



Riverdale Family Practice

Diabetes Population Health Project

A Team Approach to Managing Diabetes



Presented by
SANOFI 

Contents

Purpose/Foreword	2
Overview	3
Project Preparation	4–5
Patient Outreach/Follow-Up	6–7
Patient Education/ Accountability	8–9
A Patient's Story	10
Outcomes	11
Conclusion/Next Steps	12

Purpose

The purpose of this white paper is to profile Riverdale Family Practice's (RFP's) Diabetes Population Health Project, focusing on the patient care strategies used to lower A1c levels among the practice's highest risk diabetes patients. To that end, this white paper outlines the specific approach employed by RFP, contextualizes it through staff insights, and provides the results. This model can encourage discussion among other provider groups and interested health care organizations looking to refine their chronic disease care management process.

Foreword

The inaugural edition of *Diabetes Population Health Project: A Team Approach to Managing Diabetes* highlights the care management strategies that we implemented at Riverdale Family Practice, a leading physician organization in New York recognized as a Level 3 Patient-Centered Medical Home (PCMH) by the National Committee for Quality Assurance (NCQA).

For three decades, RFP has successfully used a team approach to care—recognizing that each member of staff plays an integral role in patient care and experience. Over the course of this data-driven project, our care team improved A1c levels among our most high-risk diabetes patients using a range of tools to educate, engage, and track this patient population. The tools we used were both high and low tech:

- Frequent phone calls and personal attention
- Individualized instruction and follow up
- Sophisticated electronic medical records
- Robust patient portal
- Customized spreadsheet for tracking medications, A1c levels, endocrinology referrals, and more

The lessons learned through this innovative, comprehensive approach will pay dividends for our practice and our patients for years to come. We hope that the process outlined in this white paper will provide other physician organizations the inspiration and best practices necessary to achieve similar results with their own chronic disease patients.

Dr. Frank Maselli
Riverdale Family Practice

Dr. Carl Franzetti
Riverdale Family Practice

“Over 670,000 people in New York City have been told by a doctor they have diabetes. Prevention and self-management has been shown to be effective. More efforts that put evidence-based interventions to work, like those implemented by the Riverdale Family Practice, are needed to help patients stay healthy.”

— Sarah Shih,
Assistant Commissioner,
Bureau of the Primary Care
Information Project,
New York City Department of
Health and Mental Hygiene



The providers of Riverdale Family Practice

Diabetes Population Health Project Overview

The RFP Diabetes Population Health Project is a data-driven patient care initiative designed to focus on the practice's diabetes patients with poorly controlled A1c levels (those with A1c levels greater than 9.0% in the fourth quarter (Q4) of 2015). Using a combination of education, one-on-one attention, and persistent follow-up, 76% of the patients tracked had lower A1c levels on their latest exam in 2016.

RFP has always approached patient care as a team, and the Diabetes Population Health Project was no different. Each member of the practice—from leadership and providers to every level of support staff—had an integral role to play in the success of the project.

Project Preparation

RFP began by identifying the appropriate patient population to track. Having decided to target patients with A1c levels above 9.0%, they identified individual patients using their electronic medical record (EMR) system, eClinicalWorks. With assistance from Sanofi, RFP's quality improvement coordinator built a spreadsheet to track the 90 qualifying diabetes patients, and worked closely with all members of the practice to analyze the medications, measures, and data to be tracked. Additionally, medical assistants (MAs) and staff members were trained on how to engage diabetes patients and inspire self-management.

Patient Outreach and Follow-Up

One cornerstone of this project was personalized attention from the practice's MAs. After being appropriately trained, the MAs called patients on an ongoing basis to discuss their diet and exercise habits, medication compliance, and barriers they were facing, as well as to encourage the patients to come in for appointments.

Patient Education and Accountability

RFP worked to empower diabetes patients and their families through an extensive educational program of group workshops, easy-to-use technology, consistent messaging from all staff members, and pertinent handouts. RFP gave patients the tools and personalized attention to change their daily habits and regain control of their health.

Assessment

The process of engaging these 90 patients, the technology used to capture vital data, and the combined efforts of the RFP team were crucial to the ultimate success of the project.



