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A ROADMAP FOR DIABETES CARE

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OUTLINE OF PRESENTATION

- WHAT IS A ROADMAP?
- WHY DO WE NEED A ROADMAP ?
- HOW DID WE GET STARTED?
- WHAT IS THE PRODUCT/ROADMAP?
- IMPLEMENTATION OF ROADMAP
- DATA TRACKED, OUTCOMES
- LESSONS LEARNED
- PDSA at its best---ROADMAP #2 !

What is a Roadmap?

- A tool that a primary care provider can use as a guide to managing chronic medical conditions such as diabetes, asthma, COPD.
- It uses evidence-based medicine to guide diagnostics, treatment strategies and referrals.

Why Do We Need a Roadmap?

- Chronic disease management is one of the cornerstones of future payment models (Accountable Care).
- We need to be patient centered—right care at the right time in the right place.
- We need to use all our resources wisely-including specialists.
- Fosters collaboration/communication between specialty providers and primary care providers.

Why a Roadmap continued..

Why a Diabetes Roadmap in particular?

- Estimated cost of diabetes (2012): \$245 billion
 - > Hospital inpatient care (43% of total medical costs)
 - > Prescription medicines to treat complications of diabetes (18%)
 - > Anti-diabetic agents and diabetes supplies (12%)
 - > Physician office visits (9%)
 - > Nursing/residential facility stays (8%)
- Previous cost (2007) was \$174 billion !!

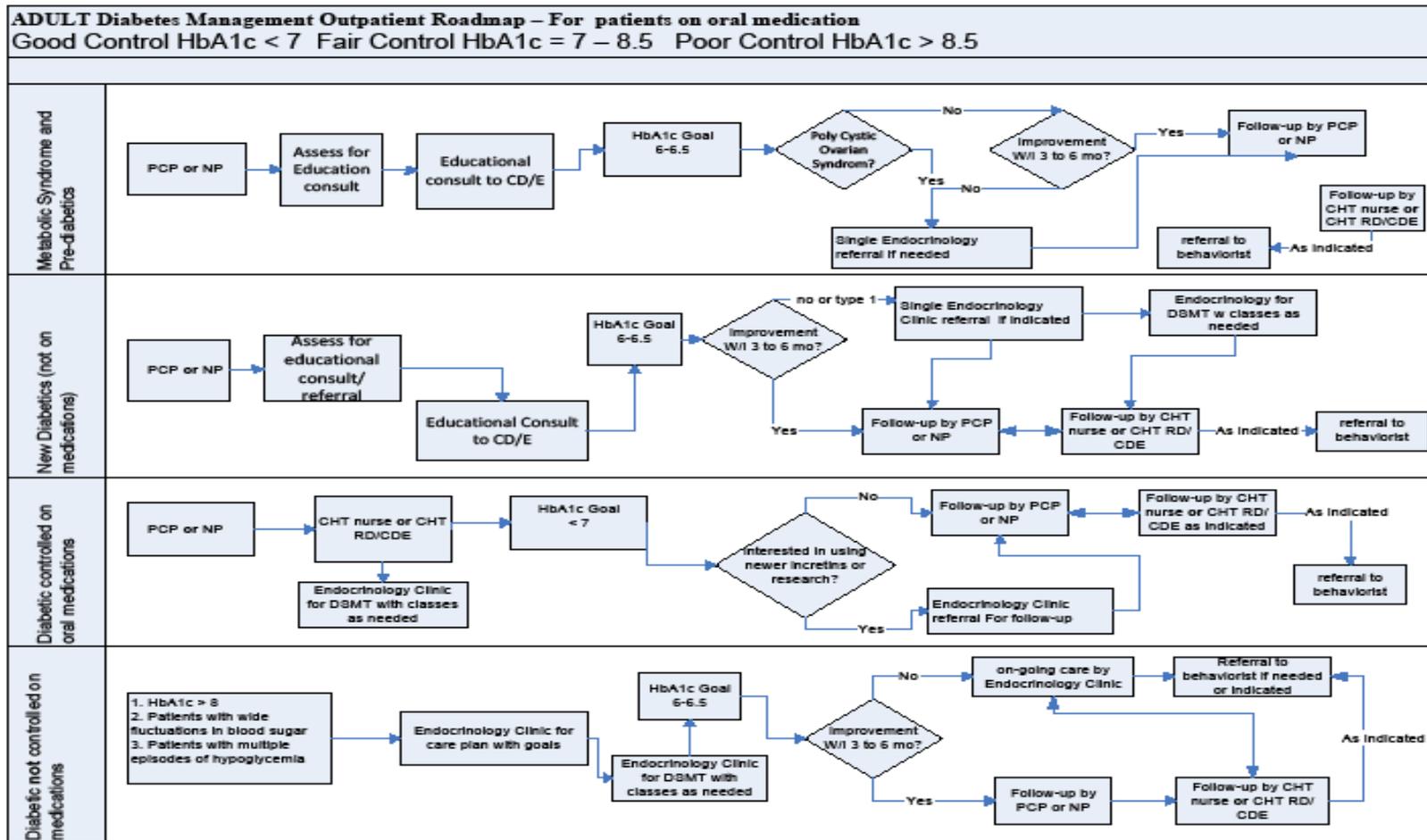
The process-where to start?

