B1-Improving Diabetes Screening and Management

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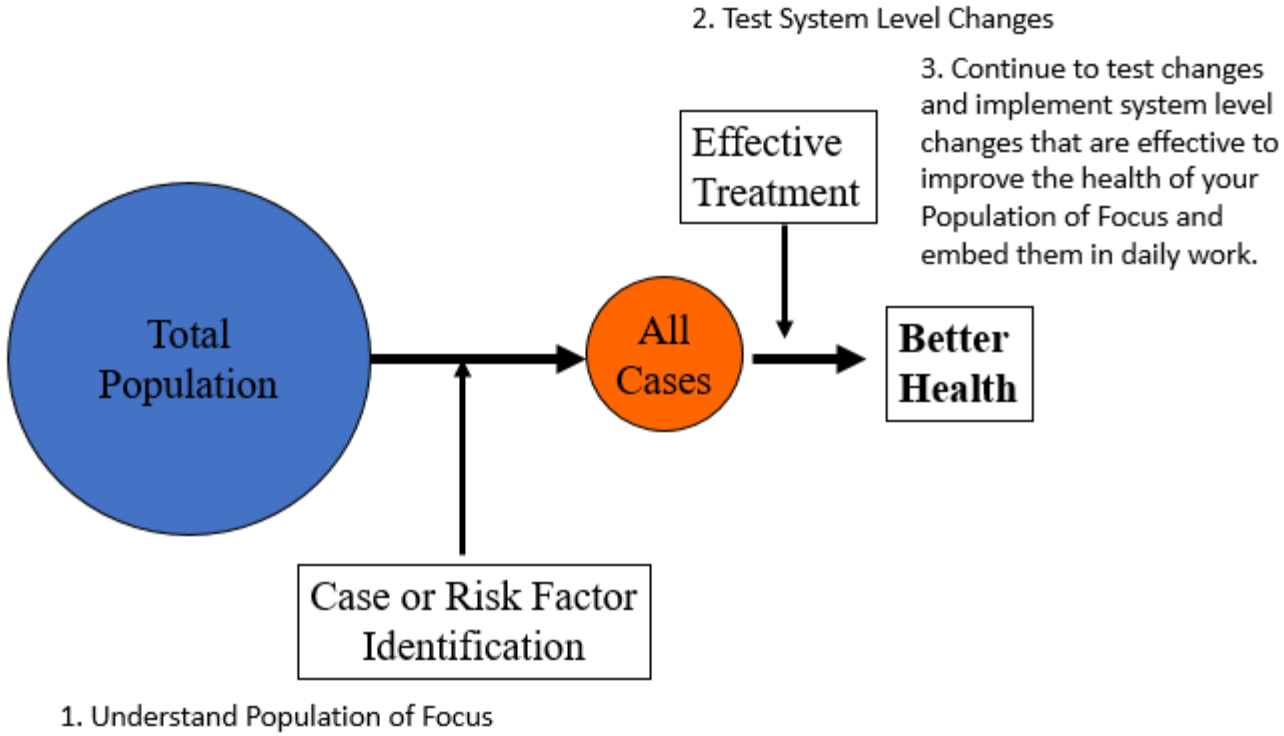
When addressing the needs of those we serve, we have a choice…

