ACPNet: Diabetes
National QI Network Initiative

Laura Lee Hall, PhD
Director, Center for Quality

November 2013

ACP American College of Physicians
Internal Medicine | Doctors for Adults®

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.

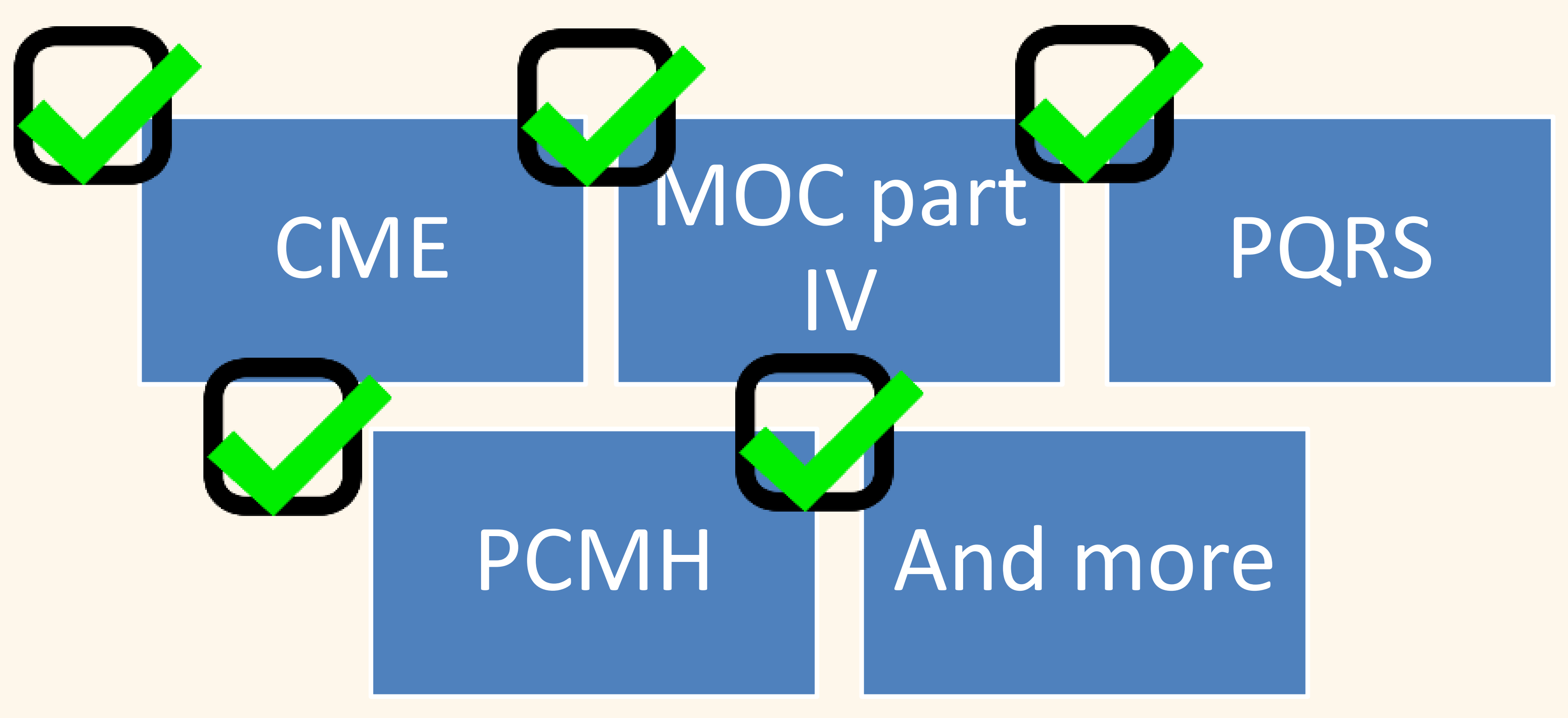
–Create new QI network of internists and other physicians and their health care teams

–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



Search the site | + Invite Colleagues | Laura Lee

Home | Apps | Patients | Performance | Ways to Improve | Community | Portfolio | Ac

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)

Home | Data | Measures | Improvement | MOC | PQRS | Export

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 ACF Medical Home.

What You Can Do

Enter Data

Add or upload your eligible patient data to your registry.

ENTER PATIENT DATA

Review Measure Results

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

REVIEW RESULTS

Find Ways to Improve

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

HOW DO I IMPROVE?

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

LEARN MORE

Measures

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

Hemoglobin A1c Poor Control

Percentage of patients aged 18 through 75 y diabetes mellitus who had most recent hem greater than 9.0%.

Low Density Lipoprotein (LDL-C) Contr

Percentage of patients aged 18 through 75 y diabetes mellitus who had most recent LDL- control (less than 100 mg/dL).

High Blood Pressure Control

Percentage of patients aged 18 through 75 y diabetes mellitus who had most recent blood control (less than 140/90 mmHg).

Dilated Eye Exam

Percentage of patients aged 18 through 75 y

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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 Medicine (ABIM) Maintenance of Certification (MOC) requirement fo performance.

Using ACP's Practice Advisor, you will earn 20 practice performanc quality improvment practices related to diabetes. ACP Practice Advi practice management tool to enhance patient care and office efficie modules related to the Patient-Centered Medical Home, managing 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)

Home | Data | Measures | Improvement | MOC | PQRS | Export

Coming Soon...

PQRS Submission Deadline: Ma

You can use your eligible patient data collected in the ACP Diabetes Registry to participate in the CMS PQRS incentive payment program. PQRS pa 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 y participant in the ACP Diabetes Registry you have access to PQRS*wizard* at no cost for the 2013 reporting period. PQRS*wizard* is an easy-to-use physicians and other eligible professions to easily and quickly report to PQRS. PQRS*wizard* will walk you through a few easy steps to get your elig your ACP Diabetes Registry submitted.

PQRS*wizard* 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**

MEDICATION ADHERENCE

We Didn't Ask… and They Didn't Tell

MARIE BROWN MD FACP

ACP Governor Illinois

Northern Region

NOVEMBER 12, 2013

MBROWNACP@MBROWNMD.NET

708 524-2121

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, Intervalve, 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)

No Data
<10%
10%–14%

Obesity Trends* Among U.S. Adults

BRFSS, 1987

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

No Data | <10% | 10%–14%

Obesity Trends* Among U.S. Adults
BRFSS, 1989

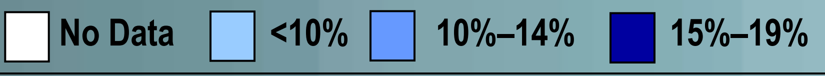
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)

No Data | <10% | 10%–14%

Obesity Trends* Among U.S. Adults

BRFSS, 1991

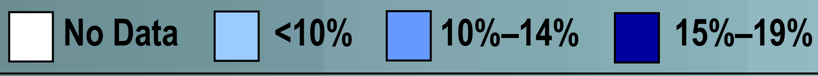
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



Obesity Trends* Among U.S. Adults

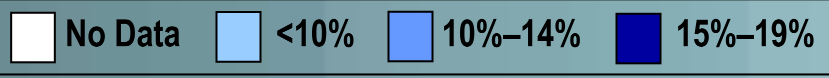
BRFSS, 1993

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



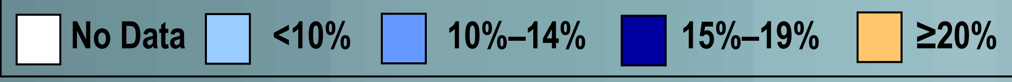
Obesity Trends* Among U.S. Adults
BRFSS, 1995

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



Obesity Trends* Among U.S. Adults BRFSS, 1997

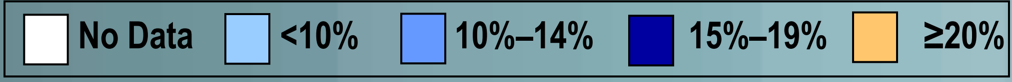
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



Obesity Trends* Among U.S. Adults

BRFSS, 1999

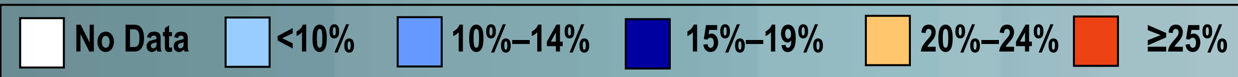
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



Obesity Trends* Among U.S. Adults

BRFSS, 2001

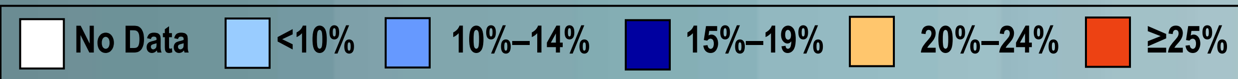
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



Obesity Trends* Among U.S. Adults

BRFSS, 2003

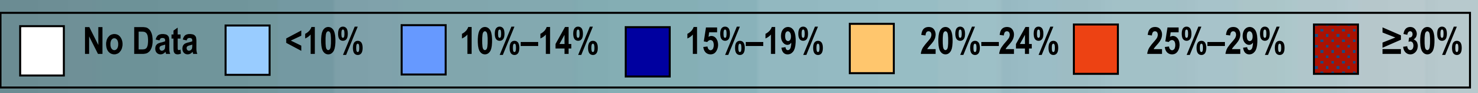
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



Obesity Trends* Among U.S. Adults

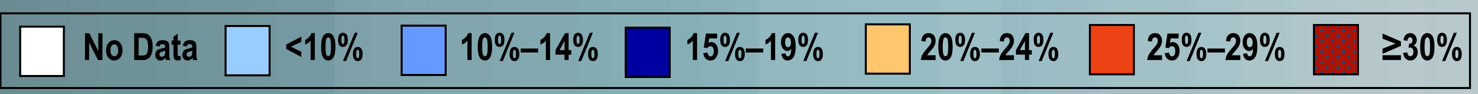
BRFSS, 2005

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



Obesity Trends* Among U.S. Adults
BRFSS, 2007

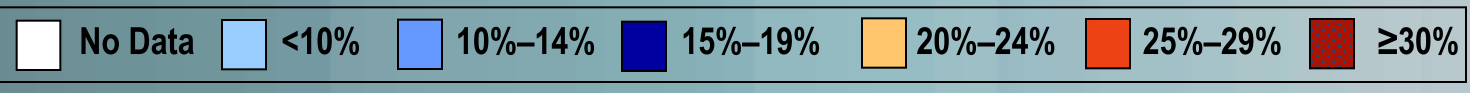
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)



Obesity Trends* Among U.S. Adults

BRFSS, 2009

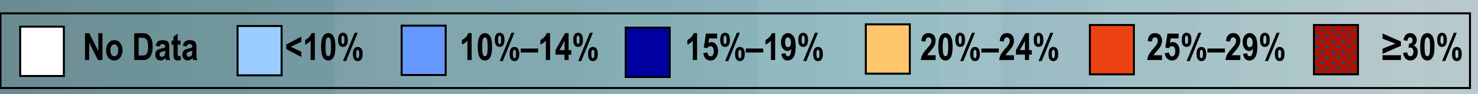
(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)



