

Moving on Up: Employing a Mobile Care Center to Enhance Access to Care for Youth with Type 1 Diabetes

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Background

- >80% of youth with T1D do not meet glycemic targets¹
- T1D-related morbidity disproportionately impacts those of lower socioeconomic status and of minority race or ethnicity
- Improving health outcomes in youth and young adults with T1D requires a multi-faceted approach, including addressing barriers to care
- Distance to clinic can pose a significant barrier for youth with T1D, especially in rural areas
- As part of a global QI initiative, Connect T1D, aimed to restructure the model of care for those with T1D, we employed a mobile care center (MCC) to bring in-person care closer to youth in need



1. Foster NC, Beck RW, Miller KM, et al. State of Type 1 Diabetes Management and Outcomes from the T1D Exchange in 2016-2018. *Diabetes technology & therapeutics*. 2019;21(2):66-72.

Cincinnati Children's Diabetes Center



■ Academic Diabetes Center

- T1D registry 2300 patients
- Average ~200 new onset/year

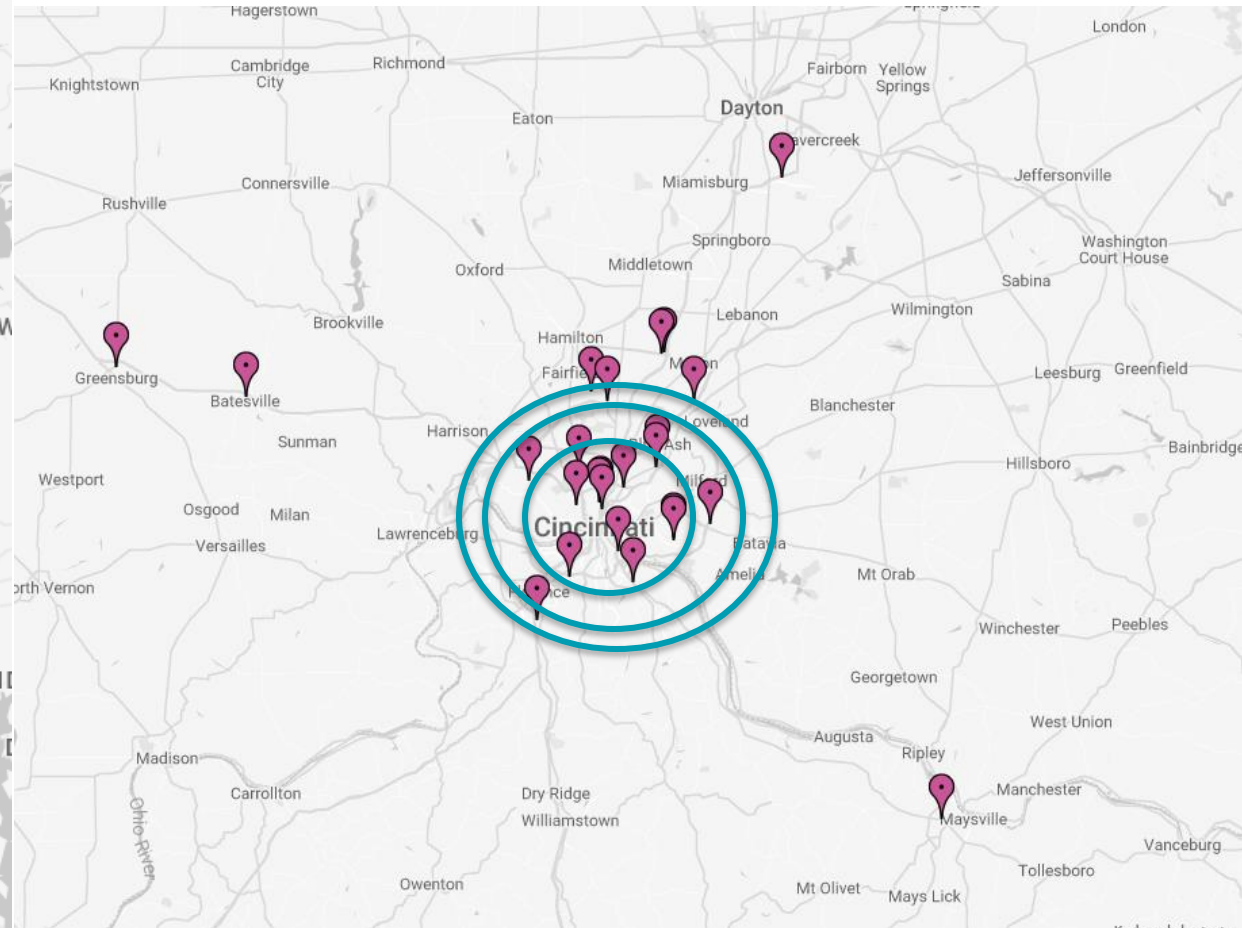
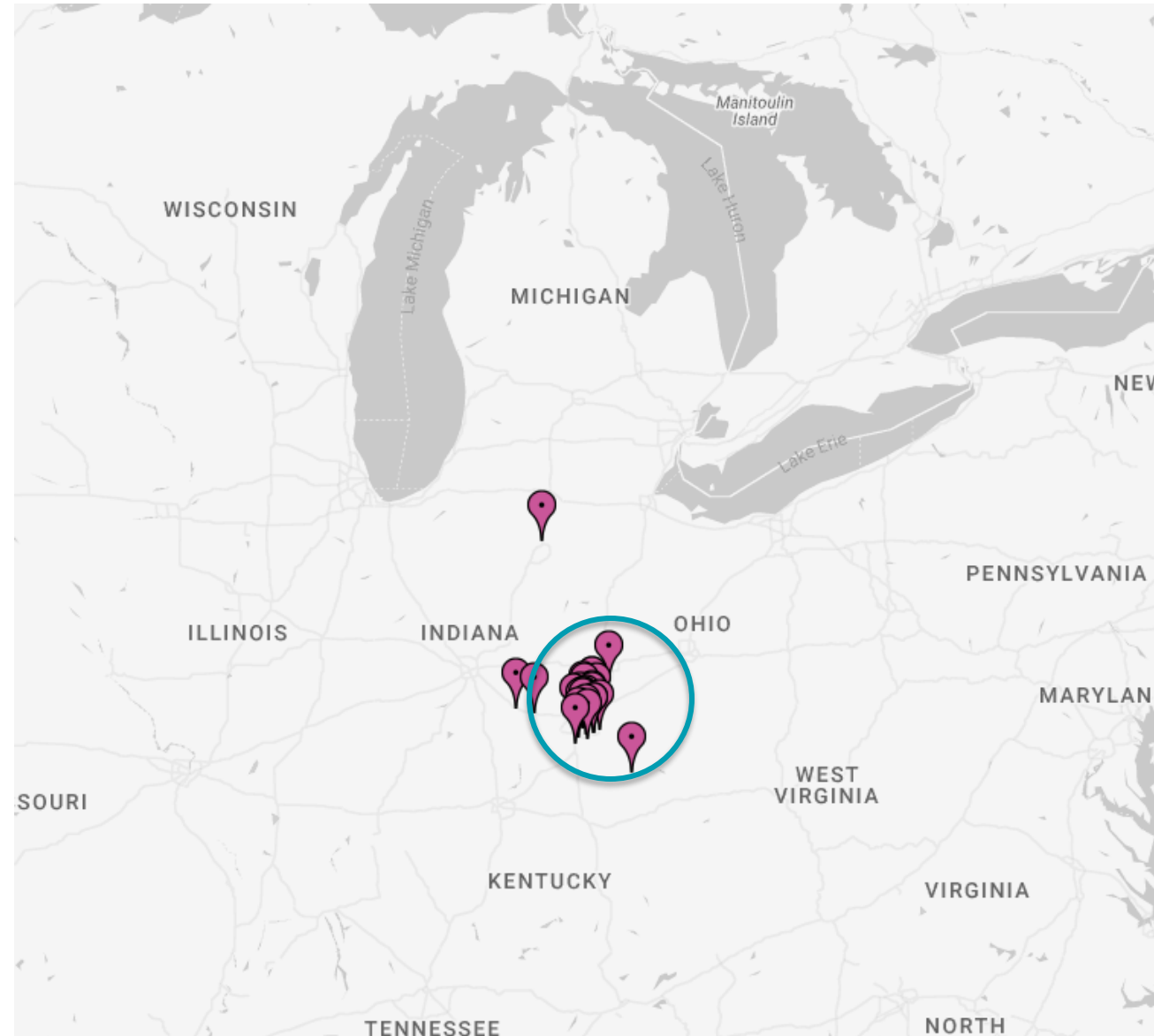
■ Our Team

