Doing Care Differently: Managing High Risk Diabetes Patients

Diabetes Center of Excellence at Primary Care Centers of Eastern Kentucky

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Objectives

1. Provide a program overview and driving force for program development.

2. Review program diabetes care management and data collection.

3. Describe projected program impact.
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WHO ARE WE?
Primary Care Centers of Eastern Kentucky (PCCEK)

Rural health clinic - based in Hazard, KY

- 3 satellite sites (Vicco, Hyden, Hindman)

- Convenient same day, evening, & weekend appointments

- Routine primary and preventative care
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June 2014 – launch of comprehensive diabetes center
DIABETES is the most expensive & widespread chronic disease & must be at the center of chronic disease management.
Goals

**Quality state of the art technologies and healthcare.**
- Diabetes care and education that is comprehensive, coordinated, cutting edge
- For those with and at risk for diabetes

**All under one roof.**
- So there’s not need to travel miles or make multiple appointments at several offices.
- All core services needed to keep our patient healthy from head to toe

**For the whole family.**
- Care for diabetes in pregnancy, pediatrics, adolescents, and adults

**Regardless of insurance status.**
- While many insurance plans do cover diabetes and nutrition education, we offer it to our patients regardless of insurance coverage
STOP THINKING ABOUT WHAT COULD GO WRONG

&

START THINKING ABOUT WHAT COULD GO RIGHT
Diabetes Center of Excellence - Mission

- Educate
- Empower
- Manage
- Support
Staff Support

It takes a village!

- 2 RD/CDE’s
- 2 Clinical Analysts
- Administrative support
- IT support
- Diabetes Care Team collaborative with Appalachian College of Pharmacy

- Additional data analyst support
  - Microclinic

- Risk Stratification Support
  - Welkin Health

- Ancillary & Case Management Support
  - Welkin Health
  - Microclinic
In addition to our premier primary care providers, our diabetes care team includes:

- CDE’s (2)
- RDN’s (1 ½-2 FTE + Consultant)
- Endocrinology
- Obstetrics (including high risk)
- Podiatry Diabetes Pedicures
- Orthopedics
- Ophthalmology
- Diabetes Pedicures (including high risk)
Services/Interventions Provided Through Diabetes Center of Excellence

- ABI/Vascular studies
- Behavioral health
- Care coordination – to help our patients get what they need, when they need it
- Continuous glucose monitoring
- Dental services
- Diabetes education and coaching by CDE’s
- Diabetes foot care -including specialized diabetes pedicures
- Diabetes support between visits by CDEs through Welkin Health mobile app
- Insulin pump therapy and clinic
- Laboratory and Radiology in-house
- Nutrition counseling with Registered Dietitian Nutritionists
- PADnet vascul testing in-house
- Pharmacy consultations / medication review
- Prenatal care for managing diabetes in pregnancy
- Retinal screening for early detection of eye disease in-house
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WHAT IS OUR PROGRAM?
Program Components

Diabetes Care Coordination

Diabetes Education & Support
Who receives Care Coordination?
- Based on referral or risk

What is included?
- Initial assessment by CDE
  - All patients receiving care coordination will ideally receive a consult for diabetes education, at least annually – more often as needed
- Tracked & coordinated care via Care Coordination Module in our EHR - alerts & prompts for care due
- Phone visits

Goals
- Continuous, comprehensive, coordinated care (getting our patients what they need, when they need it)
- Improved quality of service & health outcomes
- Partner with our patients – to help keep them as healthy as possible & ultimately prevent/reduce diabetes complications
Diabetes Education and Support

- Individual and/or Group

All those referred for Diabetes Education will receive a review for care gaps.
Diabetes Program Eligibility

- Diagnosed or undiagnosed diabetes (A1C ≥ 6.5)
- Pre diabetes (A1C 5.7-6.4) – expanded future focus

How do patients “get into” the program?

- Referrals
- Risk Level

How do we “track” patients in the program?

