

Integrating Diabetes Prevention into Everyday Practice

November 7th, 2017

Presenters

Casey Borgen, BSN, PHN – Community Wellness Partners

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Medical Center



Presenters

Casey Borgen

- RN, BSN, PHN
- Community Wellness Partners -
Community Wellness Grant



DeTasha Place

- RN, BSN
- Health Coach
- Sanford Jackson & Lakefield
Clinics



Learning Objectives

- Identify 2-3 ways to increase screening and diagnosis for prediabetes
- Describe challenges and opportunities that arise from using a patient registry
- List two benefits to working with community partners to offer expanded resources to clinic patients (and the community)

Community Wellness Partners

- Collaboration between Cottonwood, Jackson and Nobles County community health boards
- Funded by 2 sources
 - Minnesota Statewide Health Improvement Partnership (SHIP)
 - Community Wellness Grant (CWG)



Community Wellness Grant

Goals

Promote health, and support and reinforce healthy behaviors through **environmental change**.

Build support for **healthy lifestyles changes**, especially for those at high risk for type 2 diabetes, heart disease and stroke.

Improve the **quality of health system care delivery** for people with the highest hypertension and prediabetes disparities.

Link **clinical and community resources** to support heart disease, stroke and type 2 diabetes prevention

Community Wellness Grant - Health Systems Component

Goal: “Improve the quality of health system care delivery for people with highest hypertension and prediabetes disparities, as well as link clinical and community resources to support heart disease, stroke and type 2 diabetes prevention.”

We accomplish this by...

- Supporting sustainable practice changes to improve care of at risk patients
- Provide patients with resources to address and improve future health through care coordination and patient engagement
- Reduce the incidences of diabetes and hypertension

Adult Healthy Lifestyle Measure Set

| # | Measure | Description |
|---|--|---|
| 1 | Controlling High Blood Pressure (NQF 0018) | Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90) during the measurement year. |
| 2 | Presence of a Hypertension Self-Management Plan | Percentage of patients with high blood pressure who have documentation of a self-management plan within the past 12 months. |
| 3 | Undiagnosed Hypertension | Percentage of adult patients whose most recent blood pressure is elevated and do not have a hypertension diagnosis. |
| 4 | Body Mass Index (BMI) Screening and Follow-Up (NQF 0421) | Percentage of adult patients with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside of normal parameters, a follow-up plan is documented within the past six months or during the current visit. |
| 5 | Tobacco Use: Screening & Cessation Intervention (NQF 0028) | Percentage of adult patients who were screened for tobacco use at least once during the two-year measurement period AND who received cessation counseling intervention if identified as a tobacco user. |
| 6 | Prediabetes: Screening and Diagnosis | Percentage of adult patients screened for diabetes with a lab value in the prediabetic range [HbA1c (5.7-6.4); Fasting Plasma Glucose (100-125)] who have a documented prediabetes diagnosis. |
| 7 | Referrals to Lifestyle-change programs | Number of persons with high blood pressure who are referred to an evidence-based lifestyle change program. |

Clinic Project Deliverables

- MDH Deliverables
 - Measure reporting tools
 - Technical assistance through Stratis Health
 - Data collection guide (Adult Healthy Lifestyle Measure Set)
 - Data analytics
 - Coordination with Health Care Homes
 - Dissemination of resources and tools
 - Coordination of learning activities

Clinic Project Deliverables ¹

- CWG deliverables
 - On and off-site practice facilitation support
 - Convener
 - Connector

Clinic Project Deliverables ²

- Clinic Deliverables
 - Completion of MN CWG clinic assessment
 - Implementation of multi-disciplinary clinic team
 - Team participation in monthly meetings with CWG staff and Stratis Health –develop and implement clinic-specific action plan
 - Utilize EHR that supports hypertension and prediabetes identification, management and referral
 - Annual collection and submission of healthy lifestyle/risk reduction set
 - Baseline and annual submission of an aggregate number of adult patients served annually
 - Communication regarding barriers to deliverables

Why Sanford Jackson – Lakefield Clinics?

