Grant Outcome Report

Initiating a Diabetes Management Program for Underserved Populations

KEY INFORMATION:

GRANTEE
Jamaica Hospital Medical Center

GRANT TITLE
Initiating a Diabetes Management Program for Underserved Populations

DATES
March 1, 2008 – February 28, 2010

GRANT AMOUNT
$138,531

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

The Problem

Jamaica Hospital Medical Center (JHMC) and Flushing Hospital Medical Center (FHMC) sites serve patients who are predominantly African American, Hispanic, and Asian and are disproportionately affected by diabetes. These sites are located in neighborhoods that have higher than average mortality rates for diabetes—40.9 per 100,000, compared to 23.3 in all of New York City and 20.5 in New York State. To address these disparities among its client base, the New York State Health Foundation (NYSHealth) awarded JHMC a grant to develop a partnership with FHMC to implement the Chronic Care Model (CCM) at its facilities. The goal of the grant was to enhance and spread diabetes self-management programs to 500 patients in 4 outpatient sites in Queens and Brooklyn.

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 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

JHMC proposed an ambitious set of activities under the NYSHealth grant:

- Train primary care physicians on the American Diabetes Association (ADA) clinical guidelines and the CCM;

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- Provide on-site specialty care and integrate it into the primary care system;
- Use a diabetes health educator to provide patient education and remove barriers to care;
- Develop a centralized patient registry to facilitate clinical decision-making and the spread of the CCM; use community health workers (CHWs) to increase patient self-management skills; and
- Evaluate the cost-effectiveness of incorporating CHWs into diabetes care delivery and use the findings to encourage insurance funding for care management services.

JHMC offered education and grand rounds on the CCM and the ADA standards of care to primary care physicians at its participating sites, as well as to other hospital medical staff. It also introduced a diabetes flow sheet to the practices, which was then used to collect data for a patient registry. Once completed, the registry allowed for data tabulation, reporting of patient care, and evaluation.

JHMC planned to redesign how medical services were offered to patients with diabetes. In an attempt to increase the number of patients with diabetes who receive essential diabetes-related services, JHMC restructured medical services to include same-day appointments for specialty care such as ophthalmology and podiatry. A certified diabetes educator (CDE) who provided diabetes self-management education, case management, patient advocacy, and CHW supervision, was key to implementing the redesigned services. Unfortunately, JHMC had difficulty retaining a staff member in this role from the beginning of the grant period. As a result, patients with diabetes were referred to the general nutrition clinic, which does not solely focus on patients with diabetes or provide the same level of encouragement as a CDE.

JHMC enrolled 461 patients in the diabetes registry. Using the registry, JHMC studied whether patients were receiving the appropriate tests and whether their diabetes was under control, based on a range of clinical information (e.g., HbA1c and cholesterol levels). It also looked at whether patients were receiving self-management training and counseling.

During the project timeframe, patients who already had their HbA1c levels under control experienced further improvements; other patients' levels remained the same. As the project evolves, JHMC expects to see more improvement in the number of patients moving from uncontrolled to controlled HbA1c levels. Though the registry was created and used to track pre- and post-intervention results, JHMC did not use the registry as part of the actual intervention to improve practices and outcomes.

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As part of the *Setting the Standard* initiative, NYSHealth supported an outside evaluation of 10 of the 12 participating grantees, including JHMC. In addition to observing whether each grantee advanced against its proposed objectives, the evaluators also assessed how well each grantee adhered to the CCM principles. From the evaluators' perspective, JHMC was still in the initial stages of implementing the CCM, but interest from JHMC staff would propel them forward on the CCM continuum. The *Setting the Standard* grant was JHMC's first experience with planning and implementing the CCM. As such, the Foundation might have provided more technical support to assist JHMC in developing a more feasible workplan and in teaching staff members to implement critical elements of the CCM such as how to plan, pilot test, and study small changes within a delivery system.

The Future

The program has continued and JHMC expects to sustain it for an indefinite period of time. JHMC expects to enroll more patients and further the gains made with the patients currently enrolled. Additional time is needed to see whether the program has had an impact on patients' HbA1c levels, at which time costs and benefits can be projected using existing studies that have measured decrease in HbA1c levels and cost-of-care savings.

The Ambulatory Care Network, of which JHMC and FHMC are both part, applied for National Committee for Quality Assurance (NCQA) patient-centered medical home (PCMH) designation in 2011. PCMH designation encourages chronic care case management for various diseases including diabetes. New York State's Medicaid program provides financial incentives for health centers that achieve PCMH status. Many patients enrolled in JHMC and FHMC are members of either Neighborhood or HealthFirst Medicaid managed care health plans, so the centers could become eligible to receive financial incentives for these patients. The JHMC Ambulatory Care Network received level-3 PCMH recognition for all nine of its sites. FHMC achieved level-2 PCMH recognition; it submitted an add-on application for level-3 PCMH recognition after implementation of its electronic health record (EHR) system was completed on October 1, 2012.

On August 1, 2011, JHMC's hospital-wide EHR system, EPIC, was implemented. FHMC expected its EHR system to be operational by October 1, 2012. To prepare for the implementation of EPIC, JHMC had to refocus internal staff resources to build the EPIC ambulatory system. As a result, it discontinued the diabetes flow sheet, which proved to be very labor-intensive. JHMC is now able to report patient data by provider on NCQA elements, which includes most of the elements listed on the diabetes flow sheet.

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BACKGROUND INFORMATION:

ABOUT THE GRANTEE

Jamaica Hospital Medical Center (JHMC) is a nonprofit, 387-bed teaching hospital that has continued to serve Queens County for more than 100 years. JHMC is part of the MediSys Health Network, a nonprofit parent organization, which also oversees Flushing Hospital Medical Center (FHMC) and other nonprofit health care provider organizations in New York City. JHMC operates a network of 12 ambulatory care facilities that have approximately 425,000 patient visits annually.

FHMC is a 293-bed teaching facility offering primary and specialty care services, with 75,000 outpatient visits annually. It also has a community outreach department, and provides free health screenings to thousands of people every year. The endocrinology division within FHMC's department of medicine provides consultation services for patients with diabetes and other conditions. In addition, a diabetes nurse educator assists with inpatient care and helps hospitalized patients make the transition from hospital to home. More than 100 people gather monthly at FHMC's diabetes club for support and patient education.

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