- Care Coordination module in EHR
- CDE progress notes
- Global alerts in EHR
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PATIENT RISK LEVELS
<table>
<thead>
<tr>
<th>Criteria:</th>
<th>Level A</th>
<th>Level B</th>
<th>Level C</th>
<th>Level D</th>
<th>Level E</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1C ≥ 9.0 %</td>
<td>▪ DM Diagnosis</td>
<td>A1C 8.0-8.9 %</td>
<td>▪ DM Diagnosis</td>
<td>▪ A1C 7.0-7.9 %</td>
<td>▪ DM Diagnosis</td>
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<tr>
<td>A1C 6.5-6.9 %</td>
<td>▪ DM Diagnosis</td>
<td>▪ Diagnosed or Undiagnosed</td>
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<table>
<thead>
<tr>
<th>Requirements:</th>
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<th>Level D</th>
<th>Level E</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician/provider visit (quarterly)</td>
<td>▪ Diabetes Education (initial and prn to achieve goals)</td>
<td>▪ Weight (each visit)</td>
<td>▪ BMI (each visit)</td>
<td>▪ Blood Pressure (each visit)</td>
<td>▪ A1C (quarterly)</td>
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<tr>
<td>Diabetes Education (initial and prn to achieve goals)</td>
<td>▪ Lipid profile (annual)</td>
<td>▪ Microalbumin/creat (annual)</td>
<td>▪ Retinal eye exam (annual)</td>
<td>▪ Foot exam (annual)</td>
<td>▪ Immunization – flu (annual); pneumococcal</td>
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<tr>
<th>Care Management Components:</th>
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</tr>
</thead>
<tbody>
<tr>
<td>▪ Case Management</td>
<td>▪ Self-Care Management</td>
<td>▪ Medication Management</td>
<td>▪ Case Management</td>
<td>▪ Self-Care Management</td>
<td>▪ Medication Management</td>
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<tr>
<td>Physician/provider visit (annual - minimum)</td>
<td>▪ Diabetes Educator – lifestyle intervention</td>
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<tr>
<td>▪ Weight (each visit)</td>
<td>▪ BMI (each visit)</td>
<td>▪ Blood Pressure (each visit)</td>
<td>▪ A1C (annual – to screen for conversion to type 2)</td>
<td>▪ Lipid profile (annual)</td>
<td>▪ Immunization – flu (annual); pneumococcal</td>
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<td>▪ Retinal eye exam (annual)</td>
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10/14
## Baseline

### Diabetes – All indications

(March-September 2014)

N= 1304 patients

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<tr>
<td></td>
<td>Average 10.6 [9.6*]</td>
<td>Average 8.4 [7.4*]</td>
<td>Average 7.4 [6.4*]</td>
<td>Average 6.7</td>
<td></td>
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<tr>
<td>87 (7%)</td>
<td>230 (18%)</td>
<td>150 (12%)</td>
<td>257 (20%)</td>
<td>150 (12%)</td>
<td>430 (33%)</td>
</tr>
</tbody>
</table>

Average A1C 8.8 [7.8*]

% rounded to whole number

*target at 6 months
Pilot Study
Subset of Level A Risk Category
Adult patients with diagnosis of diabetes and A1C >9%  
(January 1, 2014 through June 30, 2014)  

$n = 53$ patients
Barriers to Care & Key Learnings

Barriers to Care
- Transportation challenges
- Maintaining accurate contact information
- Changing providers
- No shows / Cancellations

Learnings
- Patients generally receptive to scheduling an appointment
- Getting patients in is the first step to getting their needs met and care coordinated
- Get as much care provided as possible when we do the patient in the Clinic
- Everything takes 2-3 times longer to accomplish than projected
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DIABETES EDUCATION & SUPPORT COMPONENTS
Diabetes Education & Support Components

Individual Education
Individualized education to guide & support patient in achieving health goals

Based on AADE 7™ Self Care Behaviors:
- Healthy Eating
- Being Active
- Taking Diabetes Medication
- Monitoring Blood Glucose
- Problem Solving
- Reducing Risks
- Healthy Coping
Diabetes Education & Support Components

Group Education

- Launching 2015 Q1

- Patient and community oriented

- Provide consistent information as individual education, framed up a little differently through Microclinics International (MCI) Curriculum
Think outside the box (or bowl)
About MCI

Who is MCI?

- Not-for-profit development organization
- Seeks to revolutionize how deadly diseases are prevented & managed worldwide

Vision of MCI

To make good health contagious by establishing networks of “microclinics” in less resourced areas of our world.

Microclinic = Infrastructure of people, not buildings

Microclinic Program

- An innovative contagious health solution
- Implemented through - shared education, screenings, & social support amongst friends & family which serve as nucleus of change.

1500 microclinics across 4 continents
Small groups of friends and family (microclinics) decide they want to get healthy! They join our program...

- Learn
- Share
- Engage in interactive activities
- Encourage other members to reach their health goals
- Adopt practical health behavior changes
- Periodic health screenings to monitor their progress

95% of participants that have completed the program improved in at least 1 health risk factor for obesity, diabetes, and heart disease.
Social Networks + Healthy Behaviors = CONTAGIOUS HEALTH

“I can influence my own health; I can influence the health of others; together we can positively influence the health of the entire community.”
Incentivizing Patients

• Welkin Health mobile app - Cash rewards

• Exploring other ideas
Program Follow-up and Support

Follow up

- At least annually, more often as needed and as staff resources permit

Referrals

- Building Community Resource Referrals
- Building and expanding relationships

Support

- Diabetes Coaching/Support through Welkin Health mobile app
Diabetes Coaching & Support  
Welkin Health

- Free access to mobile app and diabetes coaching by PCCEK’s CDEs (apps, text, voice)
  - 2 core focal areas for coaching – Blood glucose & Healthy Eating

- Cash rewards

- Tracking A1C, microalbumin, & LDL at 3, 6, 9, and 12 months
### Outcomes Tracking
What Do We Track?

