Use of Roundtable Panels to Reduce Gaps in Care and Improve A1c in Patients with Diabetes

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Background

- Approximately 10% of Ohioans live with diagnosed diabetes, with its cost exceeding $12.4 billion dollars annually
- Patients are still not at goal and we struggle to deliver diabetes care services to patients with diabetes despite:
  - Improved understanding of the disease state
  - Wide availability of diagnostic tools
  - Cutting-edge treatment options
  - Vast initiatives of screening for complications
  - Advances in technology

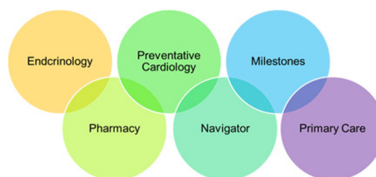
Purpose

- The goal of the project was to improve the care for employees with uncontrolled diabetes who were enrolled in our UH health plan
- The Diabetes Milestones Program was already fully established and the goal is to increase knowledge for members to feel more empowered in managing their diabetes
- The Milestones team and the endocrinology CNP collaborated to improve care of uncontrolled diabetes in our employees

Process

- Roundtables were instituted 3 days per week for 1 hour
- Employees with uncontrolled diabetes were identified with a hemoglobin A1c > 8.5%
- Our actuarial analyst identified members with above attributes
- Roundtables were completed by:
  - Population Heath CNP
  - Dietician/CDCES
  - Endocrinology CNP
  - Pharmacist
  - Patient Navigator

- This multidisciplinary team made referrals for additional specialists or education when diabetes care needs could not be met by PCP or endocrinology
- Patients needed additional assistance in addressing self-management, medication, behavioral or financial barriers
- Examples of the referrals include:



Diabetes Milestones Program

Criteria	Program Consult Attributes	Virtual Visit Topics
UH employees and dependents	No cost	Review of UH Value-Based Diabetes Insurance Program
Hemoglobin A1c > 8.5%	Shared interdisciplinary visit with FNP and RD/CDCES	Blood Glucose, Continuous Glucose Monitoring Device
> 18 years	Virtual	Diabetes Nutrition Topics
Type 1 and Type 2 diabetes	5 one hour visits every 3 weeks with specific diabetes educational topics	Physical Activity
	Individualized care plan	Social support and reputable medical sites
	Based on Patient Centered Care Model	Prevention and annual diabetes care
	Virtual 30 minute monthly post program visits	
	Referrals (Endocrine, Pharmacy, Patient Navigator, Cardiology)	

- The Diabetes Milestones Program is a free program for our employees and dependents of the employee health plan
- The American Diabetes Association guidelines encourage use of continuous glucose monitors (CGM) in all patients with diabetes
- CGM is not covered for UH insured patients with Type 2 diabetes who were not on insulin, requiring employees to pay out of pocket and possibly creating a financial barrier of care
  - For employees in the Diabetes Milestone Program, we offer free CGM trial

Outcomes and Future Direction

Participant Characteristics: Mean (SD) age was 54.6 (11.6) years, most were White (n=416, 62.5%) or Black (n=179, 26.9%) race, non-Hispanic ethnicity (n=599, 89.9%), and female gender (n=354, 53.2%).

TABLE 2. Paired sample t-test examining pre and post-program mean A1c (%) by diabetes care program referral group.

Program	N	Pre-A1c	Post-A1c	P value
Overall	666	9.52 (1.63)	8.57 (1.84)	<0.001
Multiprogram	142	9.94 (1.61)	9.07 (1.90)	< 0.001
Primary Care	124	9.05 (1.89)	8.04 (1.76)	< 0.001
Navigator	106	9.37 (1.25)	8.73 (1.56)	< 0.001
Endocrine	103	9.15 (1.5)	8.40 (1.66)	< 0.001
Milestones	81	10.5 (1.85)	8.98 (2.2)	< 0.001
Pharmacy	61	9.18 (1.06)	8.23 (1.46)	< 0.001
CINEMA	30	9.36 (1.12)	8.22 (2.1)	0.001

Small samples sizes excluded ACCENT (n=3) and CDCES (n=15) groups.

- Referrals were made to a variety of pathways to optimize patient care to achieve optimal glycemic targets
- The overall mean A1c decreased pre-post-intervention by almost 1% and in fact, all pathways exhibited a decrease in A1c. The largest was the Diabetes Milestones Program
- Quarterly, the team continues to review an updated list of employees with uncontrolled diabetes and further intervenes, if necessary
- We are continuing to track the data to publish