ACPNet: Diabetes

National QI Network Initiative

Laura Lee Hall, PhD
Director, Center for Quality

November 2013
Acknowledgements

This program is supported by a grant from Genentech and BMS
ACPNet: Version 2.0

Mission: To create and sustain a learning community of empowered physicians and other health care professionals, patients and caregivers, to improve health, care delivery and outcomes.

— Create new QI network of internists and other physicians and their health care teams
— Partnership with state chapters
— Highlight patient engagement as part of health care team
— Add value and joy to clinicians in everyday practice
ACPNet: Diabetes Will Let You

- CME
- MOC part IV
- PQRS
- PCMH
- And more
ACP Diabetes Registry

Welcome to the American College of Physicians Diabetes Registry

The ACP Diabetes Registry provides you with the ability to manually enter or upload patient data, measures your performance and provides you with tools/education to close performance gaps. Additionally, you can use your data towards participation in the PQRS 2013 incentive program and in ACP Medical Home.

What You Can Do

Enter Data
Add or upload your eligible patient data to your registry.

Review Measure Results
Once you enter your patient data, review your measure performance rate.

Find Ways to Improve
Once you have reviewed your performance, find education, resources, and tools to improve your practice.

ACP Practice Advisor for ABIM MOC
Learn how to use your registry data toward American Board of Internal Medicine (ABIM) Maintenance of Certification (MOC) Self-Evaluation of Practice Performance credit using ACP Practice Advisor for

Measures

This registry allows you to assess your performance related to the following measures:

- **Hemoglobin A1c Poor Control**
  Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent hemoglobin A1c greater than 9.0%.

- **Low Density Lipoprotein (LDL-C) Control**
  Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent LDL-C control (less than 100 mg/dL).

- **High Blood Pressure Control**
  Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent blood pressure control (less than 140/90 mmHg).

- **Dilated Eye Exam**
  Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent dilated eye exam.
ACP Diabetes Registry

The ACP Diabetes registry is an easy-to-use online tool to help you quickly and easily collect, aggregate, and analyze patient data. By using this registry, you can identify trends and possible gaps in your patient care. Links to tools and resources (view more)

Home | Data | Measures | Improvement | MOC | PQRS

Maintenance of Certification Self–Evaluation of Practice Performance

Use your data toward ABIM MOC Self–Evaluation of Practice Performance credit using ACP’s Practice Advisor

You can use the data collected in this Diabetes Registry to meet the American Board of Internal Medicine (ABIM) Maintenance of Certification (MOC) requirement for practice performance.

Using ACP’s Practice Advisor, you will earn 20 practice performance credit hours and practice improvement points for high-quality improvement practices related to diabetes. ACP Practice Advisor is an online practice management tool to enhance patient care and office efficiency. The Practice Advisor and practice modules related to the Patient-Centered Medical Home, managing chronic conditions, and improving clinical care.

Click here to open ACP Practice Advisor
ACP Diabetes Registry

The ACP Diabetes registry is an easy-to-use online tool to help you quickly and easily collect, aggregate, and analyze patient data. By using this registry, you can identify trends and possible gaps in your patient care. Links to tools and resource (view more)

Coming Soon...

You can use your eligible patient data collected in the ACP Diabetes Registry to participate in the CMS PQRS incentive payment program. PQRS participation is required to enter a minimum of 20 patients, with at least 11 of those patients being Medicare Part B beneficiaries. There is no need to re-enter your data as a participant in the ACP Diabetes Registry you have access to PQRSwizard at no cost for the 2013 reporting period. PQRSwizard is an easy-to-use software tool for physicians and other eligible professionals to easily and quickly report to PQRS. PQRSwizard will walk you through a few easy steps to get your eligible patient data into your ACP Diabetes Registry submitted.

PQRSwizard will be available early fall 2013.
THANKS!

