



Report to the CAFD Diabetes Advisory Board

New Directions in Diabetes Care (NDDC)

NDDC was launched September 2005 by the California Academy of Family Physicians to help implement AAFP's Future of Family Medicine Report recommendations

NDDC is a means to an end, and seeks to achieve complex organizational changes in:

- Clinician behavior
- Practice re-design
- Information systems enhancement (e.g., registries, EHR)
- Patient education

NDDC Overview

Goal: to match clinical excellence in diabetes care with advances in practice re-design by implementing elements of practice re-design and addressing NCQA clinical measures for diabetes.

This goal will be met by:

- Using QI principles and Institute for Healthcare Improvement theory
- Improving clinical outcomes (A1C, LDL, BP) and adopting re-design features (group visits, team-based health, patient registries)
- Providing live CME, online curriculum and small group intensive learning opportunities on clinical and practice topics

Components of NDDC include:

- 4 consecutive one-year collaboratories (a combination of in-person and web-based learning sessions)
- National live CME/CPD
- Online Resource and Learning Center
- 24/7 clinical and re-design education
- Modules developed to support the Care Model Change Package
- Link to ceCity CME Library and CEMedicus
- Links to community resources
- Open forums, blogs, podcasts

NDDC: Why Now?

The diabetes epidemic demands a response like no other. The initiative is a living laboratory for the AAFP's Future of Family Medicine Report recommendations and the Institute for Healthcare Improvement's development of quality improvement models. It addresses questions posed by the Institute of Medicine Report: Crossing the Quality Chasm, and could prepare family physicians for Pay for Performance.

Most importantly – improving how family physicians practice, outcomes, efficiency will increase their personal satisfaction and that of their staffs with what they do – and add value to the patient experience.

NDDC Collaboratory Components

Each collaboratory consists of 12 – 20 teams

- Targeting small practices (1 – 8 physicians)
- Led by a family physician or his/her key staff
- 4 highly structured learning sessions with expert faculty (1 face-to-face, 3 virtual)
- Supplemental conference calls
- Online resource center
- Robust analysis of clinical practice using web-based platform and QI markers
- Abstraction of data elements from patient records
- Performance analysis report
- Action planning and intervention support for improvement
- 2nd assessment of data elements

NDDC Collaboratory #1 (C1)

C1 began 19 September 2005 with the first learning session and ended 23 August with the final learning session. Twelve teams completed the entire year of work; five teams rolled over to the 2nd collaboratory. Faculty over the course of the year included Gordon Moore, MD, Bill Polonsky, PhD, Alan Glaseroff, MD, Kevin Grumbach, MD, Chip Renner, MD, Sue Houck, Cindy Manning, Debbie Johnson, and others – leading lights in re-design.

Sample C1 Team Results:

Clinical Measure	Average Report #1	Average Report #2	National Benchmark
A1c (average)	7.54	7.39	<7
LDL (average)	99.63	95.44	<100
Microalbumin (% yes)	47	69	>50%
Foot Exams (% yes)	39	68	>80%
Eye Exams (% yes)	39	56	>60%
Depression Screening (% yes)	20	52	>50%

PLUS:

- Implementation of patient registries – underway in multiple offices
- 10 team members have trained to become Diabetes Care Coordinators
- 16 participants attended special training on patient self-management
- Exchange of ideas and forms on CAFP NDDC forum – flow sheets, referral slips, etc.
- Emphasis on team care, coordination, and meetings

CAFP-F’s project goals include:	CAFP-F’s progress includes:
Practices demonstrate increased satisfaction with practice operations and diabetes care.	As part of the pre-work, practices are asked to complete a patient satisfaction survey. Results help the practices plan their activities. CAFP will be working with the practice teams to do a