- Assembling the team
 - Endocrinology
 - Primary Care Internal Medicine/Family Medicine
 - Community Health Team
 - Administration
 - PRISM
 - Medical Group Education
 - Pharmacy

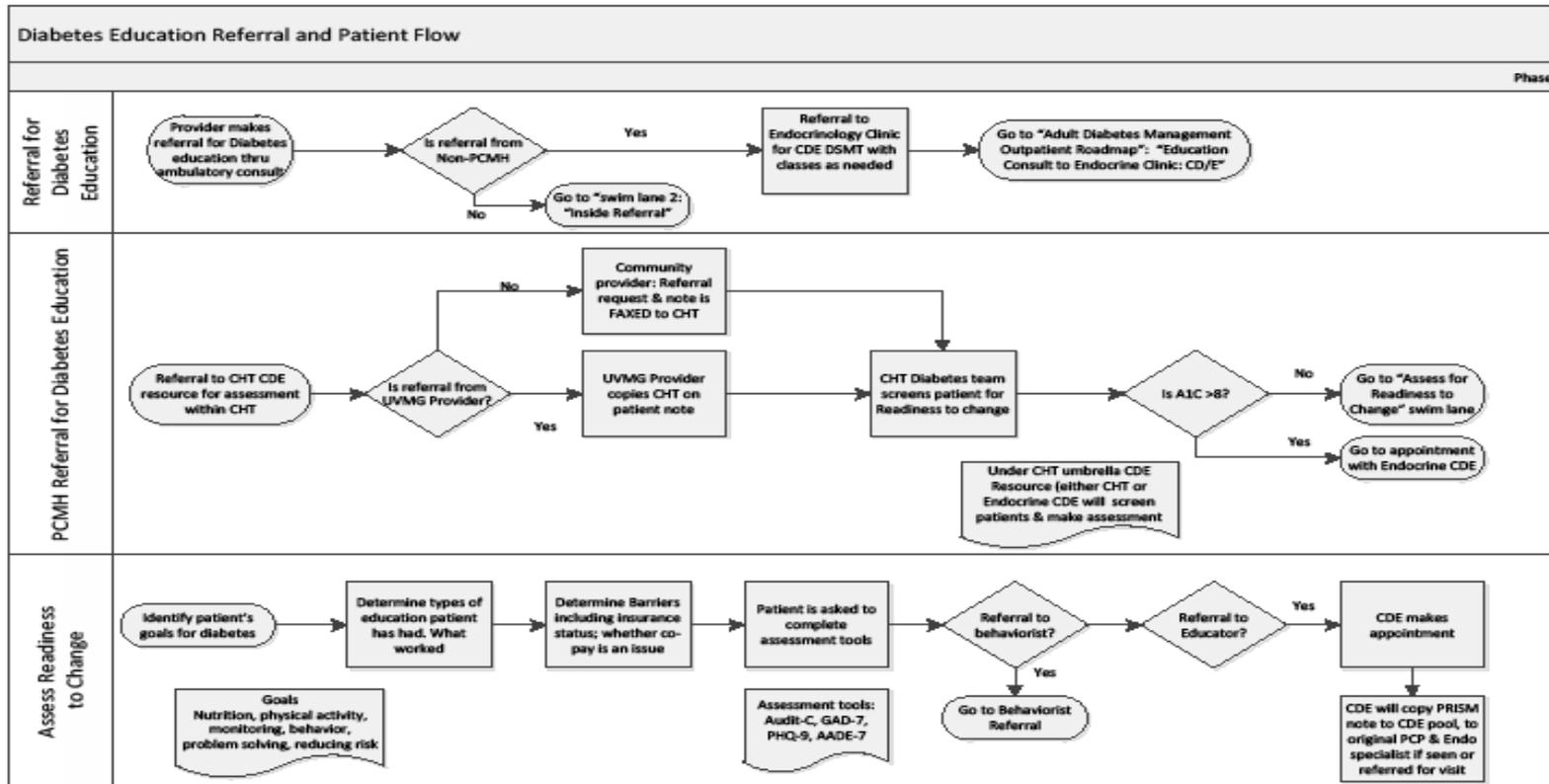
The Process--continued

- What are the basic goals for the Roadmap
 - Identify patients for referral to specialist
 - Pre-visit preparation (labs or diagnostic tests needed)
 - Streamlining referral to specialist
 - Specific recommendations for management-PCP role, specialist role
 - Clear and consistent communication

Diabetes Care Roadmap



Diabetes Education Referral



Diabetes Roadmap -Communication

Re: @NAME@
Date of Visit: @ED@
Date of Birth: @DOB@

Dear Dr. @FATO1STCC@:

I had the pleasure of seeing your patient, @NAME@, in consultation in the Vermont Regional Diabetes Center for further evaluation and management of their @DIAGX@.

@SEC2@

In addition, the patient should have a yearly assessment of their glomerular filtration rate (GFR), fasting lipids and urine micro albumin ratio. The patient should have their A1c repeated in *** months.

As always, if you have any questions or concerns regarding your patient's evaluation at the Vermont Regional Diabetes Center please feel free to contact me.

Sincerely,
@ENCPROVNMTITLE@

Diabetes Registry

- Identifies patients due for primary care follow up or who have not met treatment goals
- Identifies patients who have not met chronic disease goals and could benefit from consultation