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Anne Marie Smith, MBA, PMP, Quality Consultant, asmith@acponline.org
Laura Lee Hall, PhD, Director, Center for Quality, laurah@acponline.org
Improving Diabetes Care through Patient Engagement

This webinar offers 1.0 Hour of CME Category I Credit

November 12, 2013 from 6:00pm - 7:00pm
We Didn’t Ask... and They Didn’t Tell
Planning Committee and Faculty Disclosure of Financial Relationships

• **Marie Brown, MD, FACP** – *nothing to disclose for Marie Brown.*
• **Disclosures for spouse, Ted Feldman, MD, University of Chicago Professor:** Grants: Abbott, BSC, Edwards, WL Gore; Consultant: Abbott, BSC, Coherex, Edwards, Intervale, Diiachi Sankyo-Lilly, WL Gore; Speaker: Boston Scientific
• **Laura Lee Hall, PhD** – *nothing to disclose*
• **Linda Lambert** – *nothing to disclose*
• **Lisa Noel** – *nothing to disclose*
**Objectives:** Participants will be able to:

- Identify patient engagement techniques that result in improved patient outcomes
- Apply principles of patient engagement to diabetes patients
- Initiate a quality improvement activity for diabetes patients using the MedConcert platform
- Describe how the ACP MedConcert platform may be used to satisfy both Medicare reimbursement and MOC requirements.
Obesity Trends* Among U.S. Adults

BRFSS, 1985

(*BMI ≥30, or ~30 lbs. overweight for 5’4” person)
Obesity Trends* Among U.S. Adults

BRFSS, 1987

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)

No Data           <10%          10%–14%

[Map of the United States showing obesity trends by state in 1987]
Obesity Trends* Among U.S. Adults

BRFSS, 1989

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults

BRFSS, 1991

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults

BRFSS, 1993

(*BMI ≥30, or ~30 lbs. overweight for 5’4” person)
Obesity Trends* Among U.S. Adults

BRFSS, 1995

(*BMI ≥30, or ~30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults

BRFSS, 1997

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults

*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person

No Data <10% 10%–14% 15%–19% ≥20%
Obesity Trends* Among U.S. Adults

BRFSS, 2001

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults

BRFSS, 2003

(*BMI ≥ 30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults

BRFSS, 2005

(*BMI ≥30, or ~ 30 lbs. overweight for 5’4” person)
Obesity Trends* Among U.S. Adults

BRFSS, 2007

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults

BRFSS, 2009

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Obesity Trends* Among U.S. Adults

BRFSS, 2010

(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)
Dietary Evolution
Evolution of the Sedentary Lifestyle
After a two year visit to the United States, Michelangelo's David is returning to Italy . . .
World Health Organization:

Increasing adherence may have a far greater impact on the health of the population than any improvement in specific medical treatments.
Keep a watch...on the faults of the patients, which often make them lie about the taking of things prescribed.

For through not taking disagreeable drinks, purgative or other, they sometimes die.

Hippocrates, Decorum
Medication Adherence

World Health Organization definition

‘the extent to which a person’s behavior... corresponds with agreed recommendations from a health care provider’
Medication *adherence* implies patient agreement with recommendations

Medication *compliance* implies patient passivity

Individual medication taking behavior
Measurement of Adherence

✦ Subjective
✦ Objective
  – pill counting
  – refill records
  – EHR
✦ Biochemical
  – Drug levels
  – Addition of nontoxic markers

Osterberg L NEJM 2005 353;5:487-97
Considered Adherent if \( \geq 80\% \)

24 out of 30 days!
TREATMENT

ADHERENCE

OUTCOMES
PATIENTS DON’T TAKE THEIR MEDICINE AS PRESCRIBED 50% OF THE TIME

25% OF INITIAL PRESCRIPTIONS ARE NEVER FILLED

Rates of Nonadherence

- **Hypertension**
  - 50-80%

- **Hyperlipidemia**
  - 25-50% within 1yr
  - 75% at 2yrs

- **ASA**
  - 20-30% at 1yr

Osterberg L, NEJM 2005 353;5:487-97
Long-term persistence of statin use in the elderly over 5 yrs

N= 34,501

% of patients

Months

Benner J JAMA 2002 288;4 455-461
Persistence Declines Rapidly

![Graph showing persistence decline of various treatments over time]

