Improving Care and Analytics through CDM-QIP

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Chronic Disease Management Quality Improvement Program

Continuous improvement of chronic disease management in Saskatchewan

- CDM visit flow sheets standardized, evidence-based and reflect best practice
  - Phase 1: Diabetes and Coronary Artery Disease
  - Phase 2: Heart Failure and COPD
  - Phase 3: Two conditions to be decided
- Reports to support optimal care
- Track patients due for follow-up and tests
- CDM-QIP payments to participating physicians

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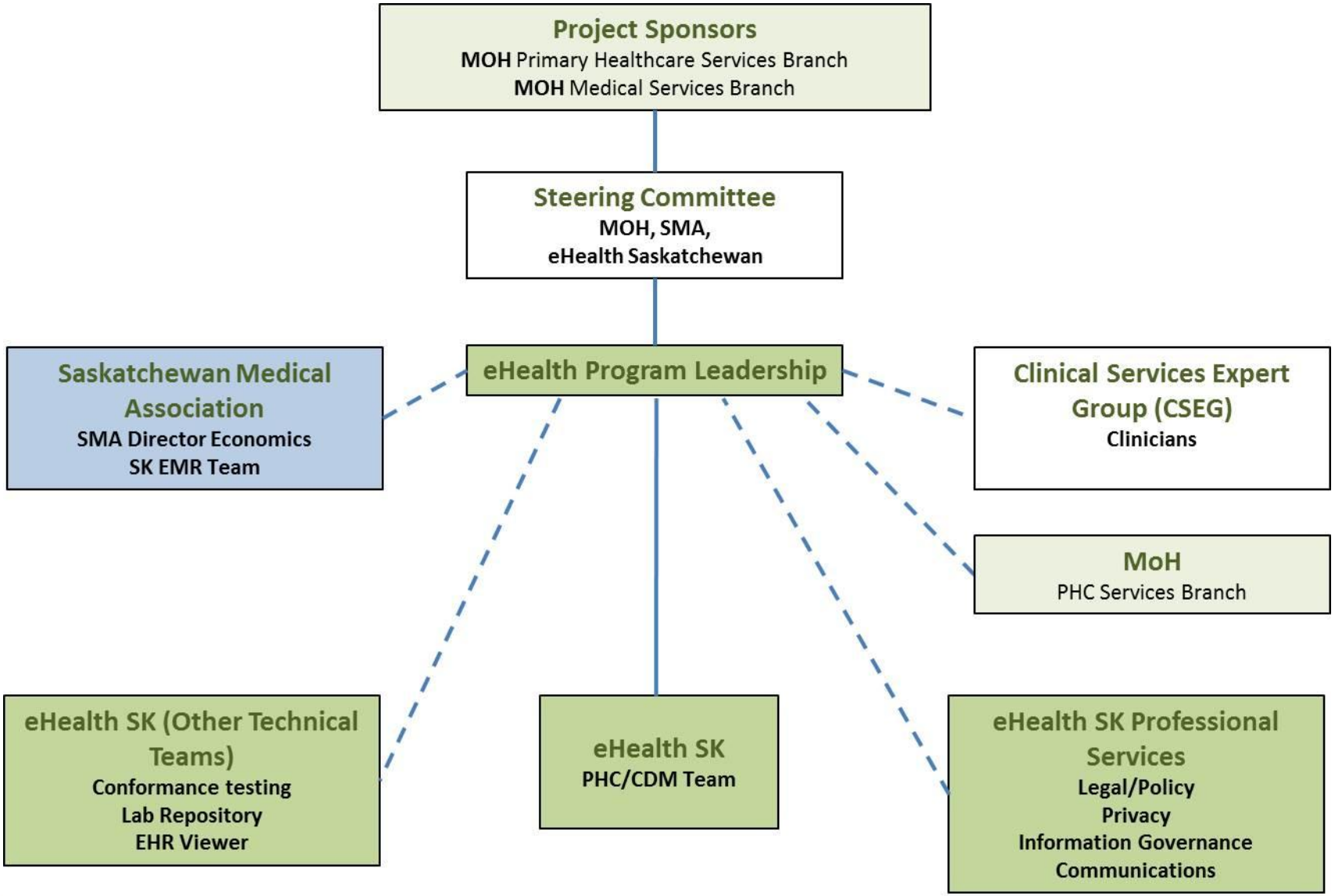
CDM-QIP - Governance



