Establishing Referral Processes to DPP in Primary Care: Two Examples

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Our organization

- 4 CDE's in 9 Providence clinics
  - 8 Primary Care and Adult Endocrinology
- DSME without billing
  - Providers have been utilizing CDE's to provide education to patients with prediabetes
- Now billing for CDE services
  - Prediabetes is not a covered CMS benefit
  - Educate providers about the needed change how we deliver diabetes prevention services so patients don't receive bills

1422 Grant in 2016

- **Implement systems to facilitate identification of patients with undiagnosed prediabetes**
  - Education for clinic staff and providers on the incidence of, identification and treatment for prediabetes
  - Identifying clinic support
  - Using the numbers to advocate for screening

Our initial approach to get patients enrolled…

- Providers just needed to screen (elevated FBS, A1c, h/o GDM) to see that they had patients with prediabetes or at high risk already in their practice
- Study showing low rate of documentation of Prediabetes in Primary Care
  - Mainous A et al. J Am Board Fam Med 2016;29:283–285
  - Affirmed at provider meetings that they indeed had A1c's in the prediabetes range in the chart, but they did not/do not assign a diagnosis or have any discussion about this with patients

What we did

- Put the nuts and bolts of DPP in place.
  - Purchased curriculum –Group Lifestyle Balance (GLB), DPP curriculum
  - Trained lifestyle coaches
  - Set up classes on our registration website
- Information to the clinics
  - Flyers for classes
    - Information to providers on how to sign patients up for DPP after risk was identified
    - Basic class structure/information
    - Drive potential participants to the website for more detailed information and to register

Points for Change

- The inability to send prediabetes patients to CDE's
- The understanding reimbursement for DDP would happen
- The numbers of patients involved
- Consistent with health care reform, preventive services

This was essentially ineffective…

The Barriers in Primary Care

- Not really a reimbursable diagnosis in the past
- Blood test screenings not covered
- Medications for those with prediabetes or risk for developing diabetes was not covered
- Primary care not wanting to have the conversation about prediabetes, diabetes risk, obesity with patients
- No resources in place for support if patients identified
- Patients don’t come in for “prediabetes”, so it is an add on to what they came in for…
- No processes in place for referring to community based services

Additional needs

1. Referral form
2. Education about referring to a community based program

- The referral tool(not required) put a process in place within the clinic
- This increased the number of referrals, but not enough for sustainability
  - The increases were primarily from IM providers and FM who were currently referring to CDE's
  - This was a clinic that got their training to the providers after the referral tool was developed, so part of the conversation initially.

1422 Grant in 2017

- **Promote linkages between health systems and community resources for adults with adults with prediabetes or at high risk for type 2 diabetes.**
- **Do a pilot project in 1-2 clinics where a full intervention is done for patients who meet the criteria of the prediabetes.**
- Send mailings and make phone calls to get patients that meet risk criteria enrolled.
- Evaluate strategies that work to reach and recruit patients.
- Implement evidence-based engagement strategies to build support for lifestyle change.

The Goal

- To develop a process within primary care for identifying patients with prediabetes and or at risk for developing type 2 diabetes, and referring them into our community based GLB
  - Two “pilot” clinics
  - Six “control” clinics

Pilot clinic #1
Clinic Champions

- One MD was a supporter from the start
  - Specialty in preventative medicine
  - worked on developing DPP programs in other communities
- Initial stab at a protocol for screening and referring
- Set dates around the education about and the implementation for a mini CQI project

Resource review

- Systems in place
  - Review of symptoms (ROS) handout to all patients
  - Vitals
  - Current referral process for GLB
- Documents to utilize
  - CDC Risk Test (free download from the Ad Council, ADA)
  - Clinical Practice Algorithm for prediabetes and asymptomatic diabetes
  - Educational support materials for the office, including CDC posters that highlights the rate of prediabetes and encourages patients to talk with provider about prediabetes risk (Ad Council)
  - GLB Flyers
  - GLB referral form
  - Patient education materials on prediabetes for patients

Documents developed

- Worked together back and forth on the procedure
- Dr. Readhead wrote smart texts for providers
  - Chart note
  - AVS
  - Positive lab

Procedure Highlights

- All adult patients (18YO and above) receive the risk test with the ROS when checking in to their appt.
- If score is less than 5 nothing is done
- If score is 5 or greater then MA pends and A1c (no POC glucose in this office at this time)
- Risk test and referral form to provider when seeing the patient
- Provider discusses risk with patient, signs referral and makes note in chart (updates problem list), follow-up appt. scheduled for lab review
  - quick texts for chart note, AVS and note/procedure if/when lab comes back positive for prediabetes (or diabetes)
- MA faxes referral to us

