

DayOne

Family Health Care

Start with us...stay with us, from DayOne.

363 Fremont, Suite 203, Battle Creek, MI 49017

269-969-6123 | www.dayonehealthcare.com

Mon-Thurs 7:30am-8pm | Fri 7:30am-5pm | Sat & Sun 8am-noon

Open 7 days a week. Convenient walk in hours. 8-9:30am daily.

Accepting new patients

Background

32 Years in Battle Creek

•*Today's Presenters*

- Philip Ptacin, MD – 32 Years
- Sheryl Tuck , Office Manager – 32 Years
- Andrea Cook, Clinical Supervisor – 22 Years
- Jamie Thomet, Front Office Supervisor – 10 Years

•*Office Staff*

- 10 Providers
 - 4 Physicians
 - 4 Physician Assistants
 - 2 Nurse Practitioners
- 34 Support Staff

Serving 30,000 patients



Extended Access

- *Open 7 days a week*
- *Designated walk in hours, Monday thru Friday (no appointment necessary)*
- *Evening hours till 8:00 p.m.*



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Philip Ptacin, MD



Bruce Galonsky, MD



Rose Lovio, MD



Peter Ansoerge, MD



Dawn Applegate, PA-C



Deborah Buford, FNP-BC



Kristen Wight, PA-C



Wendell Diggs, PA-C



Dolly Haugen, FNP-BC

*so many reasons...
ONE easy choice!*

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Sarah Niecko, PA-C

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Curmudgeon



Beginning Attitude...

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Diabetes Learning Collaborative

- *Integrated Health Partners*

- *Chronic Care Model*

- Improving the care of patients with chronic illnesses
- Informed activated patient
- Prepared, proactive practice

Aha Moment



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Measures

Measurements

Goal

- *Hemoglobin A1c*
- *Blood Pressure*
- *LDL*
- *Self-Management Goal/Action Plan*
- *Smoking Cessation offered*