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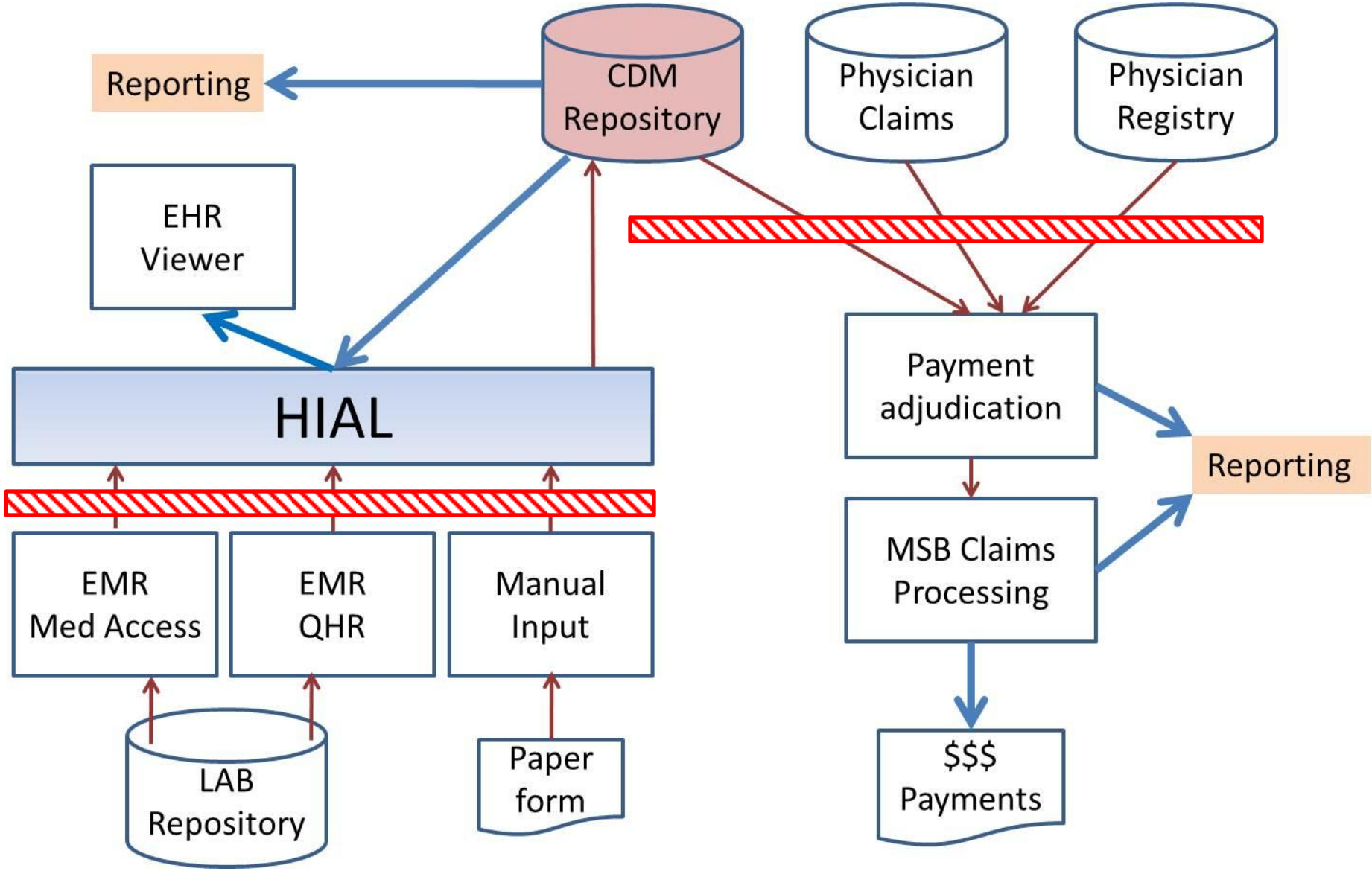

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CDM-QIP implementation

- Clinician engagement – incentives, training, support
- Managing the program
  - requirements from CSEG
  - vendor management
  - testing
  - delivery and change management
  - communication and support
  - enhancement according to new clinical guidelines

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SK CDM-QIP Diabetes Flow Sheet

Type of Diabetes: ☐ Type 1 ☐ Type 2 ☐ Other_____
Date Diagnosed / Duration DM:

Patient Name:

Date of Birth:

HSN:

Co-morbidities:
☐ Hypertension
☐ Dyslipidemia
☐ CKD – stage ___
☐ CAD
☐ PAD
☐ CVA
☐ Mental Health Condition
☐ Other
_____ _____
_____

		Date:	Date:	Date:
Lifestyle	**Nutrition/Diet review**			
	Physical Activity *(Aerobic 150 mins/week, Resistance 2-3x/week)*			
	Smoking Status *(If Smoker, indicate actively quitting; contemplating quitting; no plan to quit; or relapse)*	☐ Non-smoker ☐ Ex-smoker ☐ Smoker: _____	☐ Non-smoker ☐ Ex-smoker ☐ Smoker: _____	☐ Non-smoker ☐ Ex-smoker ☐ Smoker: _____
	Smoking Cessation Advice *(if required)*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Glycemic Control	**A1C** *(target ≤ 7% or _____)*	*test date* *result*	*test date* *result*	*test date* *result*
	Glycemic Therapy	☐ Diet alone ☐ Oral agents ☐ Insulin ☐ Other	☐ diet alone ☐ oral agents ☐ insulin ☐ other	☐ diet alone ☐ oral agents ☐ insulin ☐ other
	Diabetes medications *(Drug names/dosages)*			
	Therapy adherence/comments			
	BG record review *(do annual glucose meter/lab comparison)*			
	Hypoglycemic episodes *(consider frequency / pattern / effect on driving)*			
	Weight (kg) / **Height** (cm)			
	B.P. *(target <130/80)*			
	Patient at increased risk for CVD? *(if YES consider vascular protective medications)*	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

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QIP CDM Exporting

☐ Do not include this patient in the CDM Export

DOS: 06/01/2016 | Select Recent Values | Show All

		Next Due	Current Value
Subjective	Subjective Note		Add Comment
DM History	Date of Diagnosis		
	Diabetes Type		
CAD History and Interventions	Myocardial infarction		
	Unstable angina		
	Chronic stable angina		
	PCI/stent		
	CABG		
	Ejection Fraction		
Glycemic Control	Goal A1C		
	Hemoglobin A1C		CDA Clinical Practice Guidelines - A1C Target
	Glycemic Therapy		☐ Diet alone ☐ Oral anti-hyperglycemics ☐ Insulin ☐ Other Comments
	Insulin Prescription Tool		Insulin Prescription Tool
	Basal insulin		
	Prandial insulin		
	Type 2 diabetes therapy		CDA Clinical Practice Guidelines - Pharmacotherapy for Type 2 Diabetes
	Blood glucose records reviewed		
	Hypoglycemic episodes		Note
	Glycemic therapy comments/adherence		Add Comment
CAD symptoms since last visit	Angina class (CCS)		
	Palpitations		Add Comment
	Dyspnea		Add Comment
	Dizziness		Add Comment
	Swelling		

SK CDM Flow Sheet

CDM Alerts

No CDM bill in the last 3 months.

