CARE OF THE PRE-DIABETIC AND DIABETIC PATIENT

March 25, 2020
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Agenda

1. Introductions
2. Population Health
3. Quality Improvement
4. Pre-Visit Planning
5. Point of Care
6. Questions
Poll #1

Go to www.menti.com and use the code 27 51 39

What are your biggest challenges when it comes to managing your pre-diabetic and diabetic patients?
Caring for Patients with Diabetes
Focus Areas for Patient Care

Population Health Management
- Outreach for appointments
- Coordinating care amongst various services

Quality Improvement
- Selecting improvement initiatives
- Implementing change
- Tracking improvement initiatives

Pre-Visit Planning
- Determining procedures/labs/etc. a patient is due for
- Preparing the team for the visit

Point of Care
- Accurately documenting the care provided
- Ordering the right tests/labs/referrals
Program 1815 Measures
### Pre-Diabetes & Diabetes Measures

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Undiagnosed diabetes prevalence</strong></td>
<td>Patients age 18-75 meeting clinical criteria for diabetes based on A1C, 2 hr OGTT, or FPG test who do not have a diagnosis of diabetes in the past 12 months.</td>
</tr>
<tr>
<td><strong>Prediabetes prevalence</strong></td>
<td>Patients age 18-75 that have a diagnosis of prediabetes.</td>
</tr>
<tr>
<td><strong>Prediabetes screening</strong></td>
<td>Patients screened using the American Diabetes Association (ADA)/Centers for Disease Control and Prevention (CDC) Prediabetes Risk Assessment.</td>
</tr>
<tr>
<td><strong>Prediabetes diagnosis</strong></td>
<td>Patients diagnosed with prediabetes after using the ADA/CDC Prediabetes Risk Assessment.</td>
</tr>
<tr>
<td><strong>Diabetic prevention program referral</strong></td>
<td>Patients with diagnosis of prediabetes who receive a referral to a CDC recognized/accredited DPP from their health care provider or have completed diabetes self management goals in the last 12 months.</td>
</tr>
<tr>
<td><strong>Diabetes prevalence</strong></td>
<td>Patients age 18 to 75 who have a diagnosis of diabetes in the past 12 months.</td>
</tr>
<tr>
<td><strong>Diabetes A1C &gt;9 or untested</strong></td>
<td>Percentage of patients 18-75 years of age with diabetes who had most recent hemoglobin A1c &gt; 9.0% during the measurement period.</td>
</tr>
<tr>
<td><strong>DSME referral</strong></td>
<td>Patients with a diagnosis of Diabetes who receive a referral to a recognized/accredited DSME program from their health care provider or completed diabetes self management goals within the past 12 months.</td>
</tr>
<tr>
<td><strong>Clinical pharmacy referral</strong></td>
<td>Patients with Diabetes, HTN, or HBC referred to Clinical Pharmacy Services in the last 12 months.</td>
</tr>
<tr>
<td>Structured Clinical Data</td>
<td>Description</td>
</tr>
<tr>
<td>--------------------------</td>
<td>-------------</td>
</tr>
<tr>
<td>SMBP Referral</td>
<td>A documented referral (includes e-referral) to a community program for Self-Measured Blood Pressure monitoring (SMBP). SMBP is defined as the regular measurement of blood pressure by the patient outside the clinical setting, either at home or elsewhere. It is sometimes known as “home blood pressure monitoring.”</td>
</tr>
<tr>
<td>HTN Self Management</td>
<td>Self Management goals/plan from EHR specifically for Hypertension. Indicates a patient-specific activity vs a medical recommendation. Requires date created or last updated.</td>
</tr>
<tr>
<td>Prediabetes Risk Assessment</td>
<td>Total score of the American Diabetes Association (ADA)/Centers for Disease Control and Prevention (CDC) Prediabetes Risk Assessment.</td>
</tr>
<tr>
<td>Diabetic Prevention Program</td>
<td>Documented referral to diabetic prevention program.</td>
</tr>
<tr>
<td>Diabetes Self Management</td>
<td>Self Management goals/plan from EHR specifically for Diabetes</td>
</tr>
<tr>
<td>DSMES Program</td>
<td>Referral to a recognized/accredited Diabetes self-management education and support (DSMES) program</td>
</tr>
<tr>
<td>Clinical Pharmacy Services Referral</td>
<td>Referral to Clinical Pharmacy Services</td>
</tr>
<tr>
<td>Questionnaire Completed PRAPARE</td>
<td>The date that a social needs assessment was conducted e.g., PRAPARE or similar questionnaire of Social Determinants of Health. May include partial or complete answering of questions.</td>
</tr>
<tr>
<td>Community Resource Referral</td>
<td>Referral to a community resource for social needs identified from SDOH screening.</td>
</tr>
</tbody>
</table>
# Measure Relationships