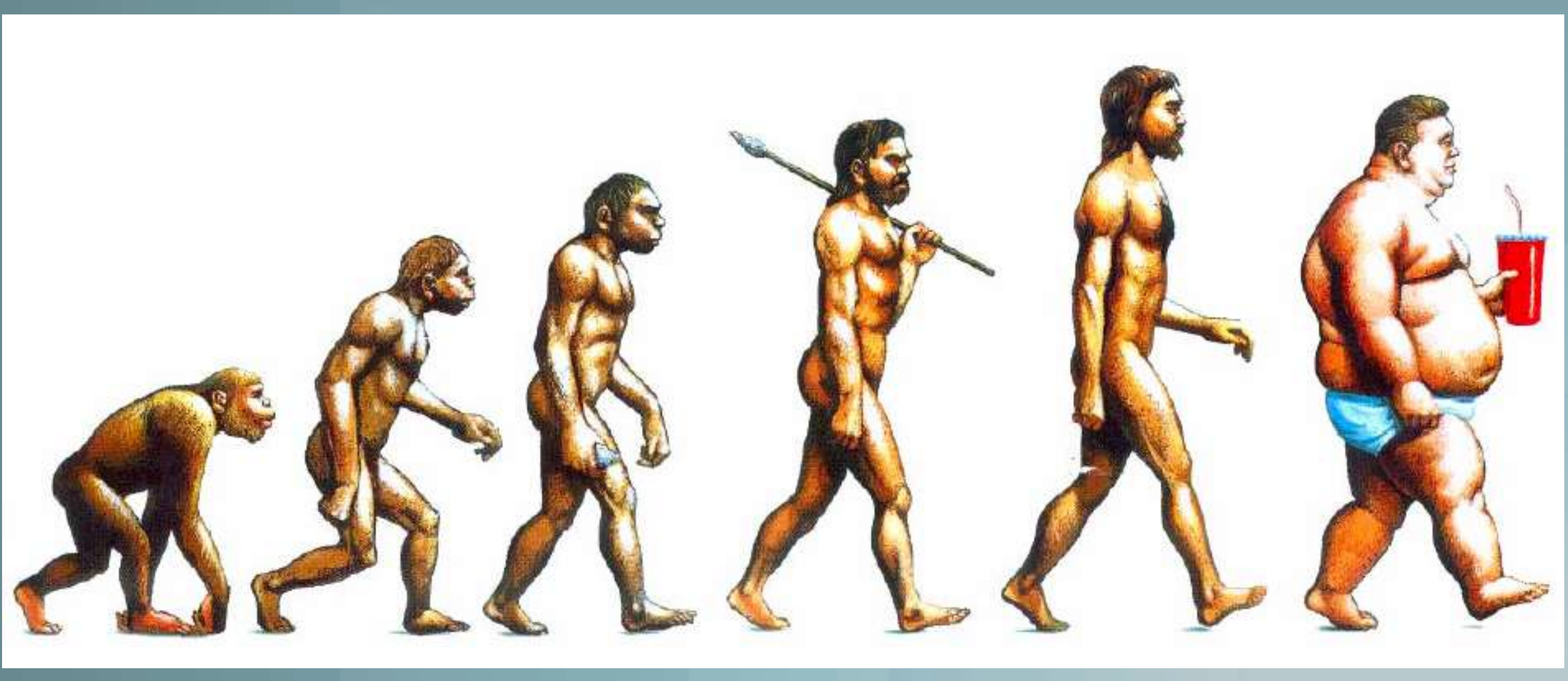
Obesity Trends* Among U.S. Adults

BRFSS, 2010

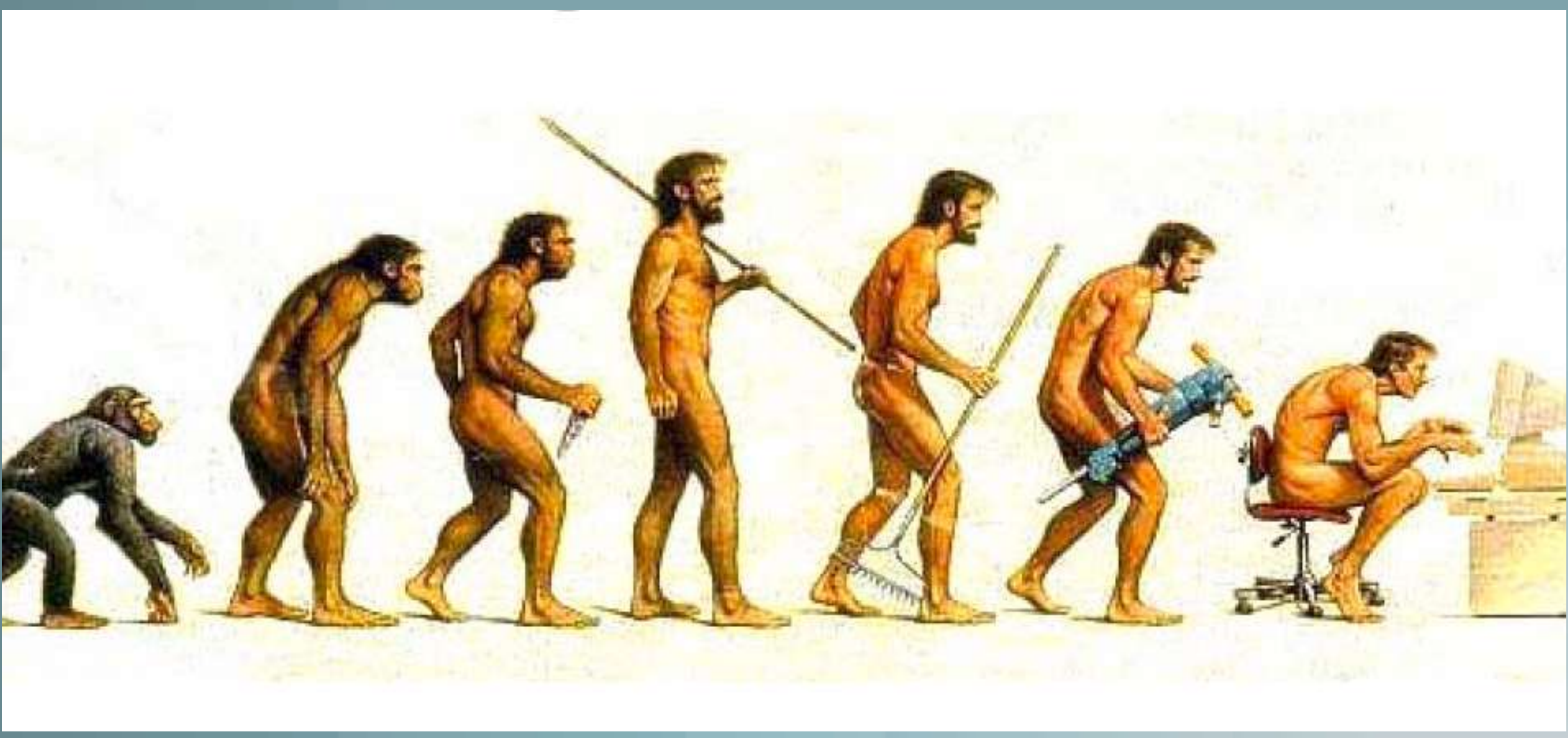
(*BMI ≥30, or ~ 30 lbs. overweight for 5’ 4” person)



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

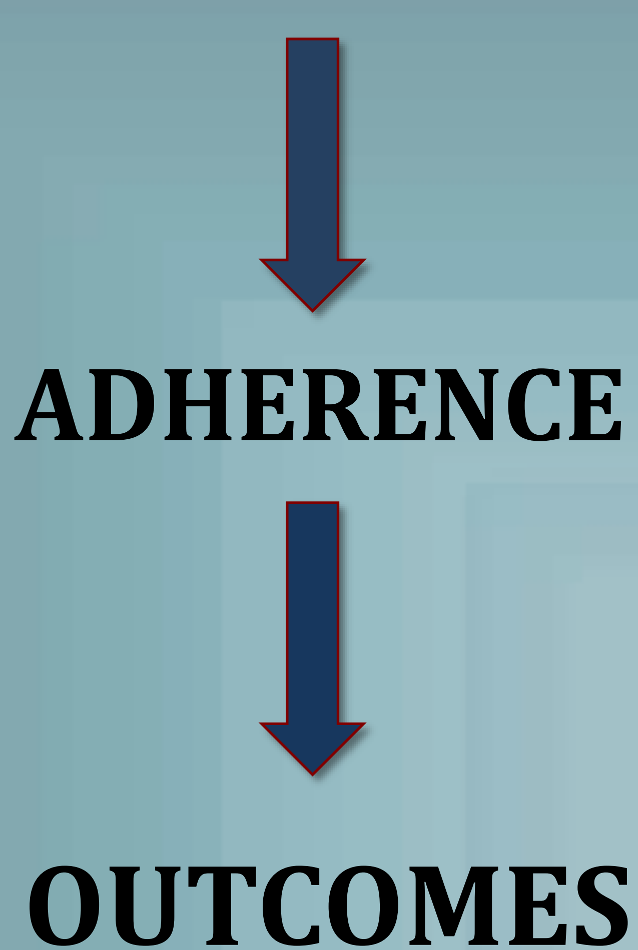
Osterberg L NEJM 2005 353;5:487-97

$$\frac{\text{\# of pills absent in Time Z}}{\text{\# of pills prescribed for Time Z}} \times 100$$

$$\frac{\text{24 pills taken}}{\text{30 pills prescribed}} = 80\%$$

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

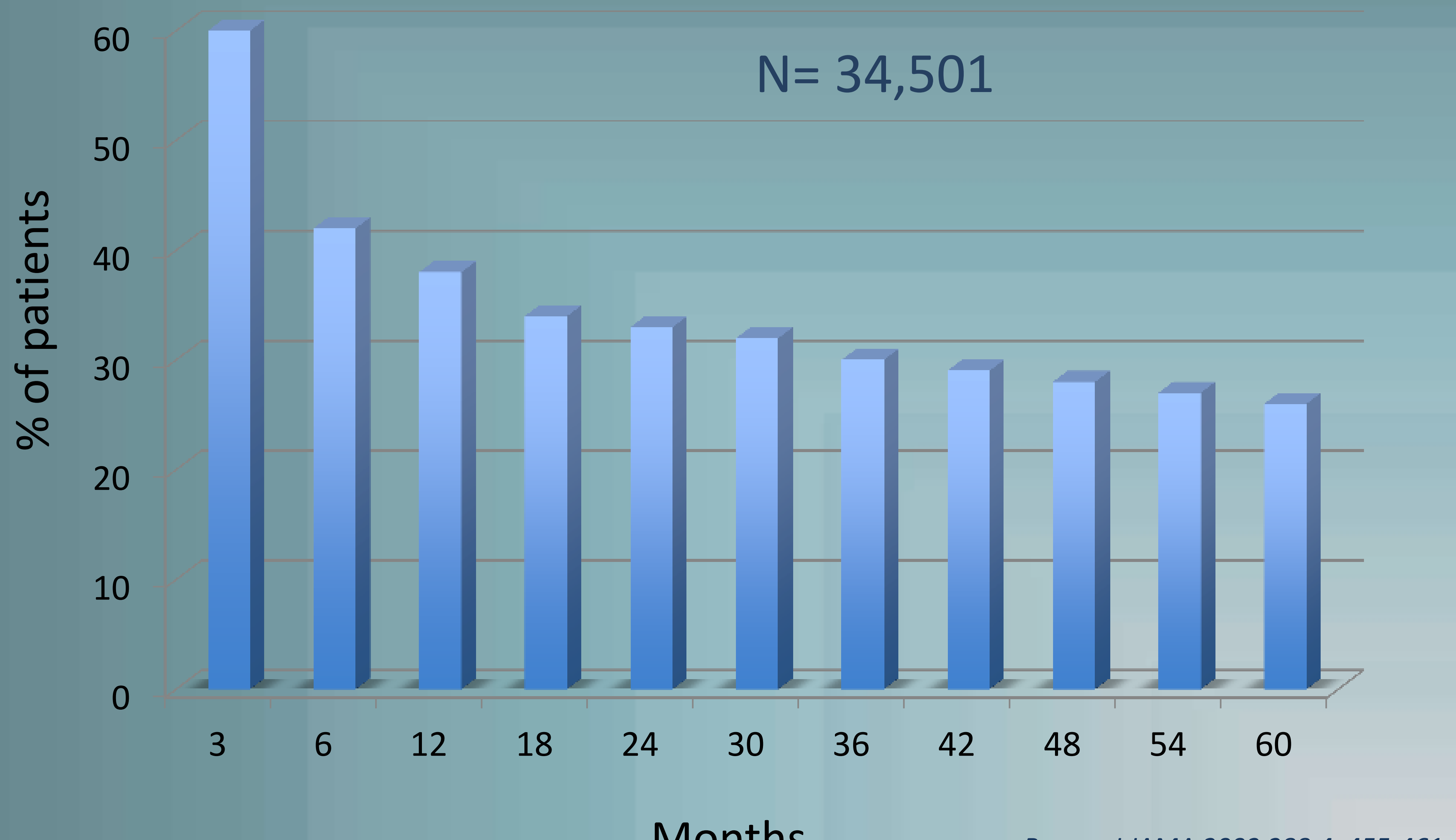
Osterberg L *N Engl J Med*. 2005;353(5):487-497
Fischer MA, Choudhry NK. *Am J Med*. 2011;124(11):1081.e9-22.
Fischer MA, *J Gen Intern Med*. 2010;25(4):284-290.