An international approach

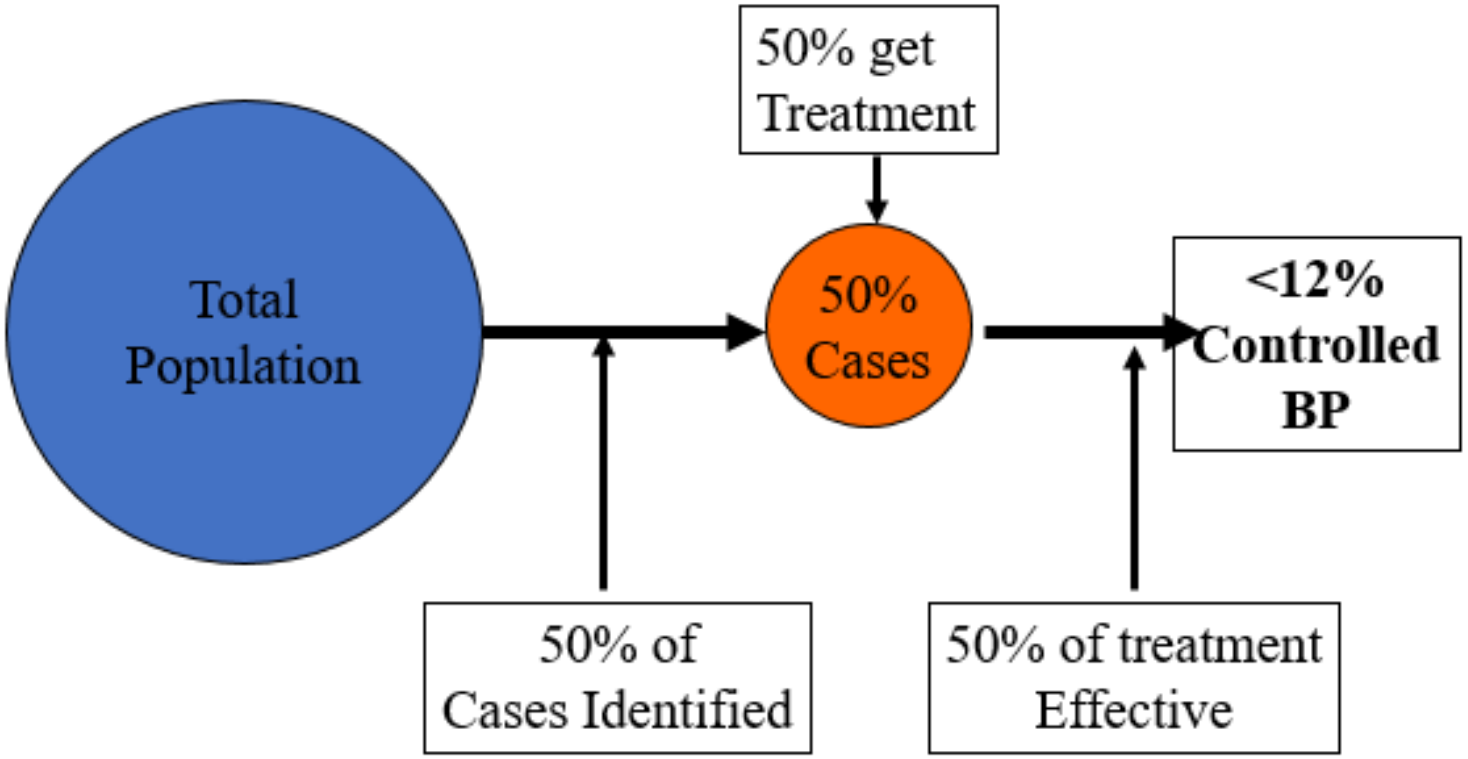
Population-based Care



Clinical Work

- Piedmont Health was founded in 1970 by a group of health care professionals at the University of North Carolina …and local community members concerned with access to primary healthcare in the community. Known then as Orange-Chatham Comprehensive Health Services, Inc. (OCCHS), the agency was organized to provide comprehensive healthcare services [to] those who weren't receiving proper healthcare.

Population-based care not happening Hypertension (1970's-80's)



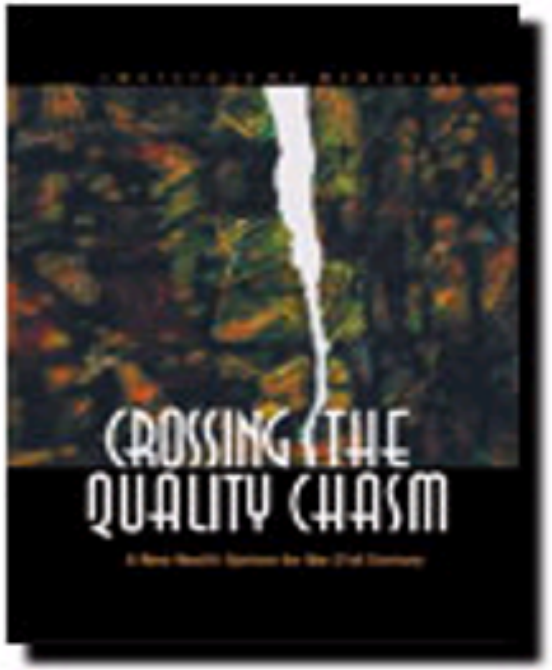
What Goes Wrong?

