Bristol-Myers Squibb
Community Health Center
University Medical Center of Princeton
at Plainsboro

Diabetes Group Visit

Learning Collaborative 5

February 12, 2015

University Medical Center of Princeton
at Plainsboro
Princeton HealthCare System

Redefining Care

Overview of PHCS's Diabetes Specialty Clinic

- Bristol-Myers Squibb Community Health Center
- Suburban underserved population in Princeton, NJ
- High risk patients from population of 400-500 diabetes patients
- Diabetes group visits: 1 day a week, 6-12 patients each day
  - Interdisciplinary Pre-conference
  - Group provider visits (Endocrine, IM Residents, RN CDE)
  - Patient group education session/therapy
  - Peer support & education groups with LCSW and RD
  - Medication assistance through pharmacy technician
- Care coordination

DSRIP Patient Clinical Criteria

- Patients with uncontrolled diabetes
- Diabetic patients with poor health literacy
- Recently hospitalized or diagnosed with diabetes
- All Type 1 diabetics
- Highest risk Diabetic Clinic Patients

Patients screened and agree to program requirements before enrollment

Demographic Characteristics

- DSRIP Enrollee Demographics
  - 54% Charity Care, 29% Medicaid, 14% Medicare, 3% other
  - Adult patients
  - 62% Female
  - Majority Hispanic
    - language barriers
    - transportation barriers
    - low general or health literacy or both
    - financial barriers (affording medications)
    - psycho-social barriers

Program Objectives

- Provide culturally sensitive, patient-centered, high-quality care to our highest risk diabetic patients, utilizing group visits and a team-based approach
  - Improve patients’ diabetes knowledge base
  - Improve caregivers’ knowledge base
  - Identify and address barriers to care
  - Perform intensive case management
    - Improve clinical outcomes
    - Reduce costs
    - Reduce ER/hospital visits/co-morbidities
  - Continuously improve our processes
  - Share our experiences and lessons learned

High Level Interventions

- Risk Stratification:
  - Diabetes Distress Screening Scale
  - Diabetes Knowledge Test
  - Psychosocial assessment
- Evidence based medicine: AACE and ADA guidelines customized to meet individual needs
- Patient-Centered
  - Group exercise classes, culturally competent recipes
  - Family and caregivers welcomed to participate
  - Translation services
  - Psycho-education & Solution-focused therapy interventions
  - On-site testing and specialty providers
- Dedicated consulting Endocrinologist
- Medication assistance:
  - Medication samples and patient-assistance programs
  - Health Center Grants

Program Schematic

DD-1 DSRIP DIABETES GROUP VISIT

Primary Outcome	*Primary Drivers*	*Secondary Drivers*
The program will meet or exceed hospital specific goals on all diabetes specific metrics. Patients will achieve scores of health literacy / knowledge base testing of 85% or more	Endocrinologist will conduct a preconference on all patients to be seen with the DSRIP team and RWJ Residents	100% of patients will be reminded of appointment by phone and confirmed
	The Team will meet with each patient at least quarterly	100% of DSRIP team staff and Providers will receive education in diabetes best practices
	The Team will provide intensive case management and follow-up	DSRIP team will monitor and address patient specific metrics
	The patients will attend peer group sessions for education and support	100% of patients will receive orientation to the program and will take pretest Diabetes Literacy / Knowledge base test

Evidence-Based Training

- Endocrinologist-led lectures to staff & providers
  - "Advances in Diabetes Medications"
  - "Prescribing Insulin"
- Interdisciplinary Pre-conference

Diabetes Measurables

- Hgb A1c
- Lipid panel yearly
- Foot exams with monofilaments yearly
- Dilated eye exam yearly
- Blood pressure <140/90
- BMI each visit
- Diabetes-related admission rates
- *Urine Microalbumin/Creat Ratio yearly*
- *CMP yearly*
- *Influenza and pneumonia vaccination*
- *Diabetes Distress Screening Scale*
- *Diabetes Knowledge Test*
- *Patient satisfaction surveys*

Customized Program Tools

- Glucometers and testing supplies provided
- Point-of-care testing on site
- Specialty care and eye exams on site
- Pharmacy technician dedicated to prescription assistance
- LCSW performs Diabetes Stress Screenings
- RD provides nutritional screening including 24-hour recall