Rates of Nonadherence

- Hypertension
  - 50-80%
- Hyperlipidemia
  - 25-50% within 1yr
  - 75% at 2yrs
- ASA
  - 20-30% at 1yr

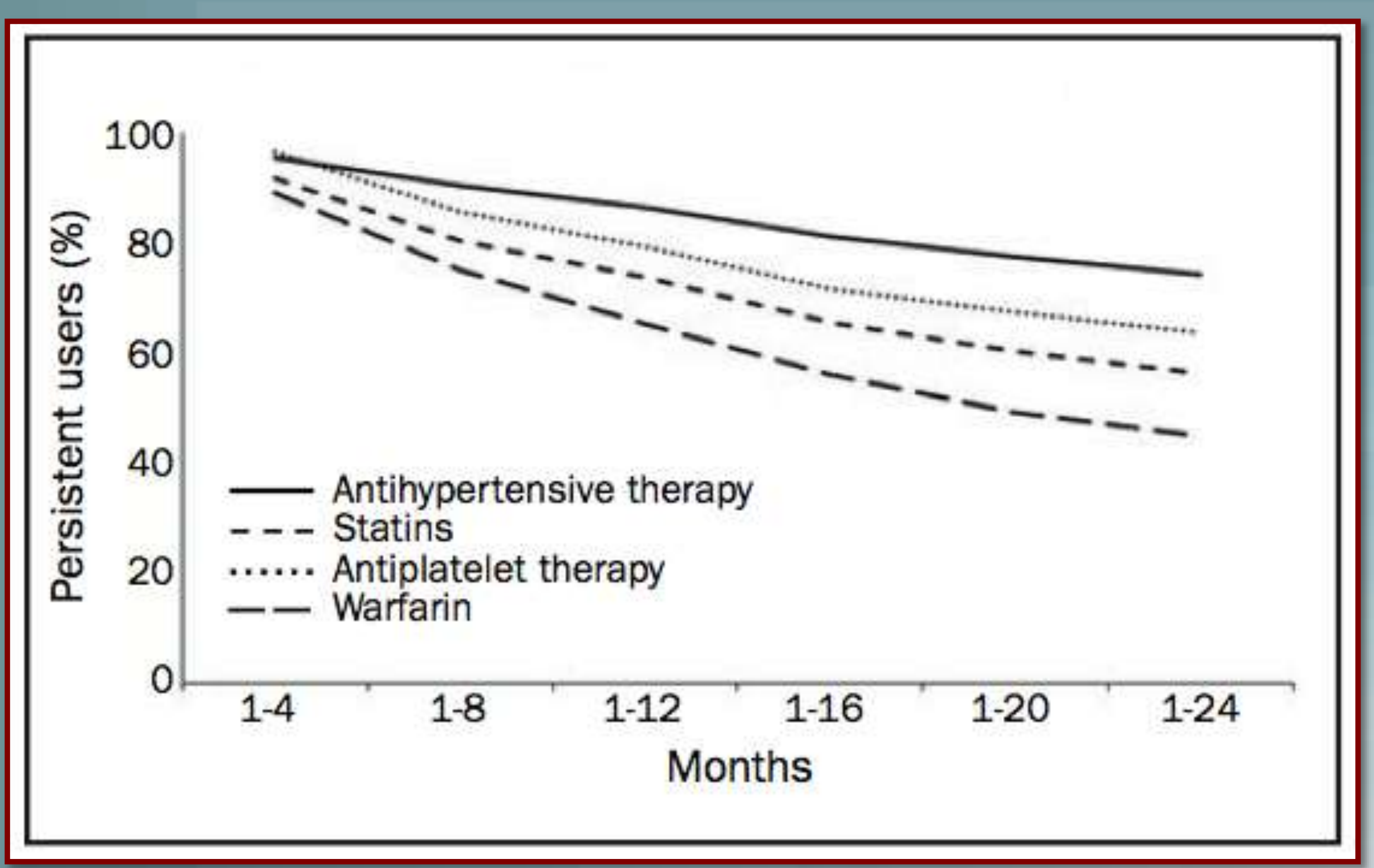
Osterberg L, NEJM 2005 353;5:487-97
Brown MT, Mayo Clin Proc. 2011 86(4):304-314