- Leverages PRISM functionality to support population management
- Criteria developed for management of registry data
 - Registry data reviewed quarterly as a component of the Transforming Primary Care Initiative
 - Action taken per protocol and/or provider discretion
 - > i.e. Patient without PCP visit in > 3 months and/or have A1C >8.0, PCP visit scheduled and A1C completed in advance of visit

Clinical Operations / Population Management

- **Clinical Care Associates**
 - Trained in how to run PRISM Registry reports for Diabetes
 - Algorithm designed:
 - > Patients with A1c>8 identified/reviewed with provider
 - > If no visit within 6 months they are scheduled (regardless of A1c)
 - > Pre-visit planning gets labs done prior to patient being seen

- **Weekly coordination huddle- reviews referral recommendations**

Diabetes Registry View

Reports

My Patients with Diabetes (A1C > 8) [1444191] as of Mon 5/6/2013 15:56
? Resize

Filters Options Chart Orders Encounter Refill Telephone Letter Generate Letters HM Modifiers Add to List Multi-patient Message

Results loaded: 28 of 28 Results shown: 28 of 28 Refresh Select All Show All

Patient	MRN	DOB	Age	Sex	Last BP (Date)	HBA1C	LDL	uAB/CR	DM Eye Exam	DM Foot Exam	Next Appt
		03/23/1979	34 y.o.	Male	120/74 [12/11/12]	9.7 [07/20/12]	132 [07/20/12]	315.0 [01/18/11]	NORMAL [11/28/11]	nl [08/02/11]	
		12/30/1943	69 y.o.	Female	126/64 [04/11/13]	9.5 [02/12/13]	Triglyceride	132.4 [09/02/10]	abnl [10/12/11]	abnl [10/03/11]	5/7/2013