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>RESULT</th>
<th>NUMERATOR</th>
<th>DENOMINATOR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Undiagnosed Diabetes Prevalence</td>
<td>16.5%</td>
<td>120</td>
<td>725</td>
</tr>
<tr>
<td>PreDiabetes Prevalence</td>
<td>74.5%</td>
<td>540</td>
<td>725</td>
</tr>
<tr>
<td>PreDiabetes Screening</td>
<td>85.7%</td>
<td>600</td>
<td>700</td>
</tr>
<tr>
<td>PreDiabetes Diagnosis</td>
<td>50.0%</td>
<td>300</td>
<td>600</td>
</tr>
<tr>
<td>Diabetic Prevention Program Referral</td>
<td>27.3%</td>
<td>150</td>
<td>550</td>
</tr>
<tr>
<td>Diabetes Prevalence</td>
<td>63.4%</td>
<td>460</td>
<td>725</td>
</tr>
<tr>
<td>Diabetes A1c &gt; 9 or Untested (NQF 0059)</td>
<td>28.0%</td>
<td>200</td>
<td>715</td>
</tr>
<tr>
<td>DSME Referral</td>
<td>41.7%</td>
<td>300</td>
<td>720</td>
</tr>
<tr>
<td>Clinical Pharmacy Referral</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Denominator for DSME Referral is essentially the same as Diabetes Prevalence, PreDiabetes Prevalence, and Undiagnosed Diabetes Prevalence with minor variances in the exclusion criteria, which is why they do not match exactly.
Population Health
Population Health Management

- The work that goes into managing patients outside of an office visit.

- Population Health Management can include:
  - Outreach
  - Engagement
  - Care coordination
  - Referral management
  - Hospital/ED follow up

- Data hygiene and EHR updates
Population View

- Snapshot of measures related to patient care, coding, and outreach.
- Should tell a story of your population.
- Can be utilized operationally or as an executive overview.
Cohorts

- A cohort is a group of patients with a certain set of characteristics.
- Important to track cohorts when measuring success.
  - Are the people you’re outreaching to coming in?
  - Are they getting their A1C?
  - Are those being managed by the CDE improving their A1C?
- Example:
  - TY December 2019
  - Diabetes A1C does not exist (NQF 0059 Modified)
Patient Lists

Registry of patient details

Filterable to patient traits

Used for care coordination
Diabetic Registry Features

- Contains patient demographics and information related to diabetes management.
  - Insurance
  - Most recent and next encounter
  - Diagnosis date
  - A1c
  - LDL
  - BP
  - BMI
  - Eye exam
  - Urine protein
  - Flu
  - PCV

- Filterable by patient traits
  - Diagnosis
  - SDOH
  - Provider
  - Race/Ethnicity
  - Care Manager
  - Risk level
Diabetic Registry Uses

- Outreach for appointment scheduling
- Ad hoc patient list creation
- Care manager patient assignment
- Data analysis of a population
- Cohort creation for tracking a group of patients
- Data hygiene review
Quality Improvement
Quality Improvement

“Data! Data! Data! I can’t make bricks without clay!”

-Sir Arthur Conan Doyle
Data Hygiene Best Practices

Don't silo data hygiene with one person. Your organization's trust in your numbers matters! Cultivate data credibility with a team approach.

**Focus**
- Document key quality measures
- Set review schedule

**Standardize**
- Map standard workflows
- Verify mappings correspond to workflows

**Train**
- Develop materials for staff on workflows
- Distribute for new hire and ongoing trainings

**Share**
- Schedule regular meetings to discuss quality improvement and validation findings
- Assign roles and responsibilities
Data Hygiene at Work

- Review the Diabetes A1c does not exist (NQF 0059 Modified) measure.
- Filter for patients with an A1c less than 5.7.
  - Clean up the problem lists.
  - Update data entry errors.
- Data hygiene errors have a ripple effect:
  - Pre-visit planning
  - Registries
  - Regulatory reporting
Selecting Measures for QI

- Important to have leadership buy-in and support throughout the QI process.
- Institute a quality culture.
- Illicit feedback and encourage staff at all levels to identify areas for improvement.
- Make selections for measures based on initiatives, staff suggestions, and data.
- Dive deeper into the measure and break it down.