Long-term persistence of statin use in the elderly over 5 yrs



Benner J JAMA 2002 288;4 455-461

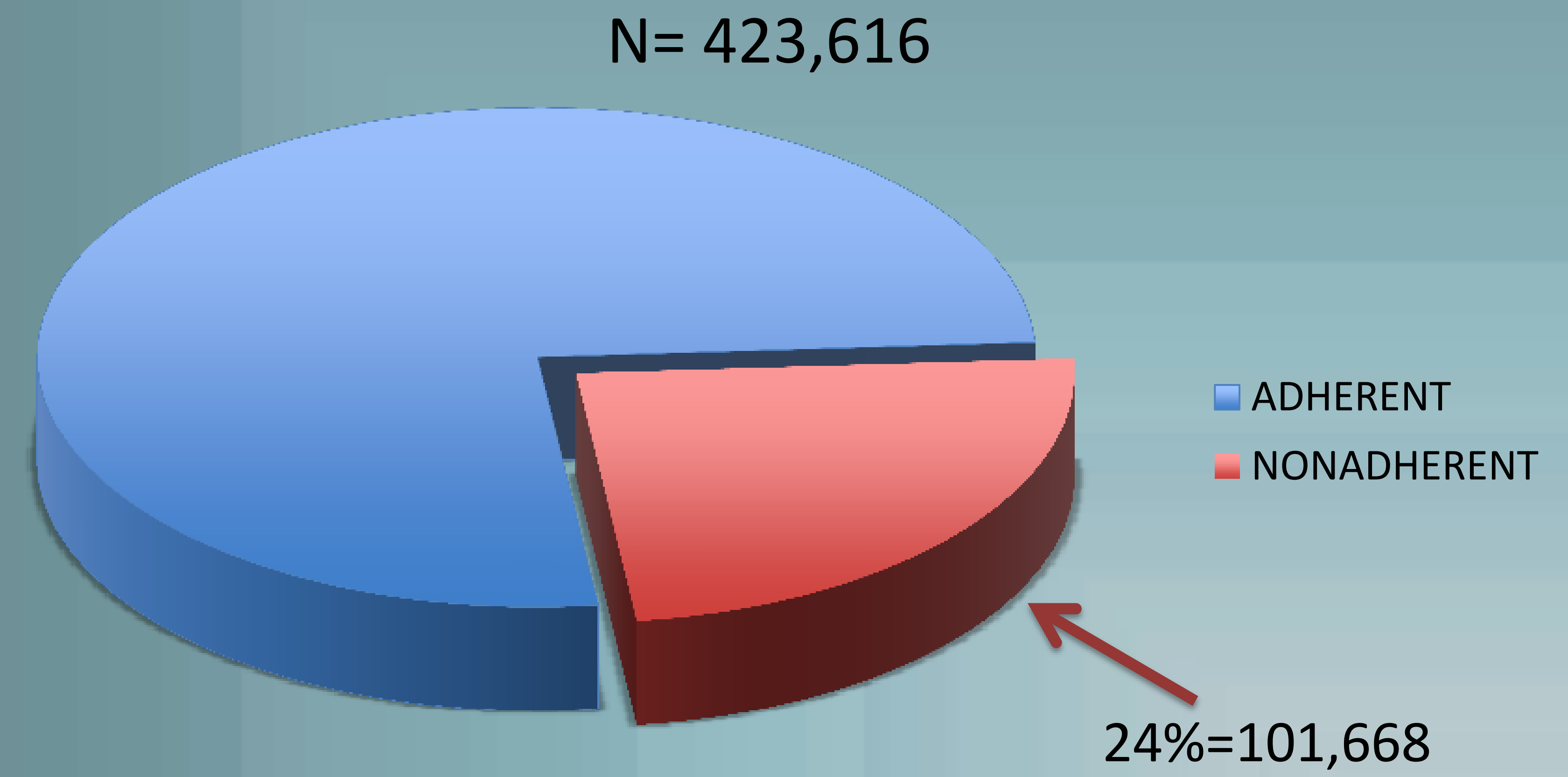
Persistence Declines Rapidly



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

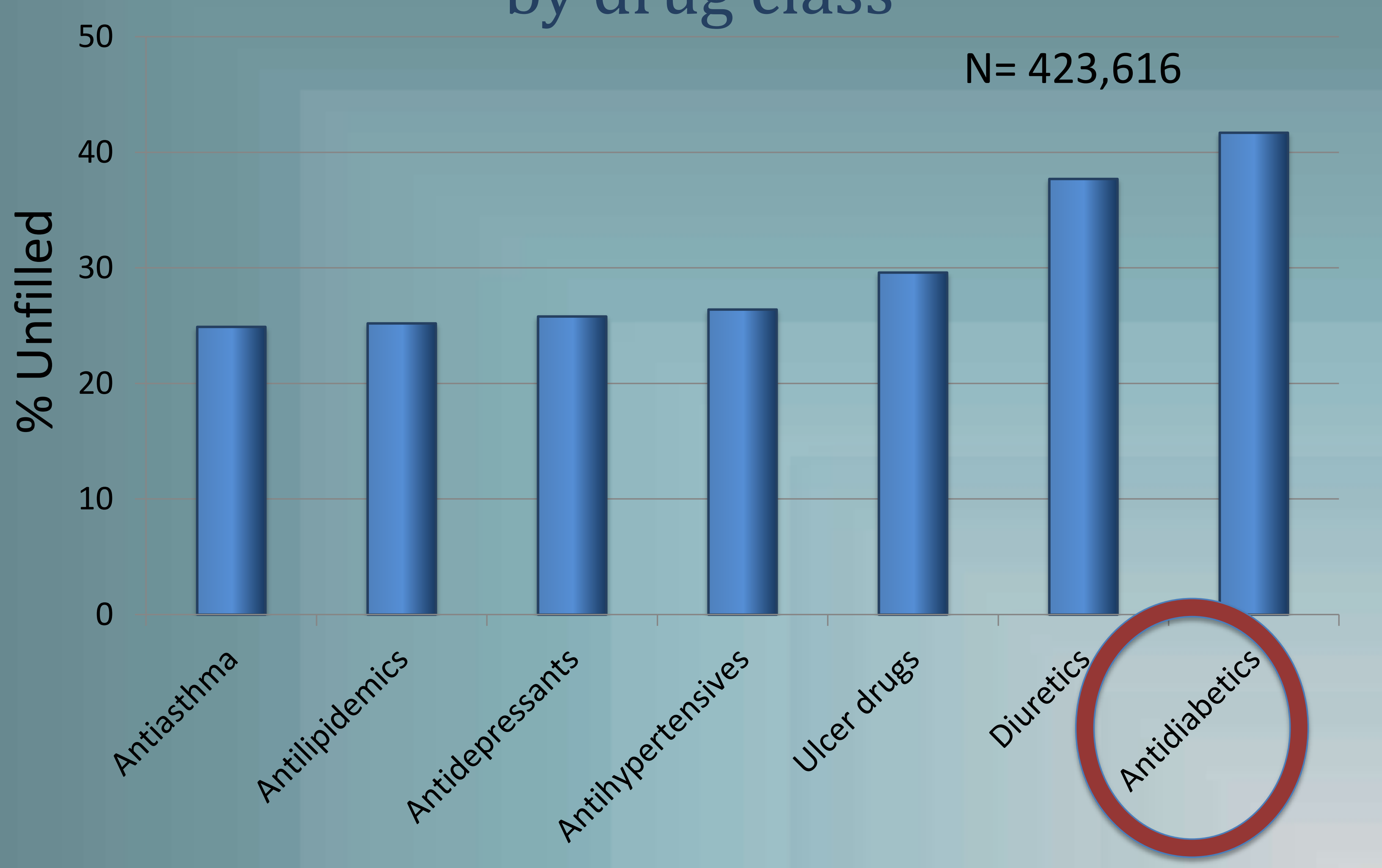
Trouble Getting Started

Predictors of Primary Medication Nonadherence



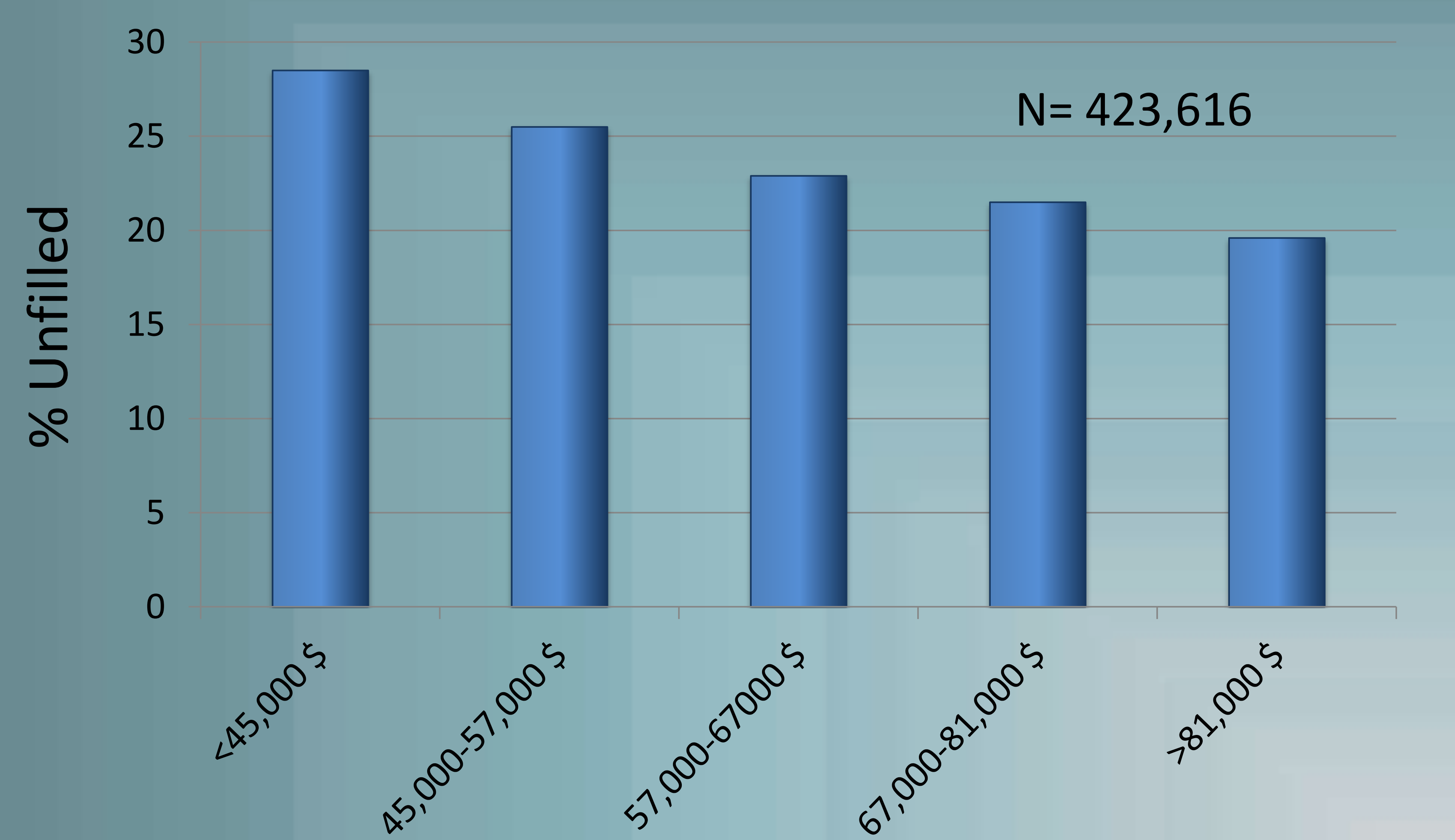
Adapted from Fischer M AJM 2011 124;1081.e9-e22

Primary Nonadherence by drug class



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

Primary Nonadherence by zip code income level



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

137,277 patients under age 65.

TOTAL COST ($)

10000
9000
8000
7000
6000
5000
4000
3000
2000
1000
0

%1-19
20-39
40-59
60-79
80-100

ADHERENCE LEVEL (%)

Sokol M Med Care 2005;43: 521–30

HOSPITALIZATIONS

137,277 patients under age 65.

Risk of Hospitalization (%)

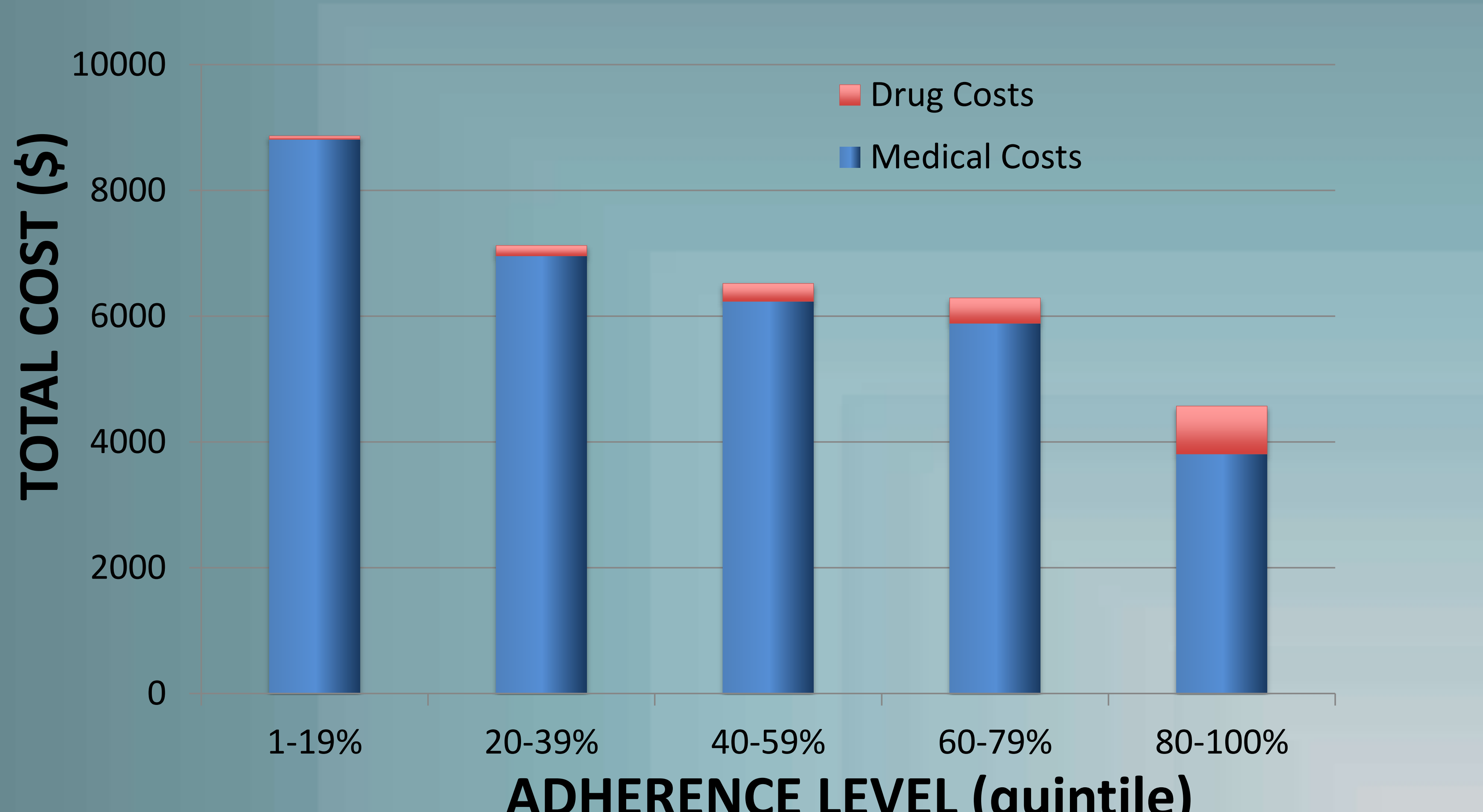
35
30
25
20
15
10
5
0

%1-19
20-39
40-59
60-79
80-100

ADHERENCE LEVEL (%)

Sokol M Med Care 2005;43: 521–30

Impact of Medication Adherence on Healthcare cost



Sokol M Med Care 2005;43: 521–30

DEBORAH
PSORIATIC ARTHRITIS

Fearful of side effects

Mistrustful of the health care system

Depression can lead to nonadherence

OBSTACLES

UNINTENTIONAL vs INTENTIONAL

UNINTENTIONAL

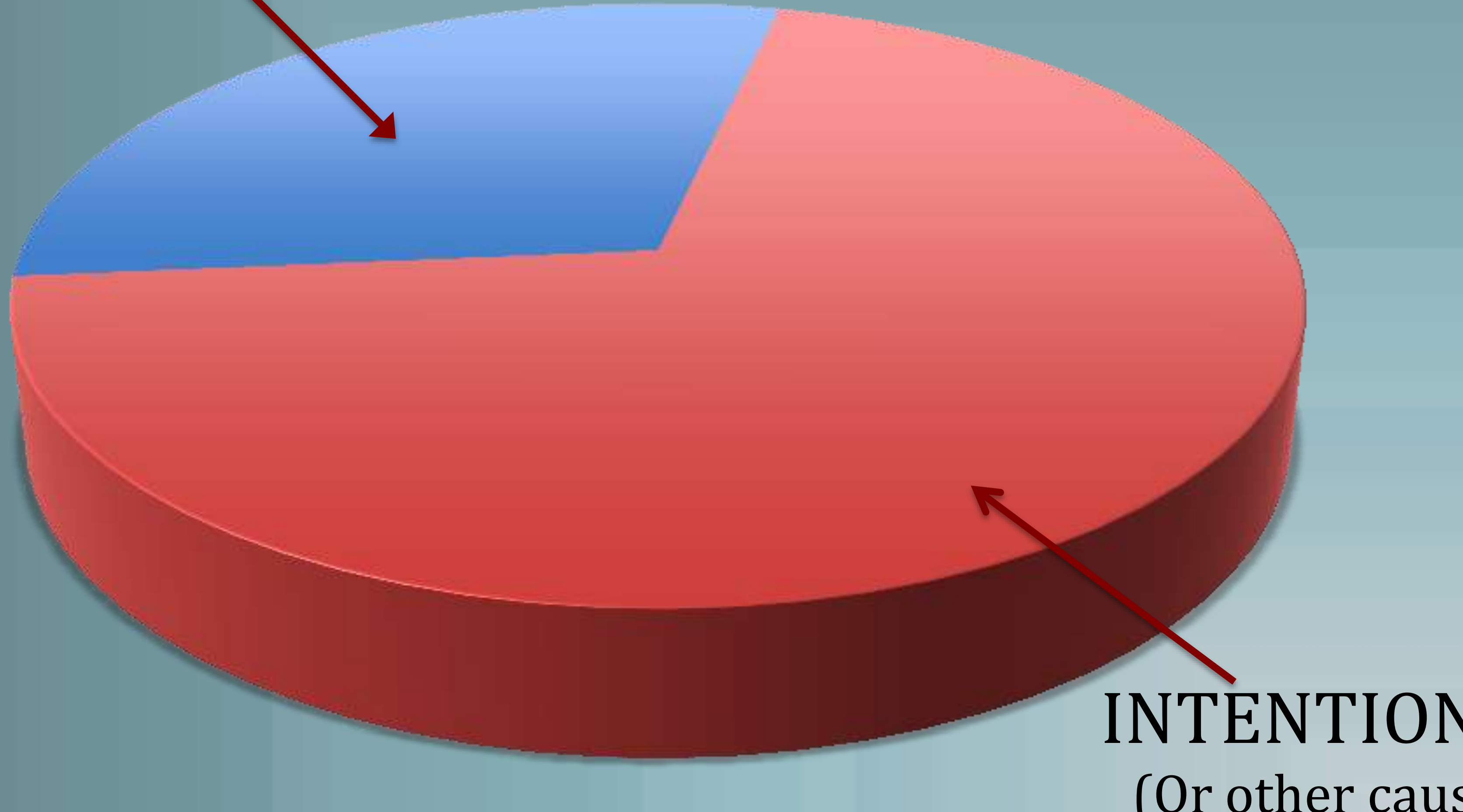
- FORGETTING
- SHIFT WORK
- COST
- CONFUSION
- WORK RESTRICTIONS

INTENTIONAL

- 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

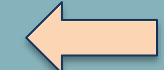
UNINTENTIONAL
(Forgetful)



INTENTIONAL
(Or other cause)