Patient has:

- Diabetes Mellitus (65B)
- Heart Failure (67B)
- COPD (68B)

*Approve CDM-QIP indicators for extract? ○ Yes ○ No

Diabetes History

DM Date of Diagnosis: 1988

Diabetes Type: Type 2

HF History

Type of HF: HF-REF

HF Date of Diagnosis: 2010

Ejection Fraction: 38 % 14-Nov-2013

COPD History

COPD Date of Diagnosis: 2012

Spirometry confirmation of diagnosis: Yes

Subjective Notes

Glycemic Control

A1C up to date (less than 6 months old)

Goal A1c: ○ <= 7% ○ 7.1% - 8.5% ○ Other

Hemoglobin A1c: 6.6 % 19-Feb-2016

Reference: CDA Clinical Practice Guidelines: Individualizing your Patients A1C Target

Glycemic therapy: ☐ Diet alone ☐ Oral anti-hyperglycemics ☐ Insulin ☐ Other

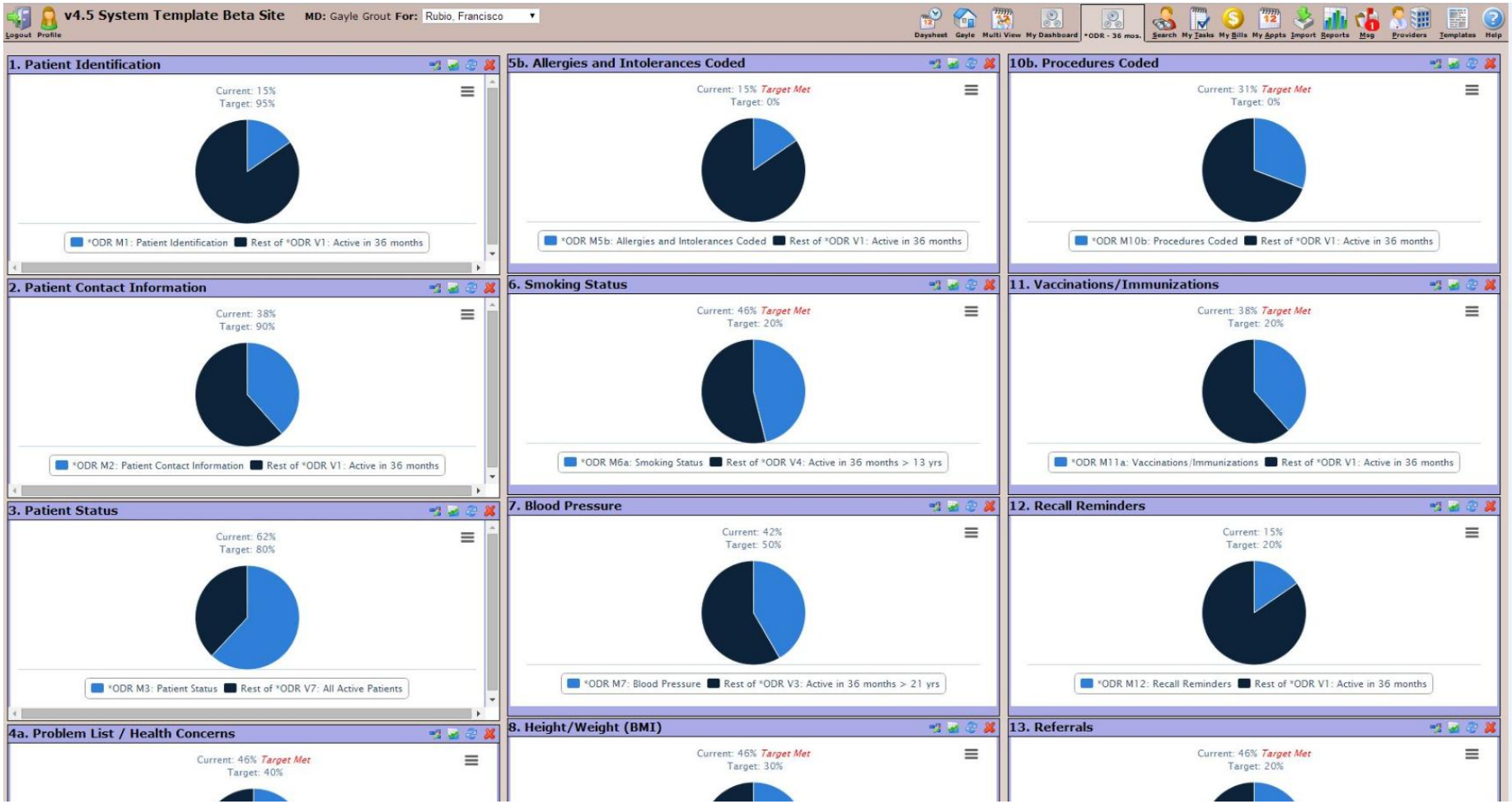
Consider metformin therapy. Patient has Type 2 DM.

