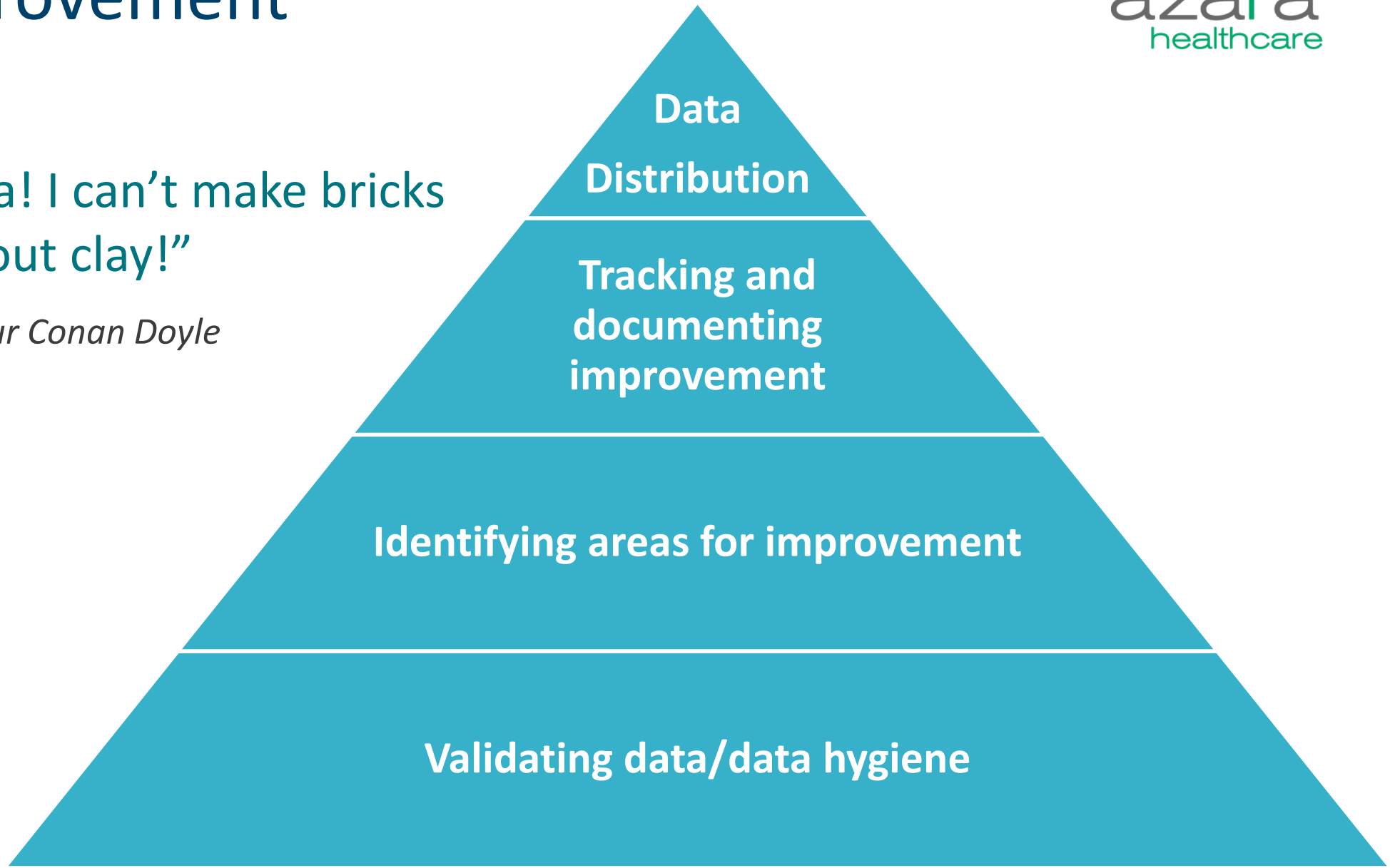
Quality Improvement

azara healthcare

Quality Improvement

"Data! Data! Data! I can't make bricks without clay!"

-Sir Arthur Conan Doyle



Data Hygiene Best Practices

Don't silo data hygiene with one person. Your organization's trust in your numbers matters! Cultivate data credibility with a team approach.

