

Patient-Centered Diabetes Care Innovations from the Utah Beacon Communities Project

Sarah Woolsey, MD and Korey Capozza, MPH

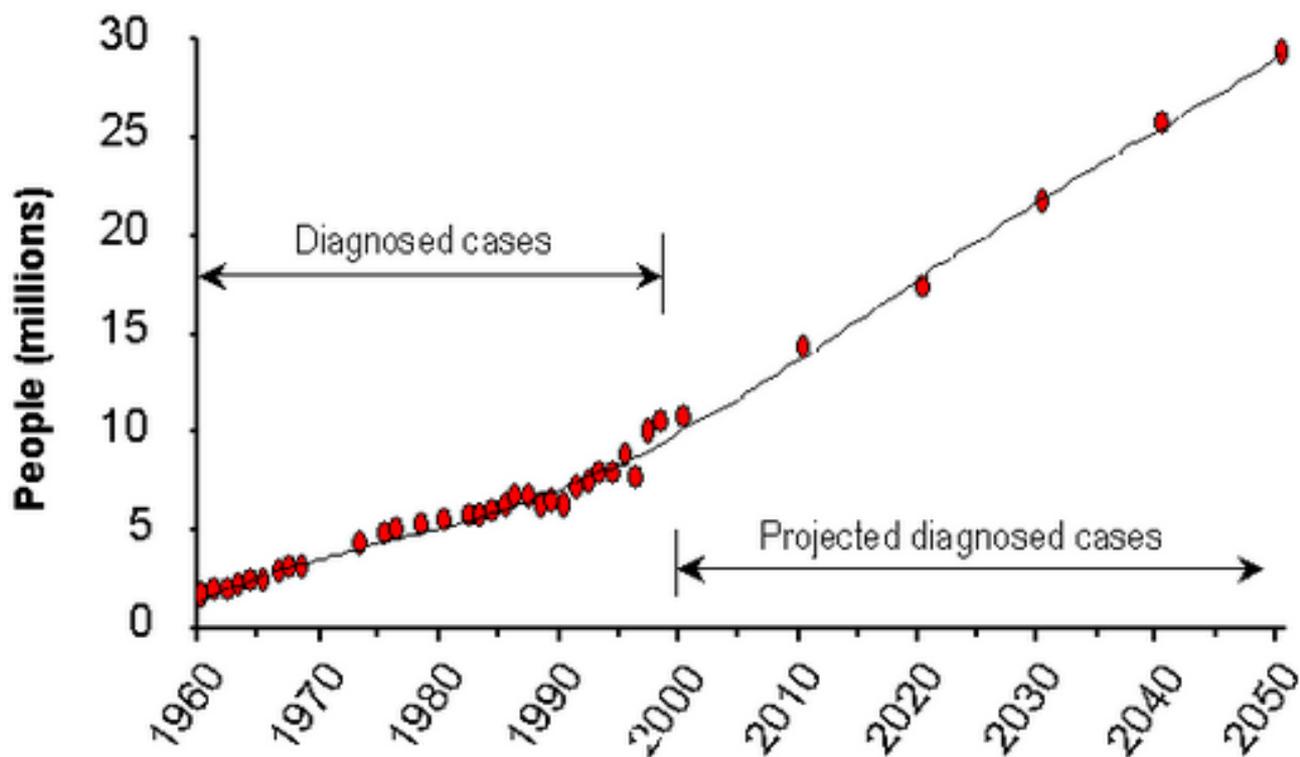
Utah Telehealth Series

March 20th, 2013



2050: 1 in 5 adult Americans with diabetes

Figure 3. Prevalence of Diagnosed Diabetes in the United States
Diagnosed (1960-1998) and Projected Diagnosed (2000-2050) Cases



Source: Data for 1960-1998 from the National Health Interview Survey, NCHS, CDC

How can we escape this diabetes epidemic/cost tsunami?

- Prevention
- Improve outcomes for diagnosed patients
- Find new, effective, low-cost ways of delivering care