← Back Diabetes Patient Summary Current Meds Health Maintenance Patient Goals Registries Summary

Registries Summary

DOB: 8/5/1965

Registry Information

	Status	First Included On
Diabetes Registry	Active	12/12/2012 0:43
Hypertension Registry	Active	4/14/2013 16:53
Obesity Registry	Active	4/14/2013 16:53

Metric Information

Diabetes Registry

Key Metrics

	Metric Value	Associated Date	Last Checked
Most Recent BMI	51.46	5/2/2013	5/2/2013 10:31
Most Recent BP - Diastolic	74	4/30/2013	5/2/2013 10:31
Most Recent BP - Systolic	128	4/30/2013	5/2/2013 10:31

General

	Metric Value	Associated Date	Last Checked
Current PCP	JACOBS, ALICIA A		5/1/2013 1:34
Primary Location	MCHV CAMPUS		5/1/2013 1:34

Past Visit Information

	Metric Value	Associated Date	Last Checked
Most Recent Encounter Date	4/30/2013		5/1/2013 1:34
Most Recent Encounter Type	History		5/1/2013 1:34
Most Recent Inpatient Admission Date	4/30/2013		5/1/2013 1:34
Most Recent Office Visit Date	4/2/2013		5/1/2013 1:34
Most Recent Visit Provider	HUNT, JOANNE		5/1/2013 1:34
Number Of Encounters	79		5/1/2013 1:34
Number Of Hospital Admissions	5		5/1/2013 1:34

Vitals

	Metric Value	Associated Date	Last Checked
First BMI	51.34	5/7/2012	5/2/2013 10:31
First BP - Diastolic	82	5/7/2012	5/2/2013 10:31
First BP - Systolic	122	5/7/2012	5/2/2013 10:31

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Referral Tracker

- Coordination of appointments between PCP office and specialty office.
 - Specialty office calls patient directly to set up appointment
 - Communication sent back to PCP office regarding scheduling appointment if conflict: Patient declined, Could not contact patient etc.
 - System alerts PCP staff when appointment is complete—to ensure that documentation received. NCQA requirement for closing the loop.

Implementation

- PILOT SITE—Colchester Family Practice

- ROLL OUT TO OTHER SITES
 - MD from team visited provider teams at sites to introduce roadmap.
 - Medical Education came to provide technical support

Data Tracked

- Number of referrals to CDE on Community Health Team
- Number of referrals to endocrine specialty office
- Length of time until first appointments
- Appointment utilization: no show, no contact
- Clinical parameters-
- ER utilization for diabetes diagnosis