Reference: CDA Insulin Prescription Tool

Reference: CDA Clinical Practice Guidelines: Pharmacotherapy for Type 2 Diabetes

Blood glucose records reviewed: ○ Yes ○ No ○ Patient does not check BG

CDM-QIP Dashboard



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CDM-QIP Metrics 2016-17

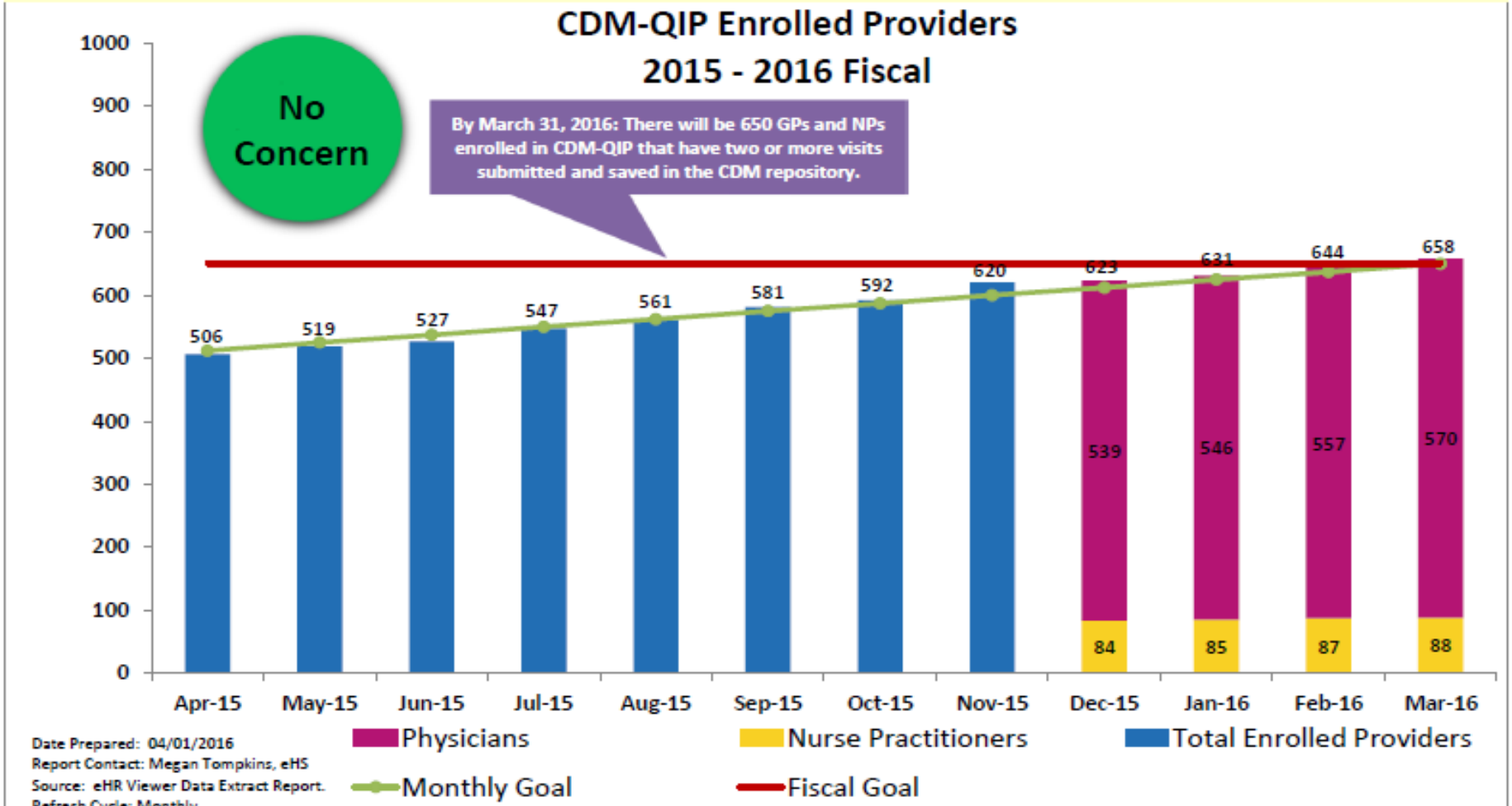
- **PHYSICIAN UPTAKE:** 765 GPs and NPs enrolled in CDM-QIP with 2 or more visits submitted to the CDM repository.

- **PATIENT UPTAKE:** 70,000 unique patients living with a chronic condition with flow sheet data in the CDM repository.

PLT April 2016 Wall Walk Update

By 2017, people living with chronic conditions will experience better health as indicated by a 30% decrease in hospital utilization related to 6 common chronic conditions (Diabetes, CAD, COPD, Heart Failure, Depression, and Asthma).

By March 31, 2020, 80% of patients with 6 common chronic conditions (DM, CAD, COPD, HF, Depression and Asthma) are receiving best practice care as evidenced by the completion of provincial templates available through approved electronic medical records (EMR) and eHR Viewer.



Date Prepared: 04/01/2016
Report Contact: Megan Tompkins, eHS
Source: eHR Viewer Data Extract Report.
Refresh Cycle: Monthly
Operational Definition: Number of unique providers (physicians and nurse practitioners) that have submitted at least two visits to CDM-QIP repository (either through eHR Viewer or via EMR export). The goal is to have 650 providers enrolled by the end of March 2016.