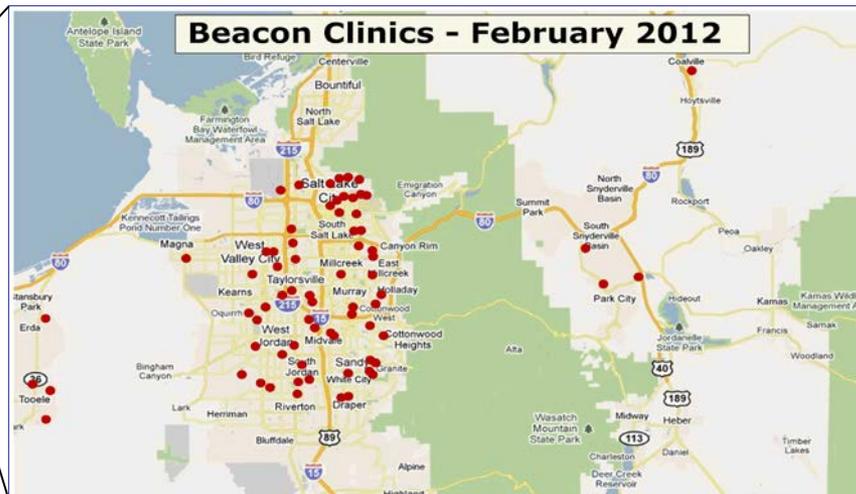
Goal: Improve diabetes outcomes across our region



Patient engagement tools



Clinical process improvement



Demonstrate Improvement Diabetes Care Measures



Beacon Community Clinical Successes

- Demonstrating improvement on 8 Diabetes care measures using EHR
 - Population health management
 - **Care Coordination**
 - Care delivery re-design
- Attaining Meaningful Use Stage 1
- Developing patient self-management programs
 - Clinical educators, CDEs
 - Group visits
 - **Care4Life SMS program**
 - **Stanford Chronic Disease Self Management Program, On-Line**



Today's Learning Objectives

- Understand new technology tools for diabetes self-management support
- Understand opportunities to leverage clinical and support staff for office-based care coordination