- Established partnership
- Project champion
- Clinic Director oversees 3 clinics in our grant area
- Sanford Jackson – Lakefield Clinics are 2 of 3 clinics located in Jackson County
- Rural Health Clinic

Sanford Jackson – Lakefield Clinics

- Adult patient population - 3,557
- Nearly half of patients publicly insured
- 5 Family Medicine providers – 3 CNPs, 1 Physician Assistant, 2 MDs



SANFORD
Jackson

Prediabetes Diagnosis Measure

| # | Measure | Description | Total Patients | Met Measure | % |
|---|-----------------------|---|----------------|-------------|------|
| 6 | Prediabetes Diagnosis | Percentage of adult patients screened for diabetes with a lab value in the prediabetic range [HbA1c (5.7-6.4); Fasting Plasma Glucose (100-125)] who have a documented prediabetes diagnosis (790.2x). ² | 933 | 81 | 8.7% |

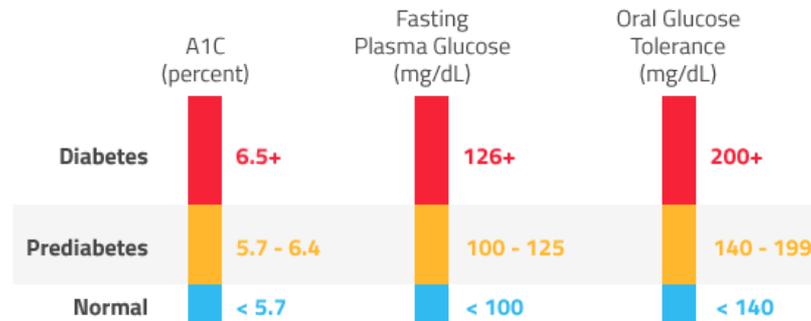
933 patients had lab values falling in prediabetic ranges, but only 81 had a documented prediabetes diagnosis.

What is Prediabetes?

- Prediabetes is a condition in which blood glucose or hemoglobin A1C levels are higher than normal but not high enough to be diagnosed as type 2 diabetes.

PREDIABETES TESTING¹

There are 3 standard test options to identify prediabetes.



Prevalence



84 MILLION ADULTS HAVE PREDIABETES¹

9 OF **10** DON'T KNOW THEY HAVE PREDIABETES²

1 IN **3** ADULTS HAS PREDIABETES¹

1 IN **2** — **age 65+**

Why Do We Care?

PROGRESSION FROM PREDIABETES TO DIABETES

Without intervention, depending on where an individual is on the prediabetes spectrum:



The population with prediabetes is heterogeneous and those at the higher end of the prediabetes spectrum have a higher risk of developing type 2 diabetes.

Why Do We Care?

WHY ACT NOW?

Compared to people without diabetes, those with diabetes are:



By referring patients to the National DPP, a lifestyle change program, you can help them lower their risk of developing type 2 diabetes as well as reduce the likelihood of:



Prediabetes is reversible!

Why Do We Care?

COST OF DIAGNOSED DIABETES¹

TOTAL EST. COST IN 2012

\$245
BILLION

\$176_B IN DIRECT MEDICAL COSTS

\$69_B IN REDUCED PRODUCTIVITY

PEOPLE WITH DIAGNOSED DIABETES



\$13,700 / YR AVG. MEDICAL EXPENSES

\$7,900 / YR AVG. DIABETES EXPENSES

2.3x HIGHER EXPENSES THAN THOSE w/o DIABETES

>1 IN 5 HEALTH CARE DOLLARS

Knowledge Check

- Approximately how many US adults have prediabetes?
 - A. 1 in 2
 - B. 9 in 10
 - C. 1 in 3

Knowledge Check

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 - A. 1 in 2
 - B. 9 in 10
 - C. **1 in 3**

