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Improving care delivery to address diabetes through community partnerships

Academic medical system uses Vizient data as their true North

Working towards better patient outcomes and quality scores, the quality leaders at a southern-based hospital system decided they needed to establish their "true North" that would help them identify quality improvement areas. The annual Vizient Quality & Accountability Scorecard uniquely allowed them to benchmark their facilities against their peers and develop a prioritized performance improvement plan.

The team determined the need for a pilot program that would demonstrate the system's capabilities to address the health of their patient population by aligning clinical data and health inequity insights, allowing them to identify and prioritize targeted interventions for their community.

> *"We use the Quality and Accountability Scorecard as our true north for measuring quality. It's tied to both internal departmental financial incentives as well as any leadership positions have this tied to a financial incentive."*
>
> **System Director of Quality Outcomes**

The system's data revealed they had a high hospital admission rate for patients with complications from diabetes. By using the Vizient Vulnerability Index™, the quality team identified the three most critical zip codes that had the highest incidence of elevated hemoglobin A1C rates and diabetic lower extremity amputations. Pulling it all together, they set about to create a cohesive diabetes management program that would help minimize inpatient hospitalizations by reducing the number of diabetic patients that progress into amputees and to improve health outcomes.

Collaboration to address access

A newly created cross-department diabetes management team used data from across all teams to identify the needs and available resources to create a multi-disciplinary approach.

They identified the greatest needs were a diabetes dashboard, case management resources and digital education to support established urgent care services and community partners, one statewide and another local, that would change the point of access for these patients, resulting in less hospital admissions.

The state-led community health initiative focused on making good health simple for all people in the state, enabled access via a network of more than 100 partners, trusted community relationships, proven revitalization strategies and layered programming. Additionally, a local faith-based coalition – a group of churches and pastors – also partnered with the system who would reach the population when the medical community couldn't.

The AMC uses the Vizient Clinical Data Base (CDB) to help identify quality improvement areas. During participation in the Improving Health Equity Performance Improvement Collaborative, the AMC accessed the Vizient Quality & Accountability Scorecard process powered by CDB.

Putting all the pieces together

Supporting the work of the diabetes management team, the dashboard was created to be a central repository. It identifies diabetic patients that have uncontrolled diabetes, long-term complications or amputees, flags those that live in the target zip codes, and centralizes clinical notes and data.

Armed with information from the dashboard, the diabetes management team was able to scheduled health fairs at three churches in the targeted zip codes to do screenings, including BMI, cholesterol, blood pressure, blood sugar and other health risks. At these fairs and similar points of access, the team learned they can quickly identify potential patients. Through their partnership with the community programs, patients in the diabetes management program can now have community health coaches visit them after discharge for follow-up, education about their condition and help to navigate the system and minimize readmission.

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