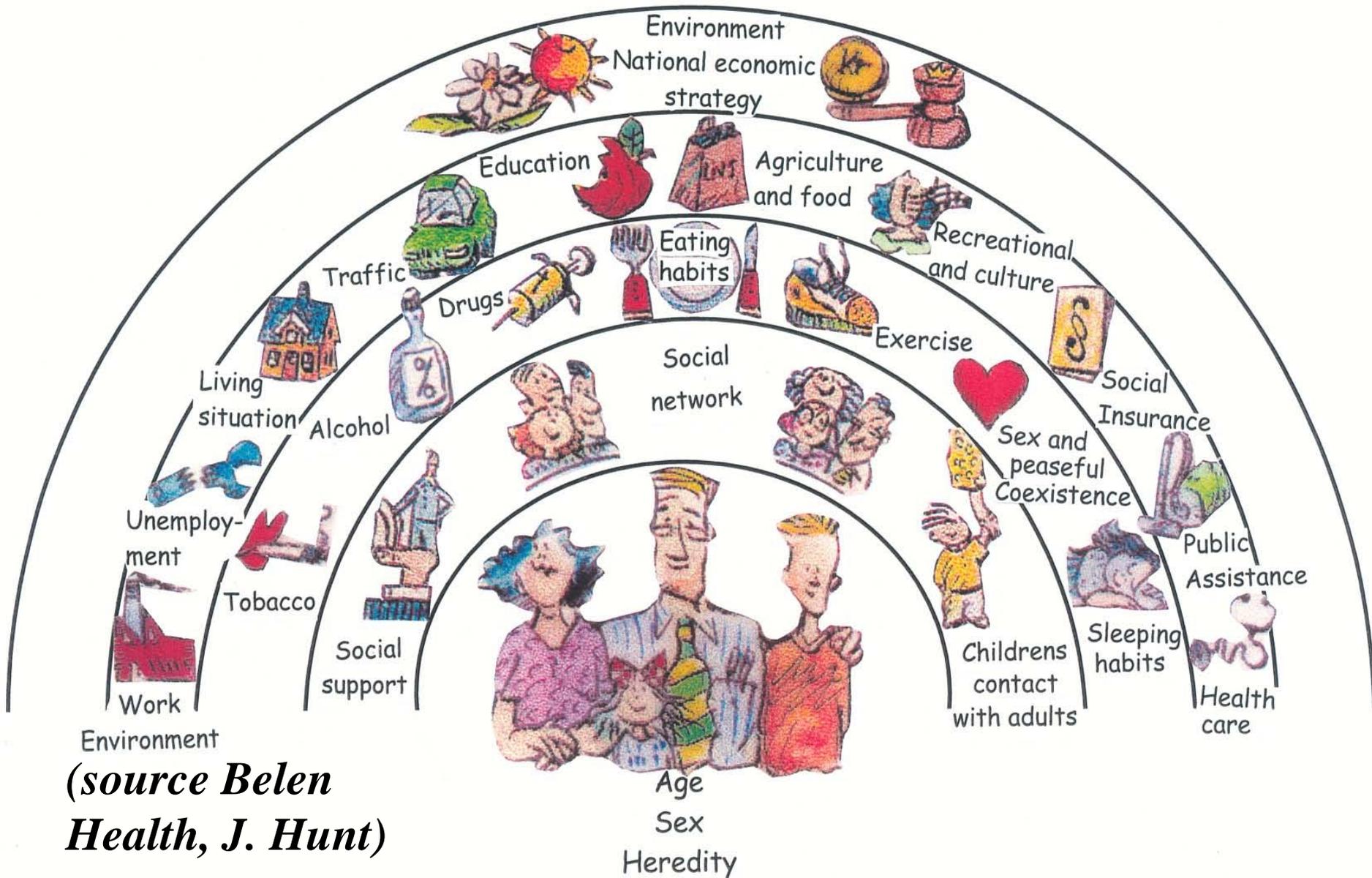


Beacon Care Coordination Pilot

Why are some of our patients
unable to get to goal? And what
can we do about it?



Determinants of health



Primary Drivers of Patient measures at goal	Secondary Drivers	Changes to test
Access to care	Communication to clinical staff	Care coordinator oversight, EMR templates for care tracking
	Appointment access/cost	
Adherence to therapies	Self-management/goal setting	Motivational interviewing training, care plan development, diabetes confidence questionnaire, complex factor EMR query of high risk DM2 patients
	System ability to identify of highest risk patients and track them	
Social network support	Connection to community resources/family support	Develop resource website for clinics/train coordinators in social support resources/develop network of care coordinators for ongoing learning

Care Coordination



- “The calculated integration of patient care activities *between* two or more participants, to facilitate the suitable provision of health care services”*
- Part of “Medical Home”
- Designed for all or *highest-risk patients*

*Closing the Quality Gap: A Critical Analysis of Quality Improvement Strategies (Vol. 7: Care Coordination). Technical Reviews, No. 9.7. McDonald KM, Sundaram V, Bravata DM, et al. Rockville (MD): Agency for Healthcare Research and Quality (US); 2007 Jun.

Essential Care Tasks and Associated Coordination Activity



- IDENTIFY and ASSESS PATIENT *Determine Likely Coordination Challenges, determine patients vulnerable to disconnected care*
- DEVELOP CARE PLAN *Proactive Plan for Coordination Challenges and Follow-up*
- IDENTIFY PARTICIPANTS IN CARE AND SPECIFY ROLES *Specify Who is Primarily Responsible for Coordination (Medical Home)*
- EXECUTE CARE PLAN *Implement Coordination Interventions*
- COMMUNICATE TO PATIENTS /Family AND ALL OTHER CARE PARTICIPANTS *Ensure Information Exchange Across Care Interfaces*
- MONITOR AND ADJUST CARE *Monitor For and Address Coordination Failures*
- EVALUATE HEALTH OUTCOMES *Identify Coordination Problems that Impact Outcomes*



Beacon Care Coordination Curriculum

- Understand Care Coordination and Self-Management
- Identify high risk patients in your system
- Assessing patients' needs and goals
 - Health Literacy
 - Motivational Interviewing
 - Stages of Change
 - Teach Back
- Implementing Care Coordination in your setting
 - EHR assessment and use
 - Care Plan documentation
 - Resource Availability
 - Who, What Where, When of the role