	<p>year-end patient satisfaction survey. We got very little data on this (it's only asked in the Practice Profile which a lot of practices didn't complete at all, or didn't fully complete). We got some staff satisfaction, but even this was limited.</p>
<p>Performance improvement through evidence-based methods such as collaboratives will be introduced to the family medicine specialty, and family physicians.</p>	<p>Multiple communication vehicles, and multiple messages, are being used by CAFP to inform family physicians, FM residents, and others about practice and quality improvement.</p>
<p>Family physicians will know and understand the tenets of the American Academy of Family Physicians' "New Model of Care." Participating practices will embrace and apply the principles of chronic care management/planned care.</p>	<ul style="list-style-type: none"> ▪ The Care Model Change Package, the basis for the work of our collaboratory practice teams, is also available to all CAFP members, and other health care professionals interested in the topic. The principles are discussed on our web site and in publications. ▪ The "New Model of Care" and the Future of Family Medicine Report are also presented to members and non-members. Each CAFP committee and the CAFP Board of Directors monitors CAFP progress on addressing the FFM report, and in a recent member survey, respondents were asked to rate how familiar they are with each recommendation, using a 5-point scale ranging from very familiar to very unfamiliar. Analyzing the data in terms of <i>very familiar</i> ratings and of all positive ratings (i.e., combined <i>very familiar</i> and <i>familiar</i>), reveals that at least half of all survey respondents are familiar with six out of the ten FFM Report recommendations. Respondents were most familiar with the recommendations on <i>Electronic Health Records</i> and <i>Lifelong Learning</i>.
<p>Participating practices will have assessed their readiness to change, employed a series of "small tests of change" and made measurable improvement in at least one National Committee for Quality Assurance mandatory measurement.</p>	<p>The Collaboratory practice teams complete a readiness scale (they do?), and regularly report on their Small Tests of Change (STOCs). The practices can measure marked change in clinical care using comparisons of the 35 pre-activity and 35 post-activity chart pulls. The data are reported for each practice, and for the collaboratory as a whole, and are measured against national benchmarks.</p>
<p>Participating practices will be able to describe the steps they have taken to improve care of patients with diabetes in their practices, and will be willing to share their steps with other members of the Collaboratory.</p>	<p>Collaboratory practice teams begin the project by adopting an Aim Statement outlining the changes they wish to make in the care of patients with diabetes and in their office systems. Changes are tracked throughout the</p>

	<p>year, at each call/WebEx, steps are shared with the other practice teams. During the graduation WebEx, each practice team reports on steps taken and changes made. These final reports are shared with the other collaborative teams, and will also be shared with the CAFP membership at large.</p>
<p>CAFP and participating practices will have definite plans for spread of success – be it within a practice, from practice to practice or outside the Collaboratory. CAFP will define one measure of success in spread if 20 more members want to participate in the next collaboratory.</p>	<ul style="list-style-type: none"> ▪ Many of CAFP’s plans for spread have been outlined elsewhere in this document, and we are working with each practice team on its “spread” activity, including the development of slides, talking points, placements, and more. We will be tracking the spread. ▪ CAFP has met the recruitment measure –22 practices registered for Collaboratory #2 (although as expected, there has been some fall-off); several of the teams have more than one CAFP member on them.
<p>CAFP and the participating practices will share their experiences in a public forum, such as CAFP’s Annual Scientific Assembly, with practice teams telling the tale of what happened to them in the Collaboratory.</p>	<p>We have already made plans for these “sharing” activities at our 2007 Annual Scientific Assembly. A panel representing four of the C1 practices (3 physicians, and one MA) will present their best practices. In addition, we will have a session on registries led by one of the practice teams, and an open house type of event for interested practices to meet those who have completed C1 and are participating in C2. One of our practices from C1 has made his office available for site visits with two teams.</p>
<p>Each team should present in one forum in their local medical community. CAFP will develop press releases, talking points and Power Point presentations to assist the practices and spread the word to their communities.</p>	<p>CAFP is working with each practice on its open forum. We have provided each C1 team with a customized set of slides that include project information and their results.</p>
<p>Participants will understand the principles of Pay-for-Performance and will be able to adapt their practices more quickly when it arrives.</p>	<p>P4P is important not just for collaborative practices, but for the majority of our members. We have provided CME sessions on Pay-for-Performance at the last two Annual Scientific Assemblies, captured the presentations for viewing on our NDDC Resource Center, and included the topic in our magazine and e-newsletter <i>Practice Management News</i>.</p>

Key Learnings

We learned a number of important things during our first year with C1 including:

- Workflow processes are inter-related. If a change is made in one process, it will affect all other processes.
- Most practices are geared toward the acute care model. To effectively manage chronic conditions, we must be able to the respond to the planned care needs of our patients in a

- reliable, consistent fashion, using tools such as flow sheets, disease registries, and group visits.
- Once the process of change is learned, it can be applied to care for any disease state.
 - Data are an essential driver of change.
 - Training staff to be diabetes care coordinators is a valuable part of the process; engaging them in change is a key to success.
 - Regular team meetings are essential to improvement – staff must speak freely
 - Technology is a tool, not a solution. Overlaying technology (e.g., EMR, disease registry) on dysfunctional office processes can be disastrous.
 - Using an electronic disease registry can be a useful “dry run” for EMR implementation.
 - Data availability and transparency (i.e., from the health plan) can be an important motivator for improvement.

Funding

- Project Funders: Physicians’ Foundation for Health Systems Excellence; Novo Nordisk; and the Wellpoint Foundation
- GlaxoSmithKline – BridgingCare Planners (DocSite) registry – free to all collaborative participants
- In kind: Lumetra, UCSF Department of Family and Community Medicine, PBGH, and others