- 19 Physicians, 9 APRNs
- 19 CDCES - 7 RNs, 12 RDs
- 6 Social Workers
- 1 PhD, CDE Psychologist
 - Additional Psychologists from Behavioral Medicine & Psychology Dept
- 1 Administrative Care Coordinator
- 1 Clinical Quality Specialist
- 2 Data Analysts
- Community Health Workers/Community Psychiatric Support Team
- Community partnerships
- Patients & Families



■ Patient Population

- 85% White
- 10% Black
- 4% Hispanic
- 1% Asian
- 67% Private Insurance
- 33% Public Insurance



Mobile Care Center (MCC)



Methods

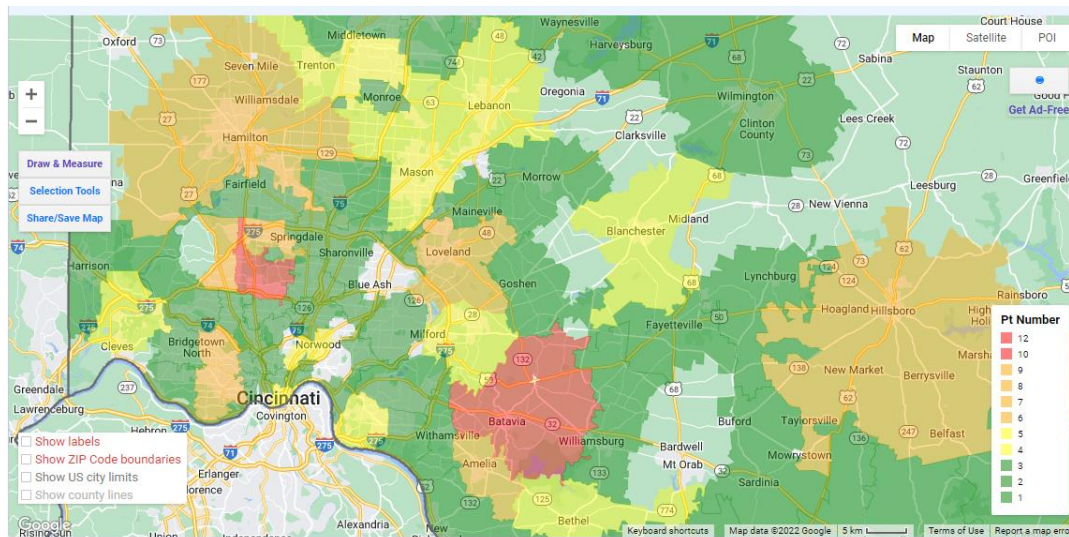
- The existing Cincinnati Children's Hospital Medical Center MCC was equipped to provide standard diabetes care
 - Point-of-care hemoglobin A1c (HbA1c) machine and kits
 - Diabetes device upload station
 - Hypoglycemia treatments
 - Diabetes education materials
 - Diabetes technology samples (e.g. continuous glucose monitors)
 - Staff: medical provider, medical assistant and registered nurse, certified diabetes educator



