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USER CONFERENCE
APR 29–MAY 1
BOSTON, MA
2025

Bridging the Quality Gap

Data-Driven Solutions for Advancing Diabetes Care

Today's Presenters

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Learning Objectives

1. Define tools and workflows in DRVS to identify patients at risk for diabetes.
2. Describe ways to stratify data in DRVS to support data-driven quality improvement processes in diabetes care.
3. Explore practices that engage care teams in collaborative and effective quality improvement planning.

Health Federation of Philadelphia

The mission of the Health Federation of Philadelphia is to promote health equity for marginalized communities by advancing access to high-quality, integrated, and comprehensive health and human services.

HFP HCCN

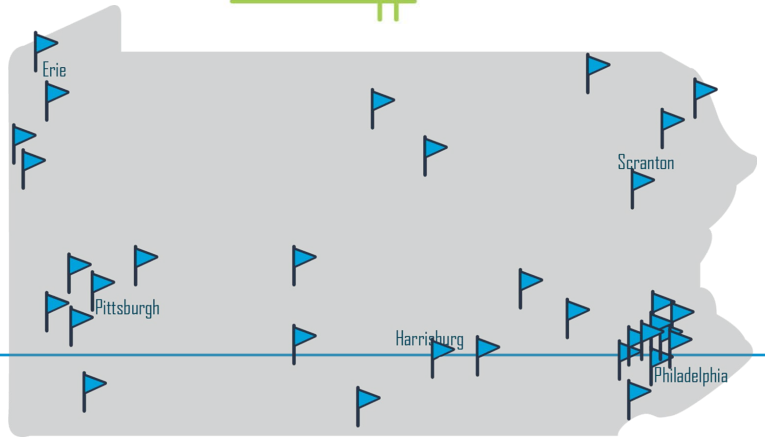
34 Participating Health Centers

253 Health Center Sites

900+ Health Care Providers

686K Patients

7 EHRs Supported



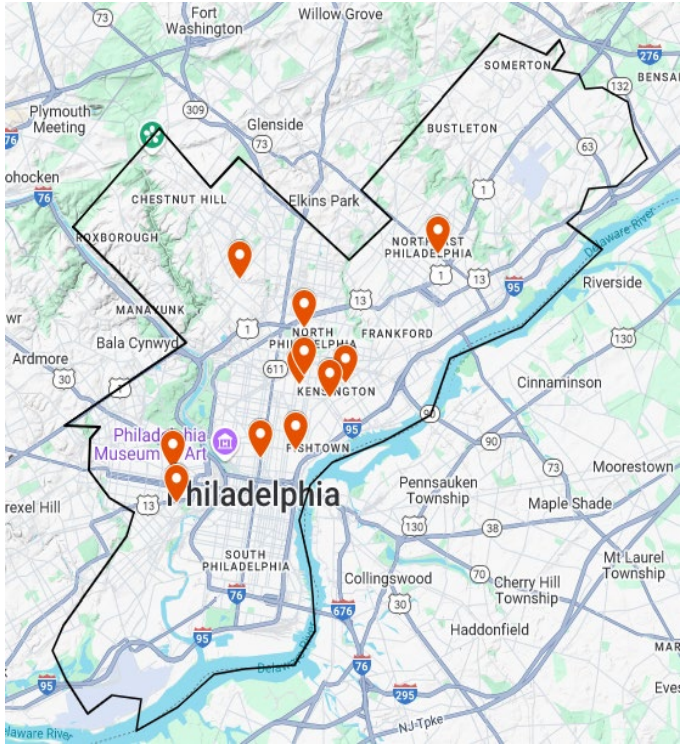
w w w. healthfederation.org

CDC 23-0020 Diabetes Project Partners

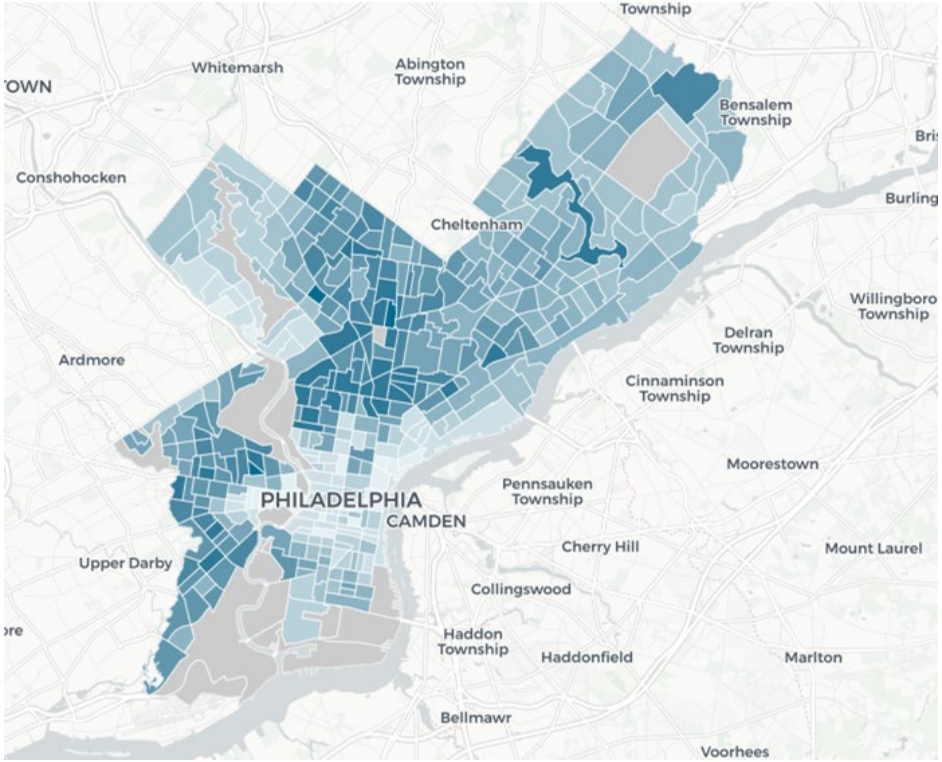
Project Participants:

- Ambulatory Health Services
- Esperanza Health Center
- Delaware Valley Community Health
- New Kensington Community Development Corporation

Total of 9,000 patients with diabetes



Diabetes: A Challenge for Philadelphia Residents



- **14%** of all adults report diabetes diagnosis, compared to 11.4% average in other US cities (1)
- **14%** report pre-diabetes diagnosis (2)
- Higher rates for Black and Hispanic/Latino populations

Sources

1. City Health Dashboard, https://www.cityhealthdashboard.com/PA/Philadelphia/metric-detail?metricId=6&dataPeriod=2022
2. BRFSS, https://www.phaim1.health.pa.gov/EDD/WebForms/BRFSSdist.aspx

Our Work to Improve Diabetes Care and Outcomes

5-year, multi-component collaborative project funded by the CDC to **improve care and outcomes for people with or at risk of diabetes**

HFP + 4 partner organizations

3 Data-Supported Aims:

1. Expand access to the National Diabetes Prevention Program (NDPP) through a collaborative model with partners.
2. Improve care for diabetic patients through data-informed QI to facilitate A1c control and early detection of complications.
3. Support partners through collaborative approach to improving patient care and outcomes.

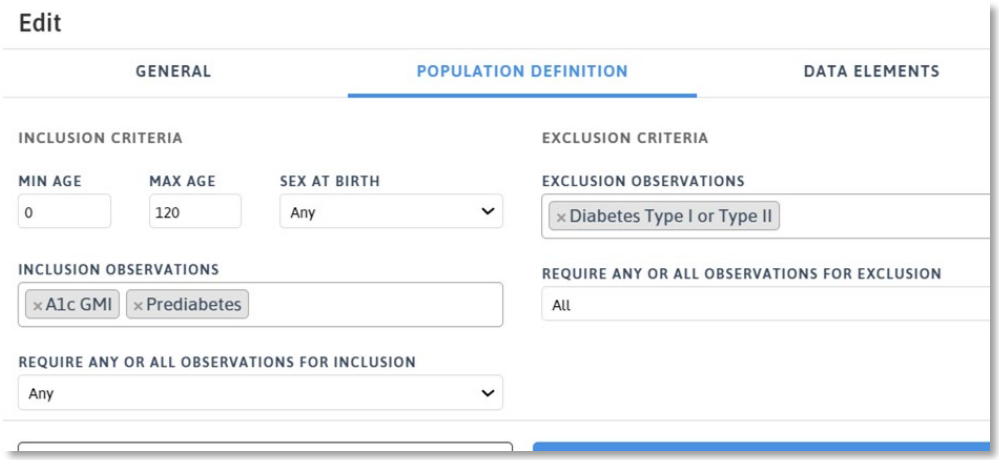
Aim 1 | Expand access to the National Diabetes Prevention Program (NDPP) through a collaborative model with partners

NDPP - Lifestyle change program to reduce risk of developing diabetes

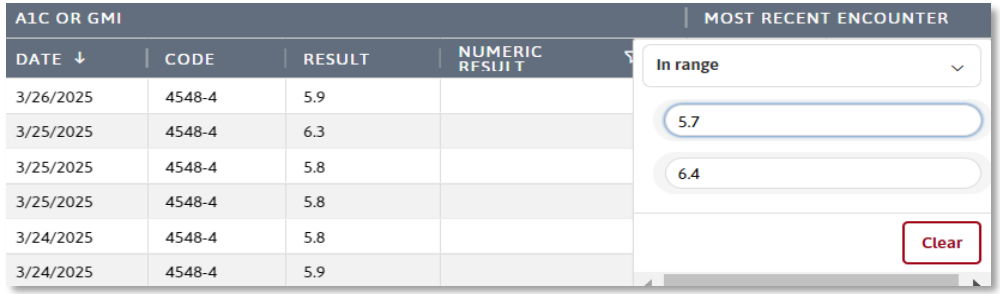
Steps to expand access with partners:

1. Identify patients at-risk for diabetes.
2. Refer eligible patients to NDPP.
3. Plan and implement NDPP groups with partners.

Aim 1 | Identify patients at risk of diabetes

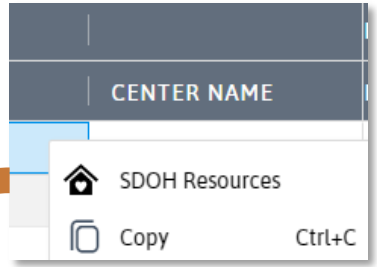


Created a custom pre-diabetes registry.

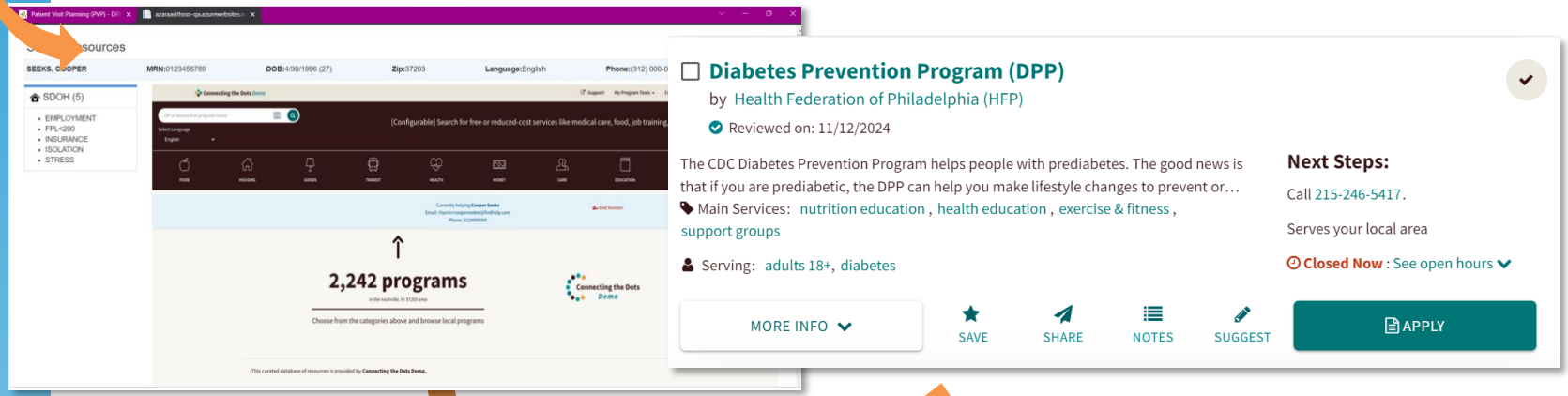


Trained HC staff to sort/filter to patients with recent A1c between 5.7 and 6.4.

