

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

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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

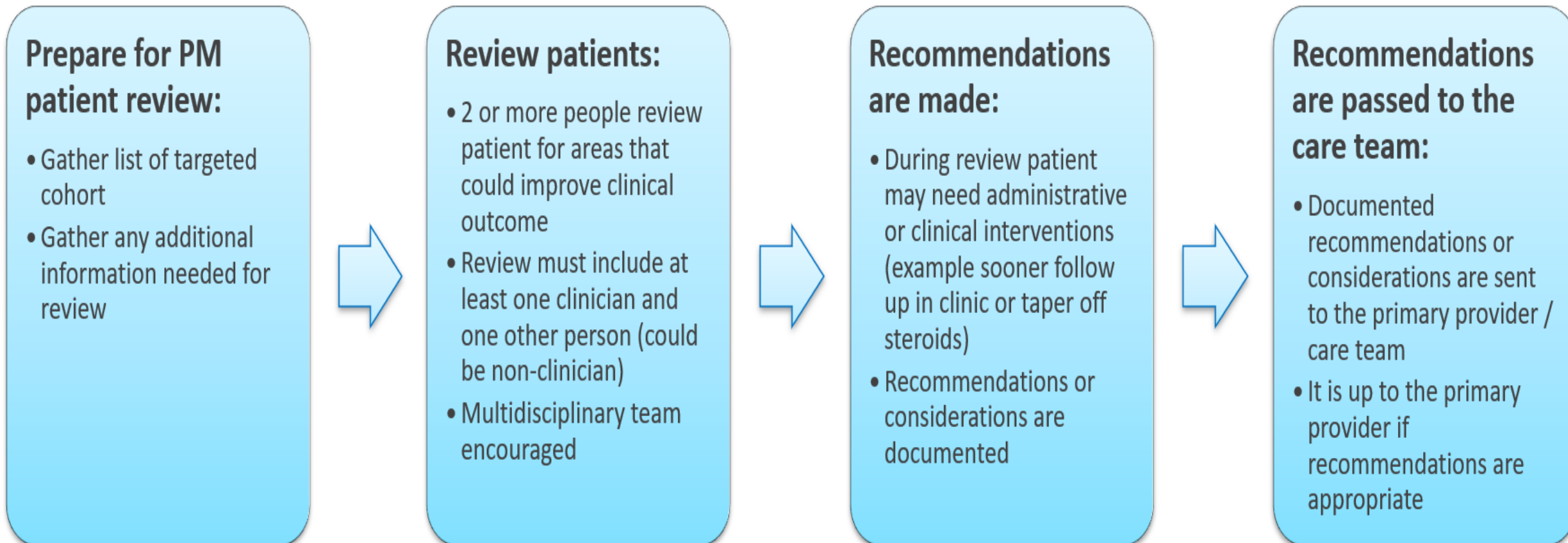
Population Management (PM) Strategies

- 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:



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