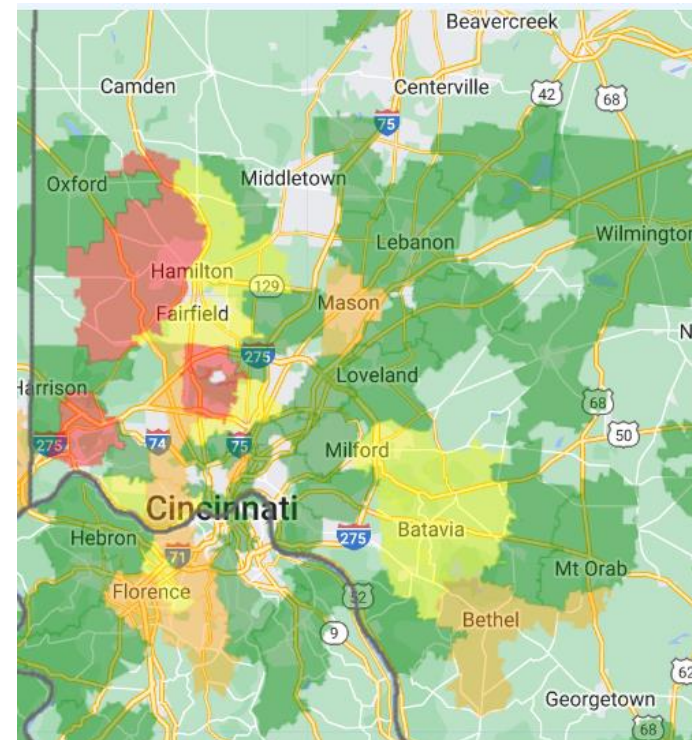
Methods

- Geocoding was used to map patients' residential zip codes and overlay rates of missed clinic visits and diabetes-related hospital admissions to identify need