Project Achievements to Date

			2014					2015 TARGET	2015												TOTAL
CORE MEASURES			AUG	SEP	OCT	NOV	DEC		JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	
		# of Enrolled Patients	**5**	**8**	**20**	**11**	**9**		**17**												**70**
		Total # of Clinic Visits	***5***	***8***	***30***	***19***	***26***		***40***												128
12.1	Lipid Management	Lipid Profile performed annually	100%	100%	95%	100%	89%	**100%**	94%												**95%**
		LDL ≤ 100 (taken at enrollment)	60%	63%	53%	36%	25%	**70%**	73%												**79%**
12.2	Foot Examination	Foot Exam w/ monofilament performed annually	100%	100%	100%	100%	100%	**100%**	100%												**100%**
12.3	Eye Examination	Dilated Eye Exam performed annually	100%	75%	35%	36%	67%	**60%**	47%												**51%**
12.4	Comprehensive Diabetes Care (CDC): Hemoglobin A1C (HbA1C) testing	Hemoglobin A1C testing performed annually	100%	100%	100%	100%	100%	**100%**	100%												**100%**
		HbA1C ≤ 8 (taken at enrollment)	0%	25%	25%	36%	33%	**70%**	35%												**40%**
12.6	Controlling High Blood Pressure	Blood Pressure taken at each visit	100%	100%	100%	100%	100%	**100%**	100%												**100%**
		Blood Pressure ≤ 140/90 (taken at enrollment)	60%	75%	70%	73%	67%	**70%**	76%												**71%**
	Body Mass Index	BMI checked at each visit	100%	100%	100%	100%	100%	**100%**	100%												**100%**
	Urine Microalbumin/Creat Ratio	Urine Microalbumin / Creat Ratio performed annually	80%	88%	70%	73%	67%	**100%**	71%												**72%**
	CMP	CMP annually	100%	100%	100%	100%	100%	**100%**	100%												**100%**
	Pneumonia vaccination	Pneumonia vaccination offered or given annually	100%	100%	100%	100%	100%	**100%**	100%												**100%**
	Influenza vaccination	Influenza vaccination offered or given annually	100%	100%	100%	91%	100%	**100%**	100%												**100%**

Partnerships

- UMCPP Community Education & Outreach (CE&O)
  - Health fairs, screenings & referrals
- Inpatient service
  - CDE consultations and referral to program
- The New Jersey Commission of the Blind
  - Free diabetic eye screenings twice a year on site
- Specialty care
  - Podiatry, vascular, ophthalmology, cardiology, nephrology, surgery and other providers available on-site and in the community for charity care patients

Lessons Learned

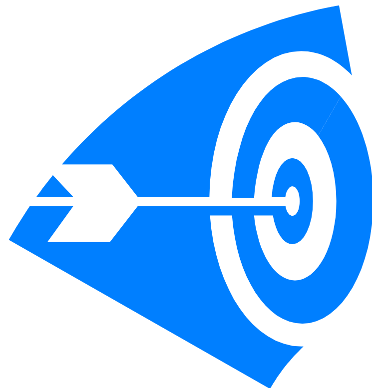
- Patients respond well to a multidisciplinary approach
- Addressing psychosocial factors and barriers improves patient adherence to recommendations and follow up
- Patient enjoy group and peer support
- Access to care improves compliance (POC testing, onsite providers)
- Education on and access to medications is instrumental to program success

Performance Improvement (Rapid Cycle Testing)

- Workflow barriers: tracking board and patient flag
- No show barriers and patient expectations: pre-visit calling

Highlights of January Survey

- High patient satisfaction scores
- Stable and effective staffing
- Active participation of staffing
- Improving patient outcomes
- Positive response to ongoing staff training
- Thoughtful changes to program in response to rapid-cycle evaluations – scheduling & follow up



Patient's Perspective on Success

Overall, the Diabetes Clinic does aims to reach and help our vulnerable diabetes patients.

- *"I am so grateful for the care that I get at the clinic. Before, when I had a job, the private doctor did not take care of me the way that the clinic does. Everybody explains everything to me and helps me to have low sugar. My mother in my home country got very sick with her diabetes, and she died. Her doctor there could not help her very much. Here, I get the care that I need, and the clinic helps me to get my medicine for free. The clinic is like my angel."*

-Anonymous clinic patient