Focus

- Document key quality measures
- Set review schedule

Standardize

- Map standard workflows
- Verify mappings correspond to workflows

Train

- Develop materials for staff on workflows
- Distribute for new hire and ongoing trainings

Share

- Schedule regular meetings to discuss quality improvement and validation findings
- Assign roles and responsibilities

Data Hygiene at Work

- Review the Diabetes A1c does not exist (NQF 0059 Modified) measure.
- Filter for patients with a A1c less than 5.7.
  - Clean up the problem lists.
  - Update data entry errors.
- Data hygiene errors have a ripple effect:
  - Pre-visit planning
  - Registries
  - Regulatory reporting

DIABETES DX		A1C NUM RES	
DATE	CODE	DATE	A1C N...
5/17/2016	E11.9	10/4/2018	4.5
10/2/2015	E11.9	1/30/2020	4.6
2/12/2020	E11.8	2/12/2020	4.6
12/6/2019	E11.9	12/14/2019	4.6
6/25/2019	E11.9	9/12/2019	4.6

DIABETES DX		A1C NUM RES	
DATE	CODE	DATE	A1C N...
10/26/2015	E11.21	8/22/2019	-10.5
7/17/2017	E11.9	8/29/2019	-9.3
6/15/2017	E11.9	7/8/2019	-6.6
11/2/2015	E11.9	7/2/2019	-6.6
12/13/2017	E11.9	7/16/2019	-5.6
11/28/2018	E11.9	9/27/2019	0
3/7/2019	E11.9	3/7/2019	0
1/29/2019	E11.9	8/15/2019	0.71
1/29/2019	E11.9	3/13/2020	0.88
12/21/2016	E11.65	6/6/2019	0.95

Selecting Measures for QI

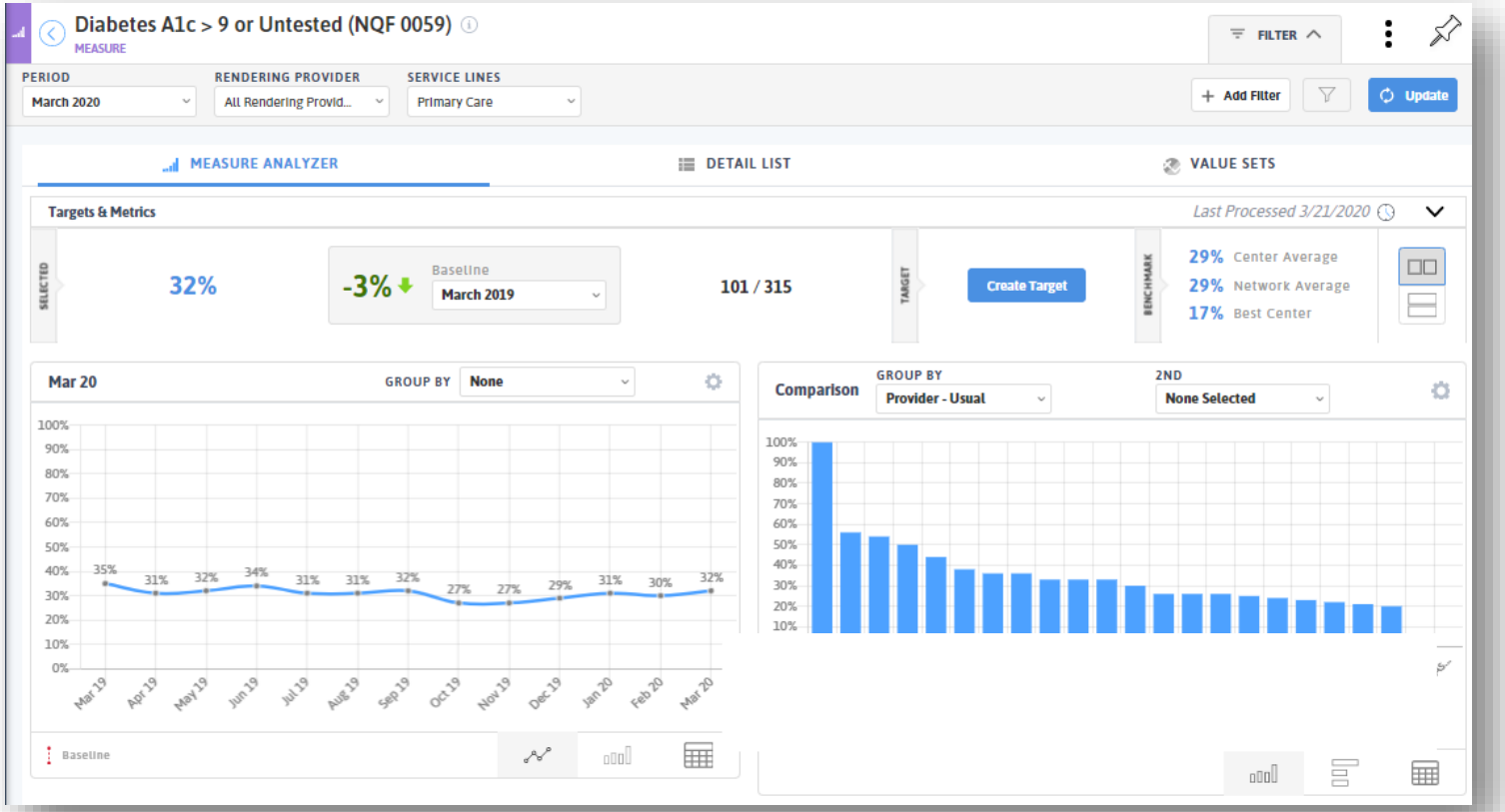
- Important to have leadership buy-in and support throughout the QI process.
- Institute a quality culture.
- Illicit feedback and encourage staff at all levels to identify areas for improvement.
- Make selections for measures based on initiatives, staff suggestions, and data.
- Dive deeper into the measure and break it down.