Osterberg L *N Engl J Med*. 2005;353(5):487-497

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
  - Cost/Health literacy/Access
  - Rational nonadherence
  - Mental illness
- PROVIDER
  - Failure to recognize/complicated regimens
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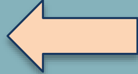
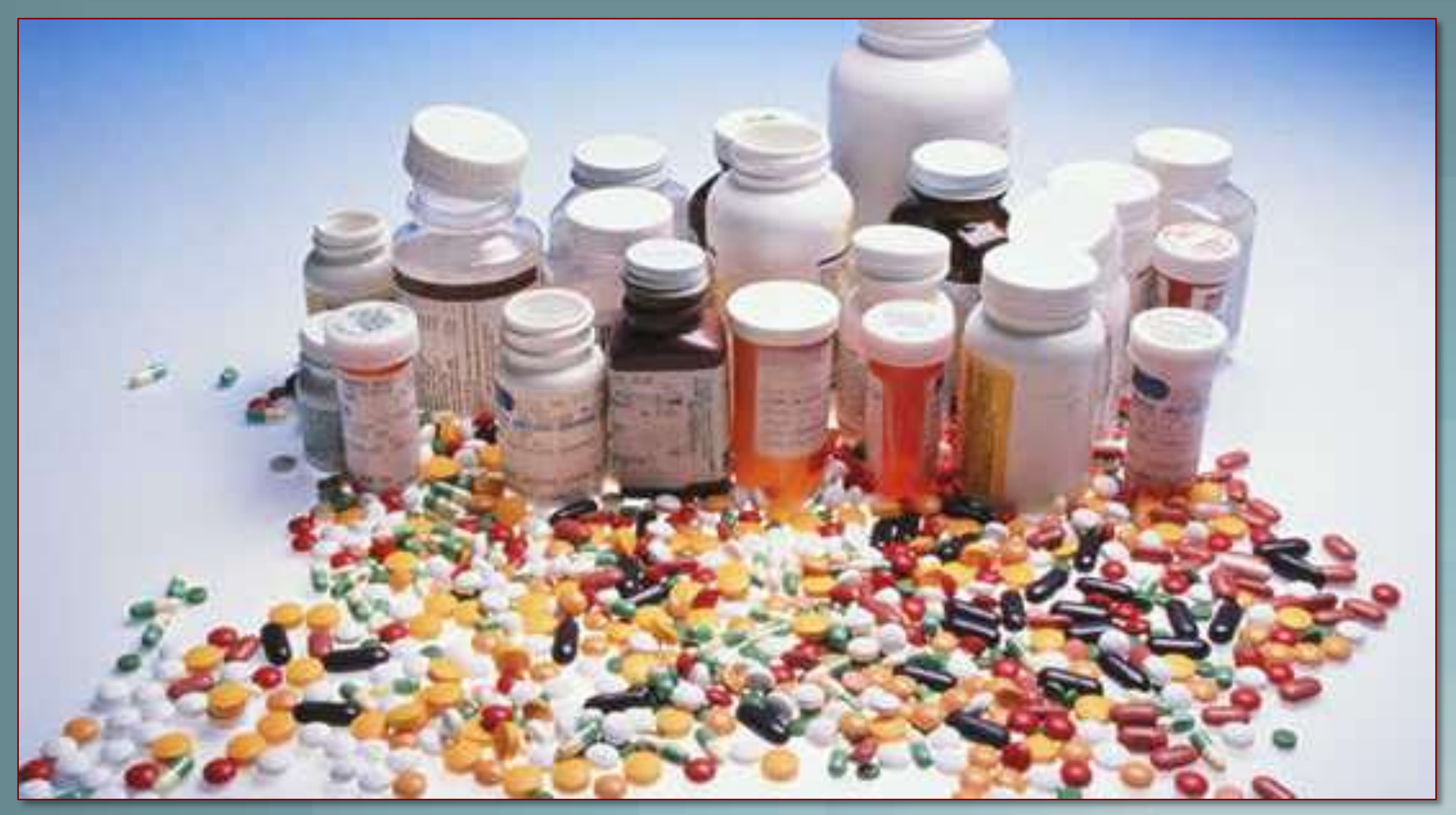




Refill Consolidation

Proportion of medications filled per pharmacy visit

Therapeutic Complexity and Adherence

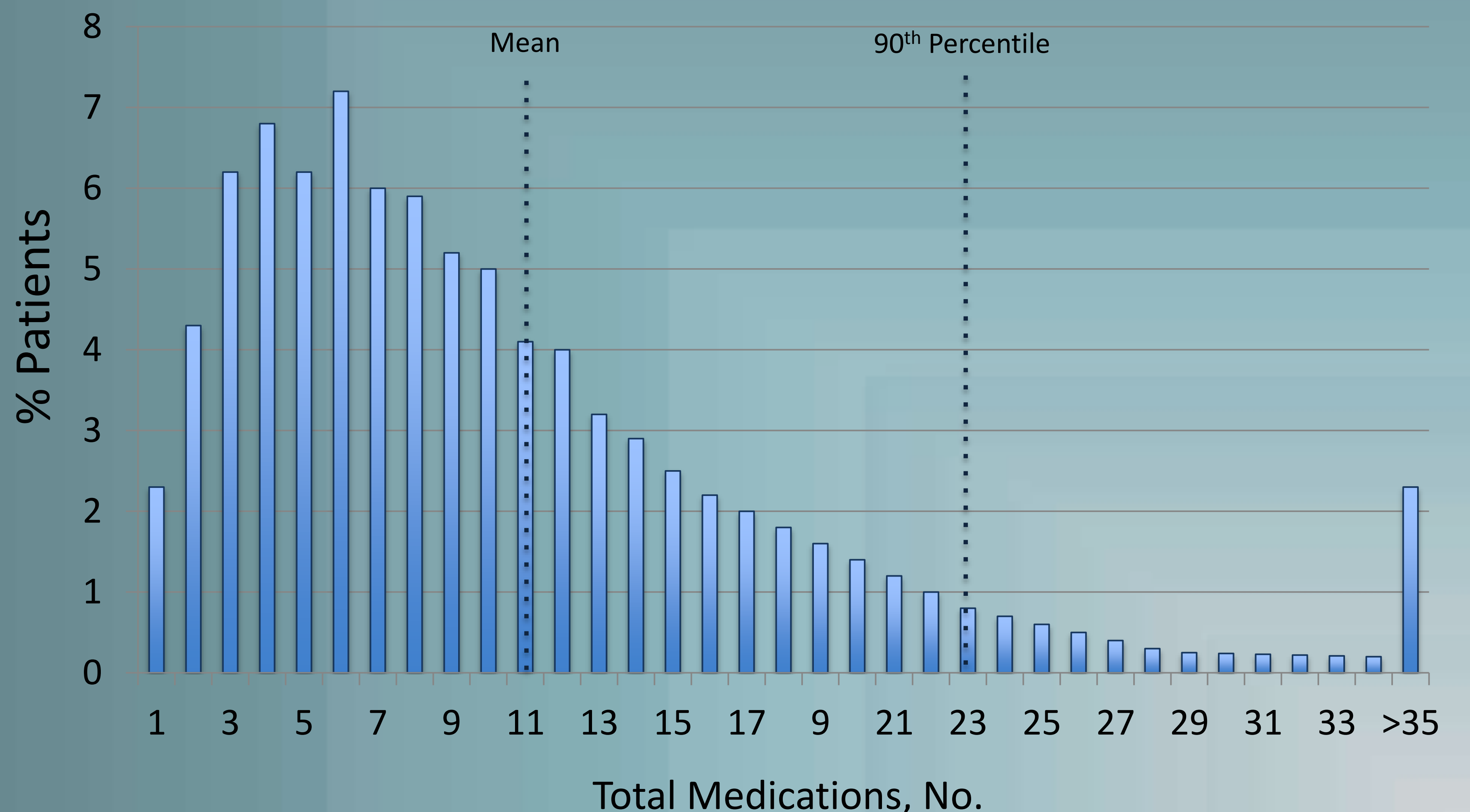
N=1,827,395 Patients

- 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

Choudhry N Arch Intern Med. 2011;171(9):814-22

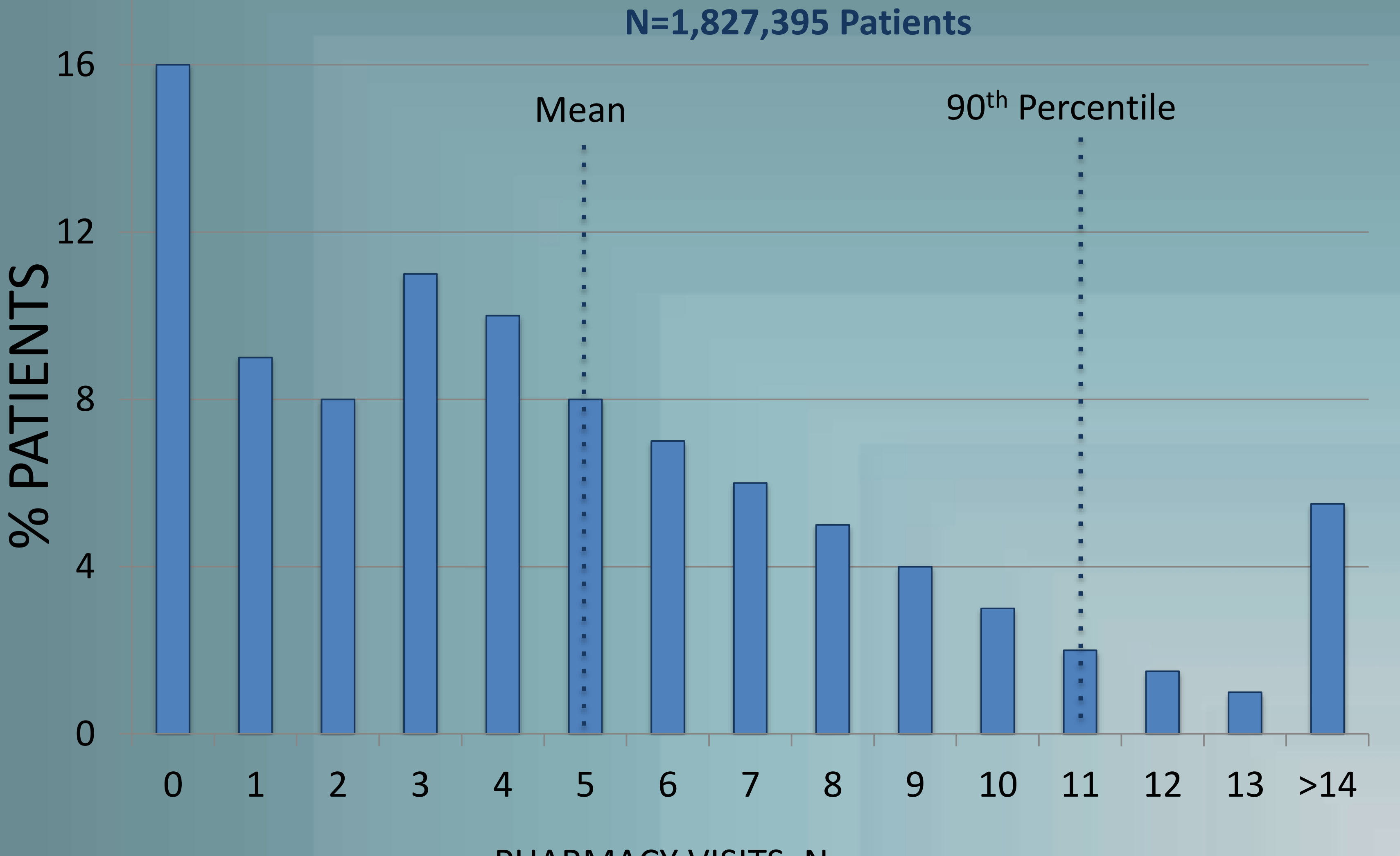
Therapeutic Complexity over 90 days among statin users