<7.0

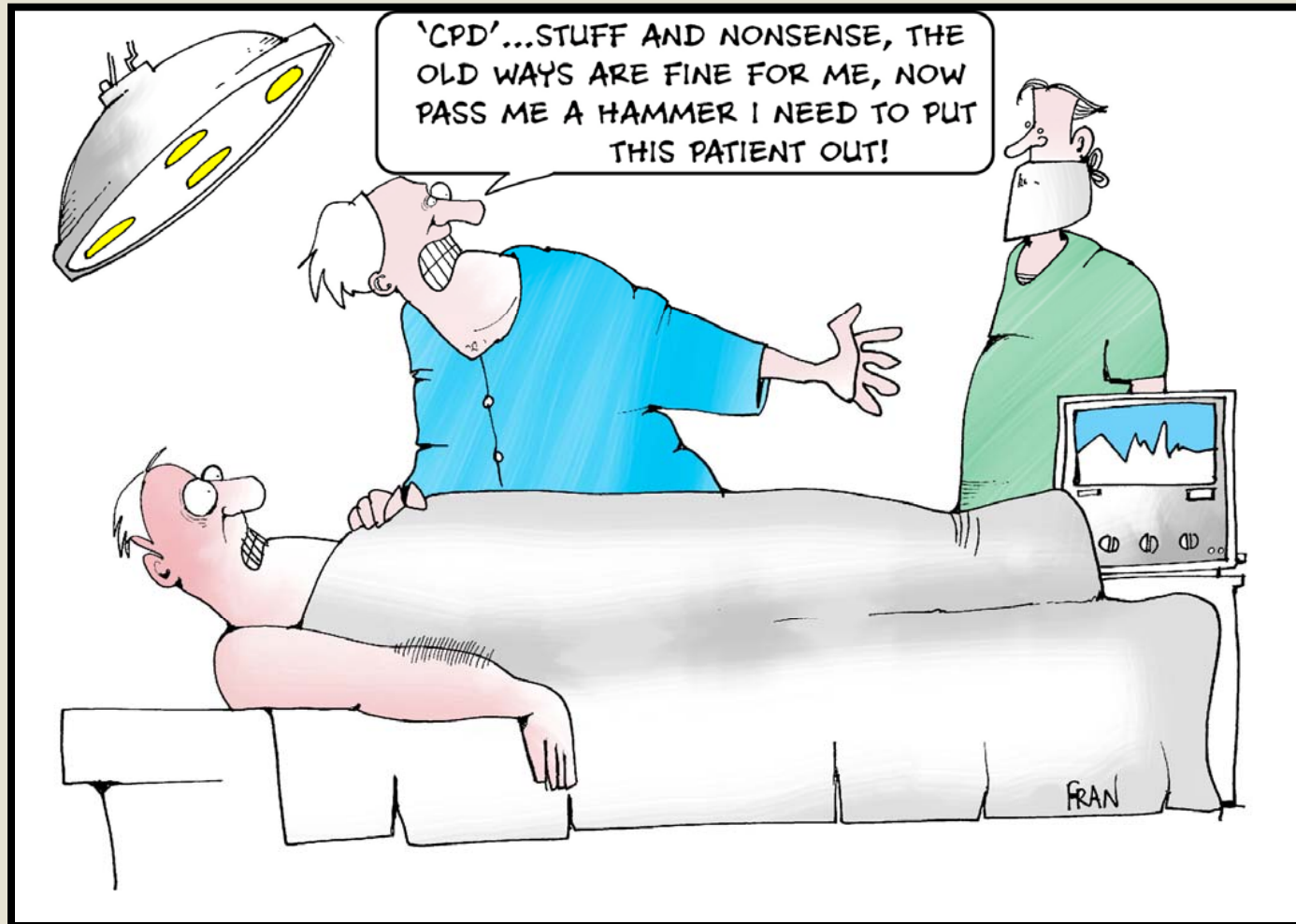
<130/80

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Delivery System Design

- *Team roles and tasks*
- *Planned visits*
- *Continuity of care*
- *Follow-up*
- *Huddles and regular team meetings*
- *Spread*

Then and Now....



IHP Learning Collaborative

- *May 2007 – May 2008*
- *Diabetic Patients*
- *Team out of the office for 7 days*
- *Already providing quality care*
- *Skeptical*



Prior to Collaborative

- *15 minute chronic care appointment*
- *15 minute follow up appointment every 3 months*
- *Visits varied by provider*
- *Limited role of nurse*
- *Patient set agenda for appointment*
- *Non-compliant patients*
- *Lack of population based data*