A1c Cascade

TY March 2020		
PTS W/ DIABETES	1,893	
DM A1c >= 7 and A1c <= 8	373	20%
DM A1c > 8 and A1c <= 9	200	11%
DM A1c > 9	521	28%
DM A1c < 7	686	36%
DM A1c does not exist	111	6%

Tracking & Measuring Progress

- Need to track and measure progress in several ways:
  - By Provider
  - By Location
  - By Month (or other short time period for PDSA purposes)
  - By various patient traits, i.e. race, ethnicity, SDOH
- Establish a baseline time period and compare current results
- PCMH Requirement



Distributing Data

- Educate stakeholders about the measure requirements and how to meet the measure.
  - Cheat sheet: one-page info sheet with measure definition and screen shot from EHR with where/how to document
- Verify data before distribution – it always comes back to data hygiene!
- Regular, reliable distribution of data. Be sure to respond timely to any concerns or questions.
- Decisions to make:
  - To blind or not blind the data?
  - What data to show?
  - Graphical or data?
- Most importantly, keep your data focused and be open to feedback.

Diabetes Prevention

DASHBOARD

PERIOD: March 2020 | CENTERS: All Centers | RENDERING PROVIDER: All Rendering Provid... | SERVICE LINES: Primary Care

DM Prevalence

March 2020

3,759
Pts w/ diagnosis of Diabetes

-1,437
Oct 19

Undx DM

March 2020

72
Pts w/ clinical criteria for diabetes

-32
Oct 19

DM Clinical Care

TY March 2020

MEASURE	RESULT	NUM	DENOM
DM BP < 140/80	42%	8,531	20,223
DM BP < 140/90	72%	14,638	20,223
Eye Exam (HEDIS CDC)	6%	1,167	20,223
DM A1c Control < 8.0%	58%	11,744	20,223
DM A1c Control < 9.0%	68%	13,804	20,223
DM A1c Control < 7.0% for Selected Population	38%	5,271	13,812
DM A1c Poor Control > 9.0%	31%	6,244	20,223
DM A1c Testing	90%	18,277	20,223
DM LDL < 100	36%	7,250	20,223
DM LDL < 130	47%	9,525	20,223
DM LDL Screening	57%	11,498	20,223
DM Nephropathy Screening	86%	17,404	20,223
DM Smoking Status & Cessation(Ret. on 12/31/18)	93%	18,856	20,223

No A1c

March 2020

199
Pts w/ no A1c

-144
Oct 19

A1c Cascade

TY March 2020

PTS W/ DIABETES	19,607	
DM A1c >= 7 and A1c <= 8	3,780	19%
DM A1c > 8 and A1c <= 9	1,984	10%
DM A1c > 9	4,018	21%
DM A1c < 7	7,961	41%
DM A1c does not exist	1,771	9%

DM HTN Control

March 2020

PROVIDER - RENDERING	RESULT	DENOM	GAP
	100%	2	0
	61%	18	7
	76%	17	4
	50%	4	2
	33%	3	2
	50%	2	1
	100%	2	0
	67%	6	2
	57%	7	3
	0%	2	2
	46%	13	7

A1c >9 by Provider

March 2020

PROVIDER - RENDERING	RESUL
	0%
	20%
	9%
	0%
	60%
	50%
	0%
	22%
	17%
	0%
	50%

DM Self-Mgmt

Diabetes Prevention

REPORT

FILTER

PERIOD: TY March 2020 | RENDERING PROVIDER: All Rendering Provid... | BASELINE PERIOD: TY December 2019