N=1,827,395 Patients



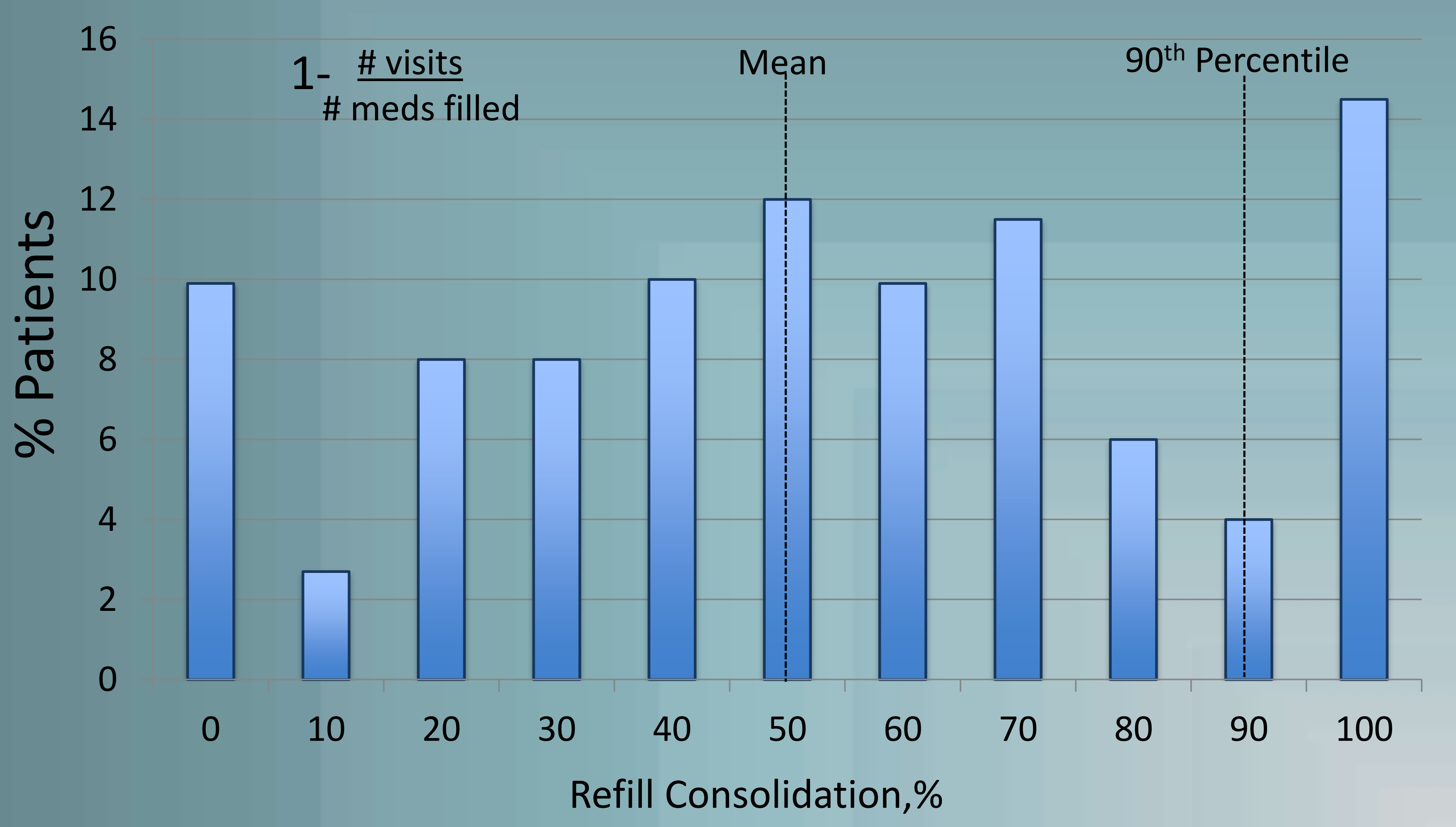
CHOUDHRY ARCH INT MED 2011 171;93 P 814-21

PHARMACY VISITS over 90 day period for statin users



CHOUDHRY ARCH INT MED 2011 171;93 P 814-21

Therapeutic Complexity and Adherence
N=1,827,395 Patients



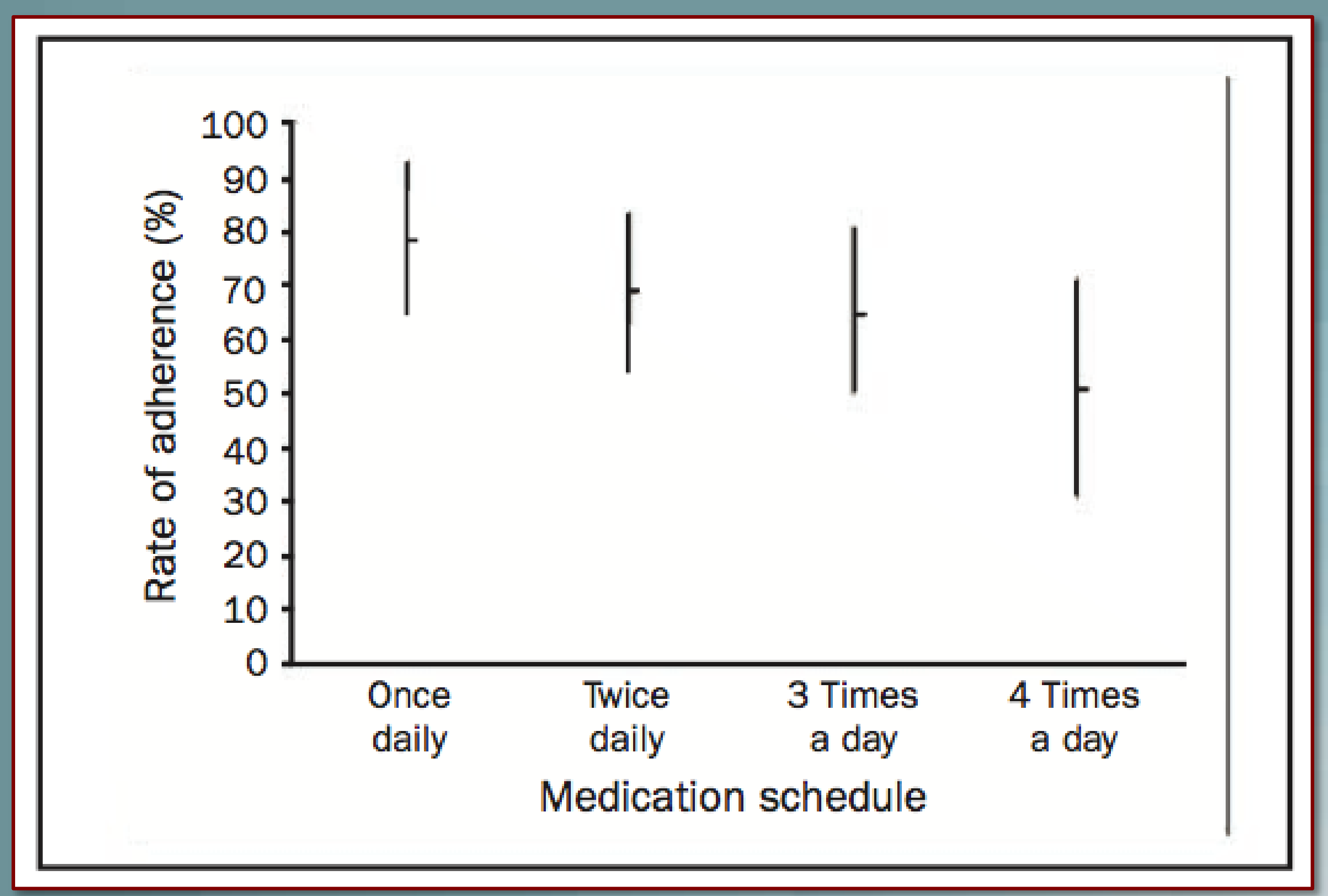
Choudhry N Arch Intern Med. 2011;171(9):814-22

Therapeutic Complexity and Adherence
N=1,827,395 Patients

Greater therapeutic complexity
was associated with
lower medication adherence
(especially for newly initiated meds)

Choudhry N Arch Intern Med. 2011;171(9):814-22

Adherence decreases as frequency of dosing increases



Osterberg L N Engl J Med. 2005;353(5):487-497

? % 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

Reach G. Diabetologia. 2010;53(8):1562-1567

Solutions Separates.wmv
MARY
PREVIOUSLY UNCONTROLLED ON INSULIN 4x/day (A1c > 12)
NOW CONTROLLED ON ONCE A DAY INSULIN (A1c >.7)
00:18
-06:56

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.

Reach G. Diabetologia. 2010;53(8):1562-1567

“It takes time to build trust….just like any relationship”

Solutions Separates.wmv
CALVIN
TOOK 5 YEARS OF ENCOURAGEMENT
BEFORE HE TOOK MEDICATION REGULARLY
01:17
-05:57

Sandra suggested the intervention that increased our medication adherence rates

Checklist for Your Medicare Wellness Annual Visit

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?

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 ?

Morisky et al. J Clin Hypertens. 2008;10(5):348-354

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?

Morisky et al. *J Clin Hypertens.* 2008;10(5):348-354

ANSWERS

Practice-2-Practice Pearls

Back to Main Menu

User-contributed Videos

Improve Your

Dr. Brown and recep
Play Video (2 min,

Improving Medication Adherence

Marie Brown, MD, F
Oak Park, IL

Dr. Brown and recep
adherence.
Play Video (3 min,

How Much Sugar is There in Soft Dr

Marie Brown, MD, F
Oak Park, IL

Dr. Brown shows a
Play Video (1 min,

ACP American College of Physicians
INTERNAL MEDICINE | Doctors for Adults

ACP

Medical Home Builder®
ACP Practice Solutions

Build a Medical Home!

Living with Diabetes

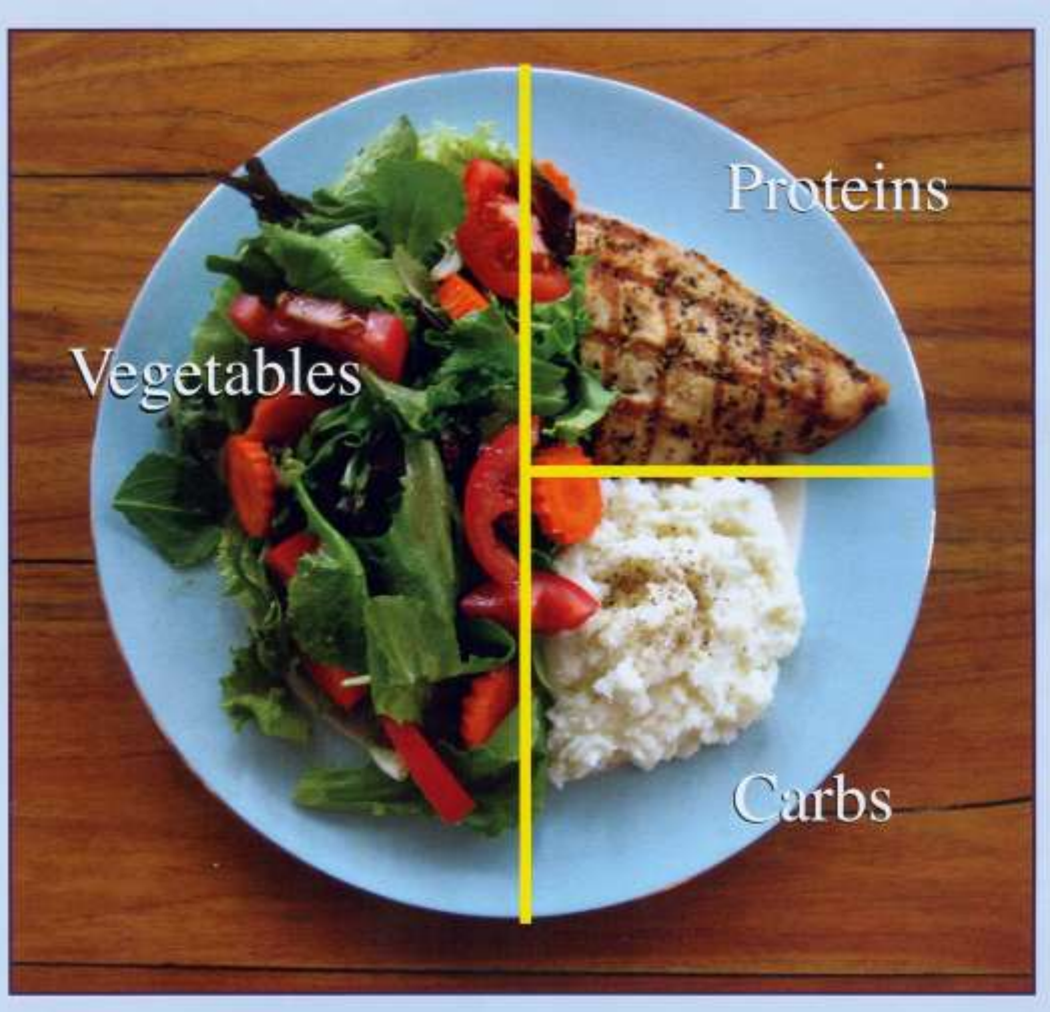
An Everyday Guide for You and Your Family

LINKS: CLINICAL IN

der patient
topics related
dation provides
d effective in

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).



