Culture of Excellence

HEALTH CENTER HIGHLIGHT

Diabetes Success at Progressive Community Health Centers

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SUMMARY

As is true in many primary care settings, diabetes and hypertension continue to be the greatest mortality/morbidity diagnoses seen at Progressive Community Health Centers ("Progressive"), making these diagnoses a continued area of focus for quality improvement efforts. Over the past year (October 2021-October 2022), Progressive has consistently maintained performance of 17%-21% in the uncontrolled diabetes measure (source: WPHCA Core Metrics Quarterly Reports). This means that usually no more than a fifth of the patients with diabetes have HbA1c levels greater than 9, which is a common marker of uncontrolled diabetes. With this high level performance, they are consistently performing at or above the 90th Percentile in the UDS Uncontrolled Diabetes measure at both a state and national level. This story highlights the initiatives and practices in place at Progressive that support sustained positive health outcomes for patients with diabetes. Progressive Community Health Centers is located in Milwaukee, Wisconsin and served over 14,500 patients in 2021.

GOAL SETTING & CLINICAL STANDARDS

Progressive's clinical goals are set and monitored by the QI Steering Committee which meets monthly and is supported and informed by subgroups, like the Diabetes Workgroup. Given Progressive's participation in many value-based care (VBC) contracts, the Diabetes Workgroup has established a clinic goal for patients with diabetes to have an HbA1c of <8%, which is more ambitious than the common Uniform Data System (UDS) goal for Federally-Qualified Health Centers, set by HRSA, to have HbA1c <9%. To drive improvement on both the testing and control aspects of the measure, the Diabetes Workgroup has also set a clinic goal that no more than 10% of the clinic's diabetic population is without an up-to-date test result at any time. The clinic standard is that diabetic patients have a visit every 3 months, regardless of whether their HbA1c levels are in control.

TEAM-BASED CARE

Team-based care is critical to the success with patient health outcomes at Progressive. Some of the key roles that wrap around the provider in caring for patients with diabetes include:

- A clinical pharmacist who manages and changes medications to best meet the patient's needs. The clinical pharmacist brings expertise in an ever-evolving pharmacy landscape to ensure patients have a medication regimen that meets their individual needs, including the introduction of newer medications when appropriate. At Progressive, the clinical pharmacist works with around 10% of patients with diabetes focusing on those with higher risk of poor health outcomes.
- A care manager who provides individual education and support for self-management as well as referrals to additional social supports. The care manager also educates patients about how diabetes control connects to other health conditions and outcomes. The care manager at Progressive works with patients who have an HbA1c ≥13% (≥10% when staff capacity allows).
- Medical assistants who are responsible for testing the patient's HbA1c obtaining orders at the beginning of the visit to ensure a current test result is available in the chart for the provider to review.

DATA & HEALTH INFORMATION TECHNOLOGY (HIT)

In order to effectively manage outcomes, teams need accurate data. Progressive engages in data hygiene practices including locating HbA1c results from outside providers and manual chart scrubbing to ensure that the data accurately reflects current patient status and needs. The Quality Improvement Coordinator reviews charts monthly to locate values from outside providers and in provider notes and enters them in a discrete data field. This ensures that all completed HbA1c tests are captured in the measure and reduces the number of false "untested" patients in the numerator.

Progressive uses HIT tools within their EHR (OCHIN Epic) such as Health Maintenance reminders and Best Practice alerts to assist the team in ensuring tests are completed at the appropriate time. Within the EHR, the

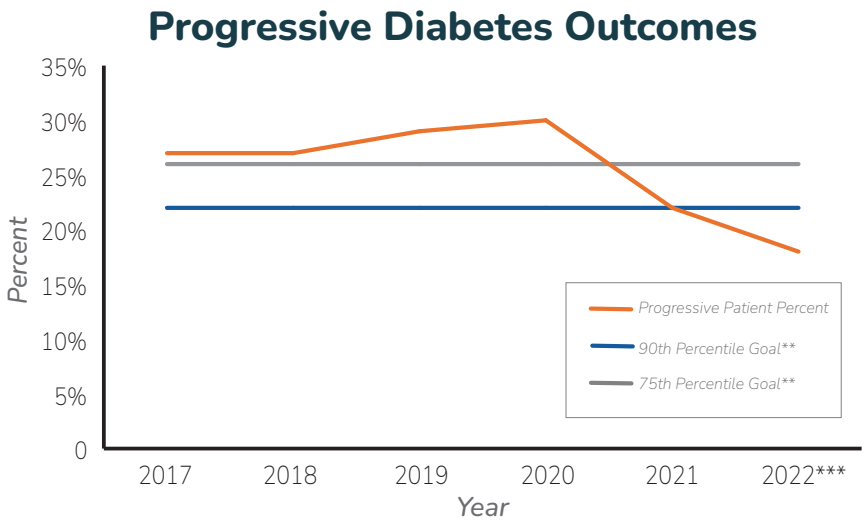
team also adds reminders via the appointment notes (e.g. “needs HbA1c”) to ensure the relevant team members are aware of what is needed during a visit. Progressive places high importance on training the team on EHR documentation practices (e.g. dot phrases, enter/edit functions) that will ensure relevant data is captured discretely as much as possible and reduce the time needed for manual chart scrubbing.

PROVIDER ENGAGEMENT

Providers at Progressive engage in clinical quality in a variety of ways beyond standard clinical care practices, which emphasizes the importance of quality and builds the culture. Unblinded data is shared regularly with all providers to promote awareness, peer learning, and group accountability. Key aspects of the diabetes measure are reviewed (i.e., how many patients are untested vs. tested with HbA1c>8%) to identify more specific goals, then individual provider goals are set based on individual data to promote continuous improvement. In instances where a provider has lower performance, the Chief Medical Officer or medical director connects with the provider to identify potential causes and problem solve together. Bonuses are awarded for strong clinical quality outcomes in organization-wide priority measures as well. Progressive sets clear expectations that the provider listed as the Primary (including OB/GYN) is responsible for managing that patient’s HbA1c and/or seeking results from the provider who is performing testing. Providers have the opportunity to offer services such as group visits for their patients as well to give space for peer support and learning.

KEY TAKEAWAYS & FUTURE PLANS

The team at Progressive commits to consistent implementation of proven quality improvement and population health practices. This consistency in practices and engagement of the whole care team is the key to achieving positive health outcomes in their patients with diabetes. Team members in clinical and operational roles collaborate to promote consistency and ensure processes are effective and efficient. Looking ahead, Progressive is planning to launch on-site retinal screening for patients with diabetes and add a Diabetes Educator to the team in mid-2023. This will support a larger vision to bring more services in-house to meet a broad range of diabetic care needs all in one place.



UDS DIABETES OUTCOMES ARE MEASURED AS THE PERCENTAGE OF PATIENTS AGED 18-75 WITH DIABETES WHO HAD HEMOGLOBIN HBA1C > 9% OR NO TEST DURING YEAR.*

**Lower percentages of HBA1C indicate better health outcomes.*

*** Percentile goals represent performance across all health centers nationally in 2021.*
**** 2022 UDS has been submitted by Community Health Centers but not verified by HRSA at the time of this publication.*