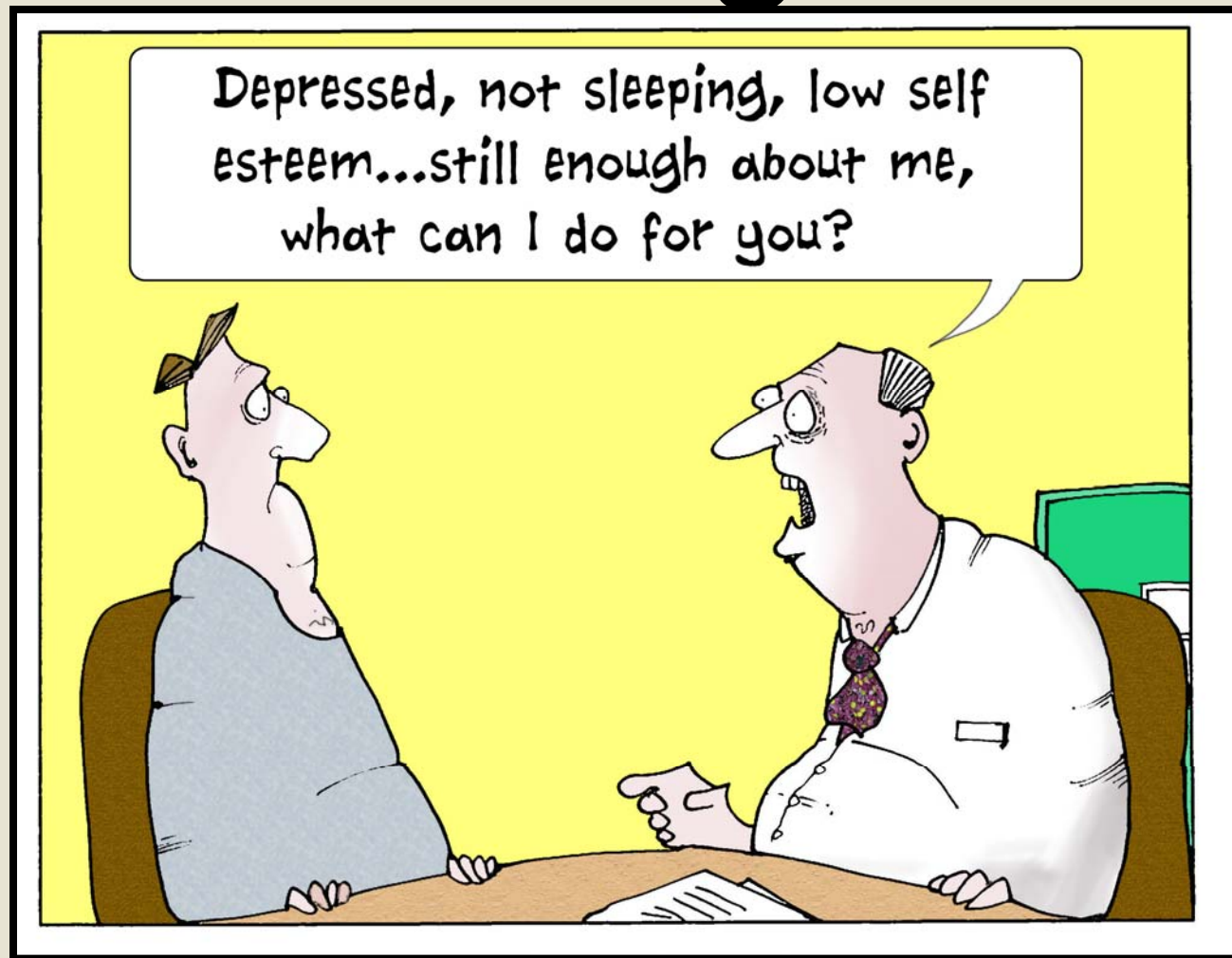
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Post Collaborative

- *30 minute chronic care appointments*
- *Visit expectations are identified*
- *Evidence based care guidelines*
- *Patient goals understood by all members of the care team*
- *Expanded nurse role*
- *Patient self management goals*
- *Population based data*
- *Routinely work gaps in care*



Self Management



Self Management – A Provider's Perspective

- *Difficult*
- *Takes time and patience*
- *Important*
- *Working to spread beyond diabetes*



Present

- *Team approach*
- *More satisfying*
- *Continually evaluate process*
- *Motivated to solve problems*