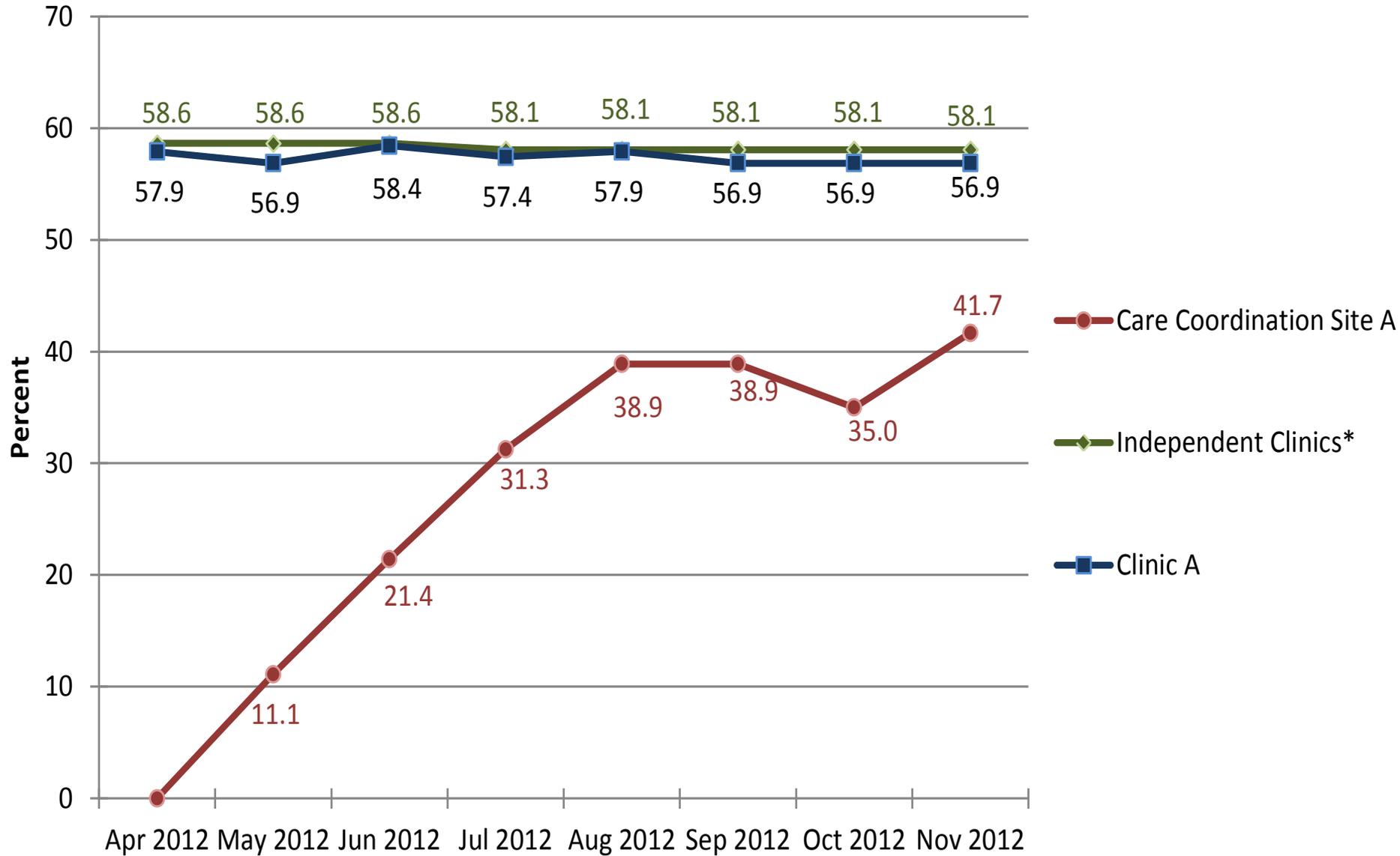
Pilot Clinic

- Urban Private Family Practice
- High number of refugees, hospital unassigned referrals
- 414 diabetes patients, 4 FTE
- Attained high levels of improvement on 8 DM measures
- Processes for Diabetes Population Care developed
- One RN manager, but no resources for hiring a CDE or Case Manager