Aim 1 | Refer eligible patients to NDPP

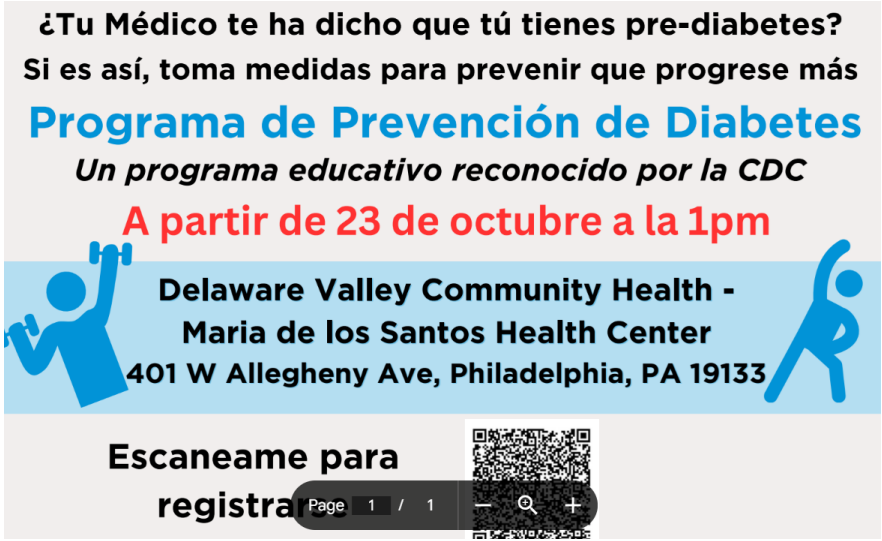


- Trained HC staff to use FindHelp integration.
- Provided training on FindHelp platform to HC staff - where to find HFP's NDPP.
- Received and followed up on referrals through FindHelp.

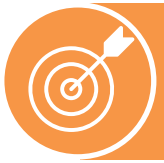


Aim 1 | Plan and implement NDPP groups

- Trained lifestyle coaches
- Coordinated logistics - time, location, staffing
- Developed recruitment materials
- Provided staffing support
- Collected and reported data to the CDC



Aim 2 | Improve Care for Diabetic Patients through Data-Informed QI

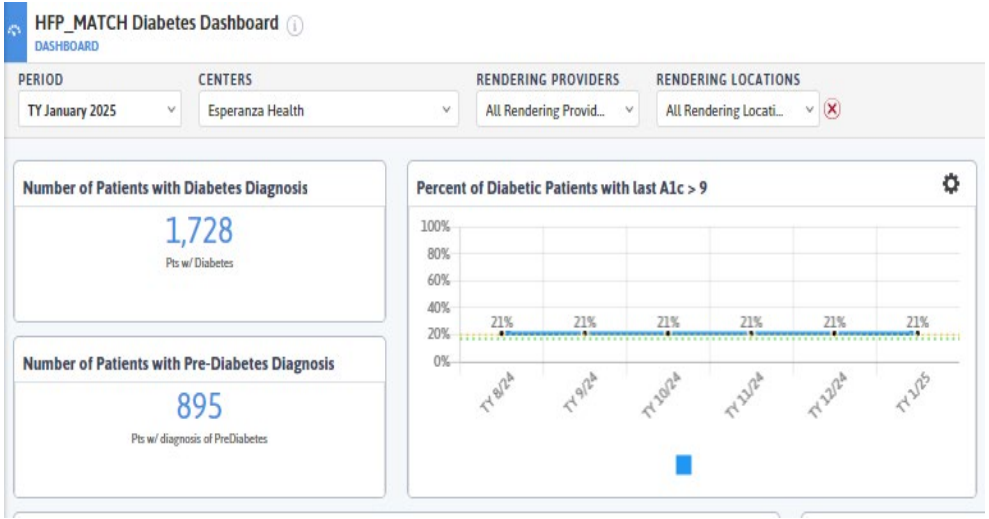


QI Focus – CKD & Retinopathy Screening, A1c Control

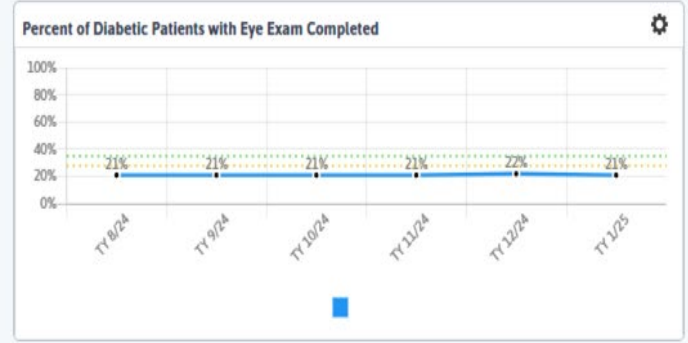
Steps to expand data-informed QI:

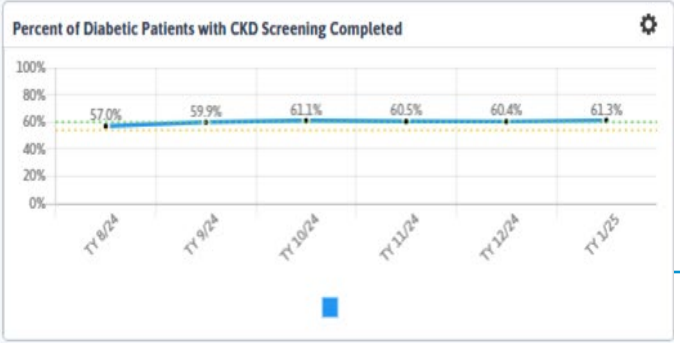
1. Provide baseline data and performance tracking.
2. Stratify data to understand variance.
3. Identify root causes and plan action steps.