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Planned Visits

- *Reality check*
- *Roles and responsibilities*
- *EMR diabetic template*

Diabetes Maintenance History

Exit

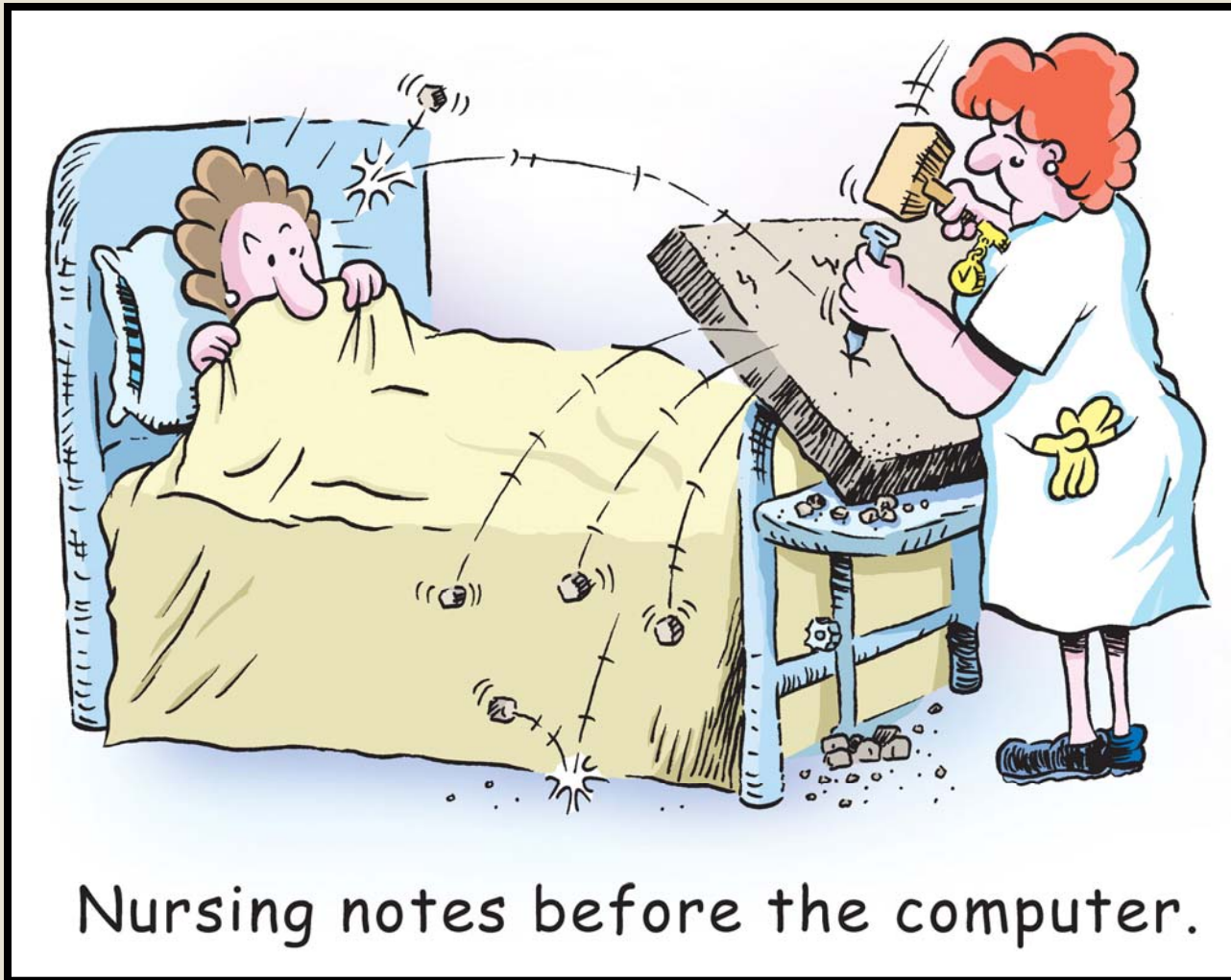
Dates may be approximated

Test, Adult Age: 29

Clinical Information being Tracked	Date Done	Notes
Foot Exam	11/11/2008	testing
Depression Screening	04/13/2008	Score was "2"
Smoking Cessation offered	04/13/2008	smoking
Lipid Panel	10/13/2008	100
Baby aspirin daily		
EKG	10/02/2008	
Self-Management Goal determined	12/20/2008	exercise 3x/wk
Self-Management Follow-Up	04/13/2008	doing well with goal
Self-Management Follow-Up #2		
Self-Management Follow-Up #3		
Self-Management Follow-Up #4		
NURSES RESPONSIBILITY:		
Eye Exam	11/11/2008	Dr. VanderPlas
Microalbumin Testing	04/13/2008	Negative
HgbA1c	04/13/2008	6.0
Foot Care	04/13/2008	Discussed with patients
Flu Shot	01/23/2009	danielle
Pneumonia Shot	04/13/2008	
Diabetes Education	04/13/2008	Classes in 2007

count	Appt No
70900	
06577	
06771	
20700.3	
20700.3	
11700.1	
00675	

Then and Now...