Knowledge Check

- Approximately 15-30% of individuals with prediabetes will convert to type 2 diabetes in ____ years?
 - A. 5 years
 - B. 2 years
 - C. 10 years

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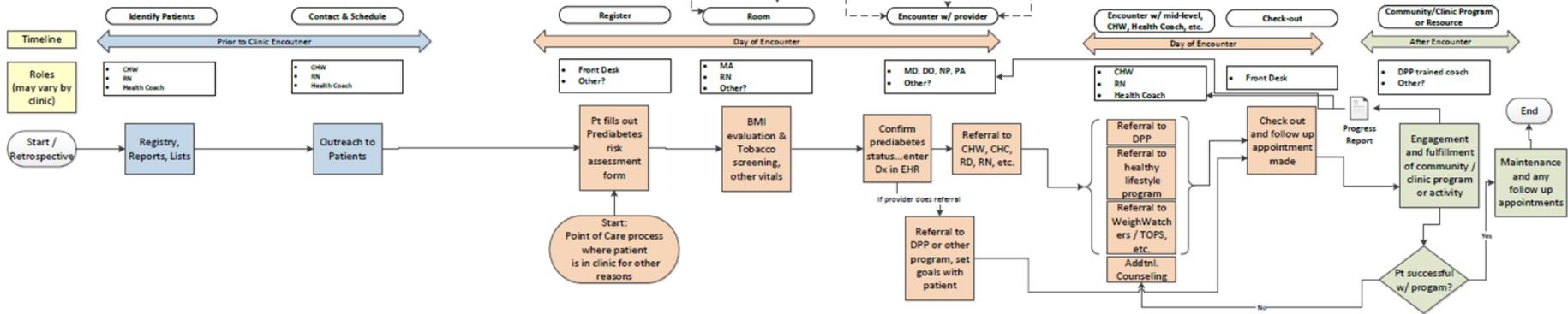
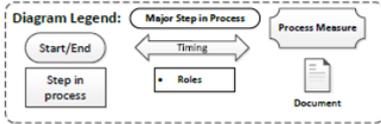
Our Process



- Monthly in-person meetings
- Stratis Health present via Zoom
- Update and refer to action plan
- Walk away with tangible to-do's for the month
- Communicate in-between meetings as necessary

Guiding Documents - Prediabetes End-to-End Workflow and Action Plan

Community Wellness Grant
Prediabetes End to End
Workflow
- Sanford Jackson/Lakefield
Clinic -
Mar. 20, 2017



Best Practices – Identify Pts. Using registry / patient list (Action Plan 3.0)

- Implement registry with A1C or FGT criteria (+ other criteria)
- Run registry and appoint person to own and utilize registry
- Risk stratify the registry
-

Best Practices – Contact and schedule Pts. (Action Plan 4.0)

- Review registry and check EMR Pt chart for comorbidities
- Contact Pts at highest risk
- Contact Pts who have been engaged with the clinic first (last xx months or 1-2 years)

Best Practices – Register / Check-in (Action Plan 5.0)

- Provide Pts with Prediabetes risk screening (for which Pts?)
- Pre-visiting Planning

Best Practices – Rooming (Action Plan 6.0)

- BMI at every visit? (Height frequency?)
- Review pre-diabetes screening form (complete?)

Best Practices – Encounter w/ Provider & Referrals (Action Plan 7.0 & 9.0)

- Protocol to identify Pts in Pre-D lab ranges (A1C/FGT, OGTT)
- Provider reviews risk screening form
- Order labs to confirm prediabetes if needed
- Utilize MI
- Goal Setting with Pts
- Enter prediabetes as a diagnosis
- Refer to other clinic staff for coaching and/or program referral

Best Practices – Encounter w/ CHW/ Health Coach & Referrals (Action Plan 8.0 & 9.0)

- Discuss goal setting
- Use MI skills
- Set goals if not already done by provider
- Provide Pt with education materials that is literacy and culturally appropriate
- Confirm follow up on any referrals

Best Practices – Check out (Action Plan 10.0)

- Set follow up appointment within prescribed guidelines (xx weeks or xx months)
- Set up appointment with Health Coach, CHW, other staff as needed.