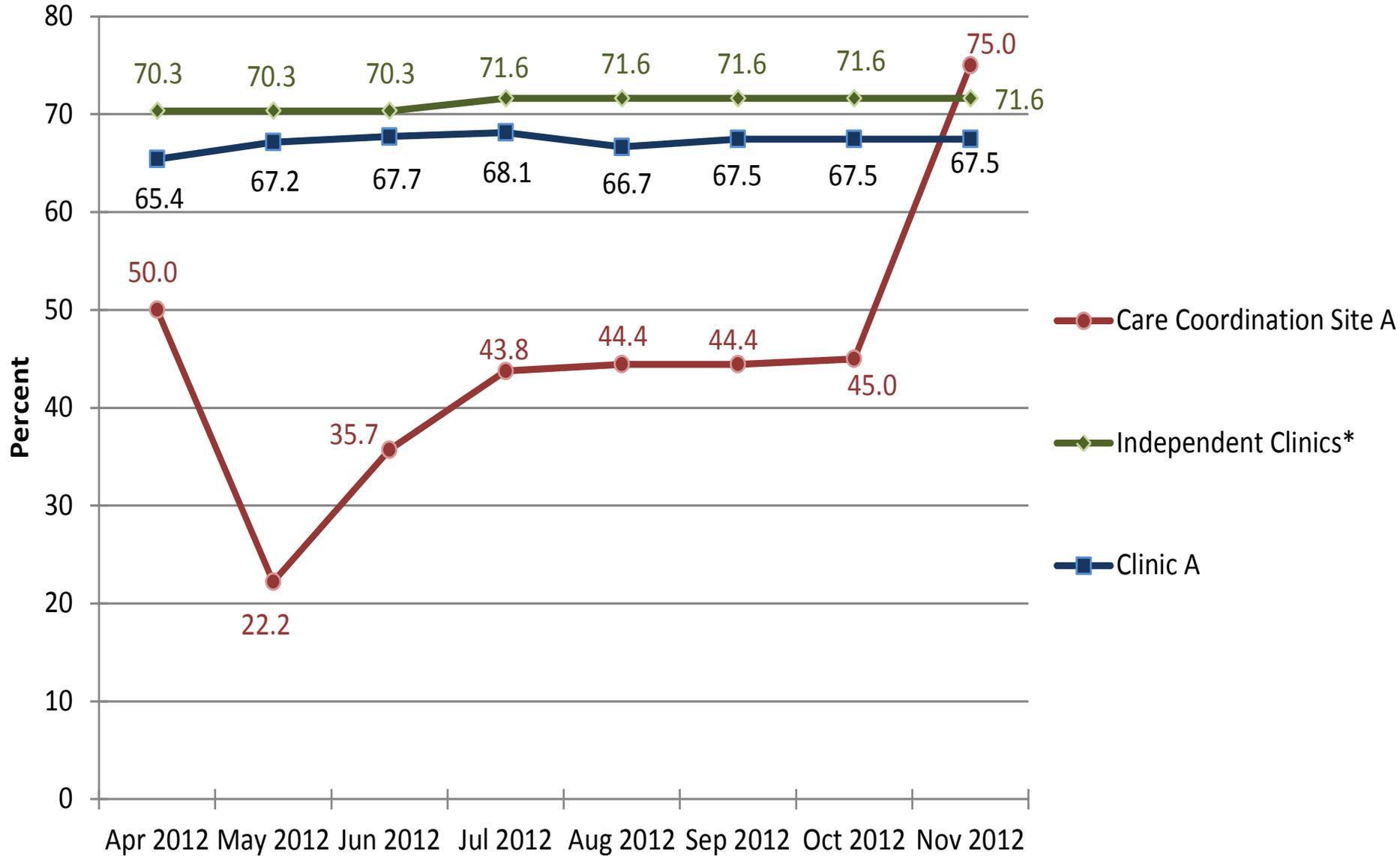
What to do about those people with A1c >10, maybe not accessing care, and socially complex?



Percent of HbA1c In-Control



Percent of BP In-Control



The Story Continues

- Practice has now hired a full time MA Care Coordinator, found affordable
- Care Coordinator manages transitions
- Billing Medicaid/Medicare as appropriate
- Sent all staff to training on Motivational Interviewing
- Continue to update documentation in EHR



What can you do?

- Assess your system for patients that might need advanced care
- Assess your EHR for ability to track complex patients
- Consider the benefits of advanced trainings for Medical Assistants/RN staff to coordinate care
- Explore opportunities to bill for coordinated care
- Explore reimbursement contracts that support development of a skilled coordination team (Medical home)
- **Improve outcomes for your highest-risk patients**



