AADE’s Vision for the Future of the Specialty: Opportunities to Ride the Population Health Wave

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• 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 credit/hours.

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American Association of Diabetes Educators (AADE)

- 2020 AADE President-Elect
- Director, National Board of Directors
- Committee Member, AADE19 National Conference
  - Track leader, Population Health
- Co-Leader, Population Health Community of Interest
- Finance Officer / Co-Chair, Texas AADE CB
- AADE Spokesperson

Thoughts presented are not represented as those of the AADE organization.

Presentation Objectives

1. Describe the core elements of AADE's Vision for the Specialty
2. Discuss the inherent role opportunities for diabetes educators within a Population Health framework
3. Outline strategies for diabetes educators to drive positive organizational outcomes
Our Current Foundation
The why....

Diabetes Guidelines

US Cost of Diabetes Care

$237 billion

$90 billion

789
What Do These Numbers Represent?

8760

6

8754

NHANES Data

Diabetes Prevalence

SS Casagrande et al. Diabetes Care, 36, August, 2013: 2271‐2279.

NHANES Data


Diabetes Prevalence

What Do These Numbers Represent?
Integration…. Diabetes is personal

Clinical Recommendations
Care Team, Diabetes Educator & Community Partners
Person with diabetes, family & support persons

DSMES Service Utilization

1 in 20 newly diagnosed Medicare beneficiaries
1 in 15 newly diagnosed Medicare beneficiaries

What is your ValYOU?
Re-Consider:

- Outcomes (Clinical & Process) – Drive data
- Risk mitigation & Safety
- Care prioritization and coordination
- Inter-disciplinary collaborator / Work force leveraging
- System or Office care design & re-design
- Quality improvement
- Strategic planning – Develop and drive operational change

Our Future ValYOU
Vision for the Future

To drive optimal outcomes through the integration of diabetes clinical management, education, prevention and support.

Strategies Supporting Project Vision

Quadruple Aim
The optimization of diabetes care delivery for the quadruple aim.

Person-Centered
Advocating for equity to person-centered care.

Related Conditions
The integration of cardiometabolic and related conditions.

Strategies Supporting Project Vision

Integration
Driving the integration of diabetes clinical management, self-management education, prevention and support.

Technology
Leveraging technology driven diabetes care, education and support.

Behavioral Health
The promotion and integration of behavioral health.
Quadruple Aim
The optimization of diabetes care delivery for the quadruple aim
Impacting quality, cost, and both person and provider experience

Strategies Supporting Project Vision

Person-Centered
Advocating for equity to person-centered care
So that every individual with diabetes and cardiometabolic conditions has access to a diabetes educator

Related Conditions
Diabetes, hypertension, obesity and cardiac diseases are not isolated disease states. We will claim our expertise in these areas of care

Strategies Supporting Project Vision

Strategies Supporting Project Vision

Strategies Supporting Project Vision
Behavioral Health
The promotion and integration of behavioral health
Promoting strategies to improve quality of life

3-4 fold increased risk for depression
- High levels of Diabetes Distress (DD):
  - Prevalence 18–35%
  - 18-month incidence 38–48% and persistent over time
  - Distinct from clinical depression
- High levels of DD significantly associated with:
  - Poor glycemic control
  - Poor self-care
  - Low diabetes self-efficacy
  - Poor quality of life, even after controlling for clinical depression


Strategies Supporting Project Vision
- Integration
  - Driving the integration of diabetes clinical management, self-management education, prevention and support
  - Our value proposition is ensuring that person-centered care plans incorporate self-management education & ongoing support. People with diabetes and cardiometabolic conditions benefit when healthcare delivery is holistic and seamless

Technology
- We will be technology experts and interpreters, trainers and consultants
  - Leveraging technology-driven diabetes care, education and support
  - Diabetes Device Technology
  - Diabetes Care Delivery Technology
  - Person’s lived world
  - Health system’s lived world
Connection to Population Health…

Your role?

Population Health

The health outcomes of a group of individuals, including the distribution of such outcomes within the group.