Healthvine (Medicaid) patients with T1D



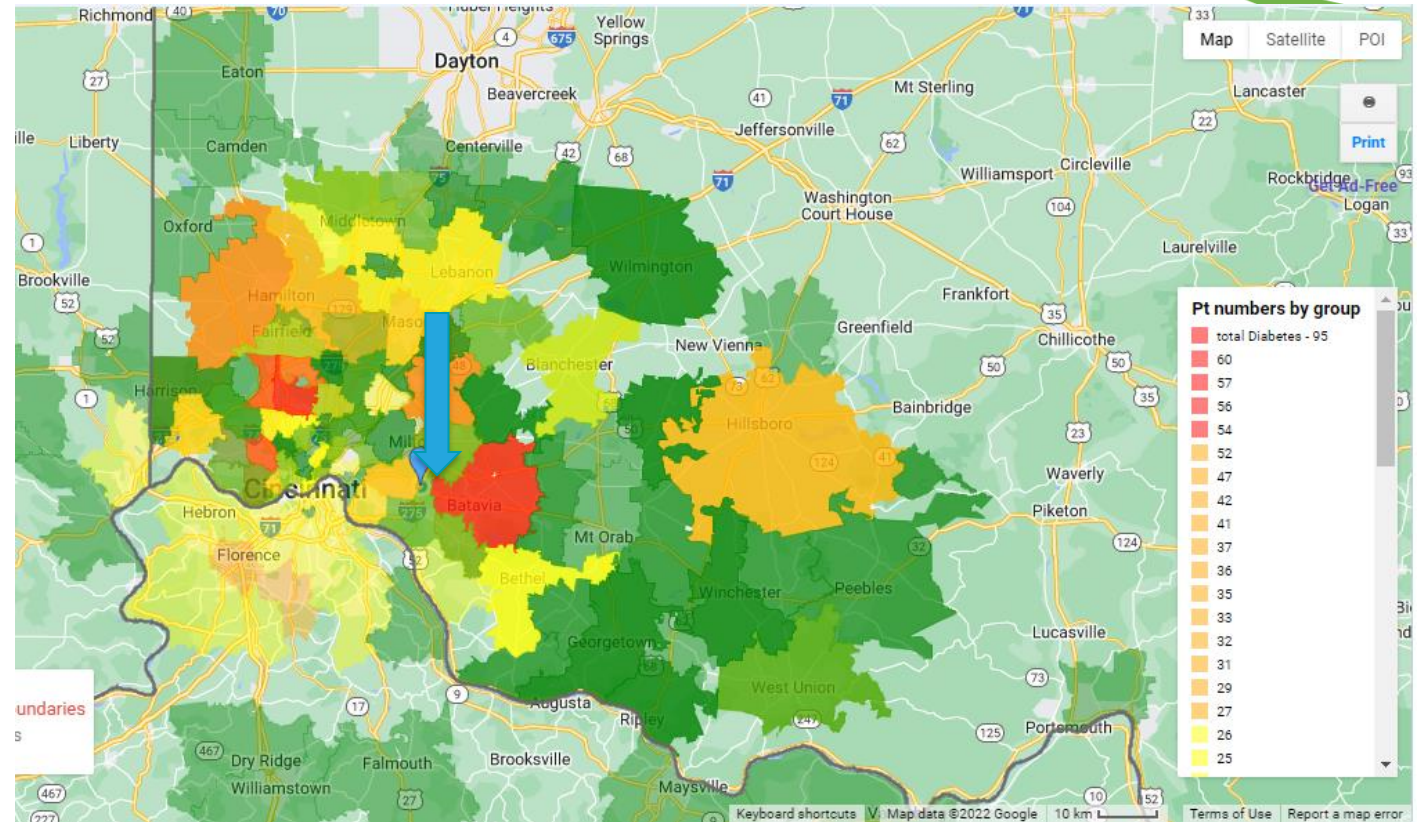
No show visits



Methods

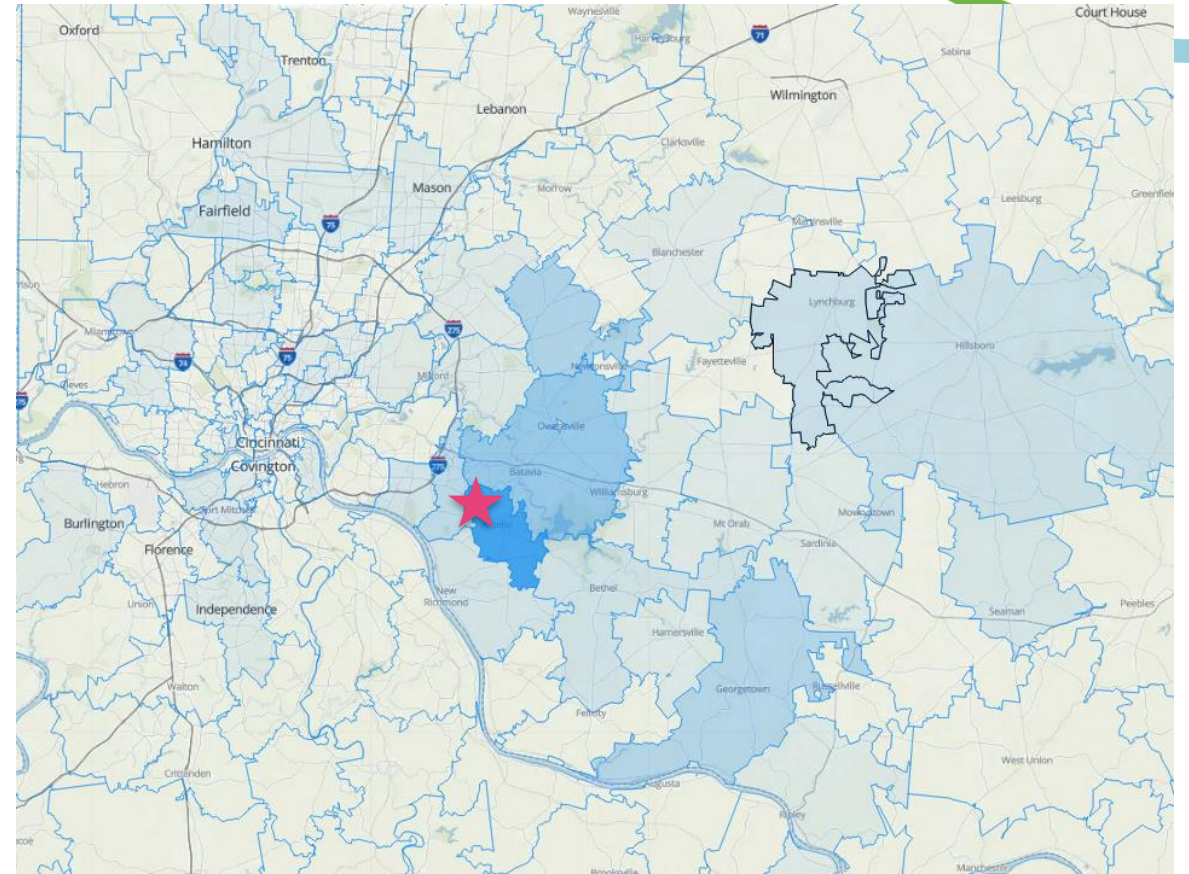
- A location in a neighboring county with an existing school nurse partnership was selected for a monthly outreach clinic
- Outcomes:
 - completed visits
 - use of diabetes technology
 - patient/family experience
 - HbA1c

