Grant Outcome Report

Expanding the Chronic Care Model for Patients with Diabetes in Central New York

KEY INFORMATION:

GRANTEE
Family Health Network of Central New York, Inc.

GRANT TITLE
Taking Charge of Diabetes, a Collaborative Approach

DATES
January 1, 2008 – March 31, 2010

GRANT AMOUNT
$250,912

FUNDING
2007 Setting the Standard: Advancing Best Practices in Diabetes Management Request for Proposals

The Problem

According to the Family Health Network of Central New York (FHN), a multi-site, federally qualified health center in Cortland County, the County's diabetes rate in 2007 was relatively low; 4% of the County's population was diagnosed with diabetes, compared to 7.2% statewide. However, the age-sex adjusted mortality rate was relatively high; more people with diabetes in Cortland County die of complications related to diabetes than in other parts of New York State. This region of the State also has the third-lowest reported daily self-monitoring of blood glucose and the fifth-lowest reported daily foot self-check among members of the New York Diabetes Coalition. In the same region, the percentage of adults with diagnosed diabetes who reported ever having a foot sore that took more than four weeks to heal is the third highest in the State. The data suggested that a target population existed that may not have had a consistent medical home, potentially due in part to issues of geographic isolation, level of education, and income.

With support from the New York State Health Foundation (NYSHealth), FHN worked to expand its existing diabetes program that was launched in 2006. FHN's diabetes program was a result of its participation in the Health Resources and Services Administration Bureau of Primary Health Care's Health Disparities Collaborative. NYSHealth funding allowed FHN to expand its diabetes services by adding more care teams and locations in Cortland County. Funding also enabled FHN to better develop underused elements of the Chronic Care Model (CCM), which identifies the essential elements of a health care system that encourages high-quality chronic disease care. FHN's particular focus on improving CCM measures included self-management support, community linkages, and clinical information systems.

This project was funded under NYSHealth's 2007 *Setting the Standard: Advancing Best Practices in Diabetes Management* request for proposals (RFP). The goal of *Setting the Standard* was to move New York State's primary care system to adopt and spread best practices in disease management

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and establish them as the universal standard of care for patients with diabetes. At the time, multiple diabetes management programs already existed throughout New York State, along with established collaboratives to maximize the impact of these programs. Thus, NYSHealth expected the grants made under the RFP to advance these programs and build systemwide capacity to support, sustain, and institutionalize these efforts. The CCM—a highly respected and accepted framework for approaching the improvements sought through this initiative—was a major reference point in the RFP.

Grant Activities and Outcomes

Prior to the grant, FHN had already established the CCM for diabetes management in two of its five medical sites. With NYSHealth support, FHN was able to support the staff, training, implementation (e.g., staff orientation and patient registration), and evaluation activities necessary to spread the CCM to its remaining three sites.

While FHN previously had used a limited diabetes registry (patient electronic care system), full registry implementation was a primary goal of this project. FHN made significant headway with its implementation during the grant period. FHN's effective use of the registry was greatly enhanced by the assignment of a full-time registry coordinator, who was responsible for data collection, data entry, and report generation, as well as patient and care team outreach to follow up on identified gaps in care prior to patient visits. Despite some concerns about data quality and completeness, the registry coordinator also produced regular performance feedback reports on a set of important measures. In addition to using the registry as a tool for ensuring that patients received indicated services, FHN issued standing orders for all routine diabetes care components based on American Diabetes Association standards to be instituted, such as annual LDL testing and referrals for eye exams.

Improving self-management support was also a high priority for FHN, and its staff at all levels participated in self-management goal-setting practices. Documentation of goals in the medical record made it possible for any member of the team to follow up on patient progress.

FHN's community outreach work included developing partnerships with local coalitions, educators, and other community-based organizations. These partnerships resulted in a range of community activities, including community-based diabetes self-management classes; diabetes screening and education at locally sponsored health fairs; cooking classes; and a communitywide weight loss challenge.

Concurrent with its activities under this grant, FHN embarked on a program to pilot the use of point-of-care testing. This pilot enhanced the power of the registry by making it easier to render services in a concentrated fashion. FHN was able to bill for point-of-care testing, allowing it to sustain this

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highly valued service. In addition, FHN also began a continuous glucose-monitoring program to provide robust data to support education and clinical decision-making for patients with poorly controlled diabetes. Program costs for interpreting the results and complementary food diaries were covered through billable diabetes education sessions with a certified diabetes educator (CDE).

All seven of FHN's primary care providers achieved National Committee for Quality Assurance (NCQA) diabetes recognition. An evaluation of return on investment using hospitalization data was conducted as proposed; however the study design resulted in the inclusion of very few hospitalizations, limiting the usefulness of the information. FHN intends to repeat the analysis over an expanded time period in the future.

To evaluate clinical outcomes, data were collected and analyzed under the guidance of an outside evaluator for the four FHN sites that had comparable data. FHN demonstrated an early trend toward improvement at two of its sites for HbA1c control and an improvement in blood pressure control at three sites. No improvements in LDL control were evident. Additionally, the evaluation revealed that patients who had formerly exhibited clinical indicators outside of the desired range now showed significant improvements for almost every clinical indicator.

As part of the *Setting the Standard* initiative, an outside evaluation of 10 of the 12 participating grantees was conducted. In addition to observing whether each grantee advanced against its proposed objectives, the evaluators also assessed how well each grantee adhered to CCM principles. From the evaluator's perspective, FHN exhibited strong leadership with a solid understanding of the CCM, including how planned care should operate, how to implement a team approach to care, and the often-missed differences between implementing patient self-management tools and offering self-care education. These strengths provided FHN with a framework for developing a rational plan to achieve both short- and long-term goals for care improvement. FHN also focused on the business case for this work and the need to support quality enhancements through new revenue streams. However, starting the work concurrently at four sites

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stressed its capacity to implement the model consistently. FHN routinely generated feedback on key performance measures, but found it difficult to use the data most efficiently, which is an important part of the CCM. The findings from FHN's grant work taught NYSHealth about the need to work with grantees to determine whether it makes more sense to pilot and perfect work at one site before attempting to spread new practices to multiple sites.

The Future

In order to facilitate reimbursement for CDE services, FHN applied for diabetes education accreditation from the American Association of Diabetic Educators. The application was submitted for review by the end of the second quarter of 2010.

FHN's diabetes program transitioned with its implementation of electronic health records (EHRs) in 2011. The EHRs now serve as the diabetes registry.

FHN plans on using lessons learned from the CCM to expand its services to include depression and cancer screenings. With these additions to its menu of services, FHN is poised to attain NCQA's highest level of patient-centered medical home recognition.

FHN's medical director and collaborative coordinator have since joined the Community Health Care Association of New York State's diabetes advisory group, which works to improve diabetes care in community health centers across the State.

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BACKGROUND INFORMATION:

ABOUT THE GRANTEE

Family Health Network of Central New York, Inc., was established in 1972 when the private, nonprofit health care organization took over three rural health clinics operated by the Cortland County Health Department. The organization has expanded to a current network of five medical clinics (DeRuyter, Cincinnatus, Marathon, Moravia, and Cortland), one dental clinic in Cortland, and four school-based health centers. All of the sites are located in health professional shortage areas and serve a rural, impoverished population—21% live below 200% of the federal poverty level. The network is the only provider of primary care (both medical and dental) to three of the five communities where clinical sites are located.

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