It’s what we do as diabetes educators

Population Health framework…

It’s what we do as diabetes educators
AADE Vision & Population Health

- Health Assessment
- Risk Stratification
- Engagement
- Communication
- Dietary/Behavioral Interventions

OUTCOMES

Making the Transition

- Fee-For-Service
- Outcome / Value-Based
- Between Visit Focus
- Clinical Focus
- Person-Focused
- Episode Care
- Stratified Care Pathways
- Sole provider or multidisciplinary team
- Interdisciplinary team & Community supports

Outcomes: Provider & Patient Experience

Payment Models

Health Care Payment Learning and Action Network-LAN

Payment Models

- Fee-For-Service
- Outcome / Value-Based
- Between Visit Focus
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Outcomes: Provider & Patient Experience
Alternative Payment Models

GOAL: High quality care, spend dollars wisely

Category 1
- Fee for Service - Focus on Quality & Value

Category 2
- Fee for Service - Link to Quality & Value

Category 3
- APHM Built on Fee for Service Architecture

Category 4
- Population-based Payment

Bundled Payment
- Episode based payment

For more information:
- https://hcp-lan.org/groups/apm-fpt-work-products/apm-report/

The Chronic Care Model

Delivery System Design

Clinical Information Systems

Community Resources & Policies

Health Care Organization

Self-Management Support

Decision Support

Informed Activated Patient

Productive Interactions

Prepared Pro-active Practice Team

http://www.improvingchroniccare.org

L. Improving Care and Promoting Health in Populations: Standards of Medical Care in Diabetes—2019
American Diabetes Association

34 35 36
Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

WHO Definition since 1946

Physical
Mental
Social

Decision Cycle for Patient-Centered Glycemic Management in Type 2 Diabetes

Adapted from Davies MJ, D'Alessio, DA, Fradkin J, et al. Diabetes Care 2018;41:2669–2701

Social Determinants of Health (SDOH)


HealthyPeople.gov – Healthy People 2020 – Understanding Social Determinants of Health

KEY
Empowering people to take ownership of their healthcare

SDOH

Physical Environment

Socioeconomic Factors

Healthcare

Social Determinants of Health

KEY: Empowering people to take ownership of their healthcare
10 Questions:
• Housing Instability
• Food insecurity
• Transportation Needs
• Utility Needs
• Interpersonal Safety

PRAPARE: Protocol for Responding to and Assessing Patient Assets, Risks, and Experiences (NACHC)

A risk score is a standardized metric for the likelihood that an individual will experience a particular outcome.

A risk stratification framework may combine several individual risk scores to create a broader profile of a person (patient) and his or her complex, ongoing needs.

Risk Stratification
Foundation for achieving Triple Aim components

Risk Stratification

https://healthitanalytics.com

Stratification & Clinical Management Pathways

Standardized evidence-based multi-disciplinary health care to create optimal patient and system outcomes

Mould, G et al. IJCC 2011.

(3): 90–97

Medication Adherence:
P-SAM Score

Key Stratification Considerations

Socio-economic Status
Pharmacy use
Food access

Educational status & capacity
Transportation
Available community resources

May account for 70 percent of data that contributes to better health

https://healthitanalytics.com

EMR
Claims Data
Patient Surveys
County Data
Disease Registries
- Identification & tracking of people with a specific chronic condition
- Facilitates health outcome management at both the individual and health organization level
- Encourages documentation of abnormal test results, missed test results, and appointments
- Tracks progress of high risk patients
- Promotes evidence-based care

Electronic Health Record
Build for success
- Registries
- Reporting Work Bench
  - Bulk Orders
  - Bulk Communication
- Documentation Templates
- Clinical Decision Support:
  - Best Practice Alerts
  - Health Maintenance
- Care Connect
- Care Everywhere
- Patient Portals

Integrating Personal Technology & Data
Optimization critical

Communication Delivery Modalities

- Patient portals
- Social Media
- Webinars
- Apps
- Telehealth DSMES/Health Coach
  - One on one
  - Video conferencing
- E-mail
- Text messaging
- Devices

Digital Health Forecast

AHA's Center for Health Technology & Innovation

Barriers to technology adoption:
1. Patients:
   - When to use apps / wearables
   - Validation & reliability
   - How to interpret & apply the data
2. Digital Device & App companies:
   - Defining the use case
   - Understanding needs (personal & clinical)
3. Clinicians, insurers, health systems, pharmaceutical manufacturers:
   - Inertia / sharing control
   - Incorporating into clinical care
   - IT implementation
   - Reimbursement

https://www.mobihealthnews.com

http://www.ahajournals.org/doi/pdf/10.1161/JAHA.118.009271

'Health techquity'

Digital health tools that Medicare members use:

- Blood glucose
- Activity tracker
- Track weight
- Track cholesterol
- Alarm
- Monitor

49 50 51
AADE: DANA Resource

https://www.danatech.org/about-dana/

Awards

Engagement & Activation

Engagement: The interventions designed to increase activation

Activation: Understanding one’s role in the care process & having the knowledge, skill and confidence to manage one’s health & health care.