Old Theory	New Theory
• Good Barrel	• Good apples
• Bad Apples	• Bad Barrel

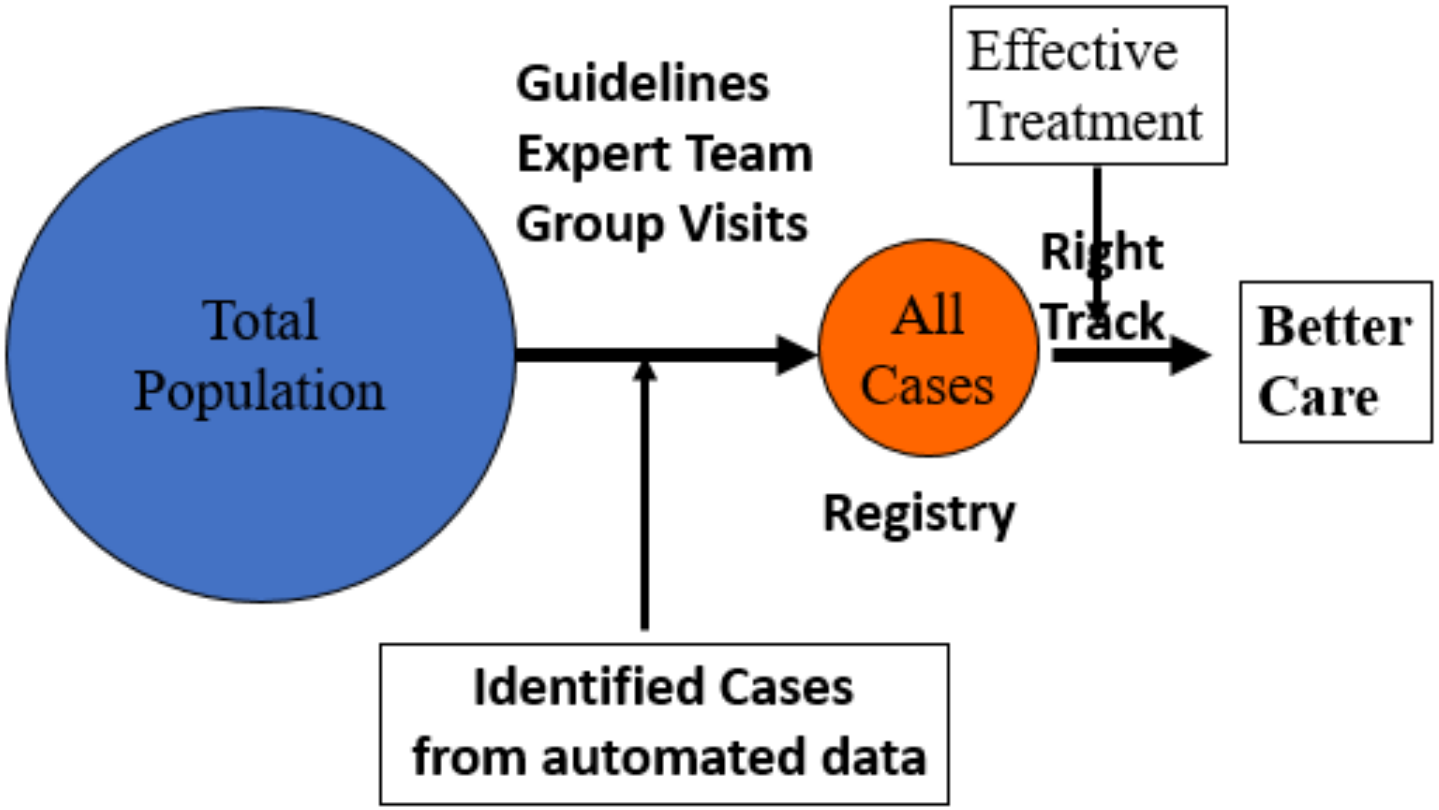
Why are we doing so poorly?

The IOM Quality Chasm report says:

- "The current care systems **cannot** do the job."
- "Trying harder will not work."
- "Changing care systems will."