Baseline data and performance tracking



Developed dashboard to track A1c >9, CKD & retinopathy screening.





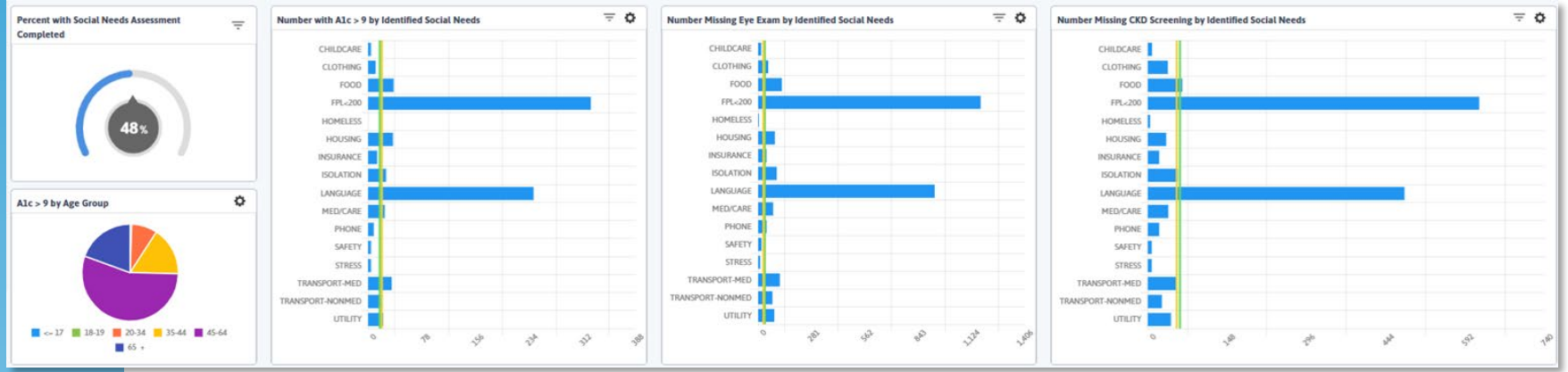
Stratify data to understand variance

MATCH Performance Measure Scorecard - Black/African American Patients

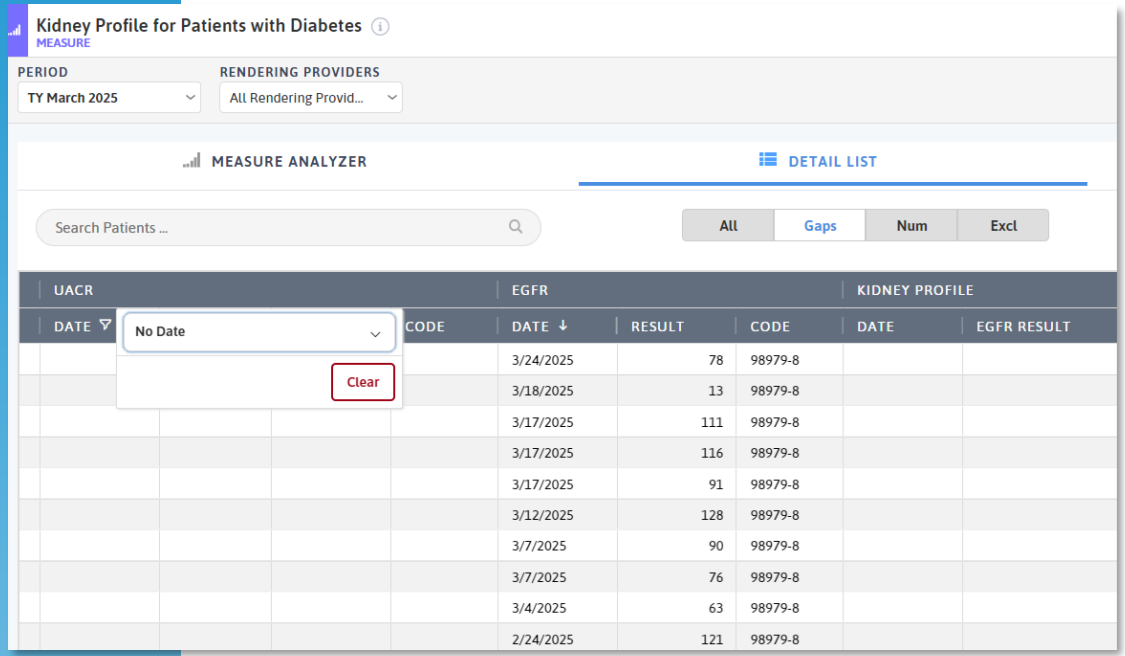
MEASURE	RESULT	NUM	DENOM	GAP	2TGT
DM Eye Exam	23.4%	57	244	187	29
Kidney Profile - DM	57.4%	143	249	106	7
DM A1c > 9	20.9%	51	244	51	10
DM A1c does not exist	12.3%	30	244	30	
DM A1c > 9 or Untested (CMS 122v12)	33.2%	81	244	81	
DM Care -Comprehensive	7.7%	19	248	229	

MATCH Performance Measure Scorecard - Hispanic/Latino Patients

MEASURE	RESULT	NUM	DENOM	GAP	2TGT
DM Eye Exam	20.8%	316	1,516	1,200	215
Kidney Profile - DM	62.1%	1,013	1,630	617	0
DM A1c > 9	21.6%	326	1,511	326	70
DM A1c does not exist	9.5%	143	1,511	143	
DM A1c > 9 or Untested (CMS 122v12)	31.0%	469	1,511	469	
DM Care -Comprehensive	7.7%	118	1,528	1,410	



Identify root causes…



Use measure analyzer.

Example: Sort/filter uACR and eGFR fields - found trends in patients completing blood tests but not urine tests.