S M T W T F S
S M T W T F S
S M T W T F S
S M T W T F S
S M T W T F S

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

METFORMIN

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 you 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 <u>if you keep taking</u> 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 resource (view more)

Home | Data | Measures | Improvement | MOC | PQRS | Export | Manage

Search for Measures

Sort by Gaps: most first

☐ Hide measures with no dat

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

Listings Per Page 5|10|20|30

Page:1 |

Measure Name	Time Period 11/07/2013	My Performance		How Do I Compare?		Outliers	How Do I Improve
		Trending	My Score	My Gaps	Me vs All		
Dilated Eye Exam	11/07/2013	view chart	Actual 52% Higher is Better	0 gap Show	100% Worst Best		
Foot Exam	11/07/2013	view chart	Actual 46% Higher is Better	0 gap Show	100% Worst Best		
Hemoglobin A1c Poor Control	11/07/2013	view chart	Actual 47% Lower is Better	0 gap Show	100% Worst Best		
High Blood Pressure Control	11/07/2013	view chart	Actual 47% Higher is Better	0 gap Show	100% Worst Best		
Low Density Lipoprotein (LDL-C) Control	11/07/2013	view chart	Actual 47% Higher is Better	0 gap Show	100% Worst Best		
Medical Attention for Nephropathy	11/07/2013	view chart	Actual 52% Higher is Better	0 gap	100% Worst Best		

ACPNet Participant Workflow

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

Review module materials (case study, practice biopsy, resource library)

(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

PDSA Detail

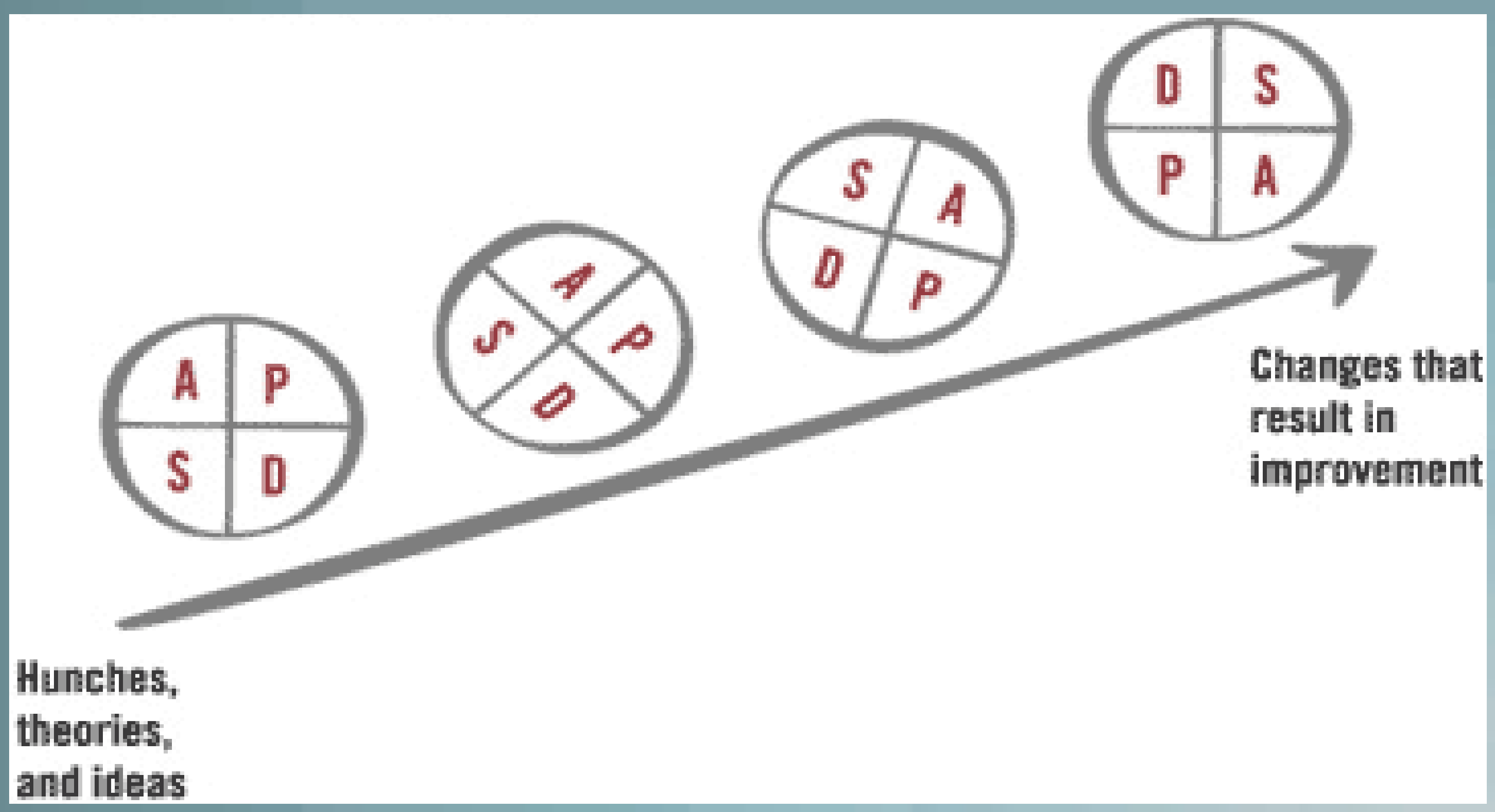
- Step 1 - Plan
  - Plan the *test* (change in process)
  - Plan for collecting data
    - Make predictions of what will happen and why
    - Develop a plan to test the change (Who? What? When? Where? What data need to be collected?)
- Step 2 - Do
  - Implement the new process during a trial period (try 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

Linking Tests of Change

adapted from Institute for Healthcare Improvement



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%)

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

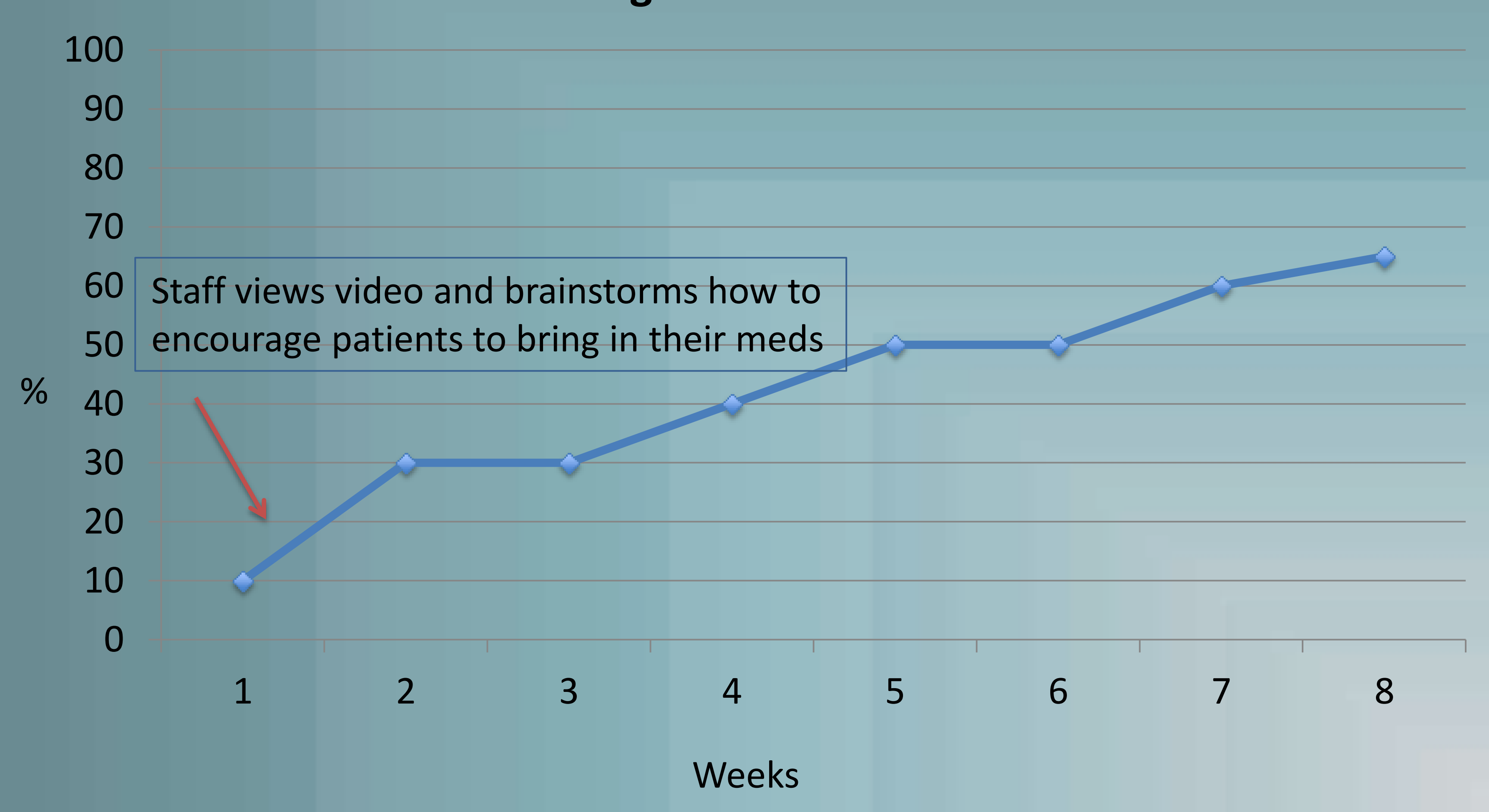
Drs Brown and Bussell

ACP website provides this free:

- http://vimeo.com/42194365 (21 minute version)
- http://vimeo.com/42144406 (5 minute version)

Simple Run Chart

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



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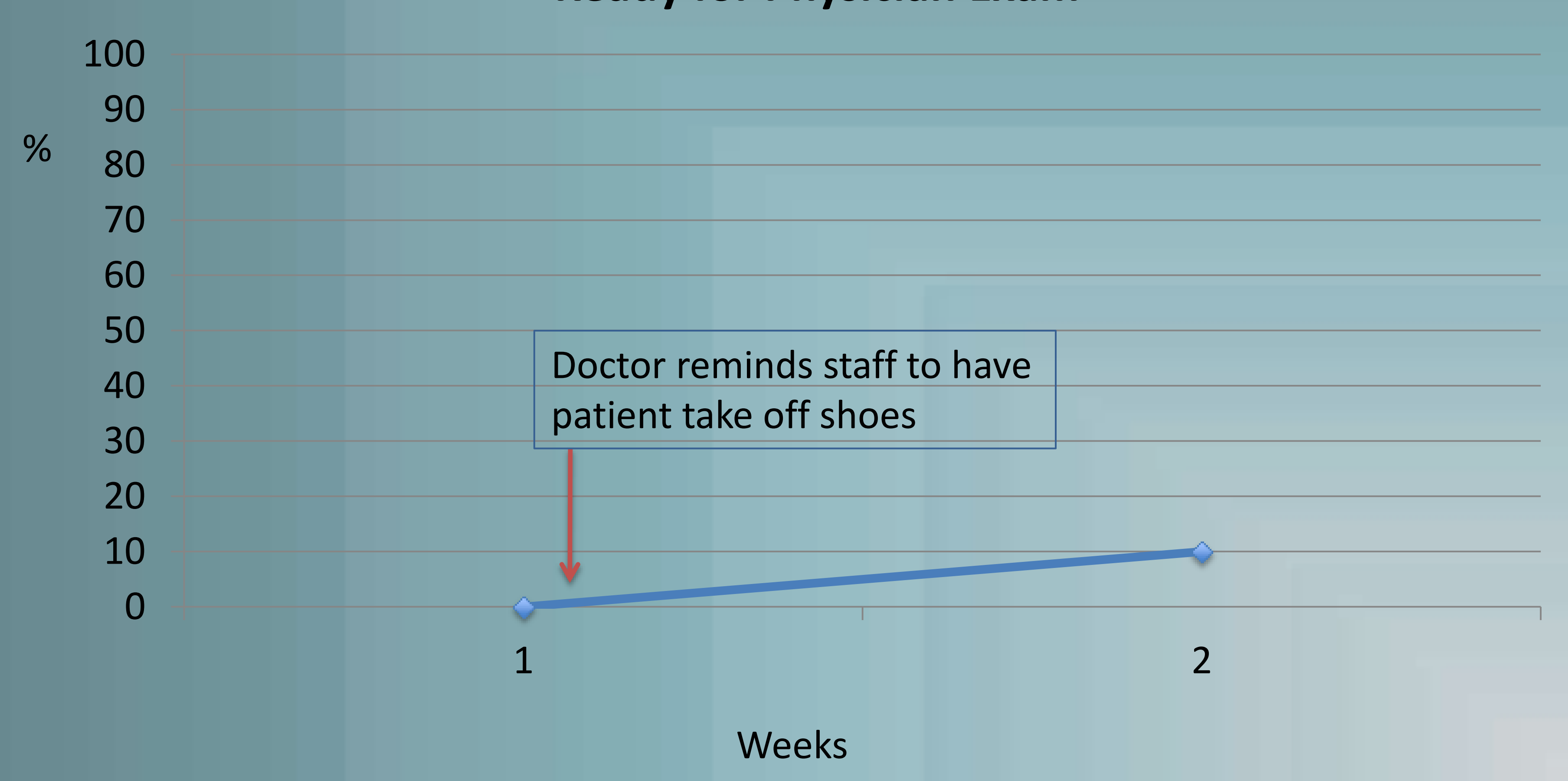
Simple Run Chart
Count how many diabetic patients each Friday are ready for exam