Measures of Success

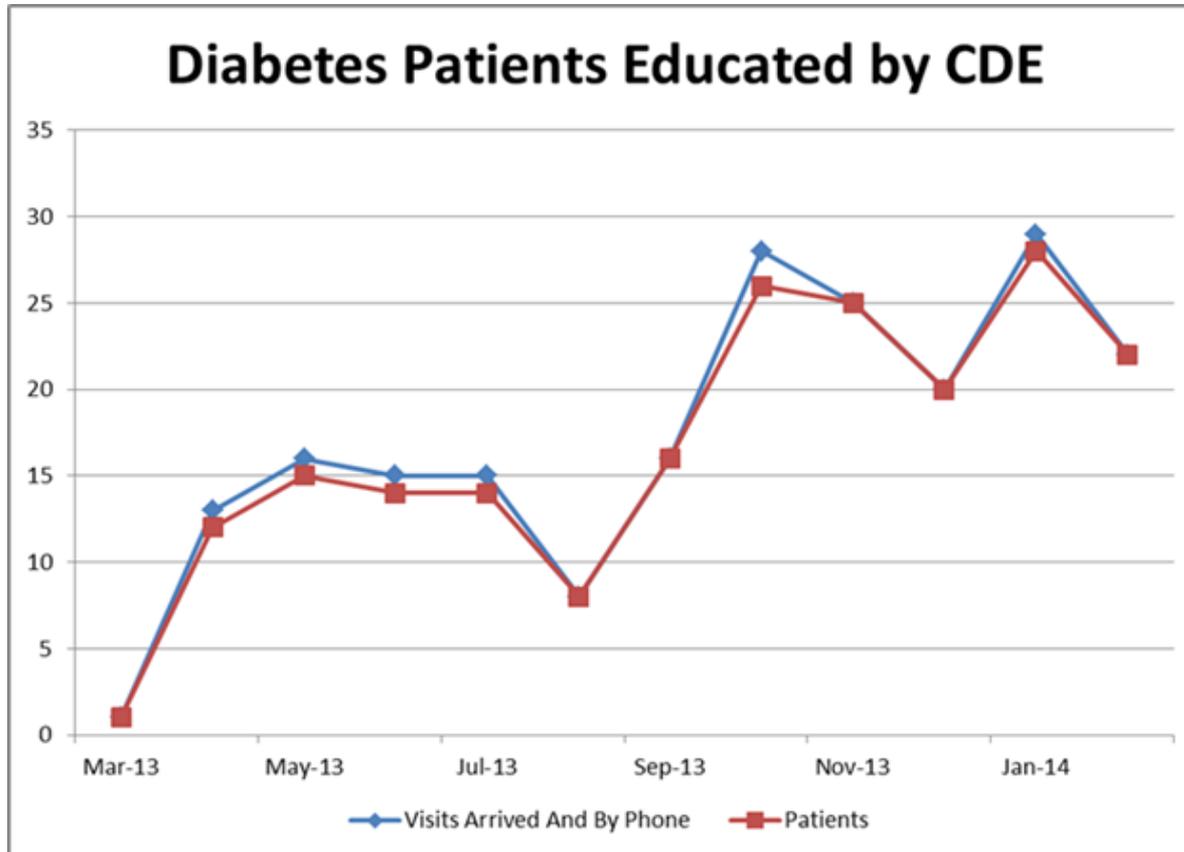
Check all the perspectives that apply:	Outcome Measure:	Baseline Outcome Measure	Target Outcome Measure
<input type="checkbox"/> Financial	Decrease in ED visits	TBD	50%
<input type="checkbox"/> Clinical	Blood pressure < 130/80 mm Hg Hb A1c < 8.0% LDL cholesterol < 100 mg/dl	TBD	80%
<input type="checkbox"/> Process	Primary care visits ≥ 2 visits per year Hb A1c 1-4 tests per year Urine protein yearly Documented foot exam at every regular visit Documented retinal exam at least yearly Total cholesterol at least yearly Smoking cessation at each visit Influenza vaccine yearly Pneumococcal vaccine per protocol Utilization of roadmap for communication	TBD	100%
<input type="checkbox"/> Learning	Increase in % of patients educated about their diabetes Increase in % of patients referred to diabetes educator	TBD	100%

Data--Roadmap Referrals

- Referrals for Diabetic Education (split 50/50 CDE/RN):
 - June 2014: 67
 - July 2014: 81
 - August 2014: 56

- Referrals for Endocrinology
 - June 2014:
 - July 2014:
 - August 2014:

Diabetes Education (March 2013 – January 2014)