Glader EL Stroke 2010;41(2):397-401
Trouble Getting Started

Predictors of Primary Medication Nonadherence

N = 423,616

24% = 101,668

Adapted from Fischer M AJM 2011 124;1081.e9-e22
Primary Nonadherence by drug class

N= 423,616

% Unfilled

Antihypertensives

Antidiabetics

Adapted from Fischer M AJM 2011 124;1081.e9-e22
Primary Nonadherence by zip code income level

% Unfilled

$<45,000
$45,000-$57,000
$57,000-$67,000
$67,000-$81,000
$>81,000

N= 423,616

Adapted from Fischer M  AJM 2011  124;1081.e9-e22
Impact of Nonadherence

- Substantial increase in morbidity and mortality - approximately 125,000 deaths/yr
- Causes 10% of all hospitalizations
- Of all medication related admissions, 33-69% are due to poor adherence
- Cost of nonadherence $100–289 billion/year

Osterberg L. NEJM 2005 353;5:487-9
Viswanathan M. Ann Int Med 2012;157:785-95
HEALTH CARE COSTS
DIABETES

137,277 patients under age 65.

Sokol M Med Care 2005;43: 521–30
HOSPITALIZATIONS
DIABETES

Risk of Hospitalization (%)

137,277 patients under age 65.

Sokol M Med Care 2005;43: 521–30
Impact of Medication Adherence on Healthcare cost

Sokol M Med Care 2005;43: 521–30
Fearful of side effects  Mistrustful of the health care system
Depression can lead to nonadherence
OBSTACLES

UNINTENTIONAL vs INTENTIONAL

✧ FORGETTING
✧ SHIFT WORK
✧ COST
✧ CONFUSION
✧ WORK RESTRICTIONS

✧ MISTRUST
✧ FEAR OF SIDE EFFECTS
✧ MENTAL ILLNESS
✧ LACK OF BELIEF IN BENEFIT
✧ FEAR OF DEPENDENCY
✧ FEAR IT IS DANGEROUS
✧ LACK OF DESIRE
✧ NO APPARENT BENEFIT
NONADHERENCE CAUSES

UNINTENTIONAL (Forgetful)

INTENTIONAL (Or other cause)

OBSTACLES

✦ PATIENT
  - Cost/Health literacy/Access
  - Rational nonadherence
  - Mental illness

✦ PROVIDER
  - Failure to recognize/complicated regimens
  - Inadequate communication/relationship
  - Accusatory approach ‘shamed’
  - Negative attitude toward the patient

✦ PROCESS
  - Fumbled hand-offs
  - Insufficient time to develop trust
  - Lack of educational resources
  - Low refill consolidation
“I didn’t want to be admonished so I told you I was taking my meds”
Needed support not blame
Concerned about doctors’ motivations for prescribing medicine
OBSTACLES

✦ PATIENT
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✦ PROCESS
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Refill Consolidation
Proportion of medications filled per pharmacy visit
Therapeutic Complexity and Adherence
N=1,827,395 Patients

- Total number of prescriptions
- Number of fills for each drug
- Number of different prescribers
- Total number of pharmacies
- Number of pharmacy visits (non mail order)
- Consolidation of refills
Therapeutic Complexity over 90 days among statin users
N=1,827,395 Patients

Mean

90th Percentile

% Patients

Total Medications, No.
PHARMACY VISITS over 90 day period for statin users

N=1,827,395 Patients

Mean

90th Percentile

% PATIENTS

PHARMACY VISITS, No.
Therapeutic Complexity and Adherence
N=1,827,395 Patients

1 - \[ \frac{\text{# visits}}{\text{# meds filled}} \]

Refill Consolidation, %

% Patients

Choudhry N Arch Intern Med. 2011;171(9):814-22
Greater therapeutic complexity was associated with lower medication adherence (especially for newly initiated meds).
Adherence decreases as frequency of dosing increases

% of doctors informed the patient of duration of cardiovascular therapy

Tarn D. Arch Intern med 2006;166:1855-1862
DON’T KILL THE MESSENGER!