Nursing notes before the computer.

Measurements &

Measurements **Goals**

Goal

Hemoglobin A1c

<7.0

Blood Pressure

<130/80

LDL

<100mg/dl

Self Management Goal/Action Plan

Smoking Cessation

Annual Eye Exam

Annual Foot Exam

Diabetes Classes

Regular Exercise

Depression Screening (annual)

Urine Microalbumin

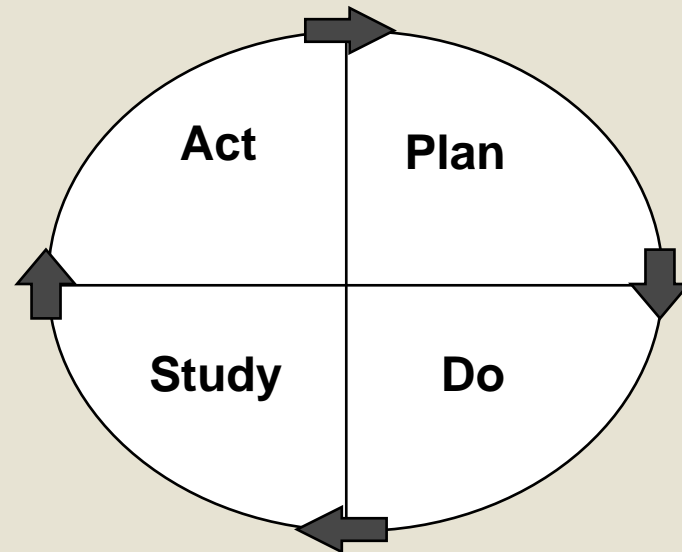
Baby asa daily

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Self Management Support

- *Staff training*
- *Progress sheet*
- *Staff satisfaction*
- *PDSAs*

Model For Improvement



Diabetic Patient Data

<u>Measure</u>	<u>12/31/06</u>	<u>12/31/09</u>	<u>Change</u>
■ <i>BP <130/80</i>	32.8%	40.3%	2.9%
■ <i>Depression Screening</i>	0.8%	2.7%	237.5%
■ <i>Foot Check</i>	18.4%	38.6%	109.8%
■ <i>Retinal Exam</i>	11.7%	33.6%	187.2%
■ <i>Self Management Goal</i>	0.5%	23.3%	4560.0%
■ <i>HbA1c <7</i>	46.8%	51.0%	9.0%
■ <i>HbA1c >=9</i>	10.1%	6.7%	33.7%
■ <i>LDL <100</i>	35.3%	39.6%	12.2%
■ <i>Microalbumin</i>	37.7%	51.1%	35.5%

Our population during this time period increased from 592 to 1140.



Other EMR Changes

- *E-prescribe*
- *Test tracking*
- *Referral tracking*



Role of the Front Office Staff, Then

High standards for customer service...when the patient reached out to us



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And, Now

- *Shared role in patient outreach*
- *Pre-visit work*
- *Use of EMR*
- *Registry gaps in care reports*
- *Monthly meetings*