Best Practices – Community/Clinic programs and resources (Action Plan 11.0)

- Provide progress reports on schedule basis to mid-level, CHW or provider
- Work with clinic to determine information needed on progress report
- Notify clinic of any program no-shows or drop-outs
- Start or continue NDPP classes

| Objective / Action Item/Tasks | Lead | Deadline | Complete | Monthly Notes /Action Items |
|-------------------------------|------|----------|----------|-----------------------------|
|-------------------------------|------|----------|----------|-----------------------------|

PREDIABETES (and Obesity) - best practices for the clinic end to end workflow

| | | | | |
|---|--|--|--|--|
| 1. Make diabetes prevention a practice priority & 2. Education and training efforts - applicable to entire process | | | | |
| | | | | |
| | | | | |
| 3. Identify Pts using registry/Patient list | | | | |
| Implement registry with A1C or Fasting Glucose Test (and/or other criteria) to identify at-risk patients | | | | |
| Run registry and stratify/rank for highest risk patients | | | | |
| Develop protocol on how you will follow patients over time that have been identified on the registry | | | | |
| Develop follow up process for retrospective identification | | | | |
| | | | | |
| | | | | |
| 4. Contact and Schedule Patients | | | | |
| Review registry and check EMR patient chart for comorbidities | | | | |
| Contact patients at highest risk and schedule provider appointment | | | | |
| Rank registry for patients who are engaged in their care (recent visits within past x months/ x years) | | | | |
| | | | | |
| | | | | |
| 5. Register / Check-in | | | | |
| Provide pre-diabetes risk screening document to patients (determine which patients will receive this) | | | | |
| Discuss previsit planning and incorporation of pre-diabetes risk screening, visit discussion topics | | | | |

| | | | | |
|--|--|--|--|--|
| 6. Rooming | | | | |
| Develop or reeview policy/practice/protocol to measure BMI on every patient (plus frequency of height/weight measurement for BMI calculations) | | | | |
| Review pre-diabetes risk screening tool for completeness and prep for provider's use | | | | |
| | | | | |
| | | | | |
| 7. Encounter with Provider | | | | |
| Develop protocol to Identify patients with prediabetes at point of care (if no FGT, A1C) | | | | |
| Order labs to confirm prediabetes if needed | | | | |
| Enter prediabetes as a diagnosis (also in support of quality metrics) | | | | |
| Utilize appropriate Clinical Decision Support, dot phrases or other EMR functionality to support prediabetes diagnosis and 'next steps' for provider | | | | |
| Utilize Motivational Interviewing to help patient take next steps and set their goals | | | | |
| Utilize patient goal setting materials/resources and/or enter goals in EMR to print on End of Vist summary | | | | |
| Referral to NDPP program or other evidence based programs | | | | |
| Refer / hand-off to other clinic staff who will make program referral and do needed patient education | | | | |
| | | | | |
| | | | | |
| 8. Encounter with CHW, Health Coach | | | | |
| Set goals with patient (utilize goal 1 page document)...utilize motivational interviewing techniques with patient | | | | |
| Referral to NDPP program or other evidence based programs (include documentation in patient chart for provider) | | | | |
| Confirm means/methods to follow up with referral program/resource to ensure patient follows through (similar to medication adherence) | | | | |
| Healthy eating and lifestyle education | | | | |