DO WE TELL PATIENTS THAT THEY WILL NEED TO STAY ON A MEDICINE FOR THE REST OF THEIR LIVES?

WHY NOT?

✦ WE DON’T WANT TO DELIVER BAD NEWS
✦ CONCERN IT WILL CAUSE PATIENT TO RESIST THERAPY
✦ CONCERN IT WILL INCREASE DURATION OF THE VISIT
✦ FEAR IT WILL INCREASE THE PATIENTS’ CONCERN THAT THEY WILL BECOME DEPENDENT ON THE DRUG
Knowledge and Emotion
Don’t ask.....
I didn’t ask....

Don’t tell...
They didn’t tell...
I wouldn’t tell the doctor that I wasn’t taking my meds so he just added another drug
Creative Solutions
GENOTYPE FOR IMPATIENCE
MARY

PREVIOUSLY UNCONTROLLED ON INSULIN 4x/day (A1c > 12)

NOW CONTROLLED ON ONCE A DAY INSULIN (A1c > .7)
The Impatient Patient

- The nonadherent patient prefers immediate rewards to efforts linked to long term therapy.
- Most people have an innate tendency to prefer smaller-sooner to larger-later rewards.
- The reward of adherence in the management of chronic disease is “to avoid complications”.
- Paradoxically this type of reward is never “received”.
- Doctors are future oriented while patients may not consider themselves as having a future to look forward to.
“It takes time to build trust....just like any relationship”
CALVIN

TOOK 5 YEARS OF ENCOURAGEMENT
BEFORE HE TOOK MEDICATION REGULARLY
Sandra suggested the intervention that increased our medication adherence rates.
How often do you have trouble taking medicines the way you have been told to take them?

- I do not have to take medicine
- I always take them as prescribed
- Sometimes I take them as prescribed
- I seldom take them as prescribed
Do You Need Help Becoming a Patient Centered Medical Home?

ACP Practice Advisor

Learn about how this product can help.
ACP Tools for the Annual Wellness Visit

The following forms and templates can be customized for use in your practice:

- Practice Checklist
- Patient Letter and Checklist
- Health Risk Assessment:
  - View a paper version
  - View an electronic version from HowsYourHealth.org
- Women's Prevention Plan
- Men's Prevention Plan
- Adult Health Maintenance Form
INTERVIEWING IN A BLAME FREE ENVIRONMENT

✧ These are difficult to take every day. How often do you skip one?
✧ There are quite a few-how many of these do you take?
✧ Most people don't take all their meds everyday. How about you?
✧ When was the last time you took drug A? B?
The Morisky 8-Item Medication Adherence Scale

1. Do you sometimes forget to take your high blood pressure pills?

2. Over the past two weeks, were there any days when you did not take your high blood pressure medicine?

3. Have you ever cut back or stopped taking your medication without telling your doctor, because you felt worse when you took it?

4. When you travel or leave home, do you sometimes forget to bring along your medications?

The Morisky 8-Item Medication Adherence Scale

5. Did you take your high blood pressure medicine yesterday?

6. When you feel like your blood pressure is under control, do you sometimes stop taking your medicine?

7. Taking medication everyday is a real inconvenience for some people. Do you ever feel hassled about sticking to your blood pressure treatment plan?

8. How often do you have difficulty remembering to take all your blood pressure medication?

The Healthy Plate

Think of your plate as different sections. One half is for vegetables, and the other half is for proteins and carbohydrates (carbs).
MEDICATIONS

In order for your Doctors and Nurses to better care for you we need your help.

Please review your medication list that has been handed to you at each and every visit.

Then we need you to look at it carefully and make some notes.