… and plan action steps

Drivers (Root Causes) of performance on this measure:
(Examples: Providers not ordering labs, patients not following through on lab orders, not getting results back).

Driver #3: Patients unable to give urine sample as not well hydrated

- What data do we have related to this driver?
  - Anecdotal experience

Of 788 gaps for measure
- Only 130 had urine micro in last year
- 486 had labs in the last year
- So major gap is in fact those who have not had urine micro (also some of the not getting labs drawn – already addressing this)

- What are some factors that contribute to this driver?
  - Patients not drinking enough water

- What are some ideas we could test to impact these factors?
  - A reminder that patient needs to drink water before the appt during robust calls
  - Diabetes team will give reminders during calls

- What are some resources available to address these factors?
  - CA team
  - Diabetes team

QI Project Plan

Root Cause to be Addressed: Patients not being able to provide urine at visits.

Intervention:
- MA will provide all patients who are unable to urinate with a cup to collect at home, then return with a sample.
- During DM navigation calls, DCC/DCN will remind about bringing specimen back.

Aim: to improve rates in diabetic nephropathy.

Questions to Consider:
1. What is the idea we will test?

MA will provide all patients who are unable to urinate with a cup to collect at home, then return with a sample.
During DM navigation calls, DCC/DCN will remind about bringing specimen back.

2. What resources do we need to test this idea?
   Staff

3. Who needs to be involved?
   Director of Clinical Services, Clinical Supervisors, Medical Assistants, Clinicians, Diabetes Team

4. What steps will be taken?
- Clinical Supervisors will review with MAs protocol to provide patients urine cups to return with specimens.
- Clinicians and MA will identify pts due for urine MA via the PVP Huddle.
- MA will provide a cup for urine specimen for patients during visit.
- If patient unable to provide urine, clinician will let MA know.
- MA will provide cup and instructions for returning with sample.
- If cup provided for patient, MA will place care alert in EHR chart.
- DCC/DCN will follow up on this during navigation calls after appointments, reminding patient to bring in.

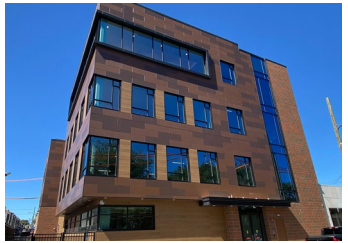
5. Where will we implement this plan?
   Clinical Hubs

6. Who is responsible for ensuring the plan is implemented?
   CS will ensure MAs trained
   MMS will follow up with providers and DM team.

Aim 3 | Support partners through a collaborative approach

- Quarterly check-ins
  - Reviewed data and QI plans
    - A1c's, CKD & Retinopathy Screening
    - Comparative dashboards
    - QI planning template
- Quarterly group strategy meetings
  - Networking and peer learning b/t partners
  - Input on training, resource development
- Connect with resources (eg, referral module)
- NDPP lifestyle coach training/support

Esperanza Health Center



"Compelled by the love of God in Christ Jesus, in cooperation with the Church and others, Esperanza Health Center is a multi-cultural ministry providing holistic healthcare to the Latino and underserved communities of Philadelphia."

Our Services

Esperanza Health Center
Compassionate Care For Everyone

- Primary Medical Care (Adult Care, Pediatrics & OB-GYN services, including Centering Pregnancy)
- Dental Care
- HIV Care
- Behavioral Health (integrated within primary care)
- Medication Assisted Treatment for Opioid Use Disorder (group model)
- Nutritional Counseling
- Spiritual Care
- Social Services
- Community Health and Wellness Programs supporting families, and residents, addressing Social Drivers of Health
- Other - Medical Legal Partnership, partnership with Everence (credit union)

Partner Highlight: Esperanza

Esperanza Health Center
Compassionate Care For Everyone

14,848 patients served last year

62% (9,168 patients) best served in a language other than English

86% identify as Hispanic/Latino

60% insured by Medicaid, **23%** uninsured, **9%** Medicare

58% living below 200% of the Federal Poverty Level

Diabetes Outreach Program at EHC

Esperanza Health Center
Compassionate Care For Everyone

Population: Diabetes outreach program is serving all patients with diabetes at EHC, with specific focus on those with A1C >9

- 1,721 patients in total with diabetes at EHC.
  - 378 patients with A1C > 9
- 914 with pre-diabetes

Goal: Provide outreach and personalized support and accompaniment to patients living with diabetes, focusing particularly on those with highest A1C's, to increase participation in recommended preventive measures and improve health outcomes.

Diabetes Outreach Program at EHC

Esperanza Health Center
Compassionate Care For Everyone

Team members:

- Damaris Vega (Diabetes Care Coordinator), Rosmery Serrano-Martinez and Darlene Burton (part time Diabetes Navigators), under supervision of Maryann Salib, DO MPH
- All new positions as part of HFP grant (apart from supervisor)

