Integrating Diabetes Prevention into Everyday Practice
November 7th, 2017

Presenters
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DeTasha Place, RN, BSN, Health Coach – Sanford Jackson 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

<table>
<thead>
<tr>
<th>Promotion</th>
<th>Details</th>
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</thead>
<tbody>
<tr>
<td>Promote health, and support and reinforce healthy behaviors through <strong>environmental change</strong>.</td>
<td></td>
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<tr>
<td>Build support for <strong>healthy lifestyles changes</strong>, especially for those at high risk for type 2 diabetes, heart disease and stroke.</td>
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<tr>
<td>Improve the <strong>quality of health system care delivery</strong> for people with the highest hypertension and prediabetes disparities.</td>
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<tr>
<td>Link <strong>clinical and community resources</strong> to support heart disease, stroke and type 2 diabetes prevention</td>
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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

<table>
<thead>
<tr>
<th>#</th>
<th>Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Controlling High Blood Pressure (NQF 0018)</td>
<td>Percentage of patients 18-85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (&lt;140/90) during the measurement year.</td>
</tr>
<tr>
<td>2</td>
<td>Presence of a Hypertension Self-Management Plan</td>
<td>Percentage of patients with high blood pressure who have documentation of a self-management plan within the past 12 months.</td>
</tr>
<tr>
<td>3</td>
<td>Undiagnosed Hypertension</td>
<td>Percentage of adult patients whose most recent blood pressure is elevated and do not have a hypertension diagnosis.</td>
</tr>
<tr>
<td>4</td>
<td>Body Mass Index (BMI) Screening and Follow-Up (NQF 0421)</td>
<td>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.</td>
</tr>
<tr>
<td>5</td>
<td>Tobacco Use: Screening &amp; Cessation Intervention (NQF 0028)</td>
<td>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.</td>
</tr>
<tr>
<td>6</td>
<td>Prediabetes: Screening and Diagnosis</td>
<td>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.</td>
</tr>
<tr>
<td>7</td>
<td>Referrals to Lifestyle-change programs</td>
<td>Number of persons with high blood pressure who are referred to an evidence-based lifestyle change program.</td>
</tr>
</tbody>
</table>
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

• CWG deliverables
  • On and off-site practice facilitation support
  • Convener
  • Connector
Clinic Project Deliverables

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

<table>
<thead>
<tr>
<th>#</th>
<th>Measure</th>
<th>Description</th>
<th>Total Patients</th>
<th>Met Measure</th>
<th>%</th>
</tr>
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<tr>
<td>6</td>
<td>Prediabetes Diagnosis</td>
<td>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</td>
<td>933</td>
<td>81</td>
<td>8.7%</td>
</tr>
</tbody>
</table>

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

https://preventdiabetesstat.org/index.html
Why Do We Care?

PROGRESSION FROM PREDIABETES TO DIABETES

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

15% - 30% of people with prediabetes1

within 5 YEARS

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.

https://preventdiabetesstat.org/index.html
**Why Do We Care?**

**WHY ACT NOW?**

Compared to people without diabetes, those with diabetes are:

- **100%** more likely to develop hypertension¹
- **80%** more likely to be hospitalized for heart attack²
- **50%** more likely to be hospitalized for a stroke³
- **70%** more likely to die from heart disease or stroke⁴

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:

[ILLNESS](#) [MEDICATION](#) [EXPENSE](#)

Prediabetes is **reversible**!

[https://preventdiabetesstat.org/index.html](https://preventdiabetesstat.org/index.html)
Why Do We Care?

COST OF DIAGNOSED DIABETES

TOTAL EST. COST IN 2012

$245 BILLION

$176B IN DIRECT MEDICAL COSTS

$69B 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

https://preventdiabetesstat.org/index.html
Knowledge Check

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

- Approximately how many US adults have prediabetes?
  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
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
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
# 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 review 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 |

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<th>7. Encounter with Provider</th>
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<tr>
<td>Develop protocol to identify patients with prediabetes at point of care (if no FGT, A1C)</td>
</tr>
<tr>
<td>Order labs to confirm prediabetes if needed</td>
</tr>
<tr>
<td>Enter prediabetes as a diagnosis (also in support of quality metrics)</td>
</tr>
<tr>
<td>Utilize appropriate Clinical Decision Support, dot phrases or other EMR functionality to support prediabetes diagnosis and 'next steps' for provider</td>
</tr>
<tr>
<td>Utilize Motivational Interviewing to help patient take next steps and set their goals</td>
</tr>
<tr>
<td>Utilize patient goal setting materials/resources and/or enter goals in EMR to print on End of Visit summary</td>
</tr>
<tr>
<td>Referral to NDPP program or other evidence-based programs</td>
</tr>
<tr>
<td>Refer/hand-off to other clinic staff who will make program referral and do needed patient education</td>
</tr>
</tbody>
</table>

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<tr>
<th>8. Encounter with CHW, Health Coach</th>
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<tbody>
<tr>
<td>Set goals with patient (utilize goal 1 page document)… utilize motivational interviewing techniques with patient</td>
</tr>
<tr>
<td>Referral to NDPP program or other evidence-based programs (include documentation in patient chart for provider)</td>
</tr>
<tr>
<td>Confirm means/methods to follow up with referral program/resource to ensure patient follows through (similar to medication adherence)</td>
</tr>
<tr>
<td>Healthy eating and lifestyle education</td>
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</table>
## 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 dropout 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
• 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

- Pre-visit planning
- Provider gap cards

**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
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?

1. 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)

2. Are you a man or a woman? ...........................
   - Man (1 point)
   - Woman (0 points)

3. If you are a woman, have you ever been diagnosed with gestational diabetes? ...........
   - Yes (1 point)
   - No (0 points)

4. Do you have a mother, father, sister or brother with diabetes? ..........................
   - Yes (1 point)
   - No (0 points)

5. Have you ever been diagnosed with high blood pressure? .................................
   - Yes (1 point)
   - No (0 points)

6. Are you physically active? ...........................
   - Yes (0 points)
   - No (1 point)

7. What is your weight category? ........................
   - See chart at right.

If you scored 5 or higher:
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).

Add up your score:

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

1 point 2 points 3 points

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/aiertday or call 1-800-DIABETES (800-342-2363).
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