1. Circle the medications for which you need refills (you should leave the office today with enough refills to last until your next visit)
2. Cross out any medications you are no longer taking
3. Add medications other doctors are giving you (this includes eye drops, creams, inhalers and especially other pills)
4. Add supplements or vitamins that you are taking (this is very important)
METFORMIN

Decreases hepatic glucose output and increases insulin-mediated glucose utilization in peripheral tissue

Pros:
Reasonable A1C reductions, especially at high baseline A1C
Proven CV benefits in obese (UKPDS)
Preservation of beta-cell function
No risk of hypoglycemia
Modest weight loss or weight neutral
Extensively researched
Inexpensive

Cons:
Contraindicated in renal insufficiency
Use cautiously in elderly
GI effects common
Risk of lactic acidosis
INITITATING METFORMIN

-LOW DOSE

-EXPECT GI SIDE EFFECTS

-INCREASE DOSE 7 DAYS AFTER GI SIDE EFFECTS HAVE RESOLVED

-EXPECT RETURN OF GI SIDE EFFECTS AFTER A BRIEF DRUG HOLIDAY (AS SHORT AS 3 DAYS)
METFORMIN

To use metformin to lose weight and lower your sugar, please follow these directions:

1. Metformin will give you a mild upset stomach and diarrhea but this will go away within a few days as your body gets used to it.

2. Take ½ of a 500mg tablet and let your body get accustomed to it. After you have no stomach symptoms for 1 week, increase the metformin to 1 whole tablet. Stomach upset and diarrhea may return every time you increase the dose. These symptoms will go away within a few days if you keep taking the metformin.

3. If you stop taking the metformin for even 2 days, when you restart it all the stomach upset will return - so try not to stop the medicine but if you do-restart at the lower dose and let your stomach get used to it again.

4. We may increase the metformin every 2-3 months depending on how much weight you lose and your A1c level. Metformin will not make your sugar go too low - we never have to worry about that.
### ACP Diabetes Registry

The ACP Diabetes registry is an easy-to-use online tool to help you quickly and easily collect, aggregate, and analyze patient data. By using this registry, you can identify trends and possible gaps in your patient care. Links to tools and resources are available.

**Performance measures and benchmarks are calculated nightly. Data added to Apps will not be reflected in the calculations below until the following day.**

#### 1 - 6 of 6 Measures

<table>
<thead>
<tr>
<th>Measure Name</th>
<th>Time Period</th>
<th>My Performance</th>
<th>How Do I Compare?</th>
<th>Outliers</th>
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<tbody>
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<td>11/07/2013</td>
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<td>Actual: 52%</td>
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<td>100%</td>
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<td>Foot Exam</td>
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After Tonight: Begin Here

1. Review Activity Overview on MedConcert and/or Practice Advisor Platform
2. Conduct baseline chart review for 25 patients
3. Review performance measure data
4. Review module materials (case study, practice biopsy, resource library)
5. (Optional) Review resources associated with practice biopsy results
6. Identify performance measure for improvement and target improvement goal
7. Complete an Action Plan describing how improvement will be achieved
8. Implement Action Plan (approx. 3 months)
9. Conduct follow-up chart review for 25 patients
10. Review performance measure data and compare to baseline performance
11. Submit final summary report/evaluation
12. Log in to ABIM to request 20 MOC points
PDSA Detail

✧ Step 1 - Plan
  – Plan the *test* (change in process)
  – Plan for collecting data
    • Make predictions of what will happen and why
    • Develop a plan to test the change (Who? What? When? Where? What data need to be collected?)

✧ Step 2 - Do
  – Implement the new process during a trial period (try out the *test* on a small scale)
    • Document problems and unexpected observations
PDSA Detail, continued

✦ Step 3 - Study
  – Set aside time to analyze the data and study the results
    • Complete the analysis of the data
    • Compare the data to your predictions
    • Summarize and reflect on what was learned

✦ Step 4 - Act
  – Decision time – (pick one)
    • Abandon the change – consider entirely new design
    • Adapt the change – modify the design slightly and retest for further (get more data) – go back to Plan
    • Adopt – change is working well. Will continue as part of the practice
    • Again – you may not have enough data so you elect to run the test for another period of time
Testing changes is an iterative process: the completion of each Plan-Do-Study-Act (PDSA) cycle leads directly into the start of the next cycle.
Tips for Successful Linked Tests of Change

✧ Scale down the size of the test (the number of patients or location)
✧ Test with “willing” volunteers
✧ Start with easy changes for easier "buy-in"
✧ Collect useful data during each test—Use what you have, not what you don’t
✧ Don’t be afraid to jump right in. Try a test quickly; ask, "What change can we test by next Tuesday?"
✧ Stop test if not working and move on
Simple Run Chart Med Adherence
Count how many diabetic patients are asked if they take their medications (1/10=10%)

Diabetics who are asked if they take their medications

Staff discusses how best to ask about medication taking behavior
What next?