Implementation Plan

- Educate staff on date, time, process, materials of mini CQI project at all staff meeting a week prior to the pilot
- Day of Mini CQI pilot
  - 7:00 AM - Provider meeting
    - Review the process
  - 7:30-12:00 - Mini CQI Pilot
  - 12:00 PM Lunch and Learn meeting
    - Review the process
    - Discuss any problems with the process and make any needed updates to the workflow

Problems with first go around…

- Added time to MA's to look for labs in the chart prior to rooming
- When risk test positive, added time to appts., this is not what the patient came in for…
- Providers needed education and support that the resource for the patients would be available to the patients
- Providers had to answer questions about the DPP program that they didn't know
  - Location, times of classes, cost…

Step	Who	What	When
1	PCC	All patients who do not have a diagnosis of diabetes (or a previous HgbA1c of ≥6.5%) are given prediabetes risk test with ROS to complete	Waiting room
2	MA	Review prior labs for any abnormal HbA1c (5.7-6.4) or FBS (100-125) & note abnormal on INHS referral form	Preload/ Rooming/ Chart review
3	MA	When updating PMH, ask patient about h/o prediabetes, GDM, h/o DM meds	Rooming (History)
4	MA	If risk score <5 and no h/o abnormal labs, process is complete, NO ACTION	Rooming
5	MA	If risk score ≥5 or abnormal lab, MA notes on INHS referral form, and patient completes contact info on form	Rooming (Referral form)
6	MA	Pends HemoglobinA1c lab test (if none done in past 6 months)	Rooming (Pending lab)
7	MA	Leave risk test & completed referral form for provider to review/sign	Rooming
8	PCP	For risk score ≥5 and/or h/o abnormal A1c, discuss risk with patient	COUNSELING
9	PCP	Update screening dx in problem list & use .prediabetesnote in A/P & use .prediabetesAVS in patient instructions	PROGRESS NOTE
10	PCP	Sign prediabetes referral form, update dx in chart, signs lab orders	SIGNATURES
11	MA	Provide patient with INHS program flyer	Discharge
12	MA	Fax referral form to INHS 509-232-8151	Discharge
INBOX	PCP	Use .prediabeteslab for positive lab	LAB RESULT

Revision History

Who	What	When
H.Readhead, MD	After first trial in clinic & hot wash with providers	2/4/2017

Change in referrals
Clinic #1

- Six months prior to the pilot, in this clinic, we had four, from one provider
- We held this ½ day pilot on a Wednesday, by that Friday of that week we had 19 referrals
- In the two months following this pilot we have had 63 referrals, coming from all of the providers in the clinic

Clinic #2
Champion Clinic

- Identified second clinic by overwhelming support from clinic manager for our DSME program

- Understands the value of diabetes prevention

Administrative support, but not necessarily provider support…

With support of the clinic manager

- Attended staff meeting to provide information to the clinic about the pilot
- Shared the resources developed by the first clinic
  - Mini CQI protocol
  - Risk tests, referrals, flyers, posters, education materials
  - Smart texts
- Set a date for the pilot
- Attended “huddle” the morning of the pilot, no formal meeting immediately after pilot to discuss concerns
- Had follow-up with providers the following week at their staff meeting

Provider concerns

- After the pilot there was no change in referrals, basically nothing had changed in their processes for identifying and referring patients
- At the staff meeting following the pilot they had many questions and concerns
  - What GLB/DPP is, class structure, codes to use for screening, class locations, costs, how to register for classes
- Addressing their concerns
  - Provided a handout detailing the answers to the above concerns
  - Provided a cheat sheet to have handy for quick answers to patient questions
- They also wanted some small procedural changes for their clinic

Some impact…

- In the 4 ½ weeks following the pilot there was an increase in referrals:
  - 15 from 1 provider
  - Eight from the rest of the clinic providers

Peer Education

- Met with clinic manager and reviewed outcomes
- Arranged for Dr. Readhead, the clinic champion from pilot #1, to come to the next provider meeting in pilot #2 clinic
- Dr. Readhead
  - Reinforced the need to screen and treat prediabetes
  - Answered procedural questions
  - Provided other time saving responses to patient inquiries
  - Provided smart texts electronically

Change in referrals Clinic #2

- 17 Referrals from all providers in the 3 weeks following the meeting with Dr. Readhead
- 2 fold increase in the referrals from the providers in Pilot #2 not typically referring after discussion with Pilot #1 Clinic Champion