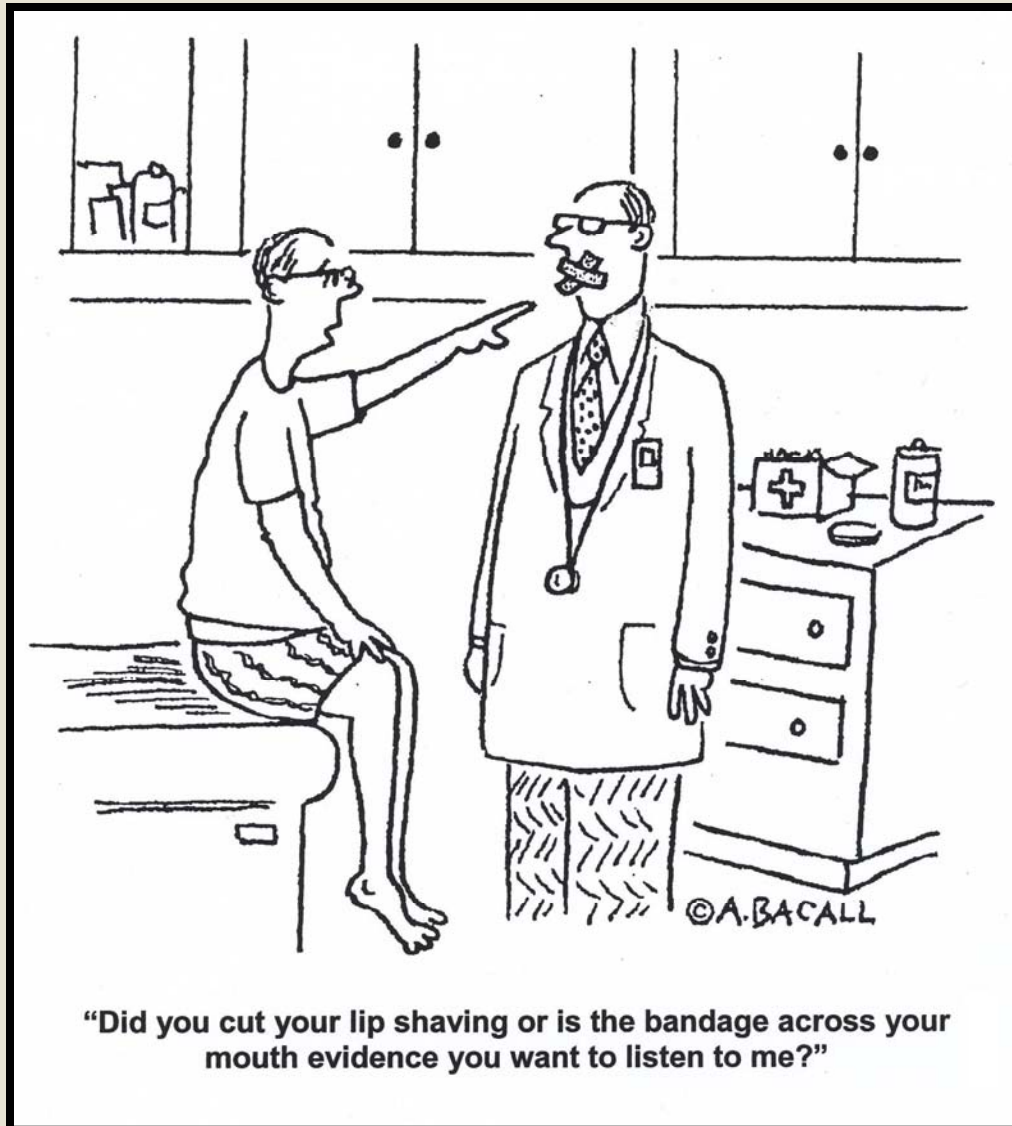
Beyond Diabetes

- *Preventive care*
- *Care Management Collaborative*
- *Hospitalists*
- *Community resources*
- *Additional chronic illnesses*

Spread and Sustainability

- *Consistency*
- *Routine chronic care meetings*
- *Education*
- *Quarterly PO meetings*

Time



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Summary

- *Embrace technology*
- *Data reports*
- *It's all about the patient*
- *Continuous quality improvement*
- *Patient Centered Medical Home designation*
- *Cohesive team*



Questions ?

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