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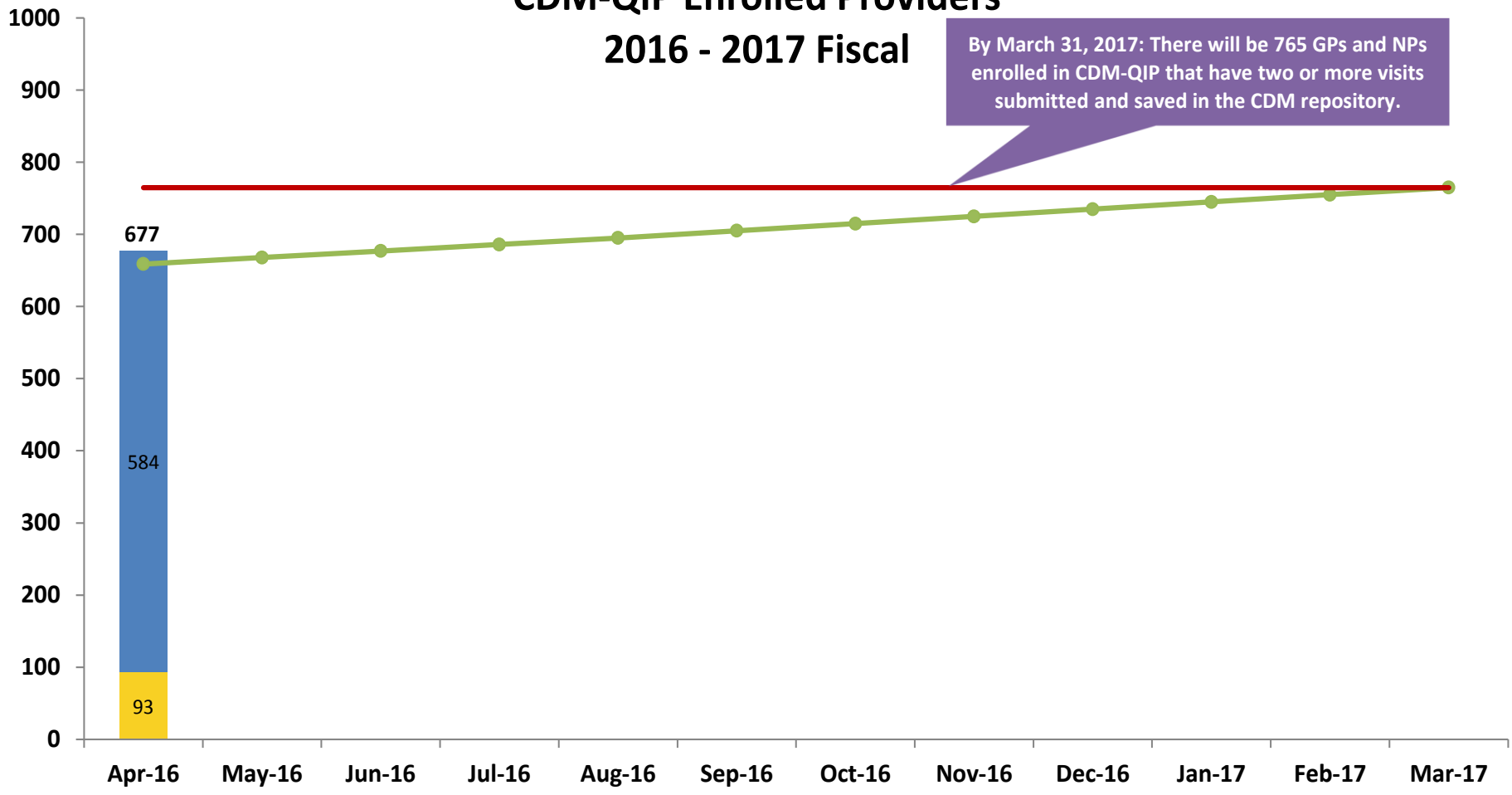
CDM-QIP Enrolled Providers
2016 - 2017 Fiscal



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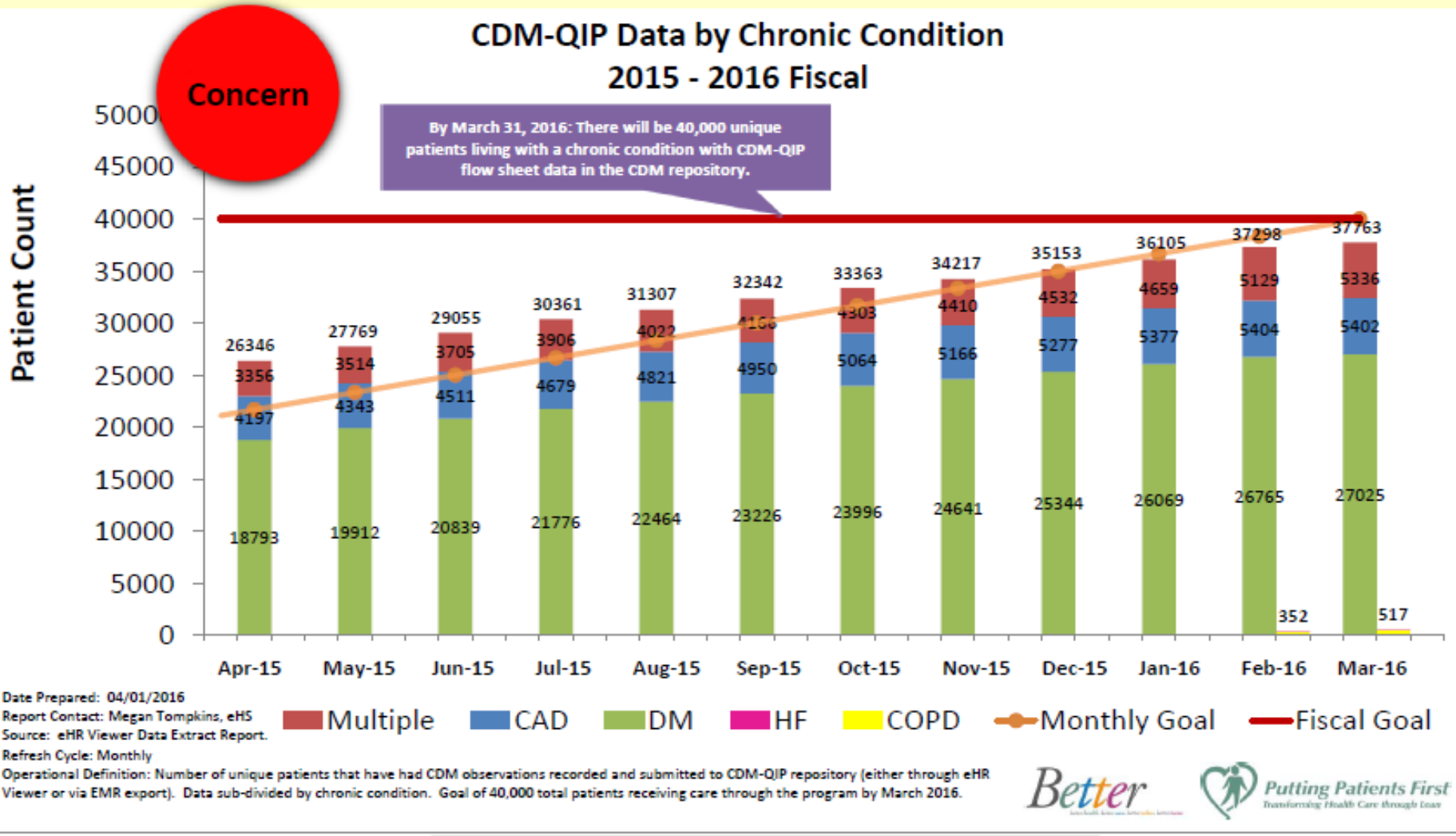