Overlay



Results

- Across 13 monthly clinics
 - 25 unique patients
 - 49 provider and 35 diabetes educator visits
- The vast majority resided within the same zip code of the MCC or neighboring region



Results

In-Person Accessibility

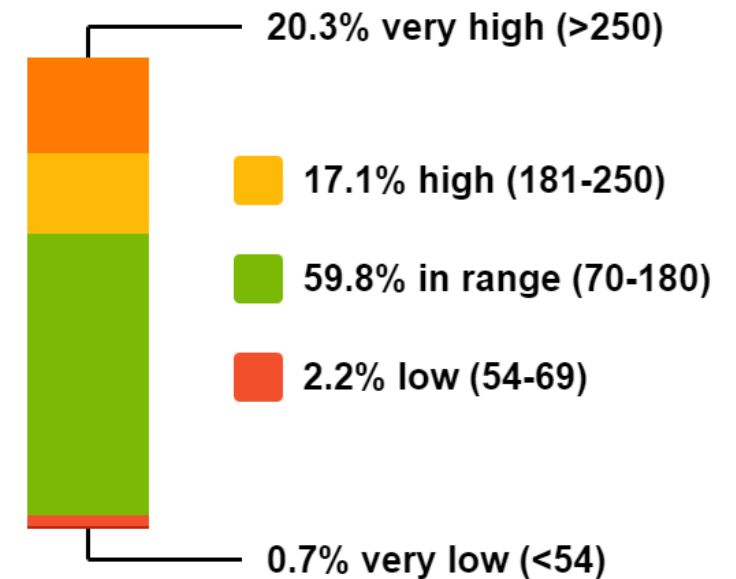
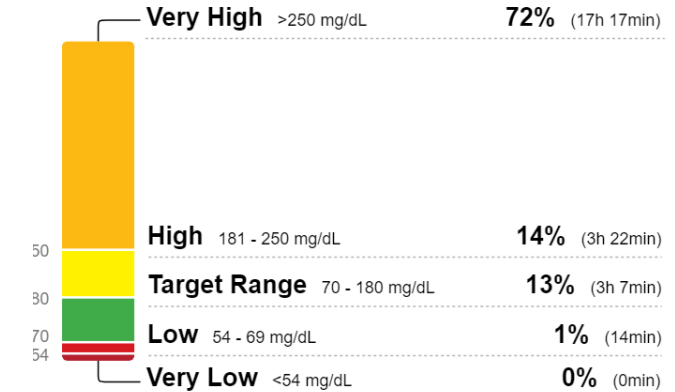
- Youth may walk in from class or by mobile transport from nearby schools +/- school nurse
 - “Coming here takes like three minutes”

Patient Empowerment

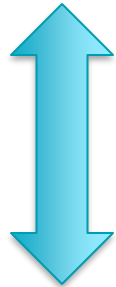
- Easing access to care and fostering independence leads to enthusiasm for engagement in patient-provider interactions
 - “Can I come back next month when you are back?”
- Clinic engagement increases participation in community events

Access to Technology, Glycemic Improvement

- Four patients started on automated insulin delivery
- “Since moving here, we've seen his A1C come down. He's seen more often...we've had better outcomes.”



Results



- Consistent visits

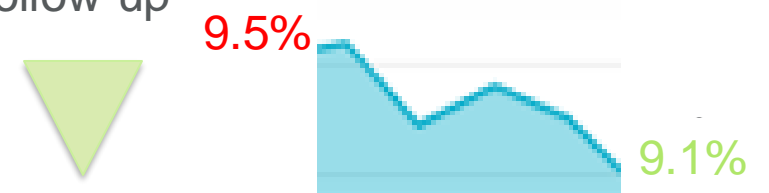
- 9 patients with MCC visits



- HbA1c

- No significant change in total population HbA1c (9.4% vs 9.3%)