Riverdale Family Practice

“When we came up with the list of patients, I realized that we’ve known many of these people for a very long time. These were the most at-risk patients, and the hardest to reach. What we hoped was that if we really started to focus on these patients specifically, we would see some results.”

— Dr. Frank Maselli

“The main benefit has been the educational aspect—the fact that we, as a team, are able to sit down and reach out to these people.”

— Dr. Carl Franzetti

Project Preparation

From EMR data and spreadsheets to staff education and guideline-based treatment plans, the team at Riverdale Family Practice worked together to lay a strong foundation for the success of this quality improvement project.

| Key Components |

- › Identify the diabetes population most in need of care, primarily based on elevated A1c levels
- › Create a comprehensive spreadsheet for capturing data, and train all team members on use of the EMR
- › Reconcile information pertaining to patients’ medication history and any changes to their medication between the EMR and the spreadsheet
- › Provide education to all staff members on diabetes care and how to inspire self-management among patients

Identify Patients

RFP established a baseline population of 90 patients by:

- Targeting diabetes patients who had an A1c level above 9.0% on their last exam, as well as those who had not visited a physician in 2015
- Using eClinicalWorks, the practice’s EMR, to find specific patient profiles that fit the requirements for the project

Implement Technology and Train Staff

RFP leadership acquired a robust EMR system, providing a comprehensive solution for:

- Storing patient profiles and logging pertinent details on patient visits
- Compiling and accessing data for the duration of the year-long project
- Facilitating detailed, efficient communication among team members

RFP's Quality Team:

- Developed and tested a spreadsheet for recording patient information pertaining to the project
- Trained medical assistants and nurse practitioners on effective use of the spreadsheet

Furthermore, all RFP members were trained to leverage the features of their EMR and patient portal, such as:

- In-house alerts via the EMR, such as when to follow up with patients to schedule appointments or remind them of upcoming appointments
- Easy-to-access notes on the EMR pertaining to patient visits, including prescribed medications and recommendations by the physician
- Messages and reminders for patients sent directly through the RFP patient portal

Medication Reconciliation

A crucial step in setting up this project was performing a detailed medication reconciliation for the patient population. Nurse practitioners (NPs):

- Gathered information on patients' previous medications by referencing patient notes in the EMR and patient files
- Logged the patients' past and present medications in the spreadsheet
- Cross-referenced changes in patients' A1c levels with their current medication or recent changes to their medication
- Reconciled medication information in the EMR with the spreadsheet on a quarterly basis

Educate Staff

RFP leadership ensured that all team members were knowledgeable about diabetes and the role that they would play in providing care to these patients:

- NPs and MAs attended Journey for Control, a program that prepared them to instruct educational courses on diabetes management
- Staff members were trained to facilitate diabetes courses
- Through a project with the Department of Health, MAs were provided with scripts for interacting with diabetes patients
- Sanofi provided lessons on motivational interviewing for the RFP team

"We had the list of diabetics who we thought would qualify for the initiative. And originally we had our own spreadsheet, but it didn't include as much information as we wanted. There were a bunch of ideas going on at one time, and it was difficult to get it to come together in one big picture. Sanofi provided support in fine-tuning what the overall spreadsheet would include."

— Nurse Practitioner
Kimberly Dy

Baseline Numbers

90

Total Patients

0

Patients Below
(A1c <9.0%)

38

Patients Low
(A1c 9.0–9.9%)

14

Patients Medium
(A1c 10.0–10.9%)

38

Patients High
(A1c ≥11.0%)

10.7%

Average A1c



“At least once a month, our medical assistants call our diabetes patients who have not been well controlled to see how they are doing—to see what kind of exercises they’ve been participating in, and how they’re eating. I’ve seen how that once-a-month phone call can have a significant impact on their improvement and results.”