<table>
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<tr>
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<tbody>
<tr>
<td><strong>Weight</strong></td>
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<tr>
<td><strong>BMI</strong></td>
</tr>
<tr>
<td><strong>Blood Pressure</strong> (Goal &lt;140/80)*</td>
</tr>
<tr>
<td><strong>A1C</strong> (Goal &lt;7.0)*</td>
</tr>
<tr>
<td><strong>Lipids</strong></td>
</tr>
<tr>
<td>Total Cholesterol</td>
</tr>
<tr>
<td>Triglycerides</td>
</tr>
<tr>
<td>HDL</td>
</tr>
<tr>
<td>LDL (Goal &lt;100 mg/dL)*</td>
</tr>
<tr>
<td>VLDL</td>
</tr>
<tr>
<td>Chol/HDL ratio</td>
</tr>
<tr>
<td><strong>Microalbumin / creatinine</strong></td>
</tr>
<tr>
<td><strong>Preventative immunizations</strong></td>
</tr>
<tr>
<td>Influenza</td>
</tr>
<tr>
<td>Pneumococcal</td>
</tr>
<tr>
<td><strong>Welkin Health mobile app user</strong></td>
</tr>
<tr>
<td><strong>Microclinic participant</strong></td>
</tr>
<tr>
<td><strong>Annual foot exam</strong></td>
</tr>
<tr>
<td><strong>Annual retinal exam</strong></td>
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#### Mechanisms for tracking?

- **Case Management Module**
- **Diabetes Flow sheet in EHR**
- **Global Alerts in EHR**
  - to prompt staff/providers to schedule tests & exams due

*Targets are based on ADA Clinical Practice Recommendations & Standards of Care*
What defines success?

- Improved health outcomes
- Metrics

Opportunities for Improvement?

- Follow-up appointments
- Scheduling for key diabetes related tests/exams
  At new facility – can’t leave without a follow-up and referrals schedule because of floor plan
- Deeper dive into WHY patients aren’t getting care (cost, access, transportation, etc.)
- Close loop with Provider education and feedback on how their patient pop is doing
- Expand ID of diabetes resources in the area
Why the Investment?

- It’s the right thing to do
- Vision and passion to positively impact those living with diabetes
- Significant opportunity /need
- Transforming our practice to PCMH
- Achieving HEDIS measures
- Achieving our projected outcomes
Select examples of contributions from a diabetes care & management program to compliance of:

<table>
<thead>
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<th>Patient Centered Medical Home</th>
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<tbody>
<tr>
<td>▪ Care team gives access to evidence based care and self-management support</td>
</tr>
<tr>
<td>▪ Documents behaviors affecting health</td>
</tr>
<tr>
<td>▪ Lists and reminds patient in need of at least three preventative health services</td>
</tr>
<tr>
<td>▪ Establish criteria and process to identify high risk or complex patients</td>
</tr>
<tr>
<td>▪ List and remind patients not recently seen by the practice</td>
</tr>
<tr>
<td>▪ Conducts pre-visit preparations, from a care plan and treatment goals, provide written care plan and documents barriers to treatment goals</td>
</tr>
<tr>
<td>▪ Develop and document self-management plans/goals in collaboration of patients</td>
</tr>
<tr>
<td>▪ Provide self-management tools (for patient to record self-care results) to patients/families</td>
</tr>
<tr>
<td>▪ Counsel patients/families to adopt healthy behaviors</td>
</tr>
<tr>
<td>▪ Ask patients/families about self-referrals and request specialists reports</td>
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</tbody>
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<table>
<thead>
<tr>
<th>HEDIS Measures</th>
</tr>
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<tbody>
<tr>
<td>▪ Hemoglobin A1c (A1c) testing</td>
</tr>
<tr>
<td>▪ A1c poor control (&gt;9.0%)</td>
</tr>
<tr>
<td>▪ A1c control (&lt;8.0%)</td>
</tr>
<tr>
<td>▪ A1c control (&lt;7.0%) for a selected population</td>
</tr>
<tr>
<td>▪ Medical attention for nephropathy</td>
</tr>
<tr>
<td>▪ Eye exam</td>
</tr>
<tr>
<td>▪ LDL-C screening</td>
</tr>
<tr>
<td>▪ LDL-C control (&lt;100 mg/dL)</td>
</tr>
<tr>
<td>▪ Influenza Vaccination</td>
</tr>
<tr>
<td>▪ Pneumococcal Vaccination</td>
</tr>
<tr>
<td>▪ Assistance with tobacco cessation</td>
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Projected Outcomes

- Better quality care
- More efficient care
- Improved well being of our patients
- Reduced health care costs over time

Improved experience of care
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