Building Bridges Between Health Care Delivery Systems, Patients and Communities

Diabetes: Wyoming Collaboration

Building bridges between health care delivery systems, patients, and communities

Hospital's Evolving Population Health Role

Current Acute Care System
- Episodic Health Care
- Lack Integrated Care Networks
- Lack quality & cost performance transparency
- Poorly Coordinated Chronic Care Management

Coordinated, Seamless Delivery System -- Patient/Person Centered
- Primary Care Access
- Focused on care management, care transitions, and preventive care
  - Transparent Cost and Quality Performance
  - Provider Networks Designed Around the patient
  - Shared Financial Risk

Community Integrated Healthcare System -- Population Health Focused
- Mobilizing Action Toward Community Health
- Integrated networks linked to community resources capable of addressing psychosocial/economic needs
  - Population based reimbursement and premium pricing
  - Learning and Dissemination - Capable of rapid deployment of best practices
  - E-health/telehealth capable

Health Delivery System Transformation Critical Path

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Institute of Population Health Goals

- Care Continuum Development: Thoughtful Partnerships
- Whole Person Care – Patient Centered Medical Homes (PCMHs)
- Well-Coordinated Care Across the System - Segment patients by risk
  High Risk (Trade high-cost services for low-cost management)
Institute Population Health Strategies

- Healthcare delivery has changed...focus is on Better Health and Better Care at Lower Cost
- High-Risk Patients Require Focused Care
Institute Partnership with Wyoming Department of Health (WDH)

Institute contracted with Chronic Disease Prevention Unit in March 2015

- CDC 1305 funding consists of 40% hypertension/ 60% prediabetes and diabetes evidence-based training
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Contracted to train providers in the most current evidence-based practice, who diagnose, treat and manage patients with hypertension, prediabetes and diabetes to decrease effects of complications from chronic disease

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Wyoming Statistical Analysis Center (WySAC) and Institute staff meets with Chronic Disease and Prevention Unit re: methodology, monitoring and evaluation of 1305 Cooperative Agreement activities
Institute Partnership with WDH

Needs assessment - determine providers most in need of training re: hypertension, pre-diabetes/diabetes evidence-based practice

Study of electronic medical records of 20 providers re: protocols for hypertension, prediabetes and diabetes
Best Outcomes Pre- and Diabetes

- Million Hearts/ Baltimore, MD
- National Diabetes Prevention Program (DPP)/ CDC Atlanta, Georgia
- Medication use to Decrease Cardiovascular Risk/ UW Pharmacy professor
- Certified Diabetic Educator (CDE)/ Risk Reduction and Goal Setting to Decrease Complications
- RN diabetic educator/ Motivational Interviewing
Best Outcomes Pre- and Diabetes

Over 40 provider attendees:

- Physician/ Nurse Practitioners
- Nurses/ clinic, public health, hospital, school, Cancer Center
- Pharmacists
- CDEs/ Registered Dieticians
- Pharmacy Interns/ QIO staff
Institute Partnership with WDH

Evidence-based practice modules created by Certified Diabetic Educators (CDEs) based on the American Association of Diabetic Educators (AADE) 7 Self-Care Behaviors
AADE 7 Self-Care Behaviors

Healthy Eating
Being Active
Monitoring
Taking Medication
Problem Solving
Reducing Risks
Healthy Coping
Seven Evidence-Based Modules

1. What Does a Diagnosis of Prediabetes Mean? (1 hour)
2. Diagnosis, Classification and Prevention of Prediabetes and Diabetes (1 hour)
3. Best Outcomes for Hypertension, Prediabetes and Diabetes: Nutrition (1.5 hours)
4. Best Outcomes for Hypertension, Prediabetes and Diabetes: Physical Activity (1 hour)
Seven Evidence-Based Modules

5. Hypertension, Prediabetes and Diabetes Pharmacotherapy (1-1.5 hours)

6. Acute Complications of Hypertension, Prediabetes and Diabetes (1.5 hours)

7. Best Outcomes for Prediabetes and Diabetes: Risk Reduction (2 hours)
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Seven Evidence-Based Modules include 9-9.5 hours of training

Applied for contact hours through American Nurses Association (ANA), will be approved by early September
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Providers will be trained on seven modules by Certified Diabetic Educators.

Teleconference is being scheduled for fall-October timeframe.

Physicians and their staff can join the presentation from their clinic.

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In addition, the Institute has recruited

- 5 RNs and
- 10 Pharmacists around the state who have completed the online AADE Certified Diabetic Educator training to begin the process of becoming a CDE
Institute Partnership with WDH

Needs assessment process is ongoing

On-site provider conference June 2015

Modules were created for provider training

Training RNs and Pharmacists to begin CDE journey

Provider videoconference late fall 2015
Thank you for your attention and I will be happy to answer any questions during the panel discussion to follow!

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