| | | | | |
|--|--|--|--|--|
| 9. Referrals | | | | |
| Determine best possible methods of referring to external resources utilizing EMR (fax/paper secondary) | | | | |
| Discuss referral process with program or resource you are referring to and set up 'close the loop' feedback report | | | | |
| Define data / info needed by provider, CHW, Health Coach on feedback report | | | | |
| Determine frequency or 'events' to trigger 'close the loop' feedback reports | | | | |
| | | | | |
| | | | | |
| 10. Check-out | | | | |
| Confirm follow up appointments with patients for provider or other clinic staff | | | | |
| Provide end of visit summary that may have prediabetes information addendums | | | | |
| | | | | |
| | | | | |
| 11. Community / Clinic Program and Resources | | | | |
| Start/Support community NDPP or in house NDPP | | | | |
| Referral to NDPP program or other evidence based programs | | | | |
| Confirm that program is providing feedback report to provider and/or clinic | | | | |
| Confirm that program is providing no-show and drop-out reports to provider and/or clinic | | | | |

Making Diabetes Prevention a Practice Priority

- Staff education efforts
 - Review existing Diabetes Treatment and Screening algorithm
 - Education at monthly provider meetings

Pre-diabetes Screening & Treatment Quick Guide

Current or previous random glucose >100 → Order A1C

A1C > 6.5 → Diabetes

Fasting Plasma Glucose >126 → Diabetes

A1C 5.7-6.4 → Pre-diabetes

Fasting Plasma Glucose 100-125 → Pre-diabetes

Pre-diabetes OR Diabetes → Health Coach Referral

Pre-diabetes → Consider Metformin if age <60 , BMI >35 , or hx gestational diabetic

- Peer based EMR training
- Motivational Interviewing training

Registry

- Sanford released pre-diabetes registry
- Trial chart audit
- Outreach- bulk mailings and messages
- Things to take into consideration (people on the registry who shouldn't be, people not on the registry)

Identifying Patients

Quality Gaps:

- A1C >8 or not done in past year
- No statin prescribed
- Tobacco use with diabetes, CAD, or PVD
- No aspirin prescribed
- Elevated blood pressure (>140/90)
- Asthma Control Test < 20 or not done in past year
- Asthma Action Plan due
- Depression PHQ-9 elevated or due for recheck
- Fasting Glucose _____ A1C _____
Add Pre-diabetes to problem list

Referral Suggestions:

- I Can Prevent Diabetes
- Diabetic Education (RN and RD) ← last visit:
- RN Health Coach ← last visit:
- Medical Home enrolled- RN Health Coach visit today

- Pre-visit planning
- Provider gap cards

Outreach

- Drafted 2 letters – reviewed at provider meeting, patient advisory board
- Initial outreach to coincide with recruitment period for I Can Prevent Diabetes!
- Able to contact patients based on preference (letter in the mail, MyChart notification, phone call)

Check in/Rooming

- BMI
- BPA for doctors and nurses adding prediabetes to problem list – adding diagnosis to problem list, creat plan to fulfill measure
- Physical activity as vital sign
- Trial risk test soon

Are you at risk for type 2 diabetes?

ALERT!DAY
TYPE 2 DIABETES AWARENESS

WRITE YOUR SCORE
IN THE BOX.

- How old are you?**
 Less than 40 years (0 points)
 40-49 years (1 point)
 50-59 years (2 points)
 60 years or older (3 points)
- Are you a man or a woman?**
 Man (1 point) Woman (0 points)
- If you are a woman, have you ever been diagnosed with gestational diabetes?**
 Yes (1 point) No (0 points)
- Do you have a mother, father, sister or brother with diabetes?**
 Yes (1 point) No (0 points)
- Have you ever been diagnosed with high blood pressure?**
 Yes (1 point) No (0 points)
- Are you physically active?**
 Yes (0 points) No (1 point)
- What is your weight category?**
See chart at right.