+ Add Filter | Update

REPORT | CARE GAPS

GROUPING: No Grouping | REPORT FORMAT: Scorecard

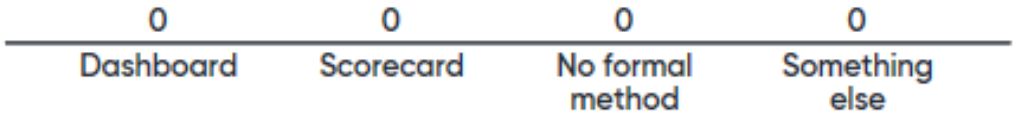
MEASURE	RESULT	CHANGE	NUMERATOR	DENOMINATOR	EXCLUSIONS
PreDiabetes Prevalence	8.0%	- 0.3% ▼	853	10,654	233
PreDiabetes Screening	0.0%	0.0%	0	0	0
PreDiabetes Diagnosis	0.0%	0.0%	0	0	0
Diabetic Prevention Program Referral	0.0%	0.0%	0	0	0
Diabetes Prevalence	17.6%	- 0.8% ▼	1,874	10,654	233
Diabetes A1c > 9 or Untested (NQF 0059)	33.5%	+ 1.0% ▲	635	1,897	0
DSME Referral	0.0%	0.0%	0	0	0
Clinical Pharmacy Referral	0.0%	0.0%	0	0	0

Poll #2

Go to **www.menti.com** and use the code **84 12 6**

What tools do you use to distribute data?