PAM: Patient Activation Measure

Workforce Engagement & Workforce Optimization
Abstract

Diabetes and mental illness generally result in worse outcomes and greater behavioral health needs and poorly controlled diabetes (A1C >8%) who:

- Have high use of acute medical inpatient or ED, inpatient psychiatry or extended hospital stay [30 days w/in past year] or Parkland Psychiatric Emergency Services [6 or more combination of any within the last year]
- Have established clinical outpatient care, but insufficient to control disease
- Do not adhere to treatment goals to manage their diabetes and behavioral health illnesses.

Methods

- A nurse practitioner (NP) and licensed clinical social worker (SW) team, liaising with psychiatry and primary care, conducted risk assessments, interventions, and education via both clinic and home visits, providing diabetes and mental health addressing barriers to care and adherence.
- Patients must live in Dallas County, have medical health coverage (or be eligible for Parkland Financial Assistance), be ambulatory and have no history of illegal substance abuse.

We present data on the first 30 enrollees (22 female, age 52±12 yrs, 32% Hispanic/32% Black) of this quality improvement initiative. Over the course of 12 months, improvement was documented in mean A1C (11.75±2.2 to 8.74±1.8%, p<0.01), mean BMI (37.1±9.0 to 33.5±8.5 kg/m^2, p=N S) and mean PHQ-9 scores (22±3 to 12±5, p<0.01). Emergency room visits fell from an annual mean of 3.0±2.8 in the year prior to enrollment to 1.1±1.4 during the intervention year (p<0.05).

Conclusion

- Both the fall in A1C and reduction in ER visits were significantly correlated to the improvement in PHQ-9 scores by the 4th quarter.
- Total cholesterol decreased from 221±62 to 160±41 mg/dl.
- Triglycerides decreased from 338±283 to 193±165 mg/dl.

Transition to Maintenance of Care for "successful" patients – occurs after 1 Initial, Comprehensive Assessment Visit – Detailed medical & psychiatric assessment (including PHQ-9 & other standardized tools), medication reconciliation, exploration/identification of patient priorities for care, extensive psychosocial assessment, revision of rationale for treatment & adherence in collaboration with physician & psychiatrist consultation.

Follow up visits – focus on mental health & diabetes status, re-evaluation of current pharmacologic treatment, case management, psychosocial support, behavioral intervention.

Face to face to phone visits – establish collaborative maintenance of care.

Need to go beyond the four walls of the organization.

References

1. Texas Health Resources
2. Parkland Health & Hospital System
3. UT Southwestern Medical Center
4. Indiana State University

This project was supported by a grant from The Meadows Foundation, and was approved by Indiana State University’s Institutional Review Board.
Faith Health Initiative
A partnership between Parkland and Dallas County Faith Communities to accomplish two primary objectives:

- Reduce ED utilization
- Connect patients to primary care
- Reduce hospital readmission
- Lowered cost of care for partnered patients

Assist congregations to build or strengthen their health ministries

Person-Centered Interventions

<table>
<thead>
<tr>
<th>No or Low Risk</th>
<th>Moderate Risk</th>
<th>High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Promotion / Wellness</td>
<td>Health Risk Management</td>
<td>Care Coordination</td>
</tr>
<tr>
<td>Diabetes Management</td>
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Timely access to required interventions

Population Health Outcomes

- Clinical & Health Status
- Psychosocial Outcomes
- Behavior Change
- Patient & Provider Productivity, QOL & Satisfaction
- System Utilization
- Financial Outcomes

Clinical & Process Metrics

The focus of your language & actions
Key CDE Strategies to Drive Change

- Believe - Be prepared to change
- Review your 'language' – Outcomes driven & align with health care / system language
- Take a system (inclusive) approach to your services – Octopus & Bridge
- Evaluate against and integrate the AADE Vision elements into practice
- Look at your current role(s) across the 6 Population Health framework categories
- Use the Quadruple Aim as your foundation for impact
- Keep your eyes and ears broadly open
- Optimize peer & public policy / advocacy networks
- Think diversely – payment models, communication, interventions, community

Apply our Strengths to Ourselves....

Resources: Project Vision

Resources: Population Health

- Each other!
- www.diabeteseducator.org
- www.ihi.org
- www.himss.org
- Population Health / Data Analytics resources – eg Athena Health, Health Catalyst, Optum
- State Departments of Health
- www.rchnfoundation.org

AADE Communities of Interest (COIs)

The Population Health Community of Interest Group provides diabetes educators with the opportunity to share approaches for managing populations of people living with diabetes from both diabetes educator and health system perspectives.

Thank you!
Questions?