— Dr. Leticia Gonzalez

Patient Outreach and Follow-Up

With the patient population identified and the Riverdale team equipped with the proper tools, medical assistants and staff members began to reach out to patients with the aim of inspiring their active participation in the Diabetes Population Health Project.

| Key Components |

- › Contact patients no less than once a month via phone and/or email
- › Prepare for a patient population that may be resistant to outreach efforts and treatment throughout the project
- › Maintain contact with patients to fuel their participation by coordinating as a team
- › Log pertinent information on patient conversations and scheduled appointments

Contact Patients

MAs and staff reached out to patients on a weekly to monthly basis to:

- Schedule and remind patients of upcoming appointments
- Check on patients’ understanding of their medication as well as their adherence
- Follow-up with patients on recent test results, A1c levels, diets, and overall wellness and provide information as needed



In the event of outdated contact information or unforeseen hurdles to communication, MAs and staff:

- Check notes and records from past visits for other phone numbers
- Contact known family members for updated contact information
- Send emails or e-messages via the Riverdale Portal for web-enabled patients
- Mail letters to patients’ physical addresses

Overcome Resistance to Care

MAs and staff provided continuous outreach to patients to educate them on the aims of the Diabetes Population Health Project.

- The RFP team found it important to maintain an empathetic approach with patients to establish trust and motivate patients’ engagement
- They also remained aware of the social and personal factors that can impede a patient’s approach to care

Work as a Team and Record Information

Coordination across all levels of Riverdale contributed to providing consistent, personalized care for each patient:

- Daily action plans outline tasks and align priorities
- Providers document thorough case notes in the EMR, enabling MAs and staff members to understand the particulars of a patient’s visit and the specific recommendations of the provider
- Providers create “Action” items in the EMR, prompts that give MA and staff members clear instruction for patient follow-up
- MAs and staff log important updates and notes for providers in the EMR

“I learned that each patient has a story. They’re not just trying to be difficult or make things hard—there are many things in their lives that affect how they approach treatment.”

— Quality Improvement Coordinator Lauren Toro

“I always say and believe, ‘It takes a village. It takes teamwork.’ Everyone has a niche in the office, and together, the sum of these interacting roles at RFP facilitate quality patient care and the successful results realized in this project.”

— Practice Administrator Catherine Franzetti



“It’s not just about their medications—it’s how they eat, the foods they’re given at home, how they exercise. We’re trying to educate patients on eating habits and how they can change what they eat and yet stay within their own culture. We try to take that into account and tailor their diet to what makes sense in their life.”

—Dr. Leticia Gonzalez

Patient Education and Accountability

Patients’ daily lifestyle choices can have an enormous impact on their disease, and RFP’s diabetes education program was designed to teach patients how to make the right choices in their everyday lives.

| Key Components |

- › Establish instructional workshops about making smart choices in diet, exercise, medication, and lifestyle
- › Use a variety of tools, personalize the message, and include family members
- › Help patients be accountable for their own health, and support them in making lifestyle changes

Conduct Workshops

RFP’s nurse practitioners taught group classes three times per month to help patients learn diabetes self-management and the effects of their lifestyle choices on disease progression. The classes covered:

- What, when, and how much patients should eat to gain control over their diabetes
- The basics of nutrition—what are carbohydrates, proteins, fats, fiber
- The importance of exercise and how to introduce it safely

These classes were very well received, and provided a supportive environment to inspire patients and encourage them to make simple changes one step at a time.



Provide Tools and Messaging

The Riverdale area of the Bronx, NY, is a diverse community, and so is the RFP patient population. Tailoring materials and messaging to different cultures, backgrounds, and levels of education are key to effective patient educational programs:

- Certified diabetes educators worked with RFP staff to hone their messaging and ensure that their educational information was current and effective
- Group classes were offered in English and Spanish, and family members and pre-diabetics were encouraged to attend
- Classes included hands-on practice in portion control, using a sample plate and food to visualize how to construct a balanced meal
- RFP customized dietary recommendations to honor patients' cultures and the foods they traditionally eat

Inspire Patient Accountability

Diabetes is a complex disease, and its treatment—particularly for the high-risk patients in the Diabetes Population Health Project—needs to be multifaceted. Ultimately, the patients who successfully lowered their A1c levels did so through a combination of appropriate medications and diet and lifestyle changes.