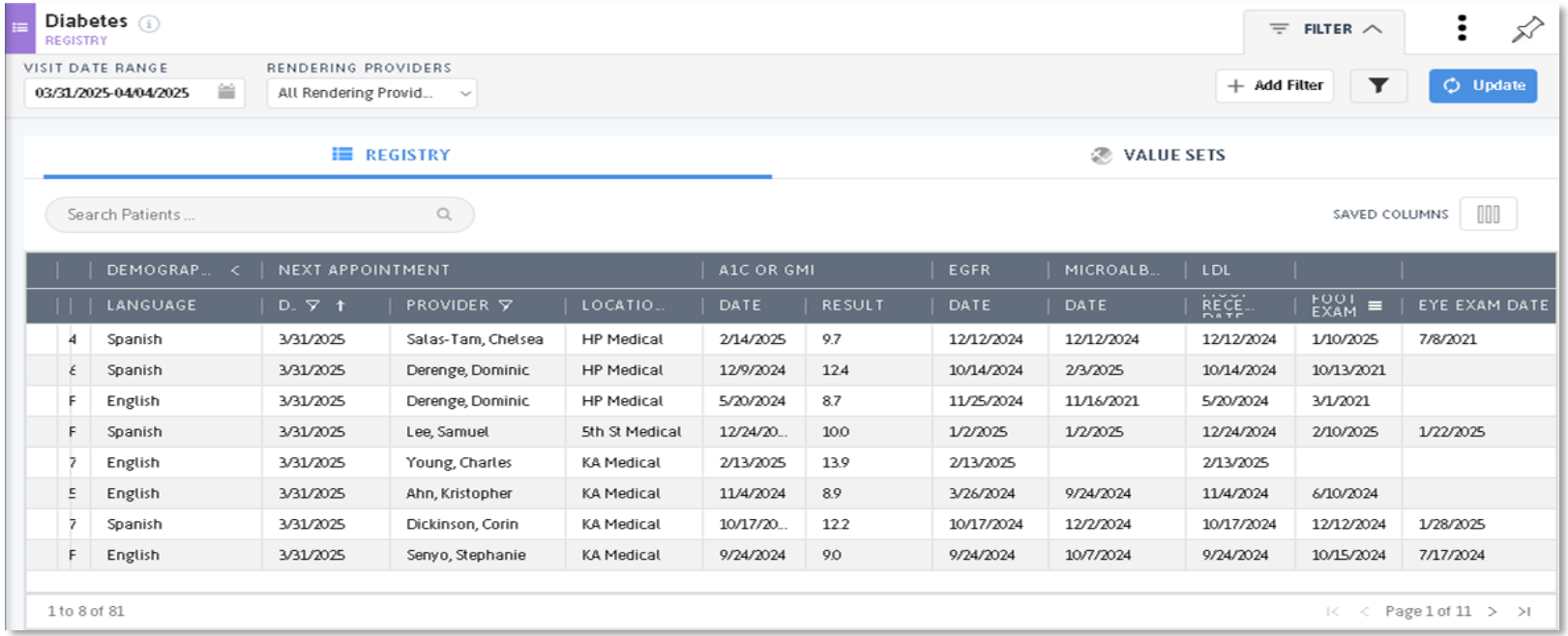
Activities

- Reports pulled monthly of patients with uncontrolled A1C
- Reports pulled for those seen in office 2 weeks ago
- Report for in office visits (for team to attend visits in office)

Monthly “Care Gap” Outreach Calls

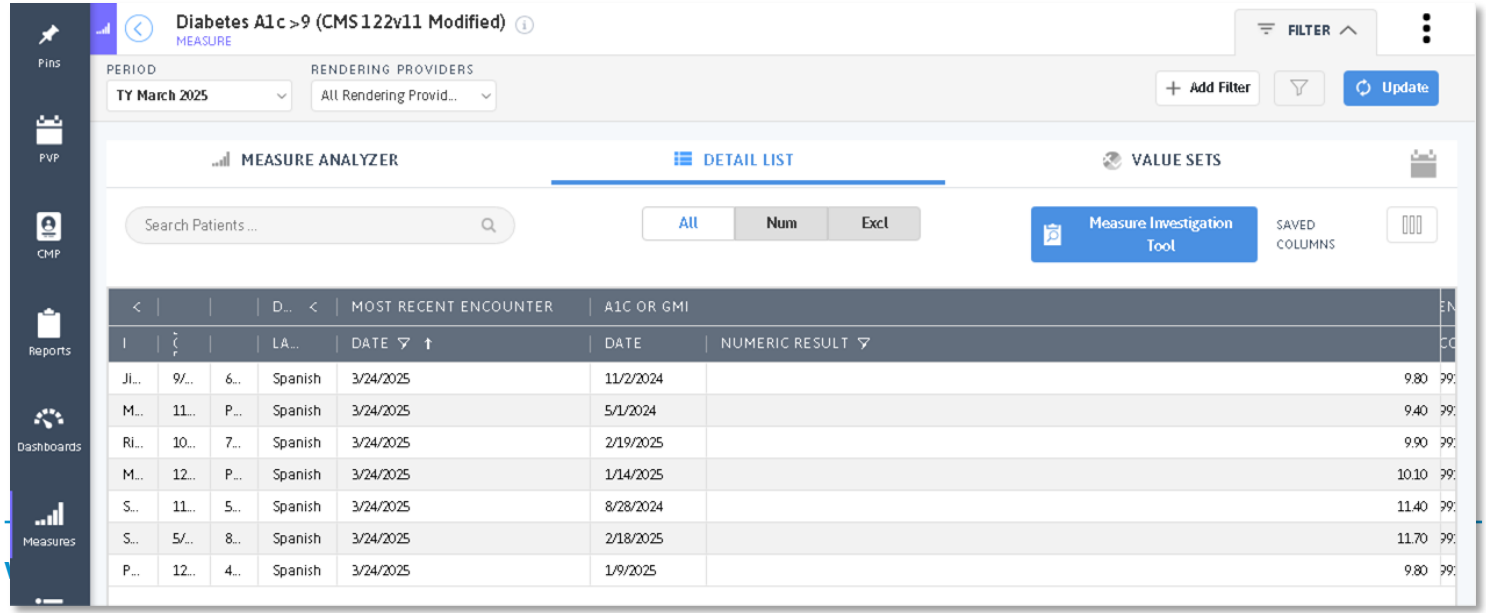
Reports pulled monthly of patients with uncontrolled A1C. Outreach calls conducted to close care gaps.

- Remind patients of labs due, and retinopathy screening.
- Conduct SDOH screening and schedule appointments as needed.