Mentimeter



Slide is not active Activate

0

Pre-Visit Planning

azara healthcare

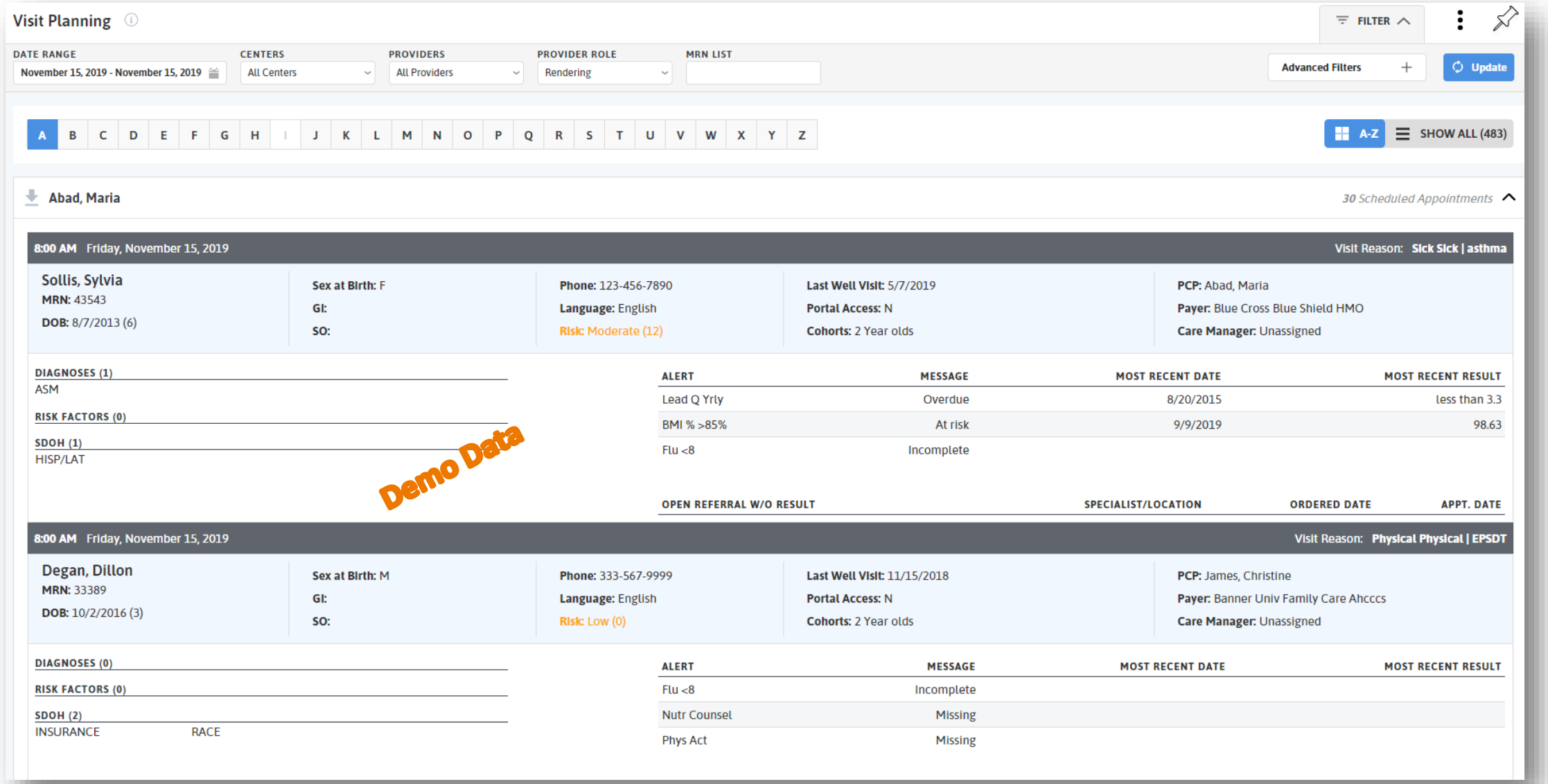
Pre-Visit Planning

- An efficient, electronic “to do” list of alerts and other data for patients with upcoming appointments.
- Key characteristics:
  - Actionable data
  - Configurable
  - Not just medical interventions
  - Contains open referral information
  - For appointments scheduled in advance and walk-in/same day

It’s easier and faster than having to go through each individual patient’s record.

-Our clients

Sample PVP


Visit Planning
FILTER
DATE RANGE
November 15, 2019 - November 15, 2019
CENTERS
All Centers
PROVIDERS
All Providers
PROVIDER ROLE
Rendering
MRN LIST
Advanced Filters
Update
A B C D E F G H I J K L M N O P Q R S T U V W X Y Z
A-Z
SHOW ALL (483)
Abad, Maria
30 Scheduled Appointments
8:00 AM Friday, November 15, 2019
Visit Reason: Sick Sick | asthma
Sollis, Sylvia
MRN: 43543
DOB: 8/7/2013 (6)
Sex at Birth: F
GI:
SO:
Phone: 123-456-7890
Language: English
Risk: Moderate (12)
Last Well Visit: 5/7/2019
Portal Access: N
Cohorts: 2 Year olds
PCP: Abad, Maria
Payer: Blue Cross Blue Shield HMO
Care Manager: Unassigned
DIAGNOSES (1)
ASM
RISK FACTORS (0)
SDOH (1)
HISP/LAT
Demo Data
ALERT
MESSAGE
MOST RECENT DATE
MOST RECENT RESULT
Lead Q Yrly
Overdue
8/20/2015
less than 3.3
BMI % >85%
At risk
9/9/2019
98.63
Flu <8
Incomplete
OPEN REFERRAL W/O RESULT
SPECIALIST/LOCATION
ORDERED DATE
APPT. DATE
8:00 AM Friday, November 15, 2019
Visit Reason: Physical Physical | EPSDT
Degan, Dillon
MRN: 33389
DOB: 10/2/2016 (3)
Sex at Birth: M
GI:
SO:
Phone: 333-567-9999
Language: English
Risk: Low (0)
Last Well Visit: 11/15/2018
Portal Access: N
Cohorts: 2 Year olds
PCP: James, Christine
Payer: Banner Univ Family Care Ahcccs
Care Manager: Unassigned
DIAGNOSES (0)
RISK FACTORS (0)
SDOH (2)
INSURANCE
RACE
ALERT
MESSAGE
MOST RECENT DATE
MOST RECENT RESULT
Flu <8
Incomplete
Nutr Counsel
Missing
Phys Act
Missing