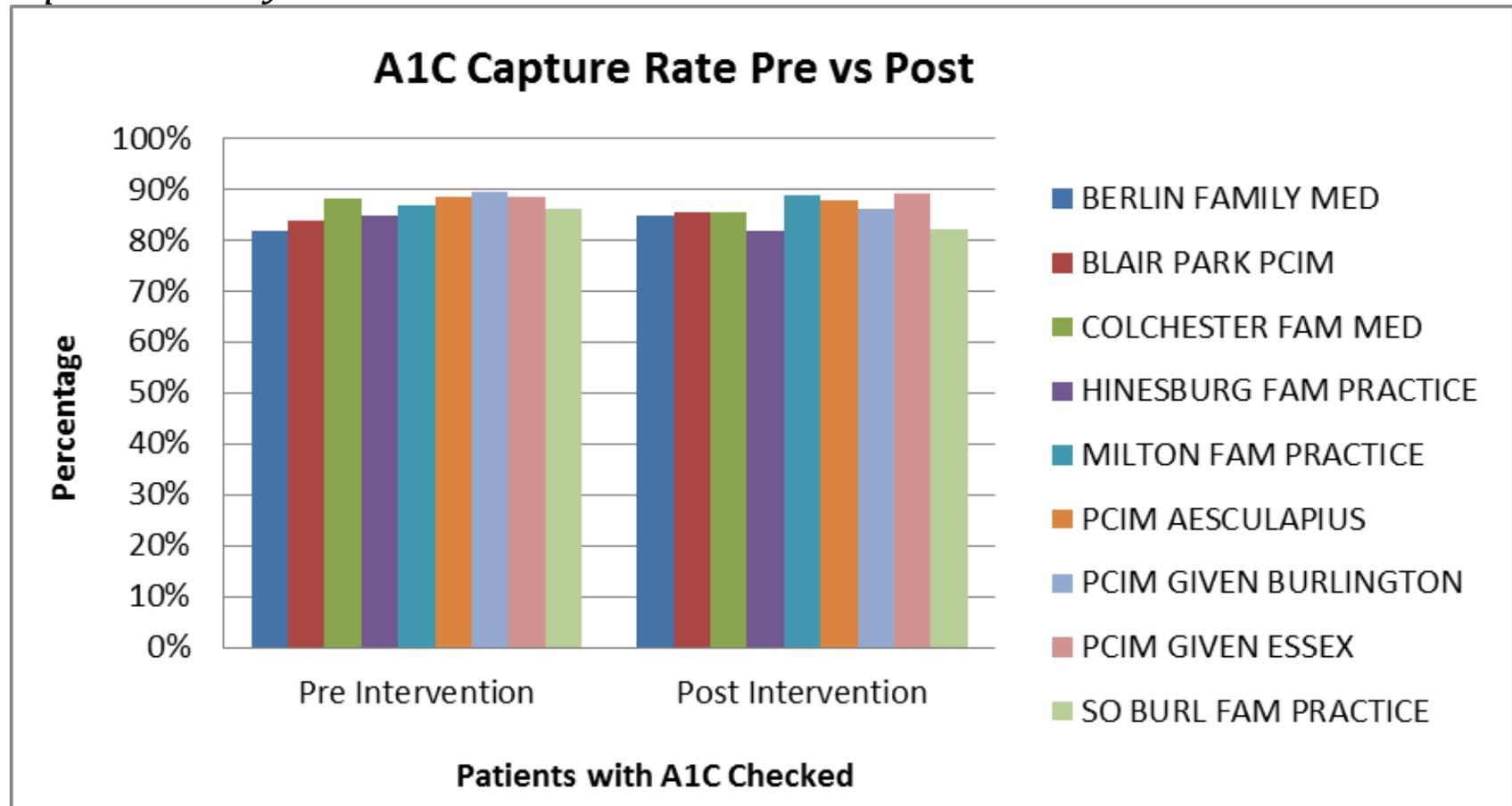


Data– clinical parameters

Referral to Endocrinology for Patients with A1C>8

	Pre-Intervention (June 2011 - Nov 2012)	Post-Intervention (Dec 2012- May 2014)
Aesculapius	17%	14%
Berlin	0%	0%
Colchester	38%	24%
Given Burlington	23%	12%
Given Essex	29%	21%
Given Williston	18%	11%
Hinesburg	34%	16%
Milton	15%	12%
South Burlington	32%	17%
Average	21%	12%