| Height | Weight (lbs.) | | |
|--------|---------------|---------|------|
| 4' 10" | 119-142 | 143-190 | 191+ |
| 4' 11" | 124-147 | 148-197 | 198+ |
| 5' 0" | 128-152 | 153-203 | 204+ |
| 5' 1" | 132-157 | 158-210 | 211+ |
| 5' 2" | 136-163 | 164-217 | 218+ |
| 5' 3" | 141-168 | 169-224 | 225+ |
| 5' 4" | 145-173 | 174-231 | 232+ |
| 5' 5" | 150-179 | 180-239 | 240+ |
| 5' 6" | 155-185 | 186-246 | 247+ |
| 5' 7" | 159-190 | 191-254 | 255+ |
| 5' 8" | 164-196 | 197-261 | 262+ |
| 5' 9" | 169-202 | 203-269 | 270+ |
| 5' 10" | 174-208 | 209-277 | 278+ |
| 5' 11" | 179-214 | 215-285 | 286+ |
| 6' 0" | 184-220 | 221-293 | 294+ |
| 6' 1" | 189-226 | 227-301 | 302+ |
| 6' 2" | 194-232 | 233-310 | 311+ |
| 6' 3" | 200-239 | 240-318 | 319+ |
| 6' 4" | 205-245 | 246-327 | 328+ |

1 point 2 points 3 points

If you weigh less than the amount in the left column: 0 points

Adapted from Bang et al., Ann Intern Med 151:775-783, 2009.
Original algorithm was validated without gestational diabetes as part of the model.

If you scored 5 or higher:

ADD UP
YOUR SCORE.

You are at increased risk for having type 2 diabetes. However, only your doctor can tell for sure if you do have type 2 diabetes or prediabetes, a condition in which blood glucose levels are higher than normal but not yet high enough to be diagnosed as diabetes. Talk to your doctor to see if additional testing is needed.

Type 2 diabetes is more common in African Americans, Hispanics/Latinos, Native Americans, Asian Americans, and Native Hawaiians and Pacific Islanders.

Higher body weight increases diabetes risk for everyone. Asian Americans are at increased diabetes risk at lower body weight than the rest of the general public (about 15 pounds lower).



The good news is you can manage your risk for type 2 diabetes. Small steps make a big difference in helping you live a longer, healthier life.

For more information, visit us at diabetes.org/alertday or call 1-800-DIABETES (800-342-2383).

Standard Protocol

- Sanford equips staff with standard treatment protocols for:
 - Diabetes Screening
 - Lab ordering
 - Diagnosis
 - Appropriate educational handouts to give
 - Appropriate referrals and follow up
 - Nursing protocol orders

Encounter with Provider

- Results Review
- Best Practice Alerts
- Goal Setting
- Referral Orders
- Health Maintenance, Follow Up

Encounter with Health Coach

- Lifestyle change education
- Goal setting
- Follow up with patient every 3 months or more if needed
- Referral

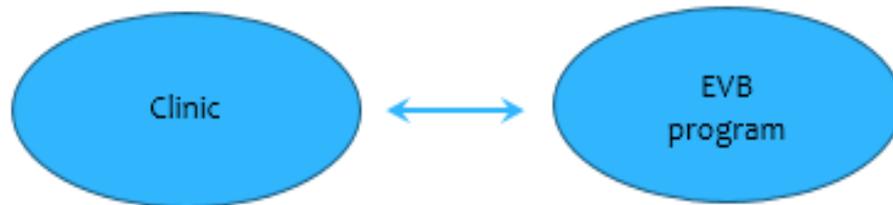
Referral to Clinic Programs and Community Resources

- I Can Prevent Diabetes! Program
 - Extension Lifestyle Coach and RN Health Coach handoff
- Taking Off Pounds Sensibly (TOPS)
- Chronic Disease Self Management Program (CDSMP)
- Sanford Profile
- Local Fitness Centers & Community Education



Work in Progress

- Better identification of at-risk patients who are not coming in for well-checks
- Enhance bi-directional referral to ICPD and other evidence-based programs
- Sustainability



Questions?

- Follow up questions can be directed to:
 - Casey Borgen – cborgen@co.nobles.mn.us
 - DeTasha Place – detasha.place@sanfordhealth.org