Beacon Patient Engagement Programs to Support Behavior Change

1. Care4Life
2. Text2Quit
3. Stanford CDSMP



30-50% of adults with type 2 diabetes are poorly controlled



Behavior Change



Mobile Phone Tools for Patient Support



RN Care Manager



1:750

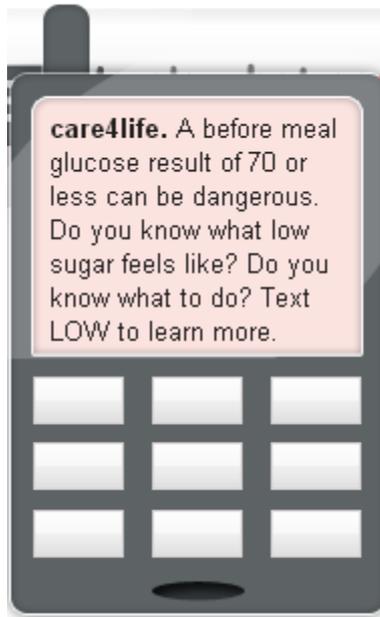


Care4Life

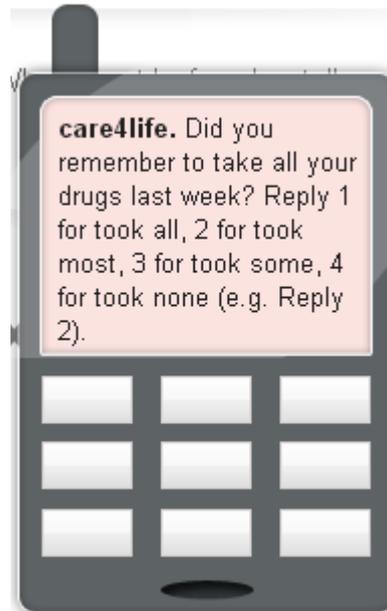


1:500,000+





Blood Glucose Tracking



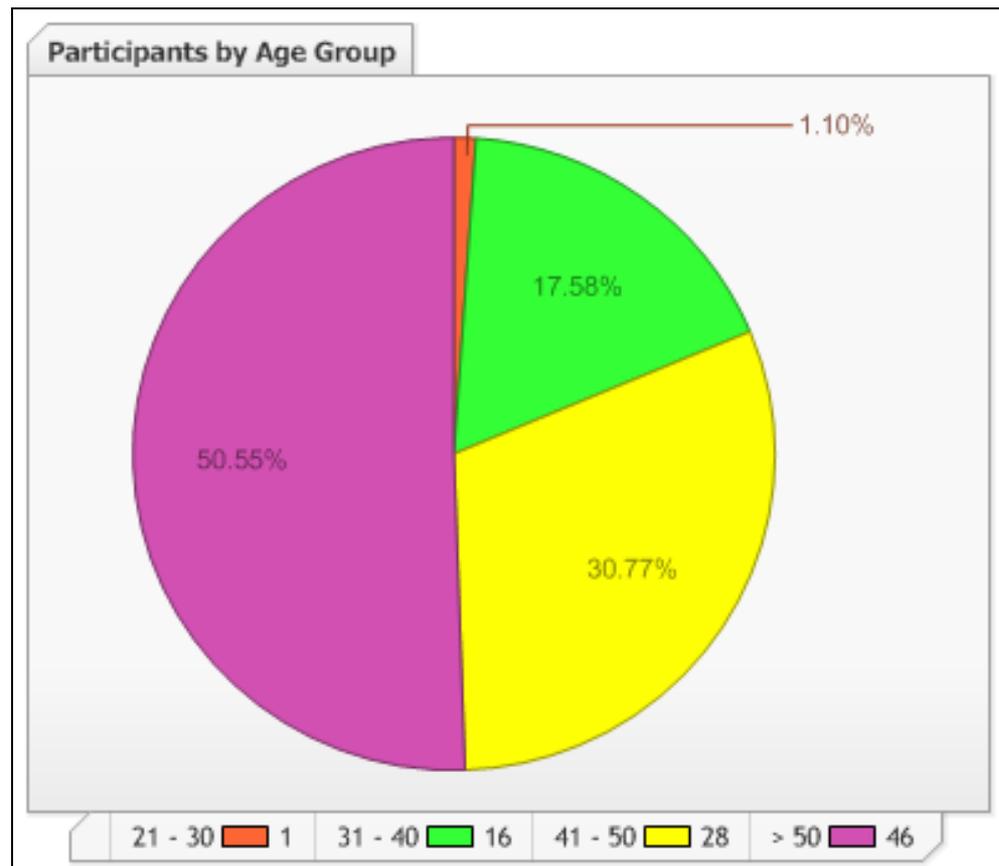
Medication Reminders



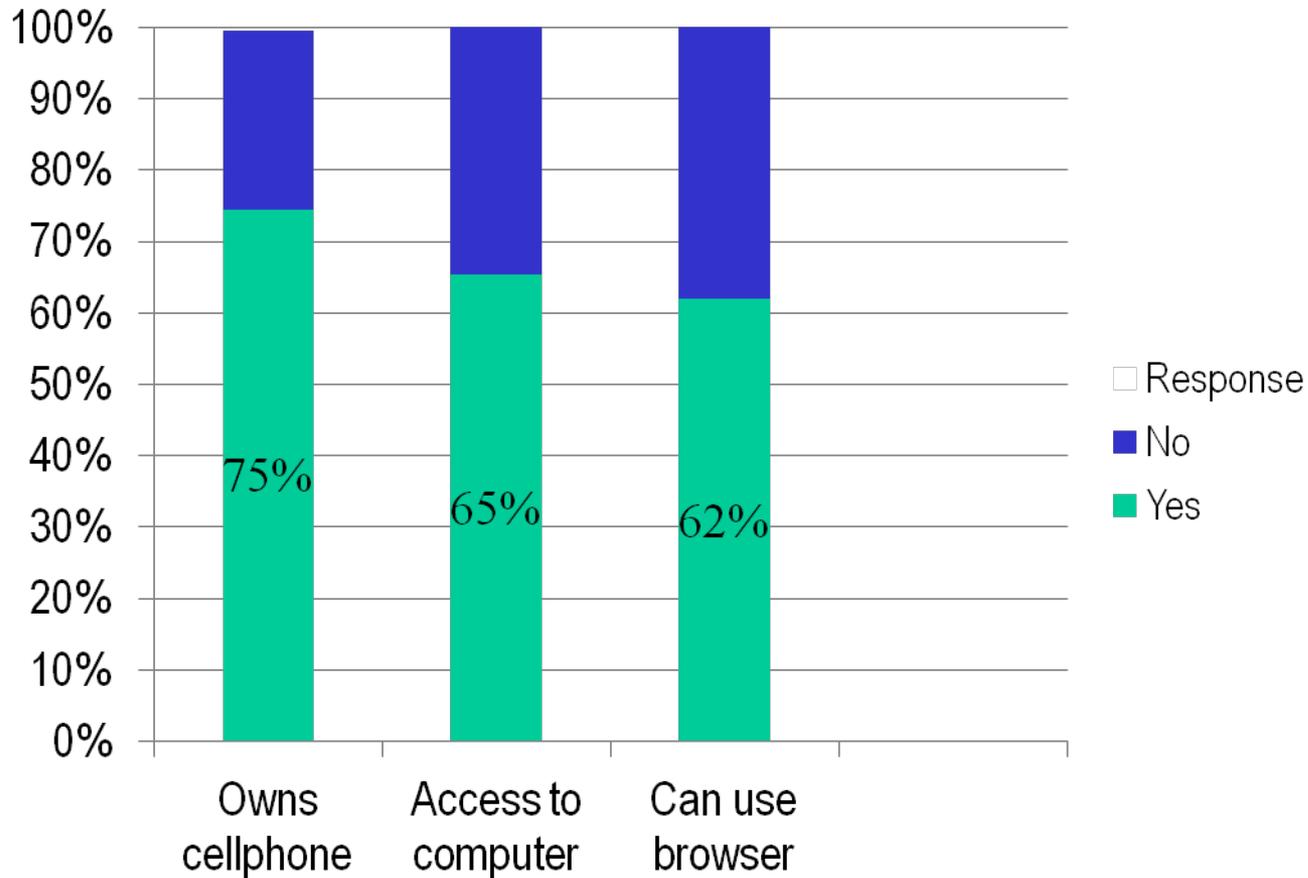
Exercise and Weight Goals



