It Takes a Village: Improving coordination of care to increase access to diabetes self-management education

Nicole O’Kane, PharmD, and Alison Shipley
HealthInsight

Objectives
• Describe how the HealthInsight QIN-QIO is helping to build capacity for diabetes self-management education in rural and underserved areas
• Share promising practices for improving self-management support in rural communities
• Help identify how your QIN-QIO can support your goals for reducing the burden of diabetes in your community.

Guiding Questions
• What would health and healthcare look like in your community if people with diabetes had the support they needed to stay as healthy as possible for as long as possible?
• How do self-management education and support services look in this future-state system?

HealthInsight QIN-QIO
• Utah, Nevada, New Mexico and Oregon
• Quality Improvement Organization contract through Centers for Medicare & Medicaid Services
  – Tasked to reduce disparities in diabetes care through spread of Everyone with Diabetes Counts Program

FRAMING THE COMMUNITY CONVERSATION

Chronic Care Model

Value-Based Payment
• Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was signed into law on April 16, 2015.
• Considers quality, cost and clinical practice improvement activities in calculating how Medicare physician payments are determined.
• Repeals the 1997 Sustainable Growth Rate Physician Fee Schedule (PFS) update.
• Changes Medicare PFS Payment through two streamlined ways: Merit-Based Incentive Payment System (MIPS) and incentives for participation in Alternate Payment Models (APMs)

Source: HIMSS 2016 CMS. cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/

Self-management Related Medicare Codes
• Diabetes Self-Management Training (DSMT)
• Medical Nutrition Therapy (MNT)
• Chronic Care Management (CCM)
• Health and Behavior Assessment and Intervention (HBAI)
• Intensive Behavioral Therapy for Obesity (IBT)

Key Partners
• State Departments of Health
• Area Agencies on Aging
• Aging and People with Disabilities Offices
• Local Health Districts
• Local Public Health Authorities
• Large Health Systems
• Health Plans
• Local Organizations Focused on Diabetes

Challenges and Opportunities
• Disparities in access to diabetes education and use of DSME benefit
  – Cultural and language barriers
  – Geographic barriers
  – Transportation barriers
• Opportunities for improvement
  – Facilitating a community solution
  – Using data and quality improvement to drive change

Community Organizing in Rural Oregon
Environment Pre-partnership

- Historical barriers to bringing self-management education to the community
- A couple of champions and some collective will already existed, but they needed help organizing
- Clinical and non-clinical partners were not talking, but they were identifying similar needs!
- Limited resources for sustainability

Organizing for Success

- Partnering with local leadership
- Bringing diverse clinical and non-clinical partners together in person
- Engaging leadership early and often
- Identifying and being responsive to diverse drivers for involvement

Readiness for Change

- Collective will and desire for self-management education
- Local champions
- Agreement on need for improved diabetes self-management education and support for underserved populations
- Linking clinical and community partners
- Engaged payer
Organizing for Success

What are we still learning:

- Operationalizing closed-loop referral across clinical and community DSME services
- Aligning with quality metrics and referral pathways for sustainability
- Managing diverse interests and drivers

DSME Referral System with the Nevada HIE

Using HIT to Improve Diabetes Care Coordination and Quality

Using HIT to Improve Diabetes Care Coordination

- Improves capacity for closed-loop referral
- Supports quality reporting needs of clinics in value-based payment environment
- More robust care coordination to support patient’s self-management journey

What is Health Information Exchange?

Referrals Using EHR Based Direct
Referrals Using Direct Only

- Referrals to DSME
- DSME Agency
- Referrals to EHR or Paper Record
- Import or File
- Consult from DSME

Using QI and Data to Drive Change

- Helping communities to collect and use their data for improvement
- Demonstrating value and alignment with quality reporting requirements
- Capturing the local story

NM Demographics and Disparate Populations: IHS Service Areas

Source: ihs.gov, retrieved on May 16, 2016.

CDEs in New Mexico

Source: National Certification Board for Diabetes Educators (NCBDE), September 17, 2014.
Key Takeaways

- Reaching underserved populations is a community endeavor and requires a multi-sector systems approach.
- Coordinating services between clinical and community entities is important to increasing access and improving patient engagement and activation.
- Self-management education is an important part of value-based care.

Questions?

Nicole O’Kane, PharmD  
Clinical Director  
HealthInsight Oregon  
noke@healthinsight.org  
(503) 382-3964

Alison Shipley  
Project Manager  
HealthInsight Nevada  
asipley@healthinsight.org  
(702) 933-7325