James L. Holly, M.D.

Critical Needs for Excellence in the Care of Diabetes
By James L. Holly, MD
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September 24th, I am participating on a panel discussion at a conference entitled *Diabetes Innovations 2012*. The meeting is described as, "Diabetes Innovation 2012 is „not a conference; it‟s a call to action. „" As part of our panel presentation, we discussed providing a handout for the participants which would give them a sense of what to do to change how they are performing at home. The following is my contribution to the discussion. It is unlikely that this will be the way the handout will look but it is worthwhile to think about. In the piece submitted to our panel, the name SETMA was changed to "our organization." For this publication, it has been changed back to SETMA.

1. **A team approach** – the essential nature of a patient-centered medical home is that all care is team based. While the healthcare provider is the "team leader," that addresses more the comprehensive oversight responsibility than it does authority or preeminence. The preeminent member of the team is the patient. Diabetes can not be treating by a single provider, no matter how expert or knowledgeable. The members of the team include: patient, healthcare provider, nurse, unit clerk, diabetes educator, nutritionist, care coordinator, social worker, psychologist, pharmacist, case management, endocrinologist, dentist, podiatry, ophthalmologist, nephrologist, etc.

2. **A robust disease management tool** – creating a culture of competence by bringing to bear upon a population of patients a level of care based on what is known rather than what a single provider knows. It allows the infusing of new knowledge instantly into a care setting such as the ADA annual diabetes update. In any organization, it can be read by a single provider and with the updating of the diabetes disease management tool, it makes new knowledge and standards accessible to all providers immediately. The disease management tool allows for the electronic aggregation of data and evaluation results, which can be incorporated into a "treatment plan and plan of care," which becomes a "baton" by which the care responsibility is passed to the patient who will l be in charge of their own care much longer than other members of the team. There are 8,760 hours in a year. If a patient receives a great deal of care, he/she will be in a provider‟s presence for twenty hours a year. That means that for 8,740 hours, the patient is in charge of his/her own care. Like the Olympic relays, if the "baton" is dropped, the team loses; if the plan of care and treatment plan is dropped, because it is not given to the patient, or the patient can‟t understand it, or the patient doesn‟t accept it, the entire team will fail.

3. **Performance Improvement Continuous Medical Education** (PI-CME) – points three through six are different faces of the same dynamic. Performance Improvement Continuous Medical Education is critical to excellence in the care of patients‟ with diabetes. First, this process requires that a provider "faces where he/she is" through analytics. Second, the provider self-designs a corrective measure through

recognition of deficiencies in knowledge, processes or outcomes. Third, after participating in self-direct CME (and this can be in a formal or informal setting), the provider applies what he or she has learned and then reassesses processes and outcomes to see if the CME made a difference.

These are the three steps to the PI-CME model developed by the AMA in 2005. However, SEMTA believes there is one deficiency in this design and that is that there is no responsibility for on-going surveillance to access sustainability of the changes which were gained by the PC-CME. SETMA believes that the gains of PC-CME are sustained with Clinic Decision Support (CDS) which incorporates the new knowledge or skills into the Disease Management Tool. With the guidance of the CDS and with regular auditing of performance, the learning process is not only sustained but persistent improvement in performance is achieved.

4. **Analytics** – A Diabetes Disease Management Tool, which incorporates quality metrics (process, outcomes, patient satisfaction, cost, etc), allows the provider, at the point of service, to monitor their personal performance. That is the goal of the AMA‟s Physician Consortium for Performance Improvement (PCPI) program. The process of healthcare delivery transformation is one of internalization of quality and the self-driving of performance improvement. The ability for providers to evaluate their own performance, while they are seeing a patient, is the first step in the analytics process. The second step is the auditing by electronics of the provider‟s performance on a population or panel of patients.

   The third step is that from the auditing results, statistical analysis can be done to allow a provider or a group of providers to see how they are performing over all their patients. The mean, the median, the mode and the standard deviation each shows the provider a different “snap shot” of their performance. In our organization‟s treatment of diabetes, our mean was 7.54 in 2000, and our standard deviation was 1.98. In 2011, our mean was 6.65 and our standard deviation was 1.2. Our goal now is to maintain the mean and to continue to improve the standard deviation. The standard deviation of our patients who are treated to goal is 0.7. That is now our goal for all of our over 7,000 patients with diabetes.

   Analytics also is the process of contrasting patients who are treated to goal with those who are not. In this way, you can look for leverage points for improving the care of all. Patterns can be found which point out the greatest opportunities for improving outcomes for all. Ethnic disparities can be exposed and addressed. Seasonal variations in results can be seen and strategies for care improvement can be devised.

   The fourth step is the transparency which public reporting of results by provider name provides. This is a self-imposed external pressure to improve care, which is different from legislative pressure. Once you open the window of performance to public scrutiny, the only place to hide is in excellence. This is the best solution to clinical inertia. The fifth and final step is the using of the tracking, auditing, analytics and public reporting in order to design quality improvement initiatives.

5. **Public Reporting** – While this is a part of analytics, it is also independent in that it recognizes quality metrics not as a goal of care, but as a guide to the quality of care being sought. Quality metrics are not the end; in fact, quality metrics should only be fulfilled incidental to excellence of care rather than as the object of care. Not only is this a means to quality care, it is also a declaration to those for whom we care that they and their health individually and as a member of a subset of patients are the end toward which we are working. In the "treatment plan and plan of care," each individual patient is told how their provider performed at that visit on their care needs as measured by evidence-based medicine and national standards of care. This way, the patient and the pubic know how a provider is doing and the provider knows that they know.