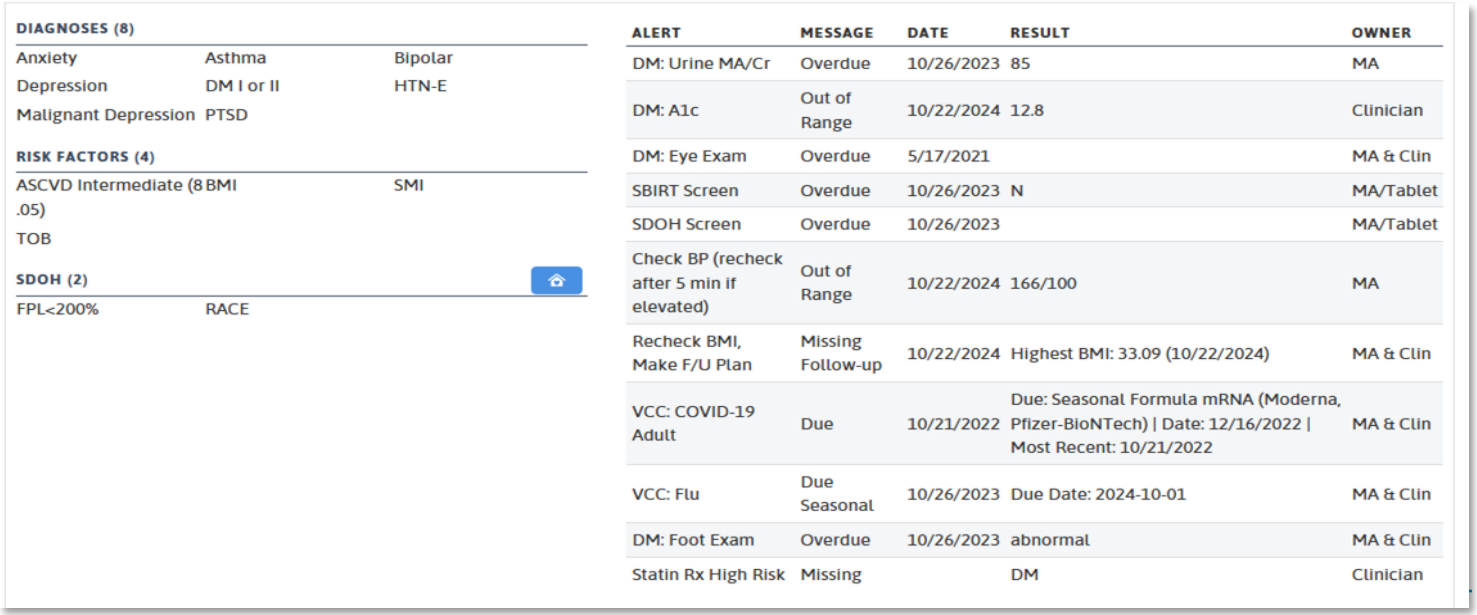
Office Visit Follow Up Calls

- Reports pulled for those seen in office 2 weeks ago
- Calls are made to follow up on adherence to provider's instructions given during that visit
- Team troubleshoots any barriers and links to other members of the care team as needed



Diabetes care provided by all EHC staff

- Team supports the existing care provided by the rest of the care team members (providers, RNs, MA's during clinic visits).
- PVP used during team huddles.



DIAGNOSES (8)

Anxiety	Asthma	Bipolar
Depression	DM I or II	HTN-E
Malignant Depression	PTSD	

RISK FACTORS (4)

ASCVD Intermediate (8.05)	BMI	SMI
TOB		

SDOH (2)

FPL<200%	RACE

ALERT	MESSAGE	DATE	RESULT	OWNER
DM: Urine MA/Cr	Overdue	10/26/2023	85	MA
DM: A1c	Out of Range	10/22/2024	12.8	Clinician
DM: Eye Exam	Overdue	5/17/2021		MA & Clin
SBIRT Screen	Overdue	10/26/2023	N	MA/Tablet
SDOH Screen	Overdue	10/26/2023		MA/Tablet
Check BP (recheck after 5 min if elevated)	Out of Range	10/22/2024	166/100	MA
Recheck BMI, Make F/U Plan	Missing Follow-up	10/22/2024	Highest BMI: 33.09 (10/22/2024)	MA & Clin
VCC: COVID-19 Adult	Due	10/21/2022	Due: Seasonal Formula mRNA (Moderna, Pfizer-BioNTech) | Date: 12/16/2022 | Most Recent: 10/21/2022	MA & Clin
VCC: Flu	Due Seasonal	10/26/2023	Due Date: 2024-10-01	MA & Clin
DM: Foot Exam	Overdue	10/26/2023	abnormal	MA & Clin
Statin Rx High Risk	Missing		DM	Clinician

QI Plans at Esperanza

QI Project Plan

Root Cause to be Addressed: Knowledge and education gaps regarding retinopathy screening for diabetic patients

Intervention: Implement outreach calls by diabetes team to patients overdue on screening

Aim: To increase retinopathy screening for diabetic patients

Questions to Consider:

1. What is the idea we will test?
    a. Several of these factors are ameliorated by the diabetes outreach calls, whether in regards to education, advising of locations for screening or emphasizing screening as priority. We will test the overall impact of diabetes outreach calls on retinopathy screening rates.

2. What resources do we need to test this idea?
    a. Diabetes team

3. Who needs to be involved?
    a. Diabetes team
    b. Supervisors

4. What steps will be taken?
    a. Diabetes team trained on importance of retinopathy screening
    b. Standing order updated so that team may be able to sign off on referrals for screening
    c. Workflow created for the processing of retinopathy screening referrals
    d. Team trained on discussing retinopathy screening with patients who are overdue (including updating charts on patients who have completed screening)

5. Where will we implement this plan?
    a. Across all three health centers

QI Project Plan

Root Cause to be Addressed: Patients not being able to provide urine at visits.

Intervention:

- MA will provide all patients who are unable to urinate with a cup to collect at home, then return with a sample.
- During DM navigation calls, DCC/DCN will remind about bringing specimen back.

Aim: to improve rates in diabetic nephropathy.

Questions to Consider:

1. What is the idea we will test?

MA will provide all patients who are unable to urinate with a cup to collect at home, then return with a sample.
During DM navigation calls, DCC/DCN will remind about bringing specimen back.

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   Staff

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4. What steps will be taken?