<table>
<thead>
<tr>
<th>PTS W/ DIABETES</th>
<th>1,893</th>
</tr>
</thead>
<tbody>
<tr>
<td>DM A1c &gt;= 7 and A1c &lt;= 8</td>
<td>373</td>
</tr>
<tr>
<td>DM A1c &gt; 8 and A1c &lt;= 9</td>
<td>200</td>
</tr>
<tr>
<td>DM A1c &gt; 9</td>
<td>521</td>
</tr>
<tr>
<td>DM A1c &lt; 7</td>
<td>686</td>
</tr>
<tr>
<td>DM A1c does not exist</td>
<td>111</td>
</tr>
</tbody>
</table>
Tracking & Measuring Progress

- Need to track and measure progress in several ways:
  - By Provider
  - By Location
  - By Month (or other short time period for PDSA purposes)
  - By various patient traits, i.e. race, ethnicity, SDOH

- Establish a baseline time period and compare current results

- PCMH Requirement
Distributing Data

- Educate stakeholders about the measure requirements and how to meet the measure.
  - Cheat sheet: one-page info sheet with measure definition and screen shot from EHR with where/how to document

- Verify data before distribution – it always comes back to data hygiene!

- Regular, reliable distribution of data. Be sure to respond timely to any concerns or questions.

- Decisions to make:
  - To blind or not blind the data?
  - What data to show?
  - Graphical or data?

- Most importantly, keep your data focused and be open to feedback.
Poll #2

Go to www.menti.com and use the code 84 12 6

What tools do you use to distribute data?
Pre-Visit Planning
Pre-Visit Planning

- An efficient, electronic “to do” list of alerts and other data for patients with upcoming appointments.

- Key characteristics:
  - Actionable data
  - Configurable
  - Not just medical interventions
  - Contains open referral information
  - For appointments scheduled in advance and walk-in/same day

It’s easier and faster than having to go through each individual patient’s record.

-Our clients
### Visit Planning

<table>
<thead>
<tr>
<th>TIME</th>
<th>VISITED DATE</th>
<th>NAME</th>
<th>GENDER</th>
<th>DATE OF BIRTH</th>
<th>PHONE</th>
<th>LANGUAGE</th>
<th>RISK FACTORS</th>
<th>LAST WELL VISIT</th>
<th>PORTAL ACCESS</th>
<th>PCP</th>
<th>CARE MANAGER</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:00 AM</td>
<td>Friday, November 15, 2019</td>
<td>Abad, Maria</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Abad, Maria</td>
<td>Unassigned</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sollis, Sylvia</td>
<td>-</td>
<td>-</td>
<td>123-456-7890</td>
<td>English</td>
<td>Low (12)</td>
<td>5/7/2019</td>
<td>N</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Degan, Dillon</td>
<td>-</td>
<td>-</td>
<td>333-567-9999</td>
<td>English</td>
<td>Low (0)</td>
<td>11/15/2018</td>
<td>N</td>
<td>James, Christine</td>
<td>Unassigned</td>
</tr>
</tbody>
</table>

**DIAGNOSES:**
- ASM
- SOOH (1)

**RISK FACTORS:**
- BMI % 80%
- Flu <8

**OPEN REFERRAL W/O RESULT:**

**SPECIALIST/LOCATION:**

**ORDERED DATE:**

**APPT. DATE:**

**Alerts:**
- Lead Q Yld: Overdue
- BMI % 80%
- At Risk
- Flu <8: Incomplete

**Most Recent Result:**
- Lead Q Yld: less than 1.3
- BMI % 80%: 98.63
- Flu <8: Incomplete
- Nutr Counsel: Missing
- Phys Act: Missing

**Visit Reason:**
- Sickle Cell, asthma
- Physical, Physical, EPSDT

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*Demo Data*
Draft Comprehensive Standing Actions

- Create a standing action for each alert you plan to use.

- Empower MAs/LPNs to support their provider by giving them the freedom and trust to follow the protocol.

- Standing actions create the basis for use of the visit planning report as a foundation for trust to delegate in team-based care.
  - Just for the pilot teams at first - which offers flexibility. Don’t have to commit for long term.