   Quality Metrics are really like a Medical GPS which tells us where we are, where we want to go and gives us guideposts along the way to see if we are moving in that direction. The deficiency in healthcare in the past has not been that we have not had a fairly clear idea where we want to go, but that we often had no accurate and objective ideas of where we started. And, we did not have the clear and valid guideposts on the route to our destination.

6. **A culture of change and of excellence** – SETMA"s pilgrimage to excellence in the care of patients with diabetes started over ten years ago, when on a trip to Boston, our CEO asked Joslin if he could show them how we treat diabetes. The desire was to find out from this premier center for excellence in treating diabetes how "we stack up." We have often said, "we are never ashamed when it is pointed out that we are not as good as we should be; we would only be ashamed if we were not willing to change and to improve." We have learned to celebrate what we have accomplished, while accepting the challenge to get better. We may never be the best but we want to be challenged by the best so that if we fall short of our goal, we fall from being the best while being very good.

7. **Training** -- Regular, periodic training sessions among all provides at SETMA has urged us toward excellence. Once a month, we close our clients for a half day. In these sessions, we may have invited speakers but most often we teach ourselves. We go over our performance transparently and without rancor. We face where we are not as good as we want to be and look for ways to be better. This is really a "continuing education" aspect of the PI-CME model of education in action. We do not believe that any of the above steps would have been effective and would have become a part of our "medical DNA" without this internal training in a learning-organizational setting.

8. **Coordination of Care** – Effecting change in outcomes requires a team and the coordination of the care which results from that care team is critical. SETMA treats a vulnerable population which has significant financial barriers to care. Therefore, we formed The SETMA Foundation to which the partners give $500,000 annually. None of the money can profit us but with it we pay for the medicines, co-pays and other needs of our patients. Care Coordination researches and presents request to our CEO for assistance. Other more traditional types of care coordination are accomplished to

increase the convenience and therefore the quality of the work that we do including follow-up calls to patients and care coaching of our patients.

9. **Utilizing technological innovations** – Diabetes is a healthcare need which particularly lends itself to innovative devices such as glucometers which automatically report the plasma glucose results to the EMR without the patient doing anything but measuring their blood sugar. There are others. In the future, healthcare is going to be dynamic, being delivered while patients are going about their regularly lives with bidirectional communions "on the run."

10. **Continuity of care** – Not only does the electronic patient record (EMR) support the diabetes disease management tool and the data analytics, it also serves as the tool for continuity of care. Our organization utilizes the same data base at all points of care. Whether in the clinic, hospital, emergency department, nursing home, LTAC, home, hospice, home health, physical therapy, the same data base is used through which to evaluate the patient and to document their care. This means that the patient receives numerous medication reconciliations every year and laboratory results from all points of care are aggregated into a single data base. Not only does this create economy due to not having to repeat tests, but it creates safety because everyone knows every thing what has been and which is being done for the patient.

11. **Diabetes Prevention program** – In the primary care setting, the excellent treatment of diabetes is important but active, intentional efforts to prevent diabetes is equally important. It is still true that the best way to treat diabetes is not to get it.

12. **Diabetes Self Management Education and Medical Nutrition Therapy** – This is part of the team but is isolated because of its strategic importance. It would be our organization‟s judgment that with the disease management tool being the foundation of care; the DSME and MNT is the next critical step. The best way to treat diabetes is for the patient with diabetes to become knowledge and able to participate in guiding their own care. .

13. **Self Guided Education materials for patients** – A key part to patient-centered medical home is the ability for patients to guide their own learning. This is not dissimilar to PI-CME for providers. When the patient, at their own pace and in their own time can "study" their care, care is improved.

14. **Patients have access to their record and their lab results** – As active members of their healthcare team, the patient must be able to review and to contribute to the accuracy and completeness of their own medical records and they must have access to their lab results as well, as having the knowledge to judge how their care is proceeding.

15. A **Plan of Care and Treatment Plan** – this is the "Baton" and it is the means by which the care is transition to the responsibility of the patient. Posters of the "baton" appear in all clinical locations at SETMA and state:

Firmly in the providers hand
--The baton – the care and treatment plan
Must be confidently and securely grasped by the patient,
If change is to make a difference
8,760 hours a year.

The poster illustrates:

1. That the healthcare-team relationship, which exists between the patient and the healthcare provider, is key to the success of the outcome of quality healthcare.
2. That the plan of care and treatment plan, the "baton," is the engine through which the knowledge and power of the healthcare team is transmitted and sustained.
3. That the means of transfer of the "baton" which has been developed by the healthcare team is a coordinated effort between the provider and the patient.

4. That typically the healthcare provider knows and understands the patient‟s healthcare plan of care and the treatment plan, but that without its transfer to the patient, the provider‟s knowledge is useless to the patient.
5. That the imperative for the plan – the “baton” – is that it be transferred from the provider to the patient, if change in the life of the patient is going to make a difference in the patient‟s health.
6. That this transfer requires that the patient “grasps” the “baton,” i.e., that the patient accepts, receives , understands and comprehends the plan, and that the patient is equipped and empowered to carry out the plan successfully.
7. That the patient knows that of the 8,760 hours in the year, he/she will be responsible for “carrying the baton,” longer and better than any other member of the healthcare team.

The genius and the promise of the Patient-Centered Medical Home is symbolized by the “baton.” Its display will continually remind the provider and will inform the patient, that to be successful, the patient‟s care must be coordinated, which must result in coordinated care. In 2011, as we expand the scope of SETMA‟s Department of Care Coordination, we know that coordination begins at the points of “transitions of care,” and that the work of the healthcare team – patient and provider – is that together they evaluate, define and execute that care.