The Diabetes Roadmap



t Wood Johnson Foundation

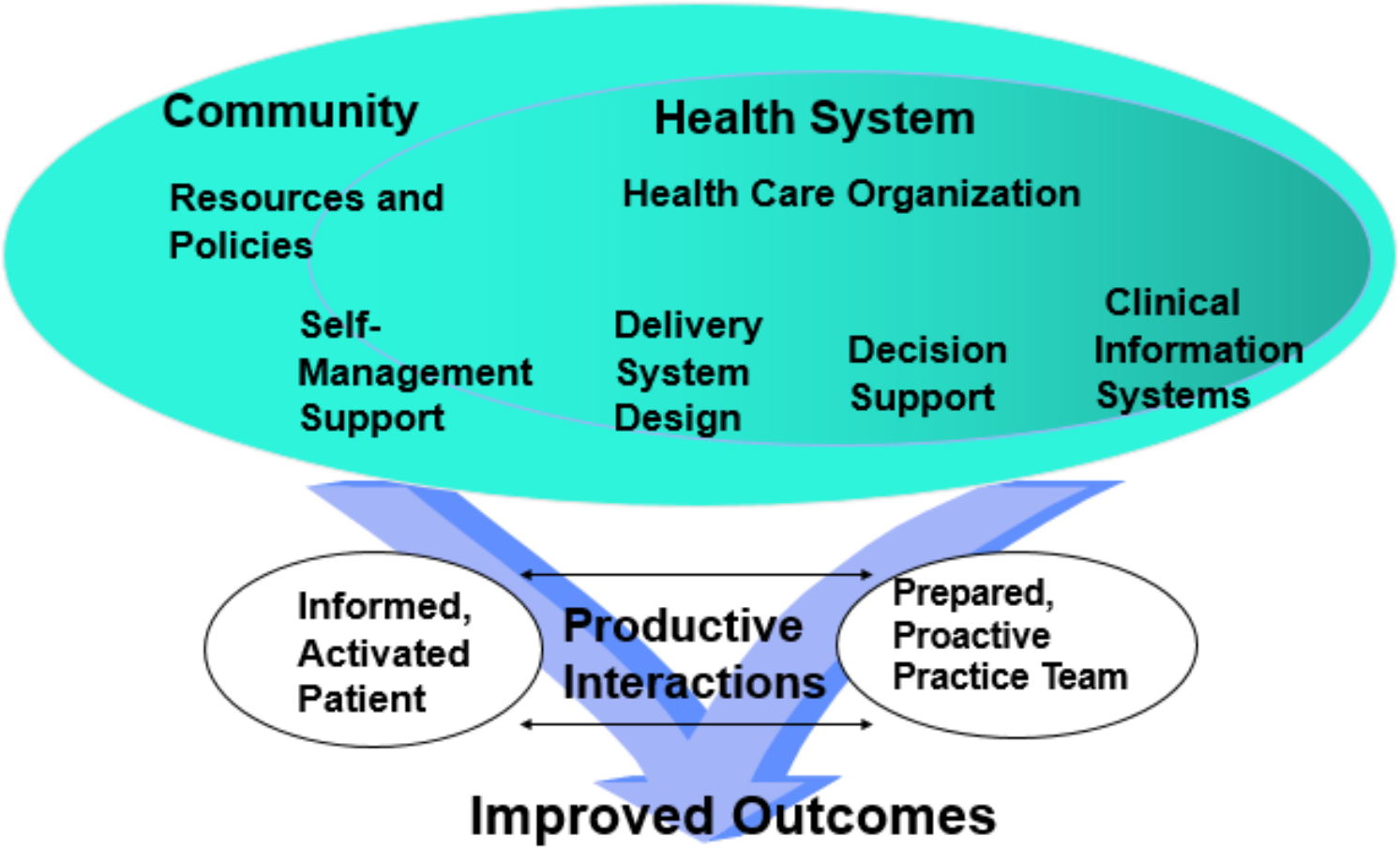
Institute *for* Healthcare Improvement

HRSA
Health Resources & Services Administration

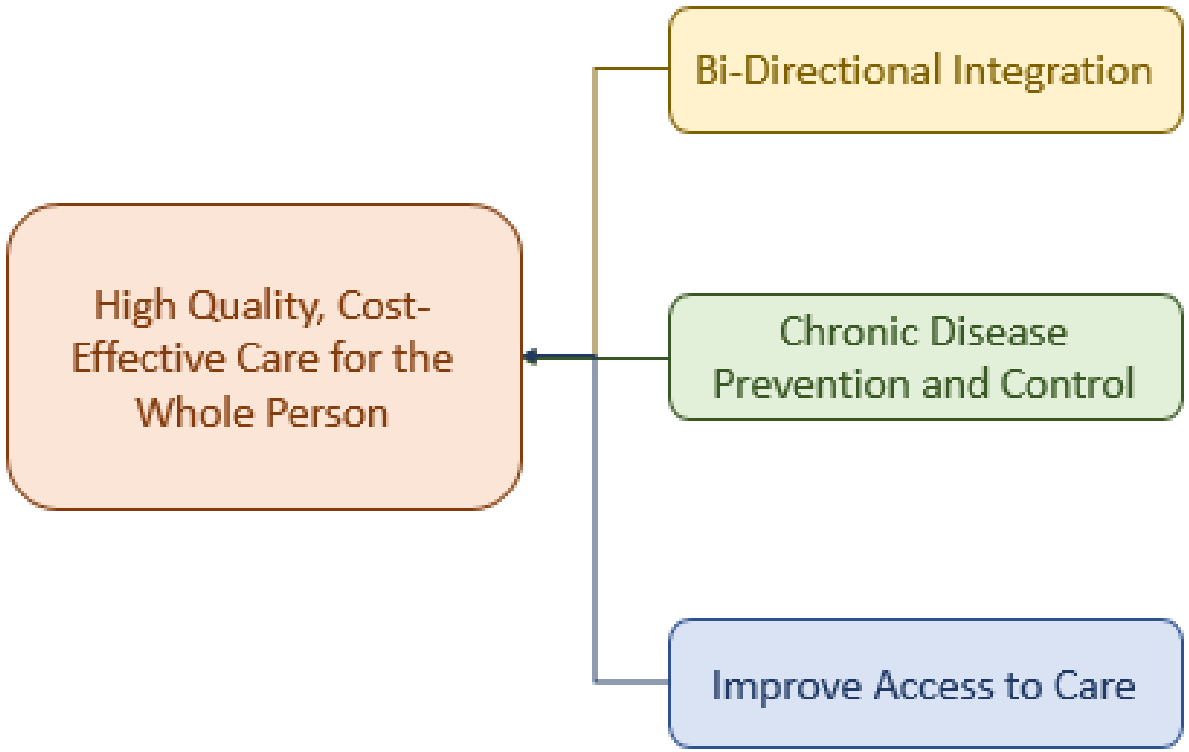
INDIAN HEALTH SERVICE · PHS · 1955 ·

Improving Chronic Illness Care

Chronic Care Model



Your Change Plan



Sequencing the changes

1. Understanding your population of focus
2. Test system level changes
3. Continue to test changes and implement system level changes that are effective to improve the health of your Population of Focus and embed them in daily work

1. Understanding your population of focus

Leaders visibly support integration of care to provide or arrange for whole person care.

Identify relevant subpopulations for proactive care.

Create enhanced data communication strategies to have access to actionable PH and BH information.