Enrollee age (80% over age 40)



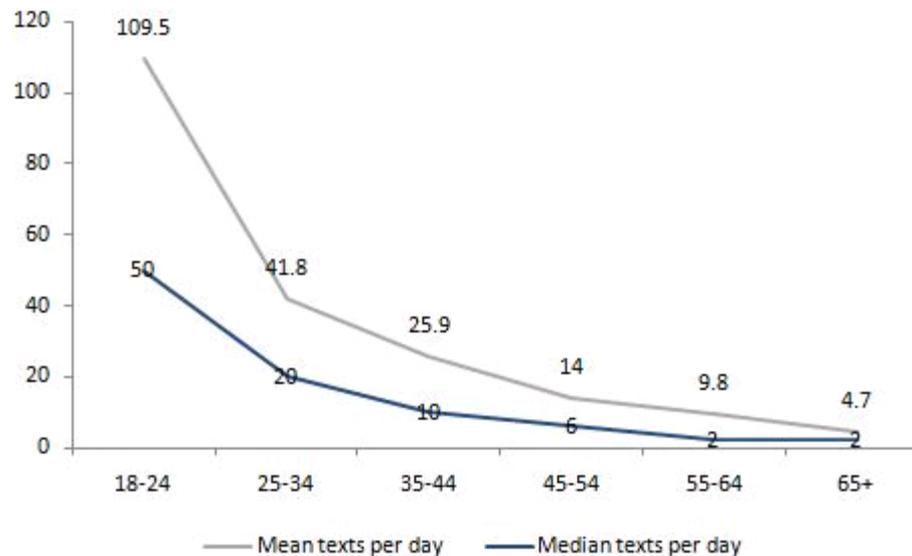
Telephone survey of invited patients (n=104)



Texting by Age Group

Number of texts sent/received per day, by age group

Based on adults who use text messaging on their cell phones



Source: The Pew Research Center's Internet & American Life Project, April 26 – May 22, 2011 Spring Tracking Survey. n=2,277 adult internet users ages 18 and older, including 755 cell phone interviews. Interviews were conducted in English and Spanish.