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Operational Definition: Number of unique patients that have had CDM observations recorded and submitted to CDM-QIP repository (either through eHR Viewer or via EMR export). Data sub-divided by chronic condition. Goal of 40,000 total patients receiving care through the program by March 2016.

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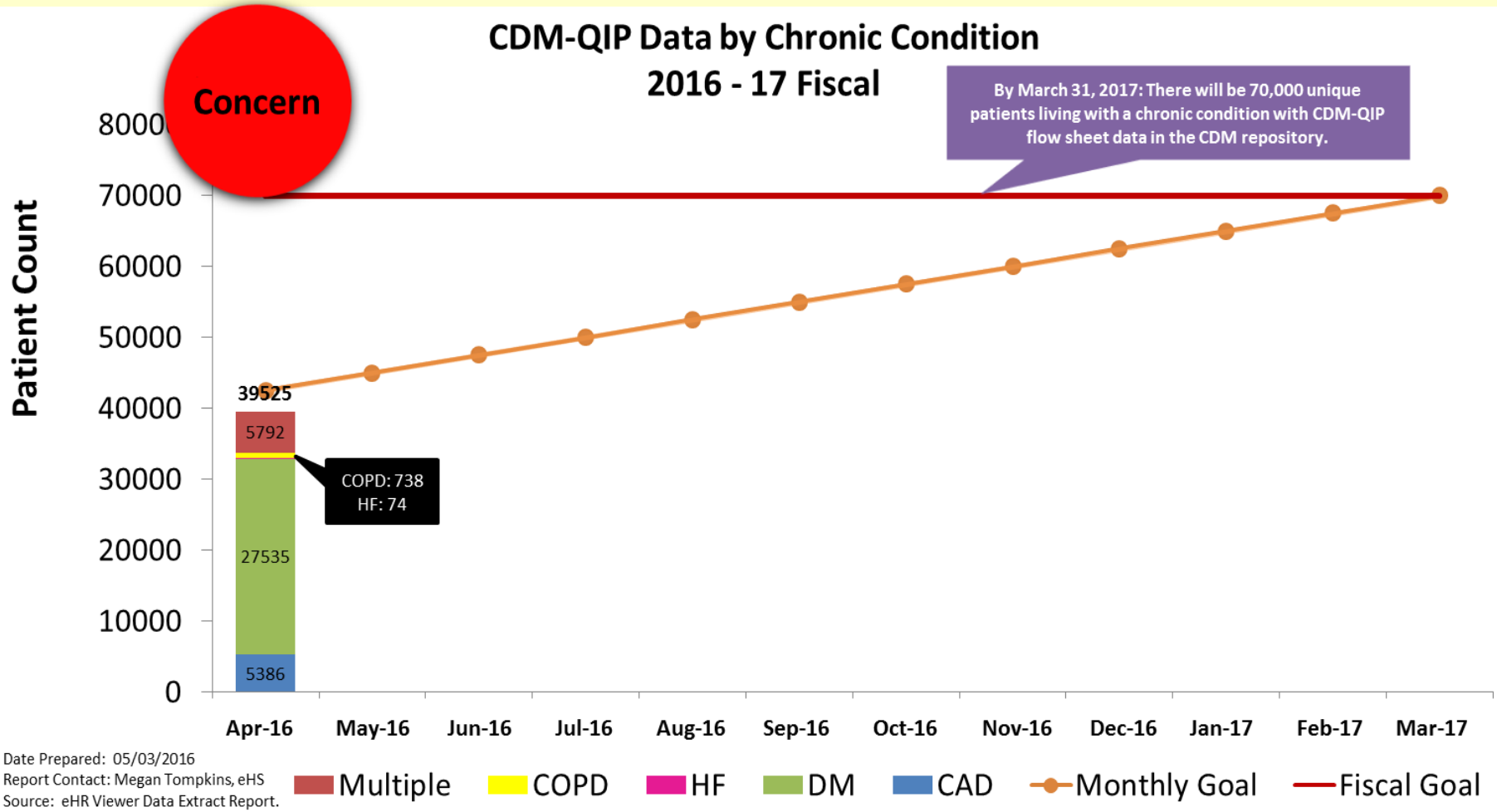