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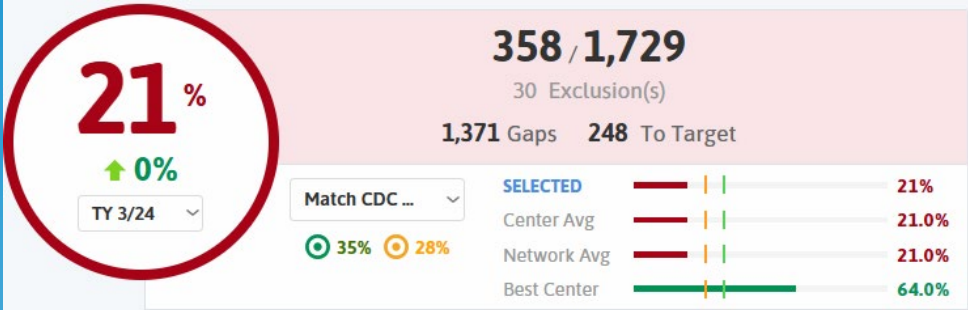
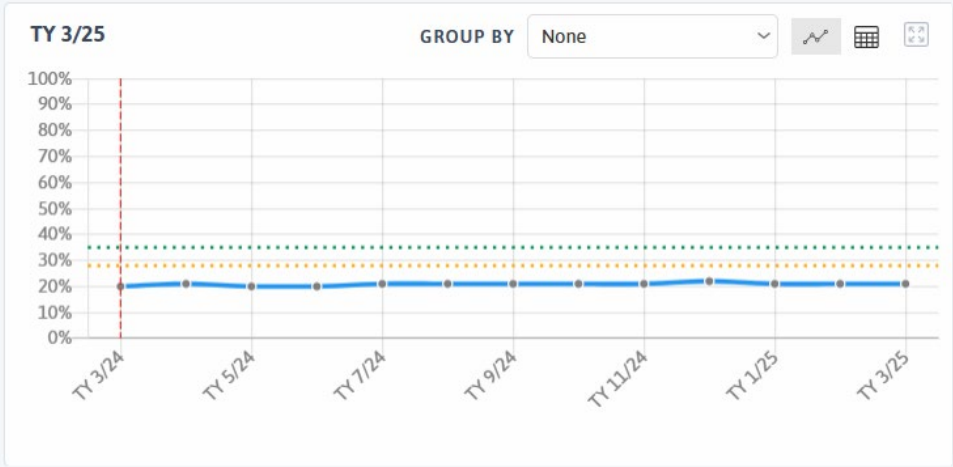
- MA will provide cup for urine specimen for patient during visit.
- If patient unable to provide urine, clinician will let MA know.
- MA will provide cup and instructions for returning with sample.
- If cup provided for patient, MA will place care alert in EHR chart.
- DCC/DCN will follow up on this during navigation calls after appointments, reminding

Special Projects at Esperanza

- [x] DPP classes (recruiting and supporting with classes)
- [x] Thanksgiving produce distribution for diabetic patients with food insecurity
- [x] DM screening event with Jefferson Health Plans
- [x] Presentation on DM to Seniors Program
- [x] Presentation on DM to Community Health Promoters Class
- [x] Diabetes Care Coordinator (DCC) supports with RD referrals, prior authorizations for diabetic medications, and troubleshooting pharmacy and insurance barriers

Progress - Diabetic Retinopathy Screening





QI Strategies:

- Outreach calls
- Referrals sent by mail
- ROI's obtained
- PVP used during huddle to advise team that patient is due for screening

Successes:

- Improved workflows with referrals (standing orders)
- DCC connecting with optometry practices to identify more locations for uninsured patients

Challenges:

- Receiving reports
- Offices taking uninsured patients

Progress - Diabetic Nephropathy Screening

QI Strategies:

- Outreach calls
- MA's collecting urine samples during visits
- PVP used during huddle to advise team that patient is due for screening

Successes:

- Increased screening

Challenges:

- Patients not being able to give sample during visit and not returning cup later

Progress - Missing A1c's

QI Strategies:

- Outreach calls by DM team
- Increasing phlebotomy hours
- Availability of POC A1C machines at all three sites

Successes:

- More patients are up to date on their A1C's

Challenges:

- Patient hesitancy - fears of their results

Diabetes Project Next Steps

1. Track progress on QI plans and impact on quality measures.
2. Build on reducing unknown A1cs and identify steps to improve A1c control.
3. Identify process measures to drive improvement.
4. Implement referral module to facilitate follow-up on obtaining retinopathy results.
5. Build relationships with ophthalmology practices to facilitate warm hand-offs.
6. Explore options for uninsured patients to access specialist services.

Contact Information

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Questions?

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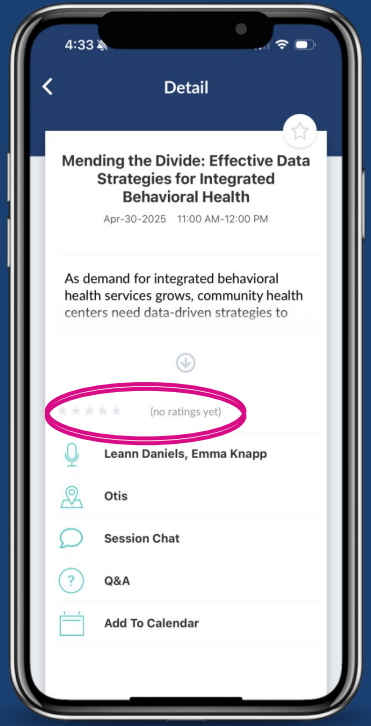
Click on the session from your agenda in the conference app.
Click the stars in the center of your screen to rate and provide feedback.



Quick and Easy

Provide brief feedback or ideas

Rate the session and the speaker(s)

Help us continue to improve

Achieve, Celebrate, Engage!

ACE'd it? Share your DRVS success story and become an Azara ACE!

azara healthcare

ACE Program

Show your organization has used DRVS to **A**chieve measurable results, **C**elebrate improvement in patient health outcomes, and effectively **E**ngage care teams and/or patients. Stories should showcase how DRVS helped your organization overcome a challenge, the tools and solutions used to drive improvement and details of the successes that resulted from your initiatives. ACEs should be able to provide examples that quantify quality improvement, cost savings, operational efficiency or patient health improvement.

Benefits:

- Azara will help tell your story and provide a client-branded version for your use
- Potential to create a 2-4 minute video or hour-long Azara-hosted webinar
- Potential to be featured at next year's Azara User Conference
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