Innovative Approaches to Population Health

What diabetes educators need to know about working with employers, pharmacists, and payors

Taking Diabetes to Work - Objectives

- Define components of an effective population health intervention
- Identify barriers to implementation and sustainability
- Discuss steps to determine effective outcome measures
- Identify opportunities for effective collaboration with stakeholders

Disclosure to Participants

- Notice of Requirements For Successful Completion
  - Please refer to learning goals and objectives
  - Learners must attend the full activity and complete the evaluation in order to claim continuing education credits/hours
- Conflict of Interest (COI) and Financial Relationship Disclosures:
  - Neither presenter have any conflicts of interest to report

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Who Are We?
• East Alabama Medical Center (EAMC)
  – 340 bed regional care hospital in east central Alabama
• Diabetes and Nutrition Center (DANC)
  – Outpatient department of EAMC
• Diabetes Disease Management (DDM) Program
  – Employee program serving employees and dependents

Current Program
• Education
  – Comprehensive DSME/MNT program
  – Quarterly follow-ups
• Benefits
  – Free medications, meter, test strips, insulin syringes and pen needles, pump supplies

Our Team
Director, Amie Hardin, MS, RD, LD, CDE
• Registered Nurses
  – Anna Carter, RN, BSN
  – Paige Kahn, RN, BSN, CDE
  – Jennifer Siggers, RN
• Registered Dietitians
  – Allison Drake, MS, RD, LD, CDE
  – Noelle Stewart, RD, LD, CDE
  – Kathryn Williams, MS, LD, CDE
• Pharmacist
  – Kayla Brown, PharmD
• Behavioral Health Specialist
  – Nicole Schultz, MS
• Registration Representative
  – Ericka Gray

Current Program
• Employee responsibilities
  – Attend scheduled appointments
  – Active engagement in behavior change
  – Meeting A1C goal

History of employee diabetes program
• Check for Success – 2004
  – Completion of comprehensive education and f/u every 6 months
  – Test strips at reduced amount
• DDM - Manage Your Health – 2006
  – “Got Sugar” campaign
  – Completion of comprehensive education, free medications and supplies
  – 2011 – implementation of hospital wellness program

Barriers
• Cost
• Employee engagement
• Educator “burn out”
• Progressive nature of disease
• Proving the worth of the program
Outcomes

• A1C
• Weight/BMI
• Decrease in medical claims
• Decrease in complications

Collaboration

• Administration of hospital
• Employee Wellness Clinic
• Endocrinologist
• Primary Care Providers
• Data analytics group

Next Steps

• Patient contract changes
• Medication changes
• Outcomes tracking

Innovative Approaches to Population Health: What diabetes educators need to know about working with employers, pharmacists, and payers

MedStar Health System
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Gretchen Youssef, MS, RN, CDE (MedStar Diabetes Institute)

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  – Presenter: Priscilla Flowers Thomas, MS, BS, RN, RD, LDN/LD, CDE, CCM
    – No COI/Financial Relationship to disclose
  – Presenter: Patryce Alyson Toye, MD
    – Omada Health – Advisory Board Meeting; air fare, hotel and stipend for participation
  – Presenter: Gretchen Youssef, MS, RD, CDE
    – No COI/Financial Relationship to disclose

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Working with Payers for Population Health Objectives

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Institute for Healthcare Improvement Triple Aim Initiative

- Improve the health of a population (outcomes)
- Improve a population’s experience with care
- Control cost

MedStar Family Choice (MFC)

- Part of the MedStar Health System
  - A Distributive Care Delivery Network anchored in Baltimore-Washington Corridor
- Maryland Medicaid Managed Care Organization (MCO)
  - 90,000 covered lives (6,000 members with diabetes and 28,000 members with prediabetes)
  - Interdisciplinary team of case managers, Medical Directors, and support staff

What Do We Do?

- Care Coordination
- Self Management Education and Support
- Quality and Performance Improvement
- Provider Education
- Clinical Authorizations
- Community Outreach

Quality and Performance Improvement

- NCQA
  - Accreditation guides operations and available services
  - Based on clinical performance and member experience
- VBP
  - Value based purchasing
  - Payment Reform. Shift in focus from volume-based to value-based care
- HEDIS Quality Metrics
  - Compares health plan performance on an “apples-to-apples” basis
  - Specifically defined measures (i.e. Comprehensive Diabetes Care)

Shift from Disease Management to Population Health

- Disease Management
  - Disease-Specific Care
  - High-cost/high-needs members
- Population Health Management
  - Whole-Person Care
  - Whole populations
  - Impacted members with emerging risk
Population Health

• “The health outcomes of a group of individuals, including the distribution of such outcomes within the group”. Kindig D, Stoddart G (March 2003)
• Healthcare Transformation

Population Health Management - Key Components

• Population Assessment
  – Screening for Social Determinants of Health (SDOH)
• Predictive Analytics
• Population segmentation and risk stratification
• Identification of member needs
• Development of goals and targeted interventions
• Evaluation of outcomes

Social Determinants of Health (SDOH)

• Conditions in which people are born, grow, live, work and age
• Non-medical needs
• Screening Tools
  – PRAPARE
  – AAFP Social Needs
  – Accountable Health Communities (CMS)
• ICD-10 Z Codes

Managing Members with Emergent Risk (Prediabetes)

• 2 year grant funded DPP (Diabetes Prevention Program) demonstration project
• MFC one of the 4 participating MCOs
  – Members identified through ICD 10 codes from claims for obesity and gestational diabetes and HbA1c data
• Education delivered through virtual (online) platform or in-person classes
• Medicaid 1115 waiver amendment submitted to expand DPP coverage in MD