Draft Comprehensive Standing Actions

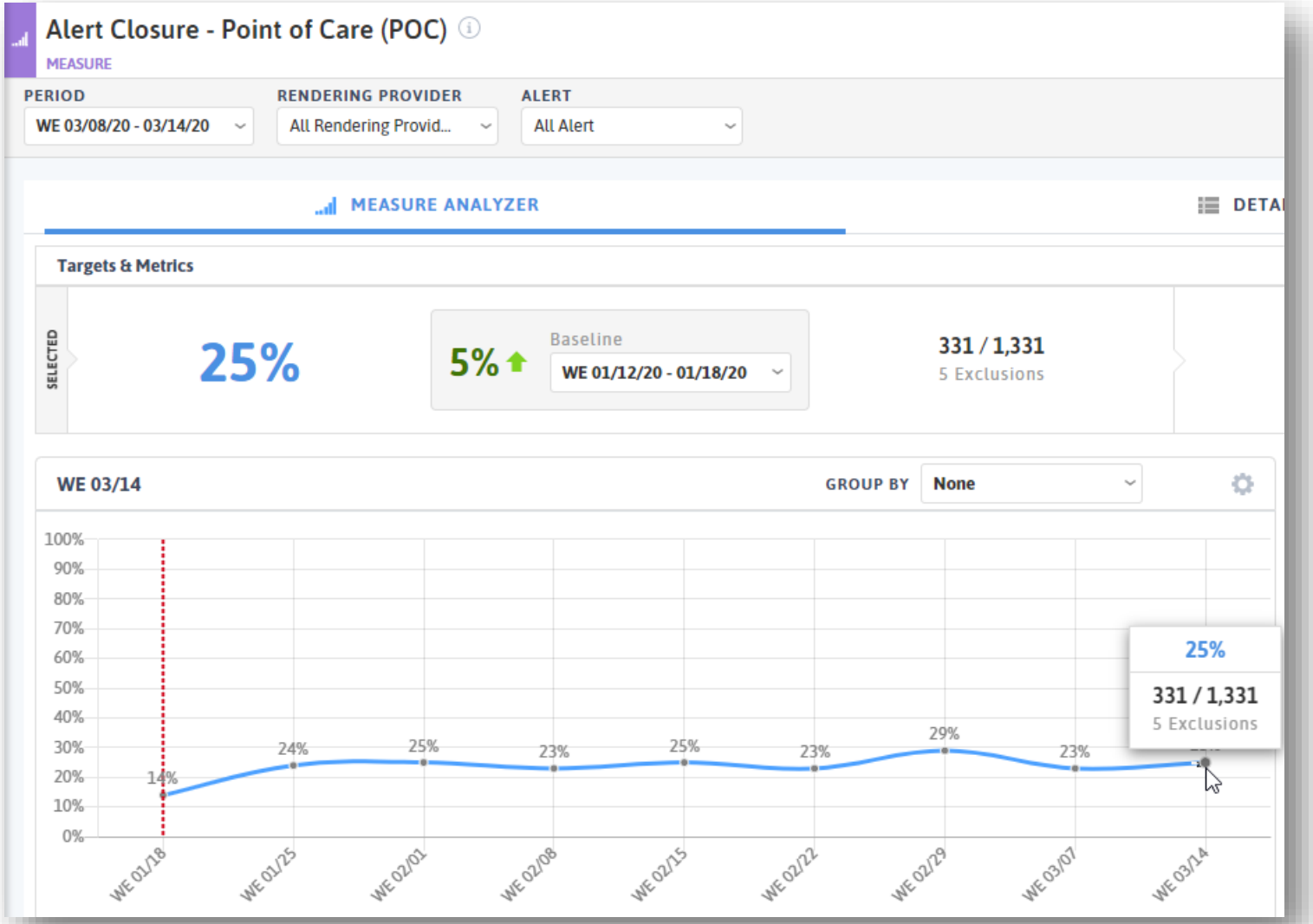
- Create a standing action for each alert you plan to use.
- Empower MAs/LPNs to support their provider by giving them the freedom and trust to follow the protocol.
- Standing actions create the basis for use of the visit planning report as a foundation for trust to delegate in team-based care.
  - Just for the pilot teams at first- which offers flexibility. Don't have to commit for long term.

Standing Actions Example

Alert Name	Description	Owner	Action
Diabetes A1c	A1c has not occurred in the last 3 months, or if the A1c value is >= 8 for patients 0 and <= 85 yrs old. Patient must have Diabetes.	MA	If patient is overdue, do a POC A1c and place order. If the most recent A1c was >=8, check with provider.
Diabetes Nephropathy Screening	Nephropathy Screening has not occurred in the last 1 years. Alert only applies to patients and <= 85 yrs old. Patient must have Diabetes. Patient must not have Known Kidney Dx or ACE ARB.	MA	Collect urine, place order for POC Microalbumin and process test.
Diabetes HTN/LDL	Alert will trigger if LDL has not occurred in the last 1 years, or if the LDL value is >= 100. Alert only applies to patients and <= 85 yrs old. Patient must have Diabetes and Hypertension.	MA	Perform POC LDL, place order, and process test.
Diabetes Eye Exam	Alert will trigger if Eye Exam has not occurred in the last 1 years. Alert only applies to patients and <= 85 yrs old. Patient must have Diabetes.	Provider	Talk to patient about preference and place order if needed.
Diabetes Foot Exam	Alert will trigger if Foot Exam has not occurred in the last 1 years. Alert only applies to patients and <= 85 yrs old. Patient must have Diabetes. Patient must not have Double Amputee.	Provider	Perform monofilament foot exam and enter charge in charge capture screen.
Elevated Glucose	Alert will trigger if patient had an A1c >= 5.7 AND <= 6.4 OR a Glucose Tolerance Test >= 140 AND <= 199 in the past year. Alert only applies to patients 18 - 75 years old. Excludes patients which have pregnancy, ESRD, diabetes , pre-diabetes, or gestational diabetes. This alert is not configurable.	Provider	Consider repeating a glucose or A1c test, and or adding the appropriate diagnosis to the problem list.