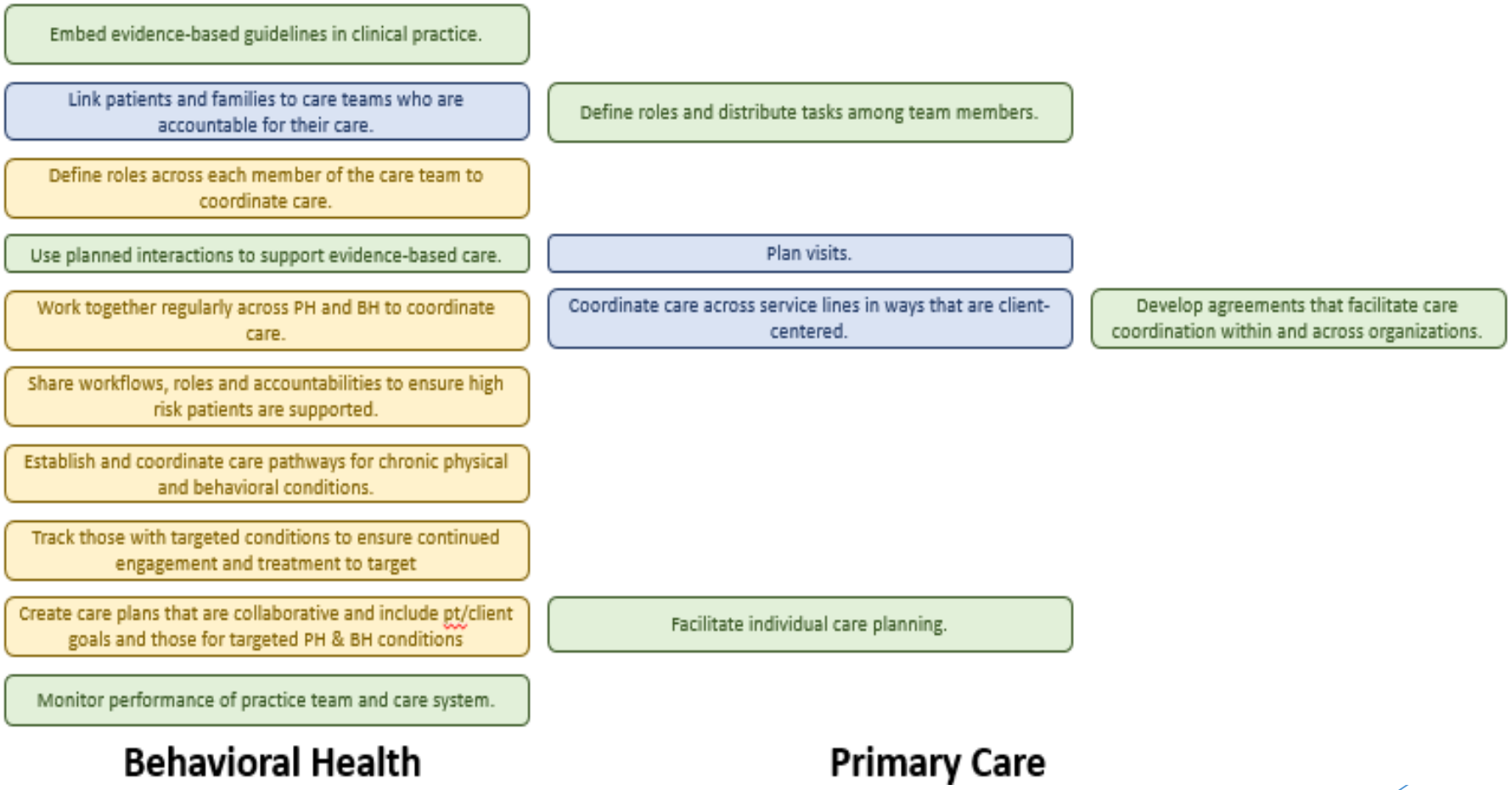
Stratify risk for both physical and behavioral health with methodologies shared across the broader team..

Dangerous assumption #1!

Behavioral Health

Primary Care

2. Test System Level Changes



Old interaction vs. new interaction

Between doctor/NP/PA and patient	Between patient and care team
Face-to-face	Multiple methods
Problem-initiated and focused	Based on care plan: “planned visit”
Topics are clinician’s concerns and treatment	Collaborative problem list, goals and plan
Ends with a prescription	Ends with a shared plan of care

Roles in Team Care

ROLE	PRIMARY CARE PROVIDER	PRIMARY CARE NURSING STAFF	BHS	CLINICAL CARE MANAGER	MA	CLERICAL STAFF	

Features of effective case management

- Regularly assess disease control, adherence, and self-management status
- Either adjust treatment or communicate need to physician immediately
- Provide self-management support
- Provide more intense follow-up
- Assist with navigation through the health care process

3. Cont. Testing and Implementation

Provide clinical case management services for complex patients.

Ensure regular follow-up by the care team.

Encourage and monitor engagement in care.

Integrate specialist expertise and primary care.

Use effective self-management support strategies that include assessment, goal-setting, action planning, problem-solving and follow-up.

Form partnerships with community organizations to support and develop interventions that fill gaps in services.

Track data to monitor access, outcomes and experience across PH and BH.

Behavioral Health

Primary Care