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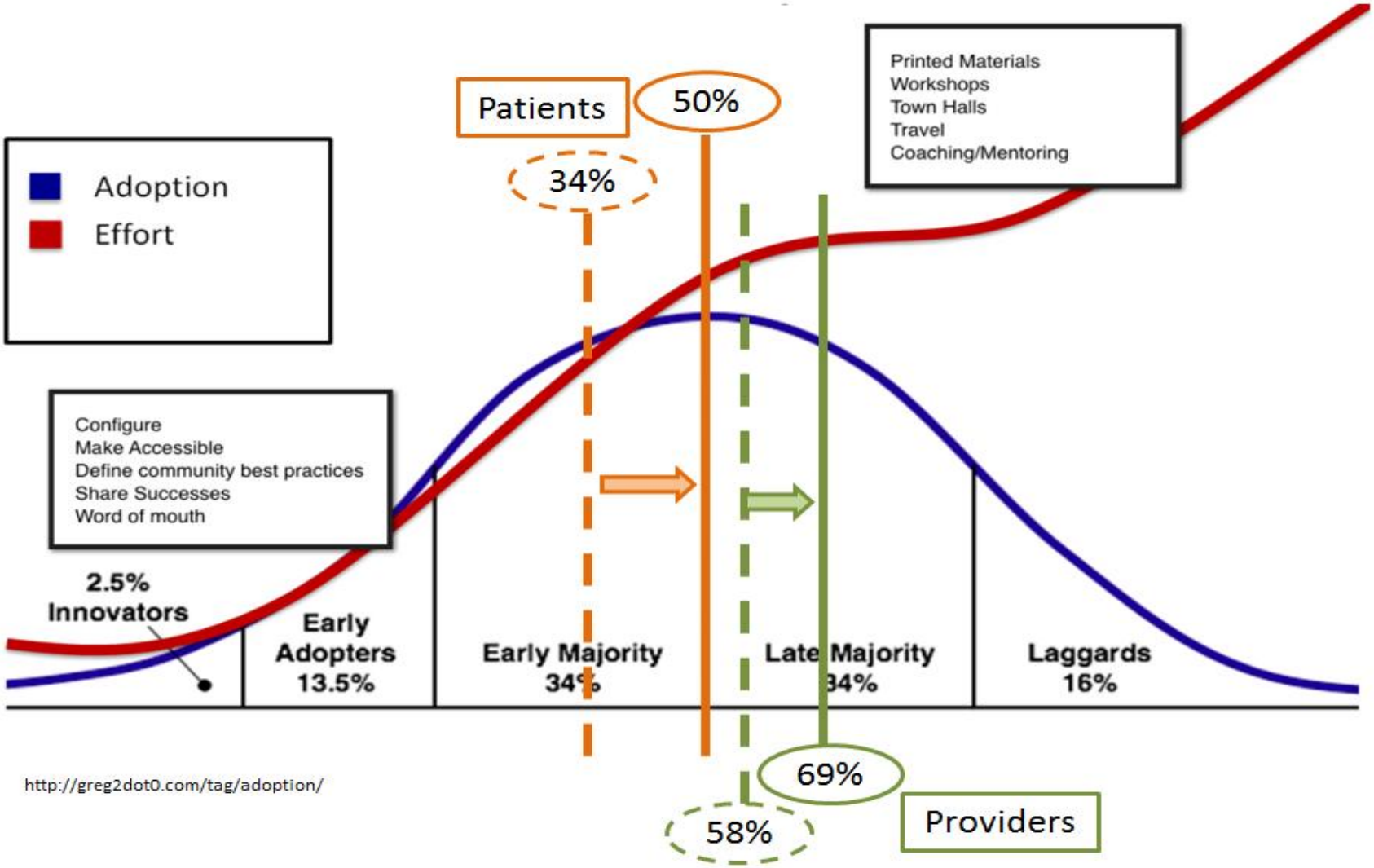
CDM-QIP Adoption Goals 2016-2017



CDM-QIP Metrics 2016-17

CONTINUITY OF CARE: Percentage of CDM-QIP patients seen by more than one GP/NP at more than one clinic is **≤1.5%.** **0.08%**

DATA QUALITY: Percentage of CDM-QIP visits that reach CDM repository successfully without data quality issues **≥95%.** **97.4%**

QUALITY OF CARE: 75% of unique patients with data in the CDM repository will have had all their best practice indicators met within a twelve month period. **12.2%**