Measure Success | Alert Closure POC

- Utilize this measure weekly to monitor the success of closing point of care measures.
- Celebrate successes and identify opportunities for learning.
- Compare Providers using PVP to Providers not using PVP.



Point of Care

azara healthcare

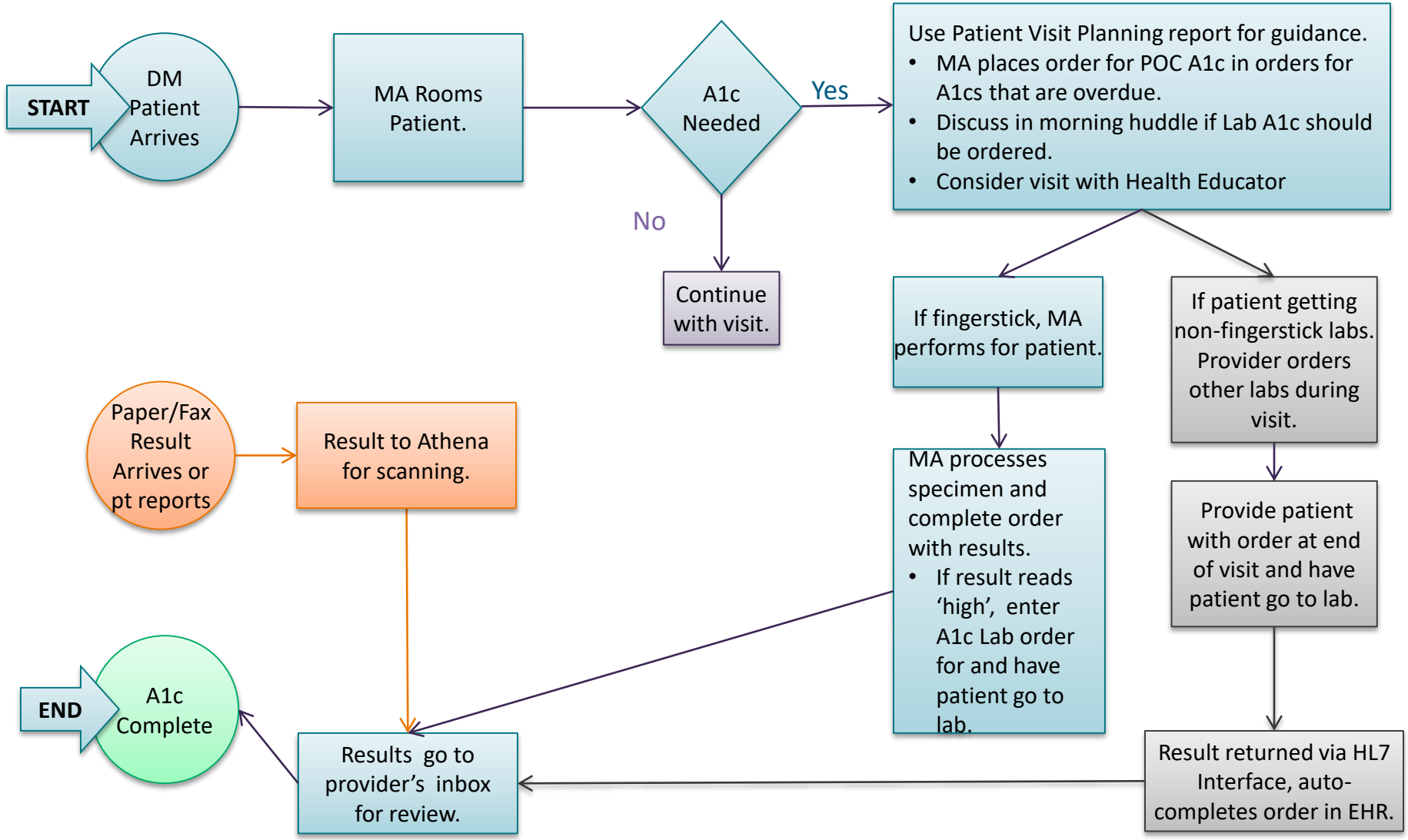
Documenting Care Provided

- It’s essential that everyone on the team know their responsibility when it comes to caring for a diabetic patient.
  - Where to document
  - What to document
  - How to document
  - Who is documenting
- If you didn’t document it, you didn’t do it.
- Will help with data hygiene – it all comes back to data hygiene!