- Amongst 9 patients with MCC follow-up



Conclusions

- Mobile care centers can bring equitable diabetes care closer to home for patients with T1D
- Increased access to care lends opportunity to improve glycemic outcomes, with positive trends in those with continued care
- Future work will target increasing capacity of the MCC and tracking ongoing glycemic improvements

Acknowledgements

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Design and Launch of the first Pediatric Subspecialty Value-based Care Program for T1D Patients (and beyond)

*Mark Clements, MD, PhD, Professor and Pediatric Endocrinologist | Children's Mercy Kansas City
Professor, Pediatrics
The Rick and Cathy Baier Family Endowed Chair in Endocrinology*



Disclosures

- Chief Medical Officer, Glooko, Inc
- Research support, Dexcom and Abbott Diabetes Care

Objectives & Presentation Outline

- Quick Introduction & Overview of CMICS (ACO) / CM Endocrinology
- Understanding the Why!
- Overview & Structure of the Program

Children's Mercy Kansas City



Only Pediatric Trauma Center and Tertiary Care Diabetes Center between St. Louis and Denver / Omaha and Oklahoma City

5
Locations in the
KC Metro Area



40+
Pediatric
Specialties



355
Inpatient Beds

8,000+
Employees



750+
Employed or
Exclusive
Physicians



20+
Outreach Clinics

15,000+

Inpatient Admissions/Year



370,000+

Outpatient Visits/Year

150,000+

ED/Urgent Care Visits/Year

47%
Medicaid as a
Percentage of Annual
Patient Revenue

175
Affiliated
Community-Based
PCPs in 17
Locations

Pediatric ACO entity with ~50% of all Kansas City Kids in a value-based payment model (36 PCP Practices | 400+ PCPs)

Children's Mercy Integrated Care Solutions



(PCN)

Network for
Medicaid
Population

- 36 Community PCP Practices
- 400 PCPs, 750+ Children's Mercy Specialists
- 7 Value Based Agreements [4 Medicaid | 3 Commercial]

Over 250,000 Value Based Lives, Approximately 50% of Kids in the KC Metro Area

Pediatric Care Network– 145,000 kids

- 4 Medicaid Capitation Agreements
 - Missouri Medicaid: 95k Capitated Lives (2 of 3 Missouri MCOs)
 - Kansas Medicaid: 50k Capitated Lives (2 of 3 Kansas MCOs)

Children's Mercy Health Network – 105,000 kids

- 3 Commercial Shared Savings / P4P Agreements (3 of 4 Major Commercial Payers) | 1 Shared Savings with Downside Risk (5% of Total Cost)



(CMHN)

Clinically Integrated
Network for
Commercial/Self
Funded Employer
Populations

National Challenges to Specialty Engagement in Pediatric Value Based Care

- **Quality Performance Incentives** within Value Base Contracts are Almost Exclusively Based on Primary Care Measures
- **Existing Specialty Payment Models Not Aligned with Value Based Care.** Specialty Business Models Primarily Driven by Fee-For-Service (Volume).
- Specialty Providers Tend to **Focus Primarily on Care for Patients Seen at their Clinic**.
- **Most Adult Specialty Value Based Payment Models (i.e. Bundled Payments) Not Likely Feasible with Pediatrics**
 - Insufficient Volume and Spend for Payers
 - Too Significant Risk and Volatility for Children's Hospitals

Innovative Response: CMICS is innovating by developing specialty-based programs within existing value based agreements



RISING TIDE ALLIANCE

n's

Rising T1DE Trending Quality Outcomes

Trending Quality Performance (CMICS Value Based Patients Only)

Measurement Year	Population Group	Patient Count	% Receiving 1 or More Interventions	Median A1C	% Median A1C Above 9	% with 1 or More Validated DKA Admits
2023	Overall	770	14.7%	8.0	33.4%	7.2%
2022	Overall	729	14.8%	8.4	37.8%	8.6%
2021	Overall	654	15.0%	8.6	41.8%	10.0%
2020	Overall	608	13.3%	8.7	43.5%	6.6%
2019	Overall	567	12.0%	8.9	47.7%	10.5%
2023	Medicaid	436	18.1%	8.7	44.8%	10.6%
2022	Medicaid	418	17.9%	9.0	49.5%	13.0%
2021	Medicaid	372	18.0%	9.2	54.9%	15.7%
2020	Medicaid	351	15.7%	9.3	55.3%	10.6%
2019	Medicaid	326	14.4%	9.6	61.4%	15.7%
2023	Commercial	370	11.4%	7.5	20.1%	2.7%
2022	Commercial	342	12.0%	7.8	23.5%	3.2%
2021	Commercial	307	12.7%	8.0	26.2%	3.0%
2020	Commercial	278	11.5%	8.1	29.7%	2.5%
2019	Commercial	261	10.3%	8.3	30.8%	4.6%