- RFP recognized that lifestyle changes were a long-term process for patients, not an overnight change
- It was important to maintain a positive, educational perspective when helping patients in order to avoid a critical tone
- RFP saw that by engaging a patient on a personal level, patients began to perceive treatment as a team effort—a process that required their active participation
- They realized that patients seeking to make and sustain lifestyle changes benefit from the support of family and friends

“You look at their ages, and for 50 years they’ve been doing it wrong. They’re not going to change overnight. It’s going to require continuous education and effort.”

—Dr. Carl Franzetti

“Utilizing technology to its maximum potential alleviates the burden of clerical work, freeing up the resources to be used in various aspects of care coordination. Such patient engagement tools continue to help us involve patients in their health by keeping them informed and giving them a sense of responsibility.”

—Senior Quality Coordinator
Amna Iffikar

A Patient's Story

"It was difficult at first, but after that first call, we started having weekly conversations, and I saw that she had a lot of concerns on her mind. I could tell she was looking for someone to talk to."

"There is no one way to reach every patient. You have to find the specific key for each patient. Everybody is different. But you have to make that first step to bring them to the office."

*—Medical Assistant
Svitlana Strutynska*

Medical Assistant Svitlana Strutynska had been reaching out to one particular patient for nearly three weeks without any reply. Her persistence paid off, however, when at last she managed to make initial contact with the patient over the phone.

Subsequent phone calls established a level of personal connection between Svitlana and the patient, allowing Svitlana the leverage to assure the patient that it was in her best interest to come in and see a doctor. Beyond informing the patient that she was overdue for an appointment, Svitlana added that she would prefer to talk with the patient in person, thereby reinforcing the personal aspect of their interaction.

Once the patient had come in and taken the necessary tests, Svitlana sat and talked with her after her appointment. Face-to-face, the patient further opened up to Svitlana about the circumstances that had distracted or prevented her from addressing her health concerns.

In fact, Svitlana learned that the patient hadn't eaten since the day before, and offered to give her some of the lunch that the office had bought that day. She brought the patient a salad—a simple gesture that solidified the patient's trust in and connection to Svitlana as someone who cared about her well-being. Svitlana took this time to encourage the patient to schedule her follow-up appointments, to take her medication and treatment seriously, and to reach out if there were any issues.

To follow-up, Svitlana called the patient several days later. The patient expressed sincere gratitude for the meal and the time they spent together. From then on, Svitlana spoke to her every week on the phone, and sometimes twice a week.