Workflow Mapping

- Get more credit. If it didn't get documented (in structured form), it didn't happen.
- More consistency = better measure performance.
- Improve efficiency of usage of your EHR.
- Increase staff knowledge of where data is mapped in your EHR and flows into DRVS.
- Promote appropriate standardization in documentation.
  - Help support staff find patient information.
  - Greater ease when new provider sees a patient.
  - Prevent double work.

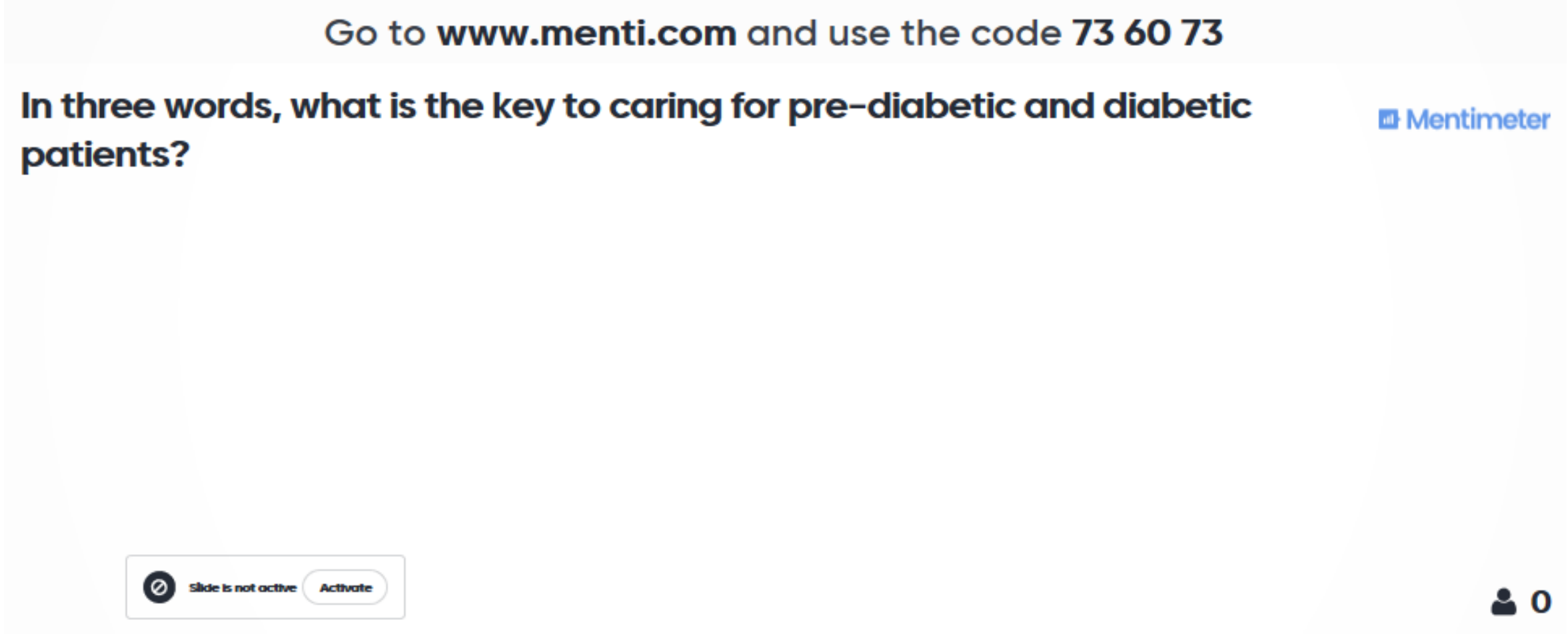
DM A1c Order and Result Workflow



Best Practices – Care Delivery

1. Consider using point of care testing for patient and provider convenience. Helps prevent lab no shows. Offers provider real-time data for decision-making.
2. Test patients' LDL even if they have not been fasting. Studies have shown fasting does not significantly impact the accuracy of the result.
3. Empower RNs, Diabetic Educators or other appropriate staff to work with patients to monitor glucose and A1cs and adjust insulin outside visits.
4. Use group visits to provide community and motivation for patients to improve their quality of life together.
5. Consider using standing actions to allow MA/LPNs to perform A1c test, also gives clinician best information for evaluating patient.

Poll #3


Go to www.menti.com and use the code 73 60 73
In three words, what is the key to caring for pre-diabetic and diabetic patients?
Mentimeter
Slide is not active
Activate
0

Focus Areas for Patient Care

azara healthcare

Population Health Management

- Dashboard
- Registry

Quality Improvement

- Measure Analyzer
- Trend analysis
- Comparison analysis
- Data hygiene
- Data distribution

Pre-Visit Planning

- PVP report
- Huddle
- Standing actions

Point of Care

- Workflow mapping
- Accurate documentation

Questions?