azarahealthcare.com
<table>
<thead>
<tr>
<th>Alert Name</th>
<th>Description</th>
<th>Owner</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes A1c</td>
<td>A1c has not occurred in the last 3 months, or if the A1c value is &gt;= 8 for patients 0 and &lt;= 85 yrs old. Patient must have Diabetes.</td>
<td>MA</td>
<td>If patient is overdue, do a POC A1c and place order. If the most recent A1c was &gt;=8, check with provider.</td>
</tr>
<tr>
<td>Diabetes Nephropathy Screening</td>
<td>Nephropathy Screening has not occurred in the last 1 years. Alert only applies to patients and &lt;= 85 yrs old. Patient must have Diabetes. Patient must not have Known Kidney Dx or ACE ARB.</td>
<td>MA</td>
<td>Collect urine, place order for POC Microalbumin and process test.</td>
</tr>
<tr>
<td>Diabetes HTN/LDL</td>
<td>Alert will trigger if LDL has not occurred in the last 1 years, or if the LDL value is &gt;= 100. Alert only applies to patients and &lt;= 85 yrs old. Patient must have Diabetes and Hypertension.</td>
<td>MA</td>
<td>Perform POC LDL, place order, and process test.</td>
</tr>
<tr>
<td>Diabetes Eye Exam</td>
<td>Alert will trigger if Eye Exam has not occurred in the last 1 years. Alert only applies to patients and &lt;= 85 yrs old. Patient must have Diabetes.</td>
<td>Provider</td>
<td>Talk to patient about preference and place order if needed.</td>
</tr>
<tr>
<td>Diabetes Foot Exam</td>
<td>Alert will trigger if Foot Exam has not occurred in the last 1 years. Alert only applies to patients and &lt;= 85 yrs old. Patient must have Diabetes. Patient must not have Double Amputee.</td>
<td>Provider</td>
<td>Perform monofilament foot exam and enter charge in charge capture screen.</td>
</tr>
<tr>
<td>Elevated Glucose</td>
<td>Alert will trigger if patient had an A1c &gt;= 5.7 AND &lt;= 6.4 OR a Glucose Tolerance Test &gt;= 140 AND &lt;= 199 in the past year. Alert only applies to patients 18 - 75 years old. Excludes patients which have pregnancy, ESRD, diabetes , pre-diabetes, or gestational diabetes. This alert is not configurable.</td>
<td>Provider</td>
<td>Consider repeating a glucose or A1c test, and or adding the appropriate diagnosis to the problem list.</td>
</tr>
</tbody>
</table>
Utilize this measure weekly to monitor the success of closing point of care measures.

Celebrate successes and identify opportunities for learning.

Compare Providers using PVP to Providers not using PVP.
Point of Care
Documenting Care Provided

- It’s essential that everyone on the team know their responsibility when it comes to caring for a diabetic patient.
  - Where to document
  - What to document
  - How to document
  - Who is documenting

- If you didn’t document it, you didn’t do it.

- Will help with data hygiene – it all comes back to data hygiene!
Workflow Mapping

- Get more credit. If it didn’t get documented (in structured form), it didn’t happen.
- More consistency = better measure performance.
- Improve efficiency of usage of your EHR.
- Increase staff knowledge of where data is mapped in your EHR and flows into DRVS.
- Promote appropriate standardization in documentation.
  - Help support staff find patient information.
  - Greater ease when new provider sees a patient.
  - Prevent double work.
DM A1c Order and Result Workflow

DM Patient Arrives

MA Rooms Patient.

A1c Needed

Yes

Use Patient Visit Planning report for guidance.
- MA places order for POC A1c in orders for A1cs that are overdue.
- Discuss in morning huddle if Lab A1c should be ordered.
- Consider visit with Health Educator

No

Continue with visit.

If fingerstick, MA performs for patient.

If patient getting non-fingerstick labs, Provider orders other labs during visit.

Provide patient with order at end of visit and have patient go to lab.

MA processes specimen and complete order with results.
- If result reads ‘high’, enter A1c Lab order for and have patient go to lab.

Result returned via HL7 Interface, auto-completes order in EHR.

Result to Athena for scanning.

Paper/Fax Result Arrives or pt reports

Results go to provider’s inbox for review.

A1c Complete

START

END
Best Practices – Care Delivery

1. Consider using point of care testing for patient and provider convenience. Helps prevent lab no shows. Offers provider real-time data for decision-making.

2. Test patients’ LDL even if they have not been fasting. Studies have shown fasting does not significantly impact the accuracy of the result.

3. Empower RNs, Diabetic Educators or other appropriate staff to work with patients to monitor glucose and A1cs and adjust insulin outside visits.

4. Use group visits to provide community and motivation for patients to improve their quality of life together.

5. Consider using standing actions to allow MA/LPNs to perform A1c test, also gives clinician best information for evaluating patient.
Go to **www.menti.com** and use the code **73 60 73**

**In three words, what is the key to caring for pre-diabetic and diabetic patients?**
Focus Areas for Patient Care

Population Health Management
- Dashboard
- Registry

Quality Improvement
- Measure Analyzer
- Trend analysis
- Comparison analysis
- Data hygiene
- Data distribution

Pre-Visit Planning
- PVP report
- Huddle
- Standing actions

Point of Care
- Workflow mapping
- Accurate documentation
Questions?