

2009 Innovations in Health Care Award

Abstracts were submitted covering the following categories:

- ⇒ **Diabetes**
- ⇒ **Cardiovascular**
- ⇒ **Kidney Disease**

These are the top abstracts submitted:

Advanced Vascular Surgery – Building an Outpatient Access Center

The hemodialysis patient presents a challenge in managing their care. The Nephrologists were frustrated with the timeliness of interventions. The patients were unhappy due to frequent appointments. The surgeons were frustrated trying to maintain an access with little communication between their office and the dialysis units. The decision was made to build an Access Center that could increase its focus to the dialysis population and take ownership of the access.

CareSource and Diplomat Clinical Services – Chronic Kidney Disease Partnership

CareSource has partnered with Diplomat Clinical Services to support the pharmaceutical and clinical needs of CareSource members with chronic kidney disease. The program provides medication review and recommendations to the Primary Care Provider; and, member education about medication adherence, nutrition, and physical activity and lifestyle choices.

Children’s Health Initiative Program (CHIP) – Childhood Obesity

The Children’s Health Initiative Program (C.H.I.P.-www.chipkids.com) is a five (5) week-ninety (90) minute interactive healthy living education awareness pilot project for elementary school children ages 8-12 and their parents. Its program extols the virtues of good nutrition, effective physical education and positive lifestyle modification and is delivered by teams of local physicians, dietitians/culinary, physical therapists/personal trainers/exercise physiologists and psychologists.

Dialysis Patient Citizens (DPC) – Michigan Patient Ambassadors Program

12,363 Michigan residents have kidney failure and rely on dialysis. It is important for them to monitor and effectively manage their overall health to avoid complications and feel empowered about their care. Dialysis Patient Citizens (DPC), a non-profit, patient-led organization, has helped improve these patients’ quality of life through garnering 685 patient members in Michigan and empowering 10 members to serve as Patient Ambassadors, educating others about dialysis and advocating on behalf of dialysis care.

Grand Valley Health Plan Family Health Centers – Diabetes Management Program

Grand Valley Health Plan Family Health Centers, regional providers of primary care services, have an obligation to provide the best care available to its patients with diabetes.

The purpose of the Diabetes Management Program is to improve the quality of care for individuals with diabetes and maximize patient self-management in order to prevent diabetes related complications by effectively targeting, tracking, educating, and managing care of diabetic patients.

Henry Ford Health System – Optimizing Kidney Disease Management: A Nurse Practitioner Model

In the United States, Chronic Kidney Disease (CKD) is frequently under diagnosed and under treated. The treatment of CKD is frequently suboptimal and its associated comorbidities and complications result in a high burden of morbidity and mortality from cardiovascular disease, metabolic bone disease and anemia. We initiated a Nurse Practitioner (NP) run CKD clinic to address these needs. Implementation of the CKD clinic resulted in appropriate CKD referrals, optimized comorbidities and became self sustainable.

Integrated Health Partners – Calhoun Country Pathways to Health

Calhoun County Pathways to Health is a multi-stakeholder initiative addressing chronic disease in Calhoun County. This coalition of employers, health plans, physicians, consumers, and community agencies developed a mission to “improve the health of Calhoun County citizens by transforming the health care delivery system and health care experience.” Through grass roots ownership, each stakeholder is addressing its role in transforming health care. The shared vision, coupled with passionate participants, creates a pathway for improved care.

Loving Hands Clinic, Inc. – Community Based Diabetes Education in a Free Clinic

We are a faith-based free medical clinic located in Lapeer County. Started in 2004, it has gone from a mobile program to help the uninsured to a freestanding clinic including primary medical care and dental services. In 2008 two volunteers, a nurse practitioner and a registered nurse, decided that our patients with diabetes needed more education opportunities. The clinic now offers classes on diabetes self-management for clinic patients, significant others and community residents. No other like classes are offered in our county.

Medical Network One—Chronic Care Travel Team (CCTT)

The Chronic Care Travel Team (CCTT) is a multidisciplinary team of health care specialists including a registered nurse, certified diabetes educator, registered dietitian, lifestyle coach, wellness counselor and exercise specialist. The CCTT brings its combined expertise to primary care physicians’ offices to evaluate, provide counseling, and reduce the risk of complications to patients with one or more of six targeted chronic diseases: diabetes, asthma, obesity, congestive heart failure, coronary heart disease, depression and lower back pain.

Mercy Primary Care Center—Improving Outcomes in Uninsured Diabetics through Increased Patient Engagement & Access to Health Care

Mercy Primary Care Center (MPCC) has improved health outcomes in uninsured patients with diabetes as measured by a decrease in hemoglobin A1c (ha1c), an increase in patients receiving eye exams, LDL kidney function testing, and foot exams, and an

increase in patient engagement. This was accomplished using a replicable model which eliminates the barriers to diabetes services, employs a diabetes registry, and utilizes a collaborative healthcare team to meet the individual needs of each patient.

OmniCare Health Plan – Kidney Kare Program

Chronic kidney disease is a worldwide public health problem associated with poor outcomes and high cost. Recognizing the individual's renal disease and initiating appropriate early-stage interventions can prevent or delay adverse outcomes. The goal of the OmniCare Kidney Kare program is to identify members at critical points in their disease process and provide actionable information to both physicians and members. The program demonstrated 4.8% in total number of members on dialysis and a 45.6% decrease in emergency room utilization.

Stephen M. Swetech, DO, Medical Center – Sweet's Survey of Sugar Supervision from Head-to-Toe

Diabetes mellitus, a costly, complex disease which can be potentially controlled with aggressive medical intervention, is a major cause of blindness, renal dysfunction, and extremity amputation/loss, and is being discovered at an alarmingly increasing rate. Health care providers are obligated and compelled by various agencies to achieve glycemic control in diabetic patients and reduce diabetes' negative health sequelae. We initiated a comprehensive program to improve compliance, and serve all ages and honor almost all insurances.

University of Michigan Health System — New Members of the Diabetes Management Team: Redefining the Role of Medical Assistants

We improved annual diabetes foot exam compliance and establishing self-management goals for patients by integrating medical assistants into the diabetes management team. The proportion of patients with annual foot exams increased from 37% to 80% and self-management goal setting from 4% to 73%. We need to evaluate who can provide the optimal care at the appropriate level of training and education of the team members, to allow us to use our financial resources wisely and provide a cost-effective model for delivery of care.