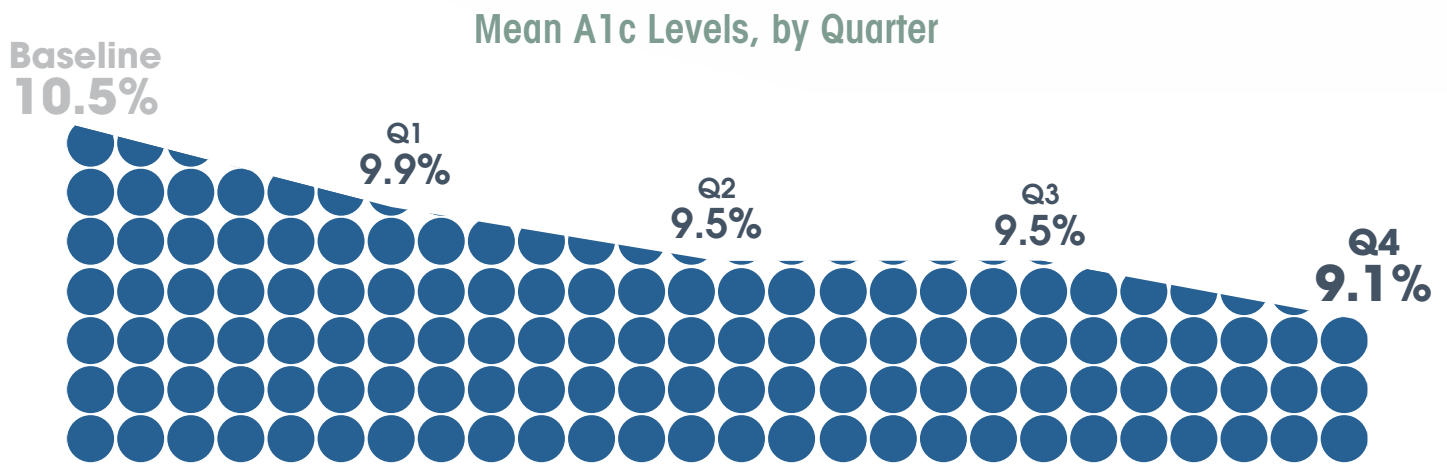
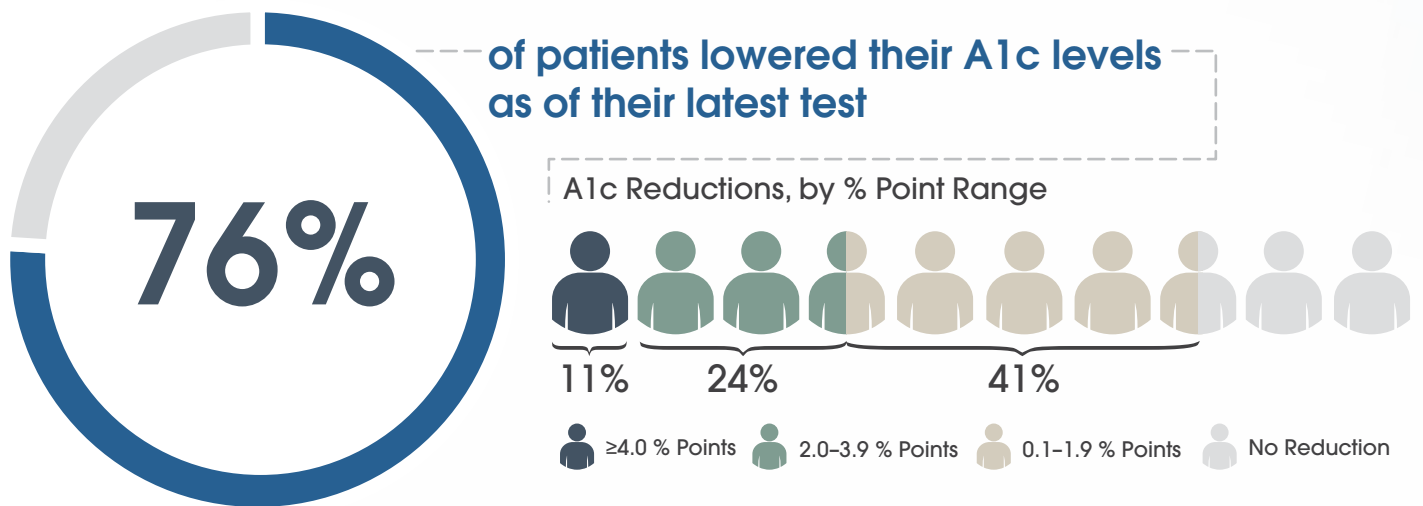
Over the course of several months, Svitlana and the Riverdale team's consistent communication and educational efforts, including information on healthy diet choices, proper medication, and simple physical activity, gradually inspired the patient to begin making changes to her lifestyle.

The impact of these changes was manifest in a drastic reduction in the patient's A1c levels. Having started the project with an A1c level of 14%, her most recent test results showed that her A1c level had decreased to 6%.

For Svitlana, this patient's story is just one example of the team's dedication to their patients. "Riverdale Family Practice," Svitlana said. "The name says everything: Family."

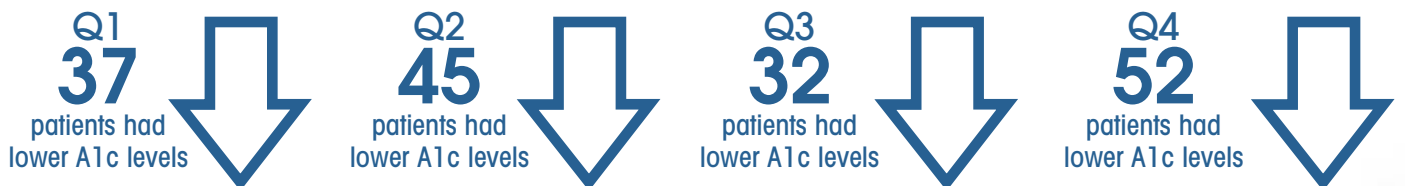
Outcomes: The Impact of a Team-Oriented Approach