- Use this tool to improve A1c, BP, lipid goals
- Share the webinar with your staff and patients

**Medication Adherence:**

*We didn’t ask... they didn’t tell*

*Drs Brown and Bussell*

ACP website provides this free:

- [http://vimeo.com/42194365](http://vimeo.com/42194365) (21 minute version)
- [http://vimeo.com/42144406](http://vimeo.com/42144406) (5 minute version)
Simple Run Chart

Count how many diabetic patients bring in their medications tomorrow (1/10=10%)

Diabetics who bring their medications to office visit

Staff views video and brainstorms how to encourage patients to bring in their meds
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Simple Run Chart
Count how many diabetic patients each Friday are ready for exam
(week 1: 0/10 = 0%)

Diabetics with Shoes and Socks Removed and Ready for Physician Exam

Doctor reminds staff to have patient take off shoes
Simple Run Chart
Count how many diabetic patients each Friday are ready for exam
(week 1: 0/10 = 0%)

Diabetics with Shoes and Socks Removed and Ready for Physician Exam

Doctor reminds staff to have patient take off shoes
Simple Run Chart

Count how many diabetic patients each Friday are ready for exam

(week 1: 0/10 = 0%)

Diabetics with Shoes and Socks Removed and Ready for Physician Exam

Doctor reminds staff to have patient take off shoes
People are far more willing to test a change when they know that changes can and will be modified as needed.

Linking small tests of change helps overcome a practice’s/organization’s natural resistance to change and ensure physician buy-in.
How many toes did you save today?
Count how many diabetic patients each Friday are ready for exam (week 5: 5/10 = 50%)

Diabetics with Shoes and Socks Removed and Ready for Physician Exam

% 100 90 80 70 60 50 40 30 20 10 0

Weeks 1 2 3 4 5 6 7 8

Staff including doctor view pictures of diabetic foot ulcers
It takes the whole team to improve medication adherence rates and ultimately patients’ health.
SUMMARY

✦ 50% OF PATIENTS ARE NONADHERENT

✦ MEDICATION TAKING BEHAVIOUR IS COMPLEX

✦ SOLUTIONS INCLUDE THINKING OUTSIDE THE PILL BOX
After Tonight:
Begin Here

- Review Activity Overview on MedConcert and/or Practice Advisor Platform
- Conduct baseline chart review for 25 patients
- Review performance measure data
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(Optional)
- Review resources associated with practice biopsy results
- Identify performance measure for improvement and target improvement goal
- Complete an Action Plan describing how improvement will be achieved
- Implement Action Plan (approx. 3 months)

Conduct follow-up chart review for 25 patients
- Review performance measure data and compare to baseline performance
- Submit final summary report/evaluation
- Log in to ABIM to request 20 MOC points
A Transition.....

✧ You need to develop an **action plan**
✧ For the plan to lead to sustainable improvement the practice needs to transform to behave more like a Patient Centered Medical Home
Goals Setting

After you have identified your treatment gap you wish to work on

- Establish a **goal**
- Establish a **time frame**

**Example:** Increase the number of patients that are referred to an ophthalmologist for retinopathy screening from 50% to 80% by July 2014.
Sooo.....

✦ Now is the time to strengthen your approach to quality improvement –

✦ But how?
Medication Adherence video with real patients sharing their stories


Medication Adherence

http://vimeo.com/42194365 (21 minute version)
http://vimeo.com/42144406 (5 minute version)
Improving Diabetes Care through Patient Engagement

This webinar offers 1.0 Hour of CME Category I Credit

November 12, 2013 from 6:00pm - 7:00pm