Remission Pathway Population Management (PM) Learning Lab Key Driver Diagram (KDD)

Project Leader(s): Fernando Del Rosario, Chip Samson, Tiawana Thompson
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GLOBAL AIM

Improve the care and health of all children and adolescents with Chron's disease and ulcerative colitis.

SMART AIM

Increase percentage of patients in remission from 81% (February 2021) to 83% by December 2022.

POPULATION

All eligible ICN center patients

KEY DRIVERS

- Effective center leadership and multidisciplinary ICN center
  Chronic Care Model (CCM): Delivery System Design
- Knowledge and use of QI methods and data
- Optimal access and communication with ICN care team
  CCM: Clinical Information Systems
- Proactive, timely, reliable, planned care and population management
  CCM: Decision Support, Clinical Information Systems
- Appropriate drug selection and dosage
  CCM: Decision Support
- Optimal nutrition intake
  CCM: Decision Support
- Optimal psychosocial health
  CCM: Decision Support, Self-Management Support
- Optimal self-management/adherence
  CCM: Self-Management Support

INTERVENTIONS

Team Leadership
- Reliable implementation of Foundations KDD

QI Methods and Effective Use of Data
- Reliable implementation of Foundations KDD

Consistent, Reliable Care
- Implement IBD Model Care Guidelines with reliability of >90%
- Implement Pediatric IBD Nutrition Algorithm with reliability of >90%
- Implement standard approach for psychosocial & nutritional assessment and treatment plans

Population Management (PM) Strategies
- Implement standardized 4 step PM process with reliability of >90%
- Regularly review automated PM reports
- Identify patient subgroups for proactive care, some examples below:
  - Patients not seen in 200 days or 13 months
  - Patients with high care stratification scores
  - Patients with persistently mild disease
  - Patients on long-term steroids
- Design, coordinate, and manage care for specific segments of the practice population
- Provide structured care recommendation communications to patients and families
- Integrate patient reported outcomes into PM strategies
- Standardize PM meeting agenda to track interventions and resources needed/requested

Self-Management Support
- Provide patient education to promote awareness/understanding of IBD and ICN
- Define team roles and responsibilities for SMS
- Elicit patient and family priorities for SMS
- Confirm patient understanding of new information
- Set patient goals collaboratively
- Monitor and document progress toward SMS goals at each visit

Population Management is the process of identifying a cohort of patients that may need care gaps addressed or are at risk. With in the process, the following steps occur:

Prepare for PM patient review:

- Gather list of targeted cohort
- Gather any additional information needed for review

Review patients:

- 2 or more people review patient for areas that could improve clinical outcome
- Review must include at least one clinician and one other person (could be non-clinician)
- Multidisciplinary team encouraged

Recommendations are made:

- During review patient may need administrative or clinical interventions (example sooner follow up in clinic or taper off steroids)
- Recommendations or considerations are documented

Recommendations are passed to the care team:

- Documented recommendations or considerations are sent to the primary provider / care team
- It is up to the primary provider if recommendations are appropriate

** One person or the team must determine if the PM process was completed successfully for each opportunity and for every patient