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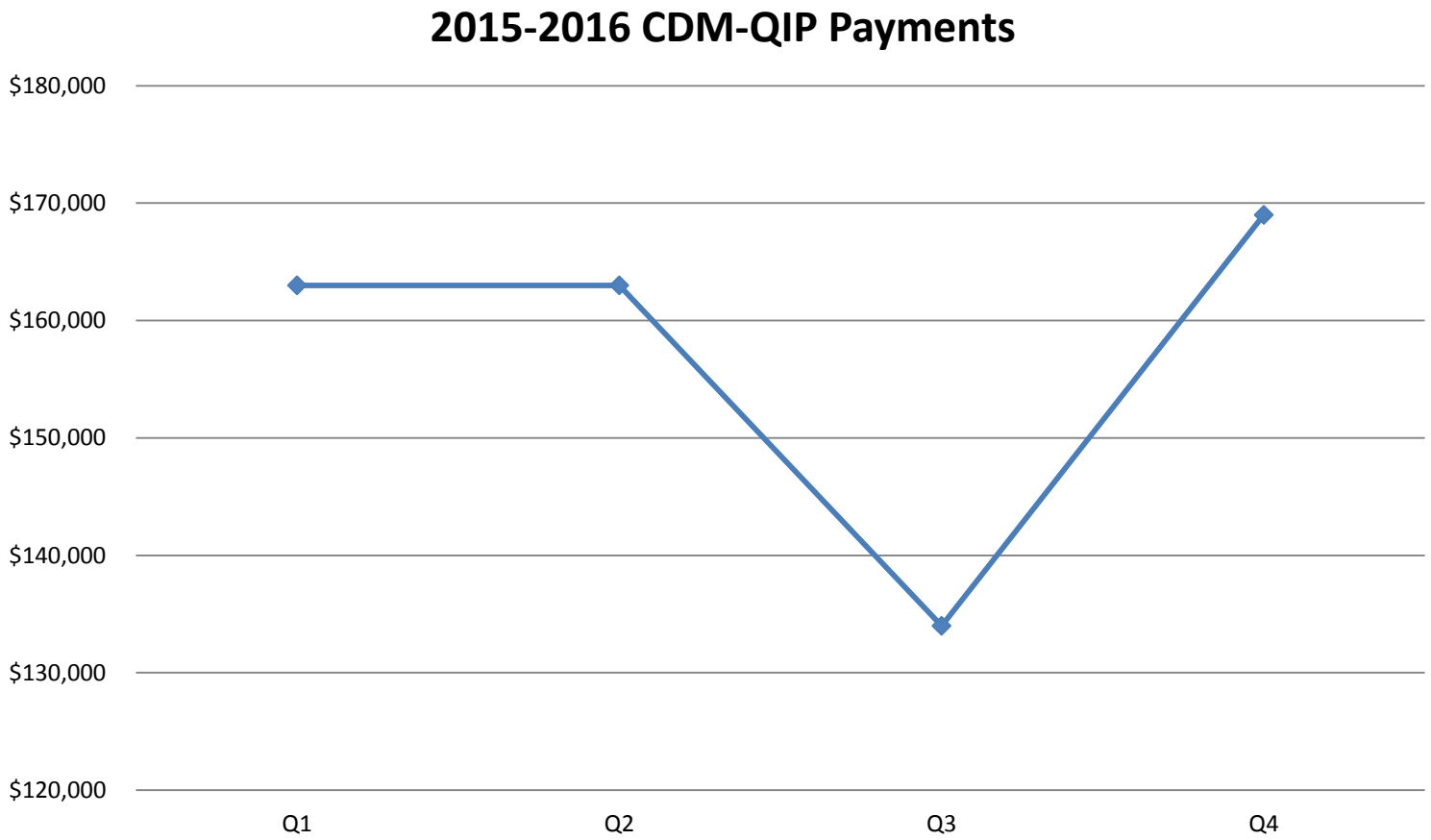
CDM-QIP



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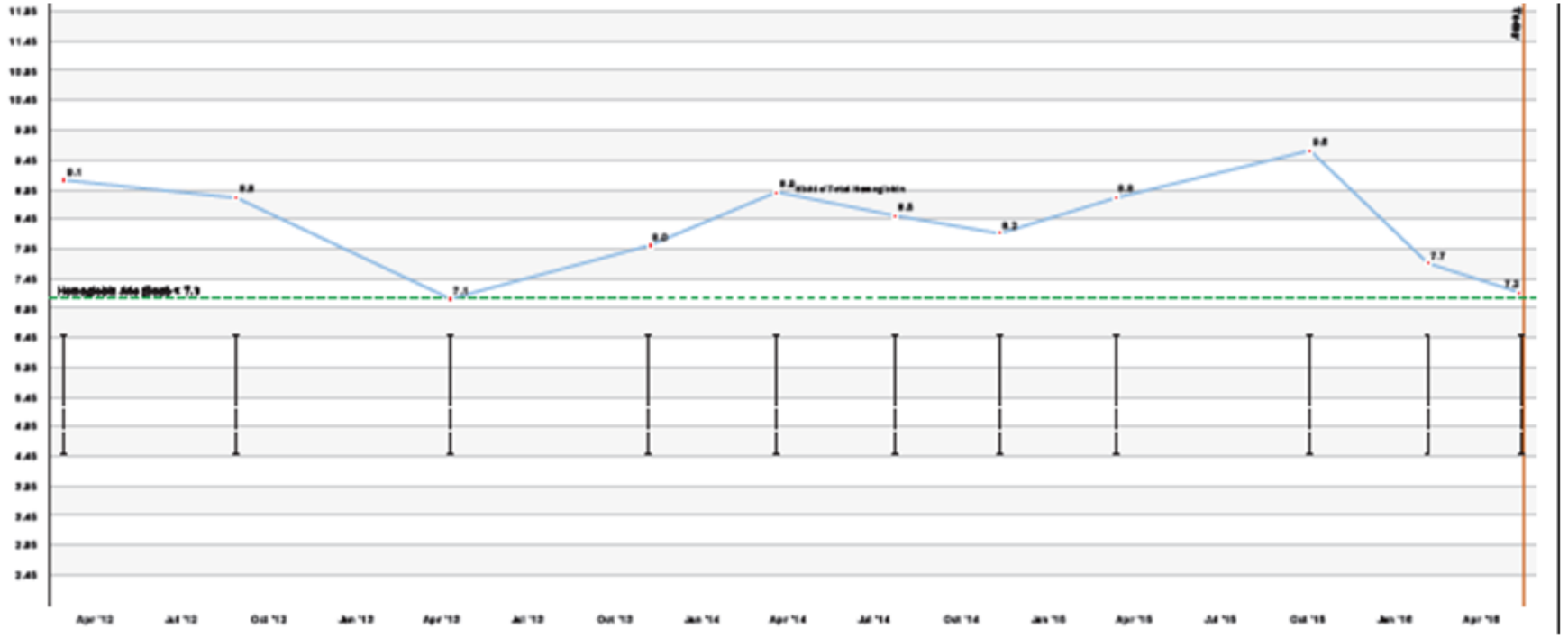

65 yr old male with type 2 diabetes – A1c values since 2012. Blood sugar control worsening in 2014 - 2015 as indicated by increasing A1c values. Able to show patient this by graphing lab values, and he agreed to start on insulin therapy in Nov 2015. Since then addition of insulin plus improved lifestyle self-management has resulted in a significant improvement in A1c – which can be shown to patient by graphing lab results.

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Thank you

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