(week 1: 0/10= 0%)



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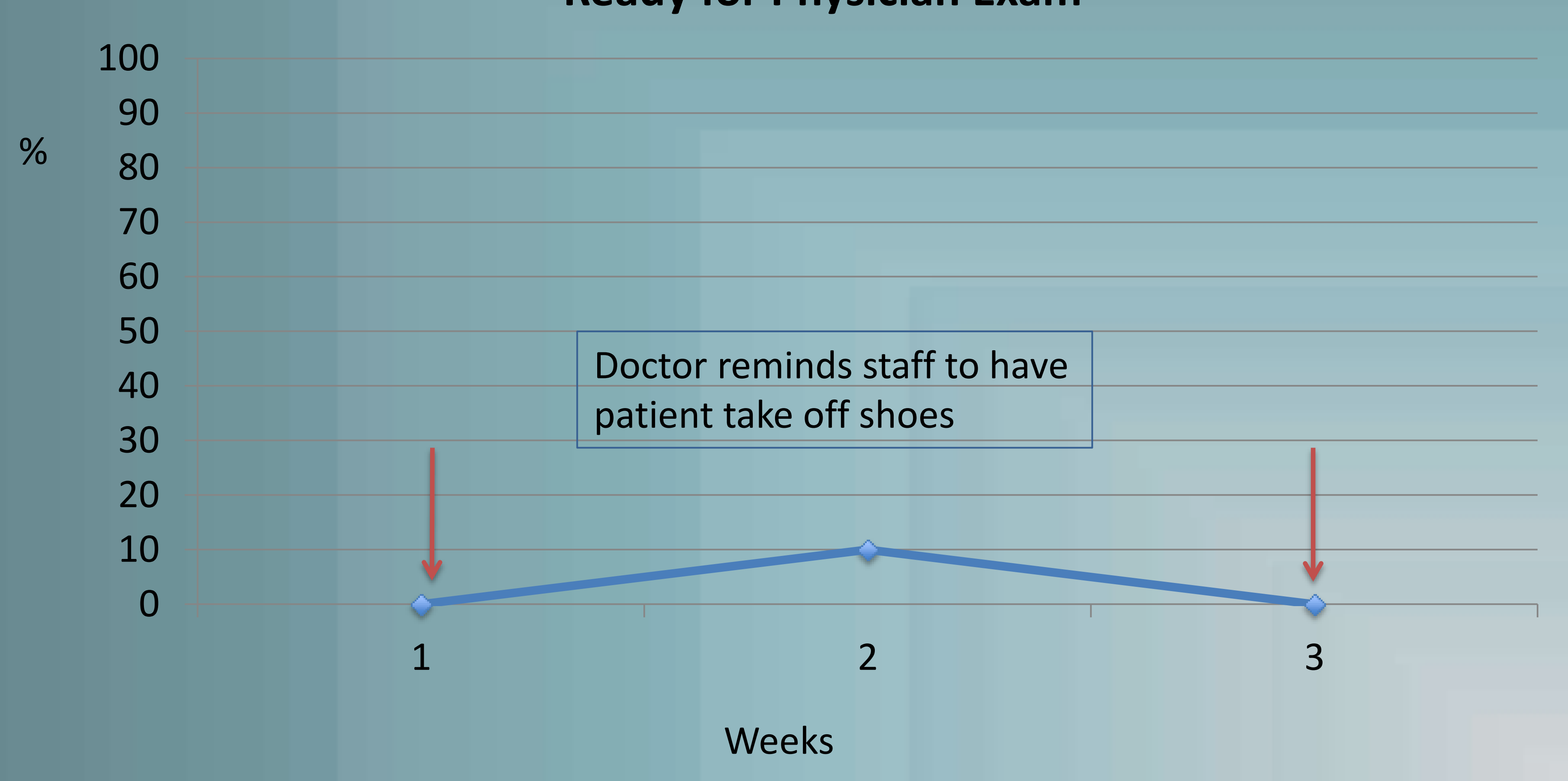


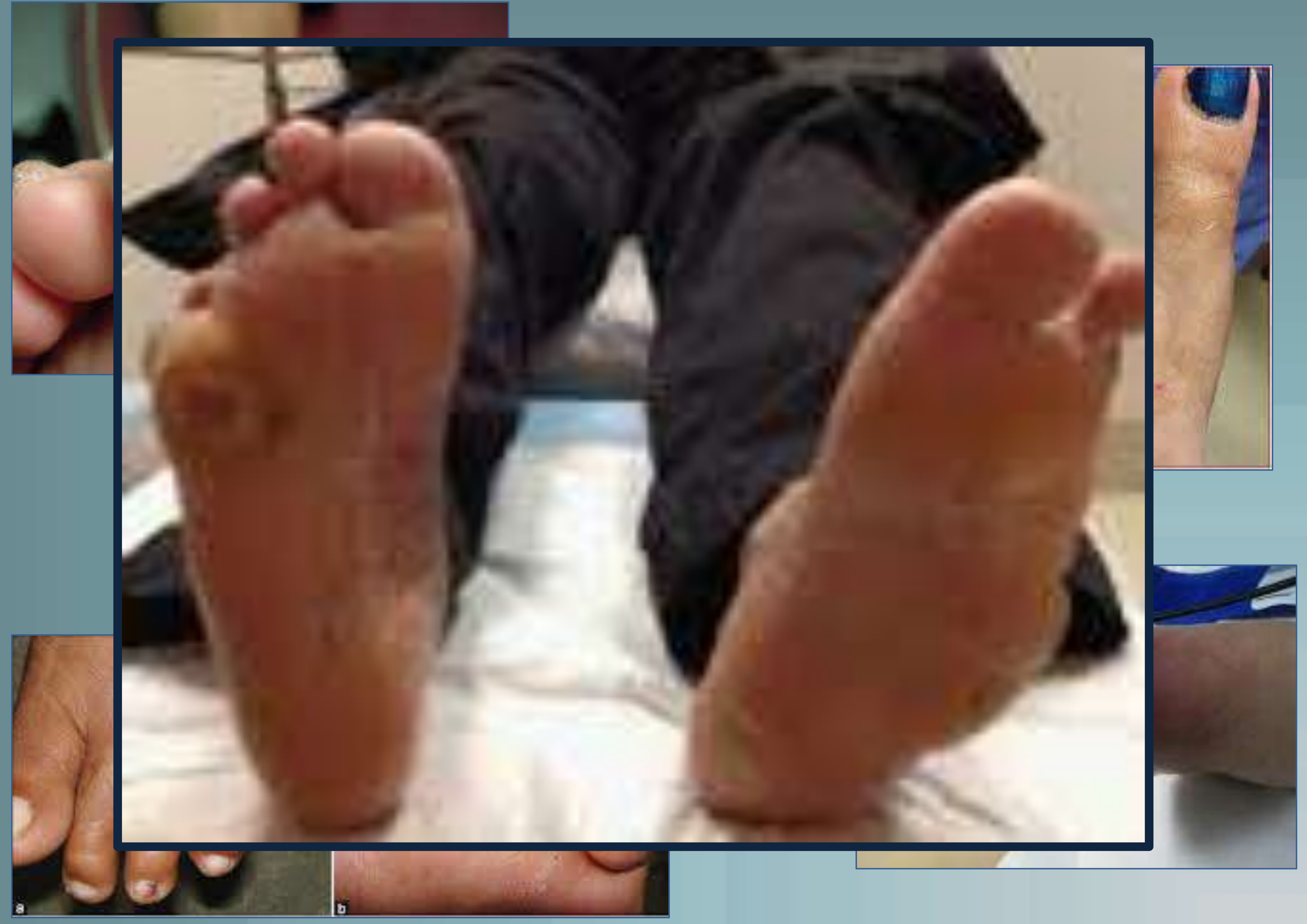
Simple Run Chart

Count how many diabetic patients each Friday are ready for exam

(week 1: 0/10= 0%)

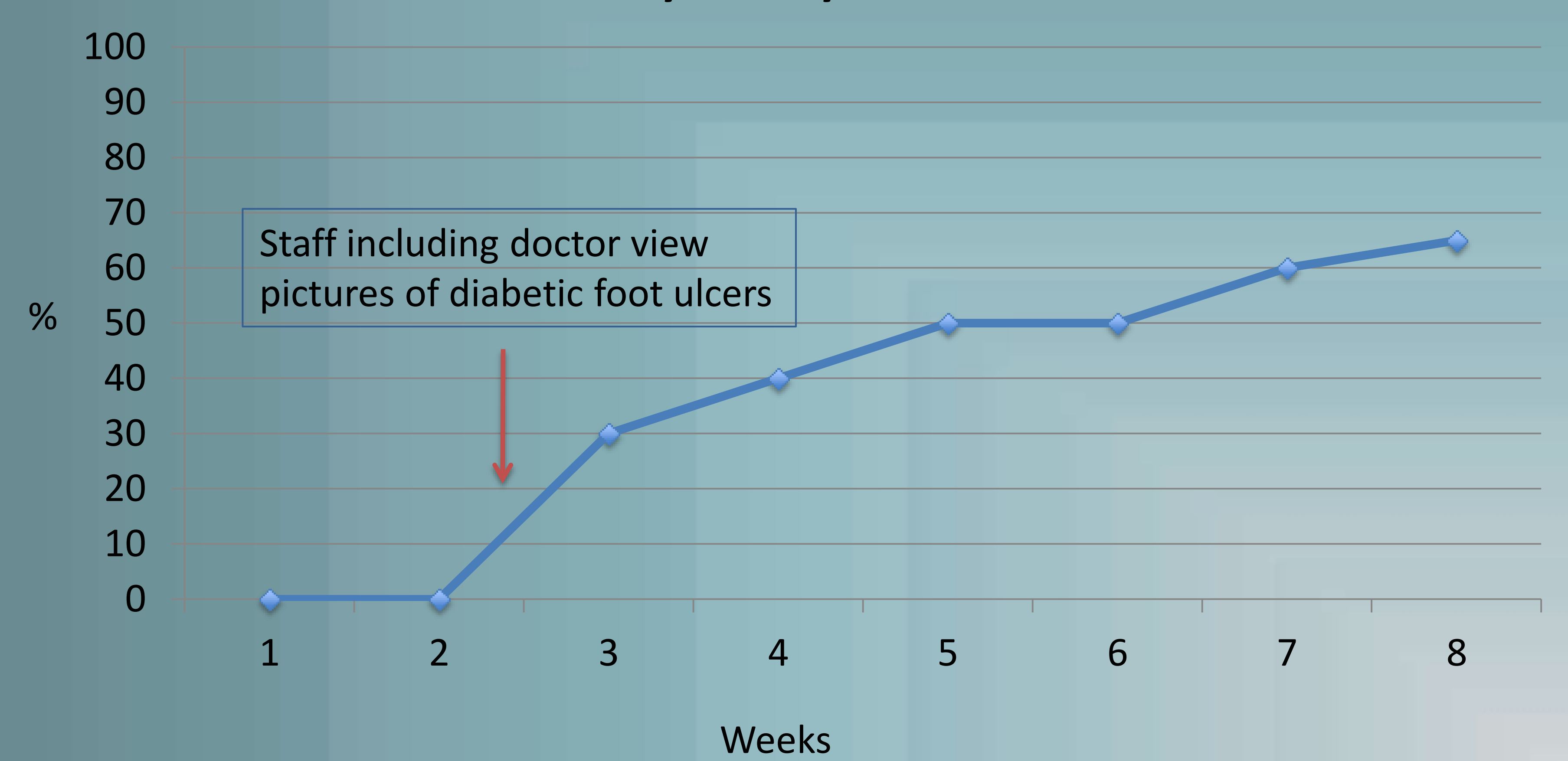
Linking Small Steps of Change

- 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%)



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

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Log in to ABIM to request 20 MOC points

A Transition…..

- You need to develop an **<u>action plan</u>**
- 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 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

https://www.practiceadvisor.org/modules/improving-clinical-care/manage-patients-medications/login?ReturnUrl=/modules/improving-clinical-care/manage-patients-medications

Medication Adherence

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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**