A1C Capture Rate by Clinic



Data-continued

Analysis

Diabetes Patients with A1C>8

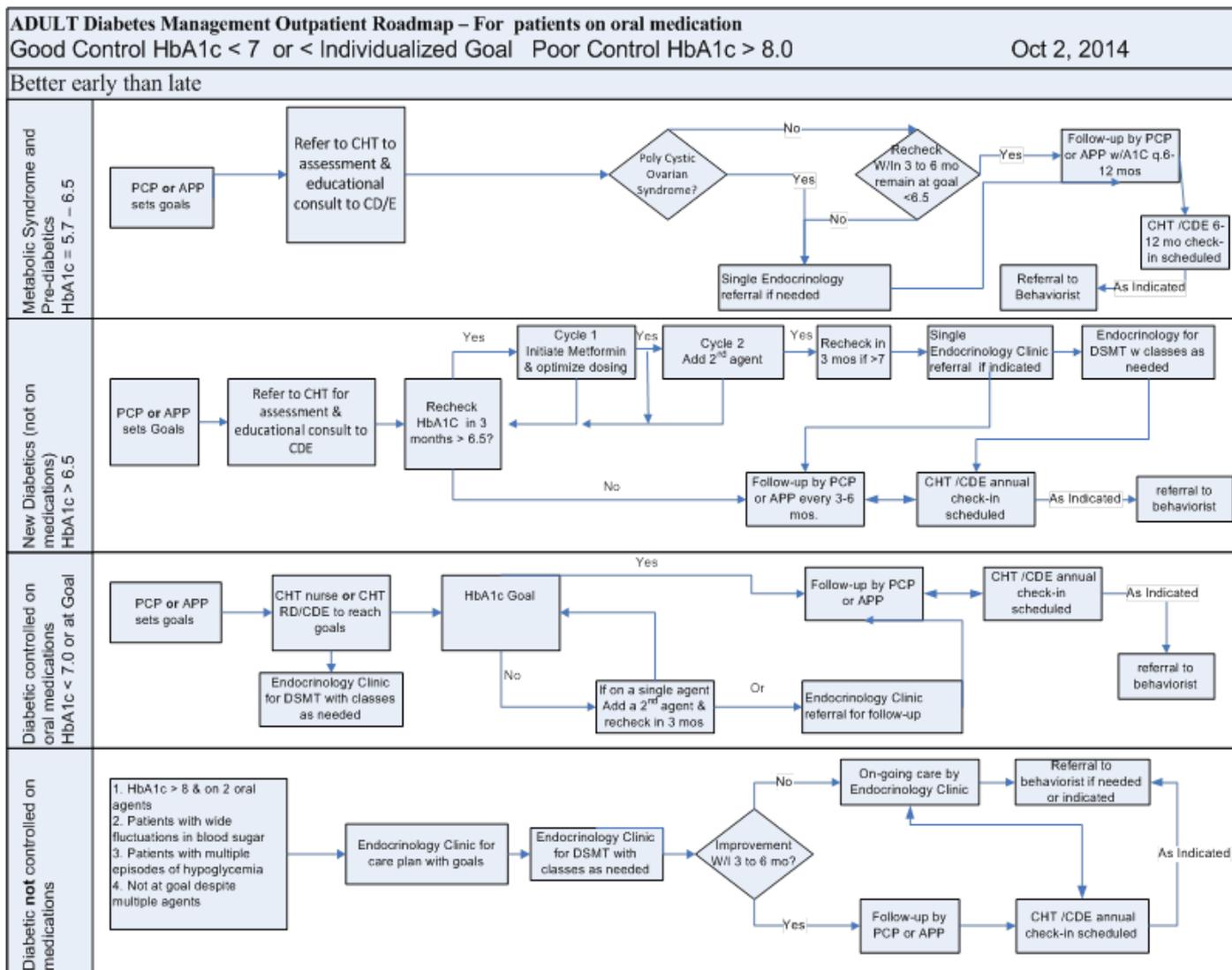
	Pre-Intervention (June 2011 - Nov 2012)	Post-Intervention (Dec 2012- May 2014)
Aesculapius	20%	22%
Berlin	28%	31%
Colchester	30%	33%
Given Burlington	27%	27%
Given Essex	20%	23%
Given Williston	18%	25%
Hinesburg	20%	24%
Milton	29%	32%
South Burlington	28%	28%
Average	24%	27%

Although it may be too soon to see rates of A1C>8 decline, this number should decrease over time as more patients are managing their condition, through medication and/or lifestyle change. The increase percentage of patients A1C>8 might be due to worsening of one's condition or because perhaps more providers are getting better at testing for A1C.