The dedicated, coordinated efforts of the RFP team yielded notable results: over the course of 2016, 76% of the patients who participated in the initiative recorded a reduction in their A1c levels on their latest test. In fact, more than one out of every ten patients lowered their A1c levels by at least 4.0 percentage points, and one out of every four recorded A1c level reductions ranging from 2.0 to 3.9 percentage points. These outcomes contributed to the significant drop in mean A1c levels among this patient group. At the start of the initiative, baseline measurements showed a mean A1c level of 10.5%; by the end of the fourth quarter, this mean fell by more than one percentage point to 9.1%.



Note: Quarterly A1c levels were calculated as trim means, discarding an equal amount of both high and low data points.

A1c Levels Compared With Baseline, by Quarter



Data source: Riverdale Family Practice © 2017

Conclusion

The accomplishments of the Riverdale Family Practice team over the course of the Diabetes Population Health Project hinged on their cooperative efforts to develop and maintain a process. That process began with identifying the most at-risk patient population for the project; readying all levels of the team for interacting with diabetes patients; and bolstering the technological means of capturing critical patient data and communicating efficiently with team members.

Through persistent outreach, MAs and staff members began to engage this challenging patient population, eventually earning their trust. From there, these often difficult-to-reach patients began face-to-face interactions with providers and staff at RFP. By providing ready access to patient-specific information for all team members, maintaining consistent contact with these patients, providing them with education and a unified message, and approaching them with knowledge and empathy for their individual challenges, the team at RFP was able to motivate patients to become active participants in their own treatment.

By the end of the project, 76% of the patients who participated in the initiative recorded lowered A1c levels as of their latest exam. In the fourth quarter alone, 52 participating patients saw a reduction in their A1c level compared to their baseline measurement at the start of the initiative.

Next Steps

To continue the progress of the Diabetes Population Health Project, RFP intends to:

- Leverage the advanced features of their EMR to create a single hub for logging patient information, recording clinical data, and communicating vital information and action plans between team members
- Research an app or tool that would prompt medical assistants and staff to ask targeted questions when capturing information on new patients, such as the patient's lowest and highest blood sugar levels, or the date of their last A1c test
- Look into web-based training for medical assistants and staff members to provide them with a deeper look into diabetes and the role that primary care providers play in caring for these patients
- Explore how this process could be adapted to benefit patients with other chronic diseases who have been exhibiting poor results on routine clinical tests

About Riverdale Family Practice

Riverdale Family Practice (RFP) has served the Riverdale, NY, community for 30 years, providing skilled medical care and personal attention to patients from birth to senior years. RFP is recognized by the National Committee for Quality Assurance (NCQA) as a Level 3 Patient-Centered Medical Home (PCMH) under 2014 standards. In 2016, RFP achieved this highest level of recognition for the fourth time.

In its three decades of practice, RFP has always put patients first and empowered them to actively participate in their own care. They offer a host of patient-focused features and programs, including:

- Extended office hours (Monday–Friday, 8 a.m. to 8 p.m.)
- Emergency appointments every Saturday morning
- 24/7 on-call physician
- Educational programs for chronic disease patients and their family members

The practice invests in the latest health information technology to improve care, track progress, and engage patients, including:

- Sophisticated EMR to facilitate care coordination
- Patient Portal to communicate with RFP staff and access their medical information
- HEALOW, a mobile smartphone app to view lab results and request prescriptions and referrals
- iPad kiosks in the reception area facilitating efficient patient check-ins

RFP is an integral part of the Riverdale community at large, and is affiliated with the numerous area hospitals. The practice is part of the Quality Initiative Committee in the Bronx Accountable Care Organization (ACO) and partners with the New York City Department of Health (NYCDOH) on a variety of quality initiatives.

RFP treats every patient like a family member.