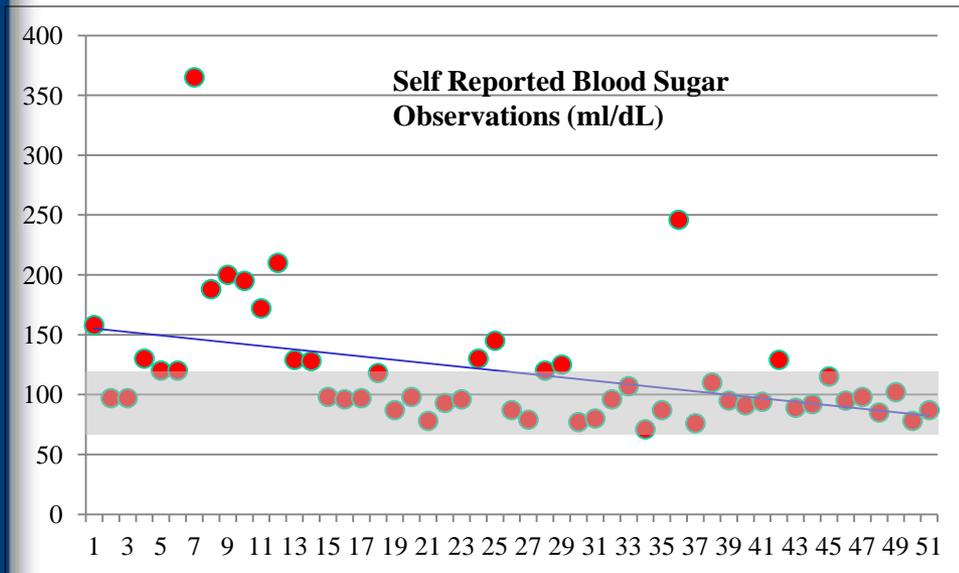


Very High Patient Satisfaction

- 94% of SMS survey respondents would recommend it to another patient with type 2 diabetes (n=25)
- Patients who responded to an exit survey (n=33) using a standard instrument for measuring satisfaction reported high satisfaction (mean score of 28 out of 32).



Remarkable Behavior Change for Some: Martha, 56-year-old female



"I had put off having hernia surgery because my blood sugars were too high and it would take too long to heal. I said, clearly there is a problem here. That's why I've been sticking with it and working it into my routine. I can feel the difference: I'm more energetic, more alert, not so sleepy and tired."

HbA1c lab data (from the clinic EMR):

Baseline=8.3 → 90-day=6.6



Interesting Nuances

- Younger users had greater declines in A1c at 6 months ($p < .05$)
- People with the highest baseline a1c show a statistically significant ($p < .001$) greater decline in a1c at 3 months.



CDSMP - LivingWell



- A 6-week self management training program for multiple chronic conditions developed by Stanford
- In partnership with National Council on Aging and Utah Department of Health
- Focuses on common skills, coping, goal setting, peer support
- 20 years of evidence that shows:
 - Improved outcomes
 - Fewer hospitalizations and ER visits
 - Lower costs



Core Skills Learned

- Short term goal-setting
- Problem solving
- Exercise
- Fall Prevention
- Pain/fatigue management
- Nutrition/Diet
- Medication management
- Depression management
- Decision making
- Relaxation/Stress reduction



Are you ready?

Find out

Learn how it works

Watch the video

Find a workshop

Sign up now

See success stories

Improve your life

FAQs

Learn more

Re-Imagine Your Life

Tired of being tired, anxious, or in pain? Unsure about how to best handle an ongoing health condition? Try something new. Join a self-management workshop and discover fresh, practical ways to live better and healthier.

▶ **Are you ready?**



Do You Have Diabetes?

There's a special online workshop just for you.

▶ **Find Out More**

Take the Workshop

Developed at Stanford University, this safe, supportive, workshop can help you take control of your problems and re-start your life.

▶ **Sign Up Now**

See What Others Say

"Now I have [self-management skills], and it's changed my whole life. It's the best program I've seen in years, and I have been looking for some time."



Online Workshop

- As effective as in-person workshop?
- Does the convenience increase completion rates?
- Usability adequate for an older, sicker population?



What can you do?

- If you work with DM patients on the Wasatch Front, consider connecting with Care4Life or the online CDSMP
- Promote Text2Quit for your smoking patients: Text “truth” to 83043
- **Improve outcomes for your highest-risk patients**



Thank you

Contact information

Sarah Woolsey , M.D., F.A.A.F.P.

Korey Capozza. M.P.H

swoolsey@healthinsight.org

kcapozza@healthinsight.org