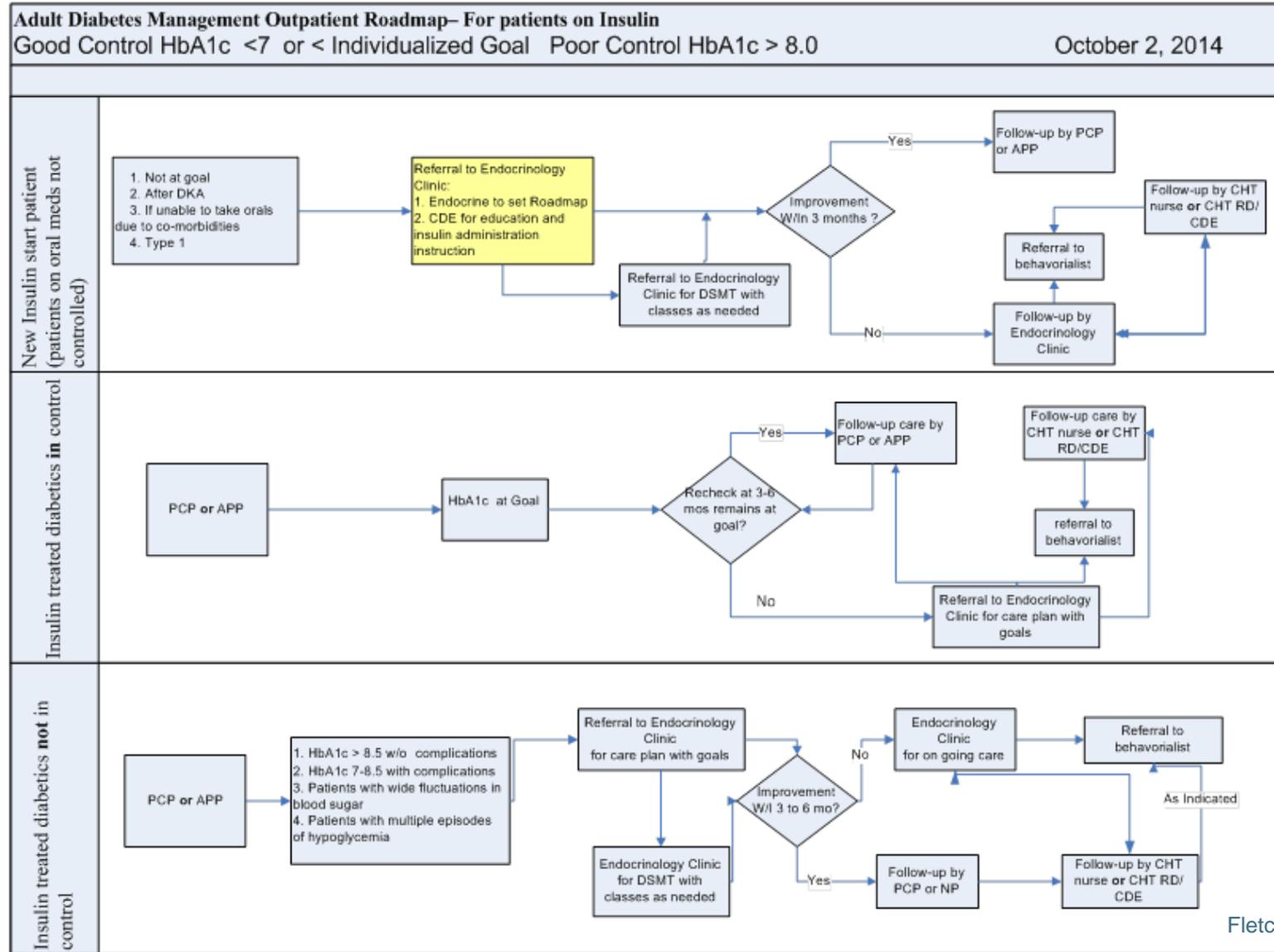
Lessons Learned/Challenges

- Getting provider “buy in” to this new system
- Getting patients to engage
- Changing recommendations from medical societies (ADA, USPTF, ACC)—hard to keep up at times.

PDSA cycle at its best—ROADMAP#2 !!



Roadmap#2-continued



Next steps

- Will introduce this new/updated Roadmap to the primary care sites.
- Continued registry work and reinforcement of protocol with CCA staff.
- Spread to our affiliate practices in Plattsburgh.
- Recollect data and analyze twice per year.