Keeping Members Healthy

Member and Family

Healthy People 2020

O’Gurek, D and Henke C. 2018
Outcomes Across Settings

• Manage health resources utilization
• Reduce Low Acuity Non-Emergent (LANE) ED utilization
• Facilitate safe and appropriate care transitions
• Avoid readmission within 30 days of high-risk discharge

“Diabetes Boot Camp”- Collaboration between MFC and MedStar Diabetes Institute

• 12 week intensive program focused on diabetes medications management and diabetes survival skills education
• Provides support for providers and patients with uncontrolled type 2 diabetes
• Targeted glycemic control and reduction in health resources utilization
• Collaboration with MFC around cost structure, data sharing, and referrals

Available Resources and Tools

• Resources
  – Case Management and Outreach services
  – Coverage for DSMES and for prediabetes (coming soon for Medicaid)
• Tools
  – Electronic Pill Boxes
  – Mobile services
  – 24/7 after-hours nurse line
  – Patient Portal for education and support
  – Transportation assistance (i.e. Uber Health)

Opportunities for Collaboration

• Population Assessment
  – Community Needs Assessments
  – Screening for SDOH
• Linkage to community resources
  – 2-1-1 and Aunt Bertha
• Quality metrics, wellness and preventive screenings, and health resources utilization
• Communication on referrals for DSMES and prediabetes education
• Data sharing

Barriers to Population Health Management

• Data
• Member engagement
• Provider resources
• Changes to current system of healthcare
• Developing effective collaborative relationships

Summary

• Reviewed components of an effective Population Health intervention
• Identified barriers to implementation and sustainability
• Discussed effective outcomes measures such as HEDIS, ED and readmission rates
• Identified opportunities to collaborate with payers on access to resources and tools
References


Questions

The Blue Bag Initiative

Objectives:
1. Overview
2. Goals
3. Objectives
4. Supplies Needed
5. Process
6. Collecting Data
7. Apple Pharmacy program
8. Questions

Turning the Brown Bag.................Blue

The Blue Bag is a dynamic, innovative initiative that brings a new twist to the evidence-based brown bag medication review. When pharmacists are included in a team-based approach, chronic disease outcomes improve and adverse drug events (ADE) decrease.
Blue Bag Initiative

Goals Of the Blue Bag Initiative

- Provide an easy to use program
- Facilitate the creation of an accurate medication list
- Help participants take an active role in managing their medications
- Identify and address medication errors
- Provide a reusable bag to carry their medications
- Separate discontinued/expired drugs from the “active” drugs

Objectives

- Adapt this initiative for use in different settings
- Provide simple steps to organize, implement, measure and analyze effective medication therapy management
- Improve participants’ understanding and health literacy through this “hands-on” activity

Objectives – cont.

- Increase the efficiency and consistency of medication safety initiatives
- Collect data to measure adverse drug events prevention

The Blue Bag Initiative

Supplies Needed

- Blue Bags
- Discontinued/expired medication bags (white)
- Notebook
- Instructions for providers
- Pharmacist/Physician forms
  - Medication Review
  - Participant Evaluation
  - Data Collection
  - Worksheet

This Process Includes 5 Steps:

1. Develop a list of current medications
2. Make clinical decisions based on the list review and participant interview
3. Verify medications are “the right drug, with the right dose, at the right time”
4. Create a list of suggested changes for the prescriber
5. Communicate suggested changes for the prescriber to appropriate caregivers and to the participant

How Does Using Comprehensive Medication Review Prevent Errors

The causes of errors found during medication reconciliation reported to MEDMARX included:

1. Performance deficit: 88%
2. Transcription inaccurate/omitted: 84%
3. Documentation: 83%
4. Communication: 82%
5. Workflow disruption: 80%
How To Get Started

Pick a Setting
1. Community Pharmacy/Physician Practice
2. Assisted Living
3. Health Fair
4. Immunization Clinic
5. Hospital Discharge

Pick Marketing Forms
1. Flyers
2. Appointment Cards
3. Rack Cards
4. RX Bag Cards
5. Signup Sheets
6. Participation Evaluation Form
7. Medication Review Form
8. Follow up Questions

Measures of Success

Number of Patients Completing Blue Bag Initiative

Number of Pharmacists' Identified Medication Related Problems

Collecting the Data

Data Collection Worksheet

Blue Bag Initiative in a Rural Independent Pharmacy

Apple Discount Drugs – Core Clinical Care

• Utilized Community Pharmacy Resident to incorporate medication reconciliation in the diabetes clinic.
• Resident conducted a research project to highlight the impact of medication reconciliation on improving health outcomes and sustaining clinical services.
• Results highlighted pharmacists' role in preventing and resolving medication related problems; especially in the diabetic population.

Results

Volume and % of Patients Screened with Potential Adverse Drug Events Identified

Results

Volume and Rate of Potential Adverse Drug Events Identified per 100 Participants
**Tips & Tricks!**

- Determine a Blue Bag Champion
- Stay Organized
- Assign Roles
- Train Staff
- Review Process

**Contact Information**

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**A Value Added Service!**

**The Impact of the Blue Bag Initiative**

- Provided a pathway for diabetes follow-up
- Improved patient satisfaction and rapport
- Increased interprofessional transitions of care

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**Future Implications**

- Expanding the Blue Bag Initiative at Apple Discount Drugs

- Increased amount of Blue Bags
- Incorporating student pharmacists
- Looking for new avenues to bill for services
- Expanding the service outside of the diabetes clinic
- Equating a cost savings for identifying pADEs