Target Objectives

1. Year-Over-Year Improvement
2. Sustain/Maintain Best Practice Performance
3. Align with National/Regional Benchmarks

Target Setting References

5% Improvement from MY2023	15.4%	7.6	31.7%	6.8%
10% Improvement from MY2023	16.1%	7.2	30.1%	6.5%
30 More Patients w/ Interventions	18.6%	N/A	N/A	N/A
Average Overall Yearly Change	N/A	(0.2)	-3.6%	-0.8%

Final Agreed Upon Targets	18.6%	7.8	30.0%	6.8%
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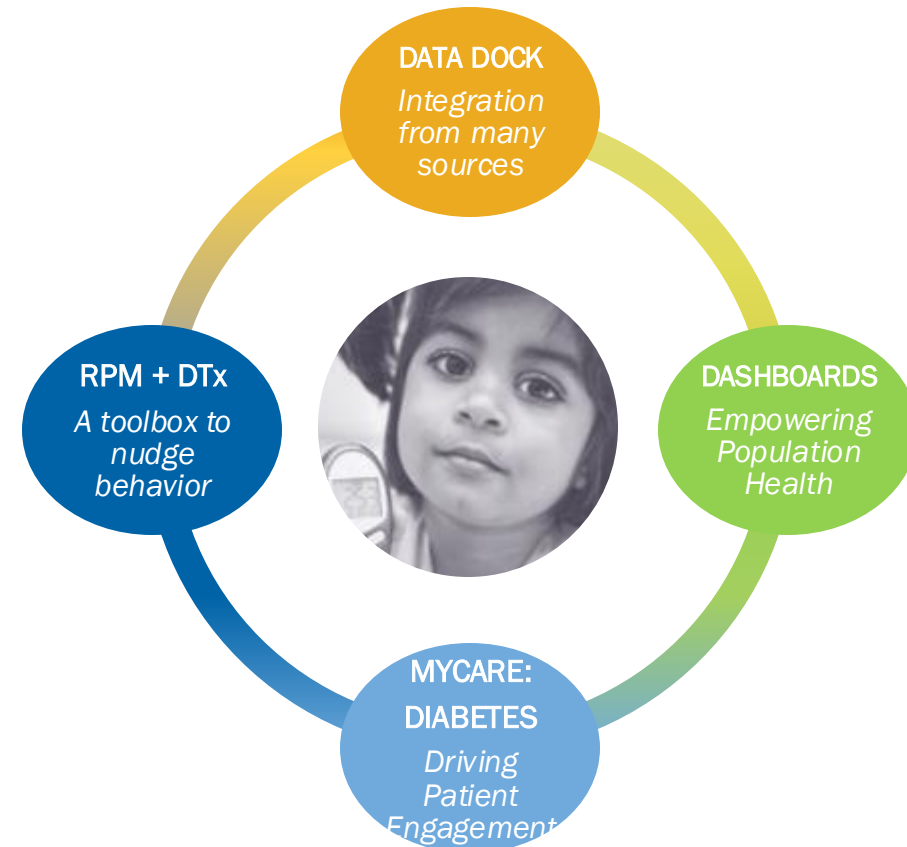
CMICS Comments	Target 30 <u>more</u> CMICS VBC patients than 2023. Adjusted down from target of 50 more since limited to 2 interventions (RPM, CMICS Care Management)	Set based on average annual decrease of 0.2.	Set based on 3.4% annual decrease (~ avg annual decrease of 3.6%).	Due to increased annual variability, set to 0.4% decrease (vs. annual avg decrease of 0.8%).
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Rising T1DE Alliance @ Children's Mercy Endocrinology

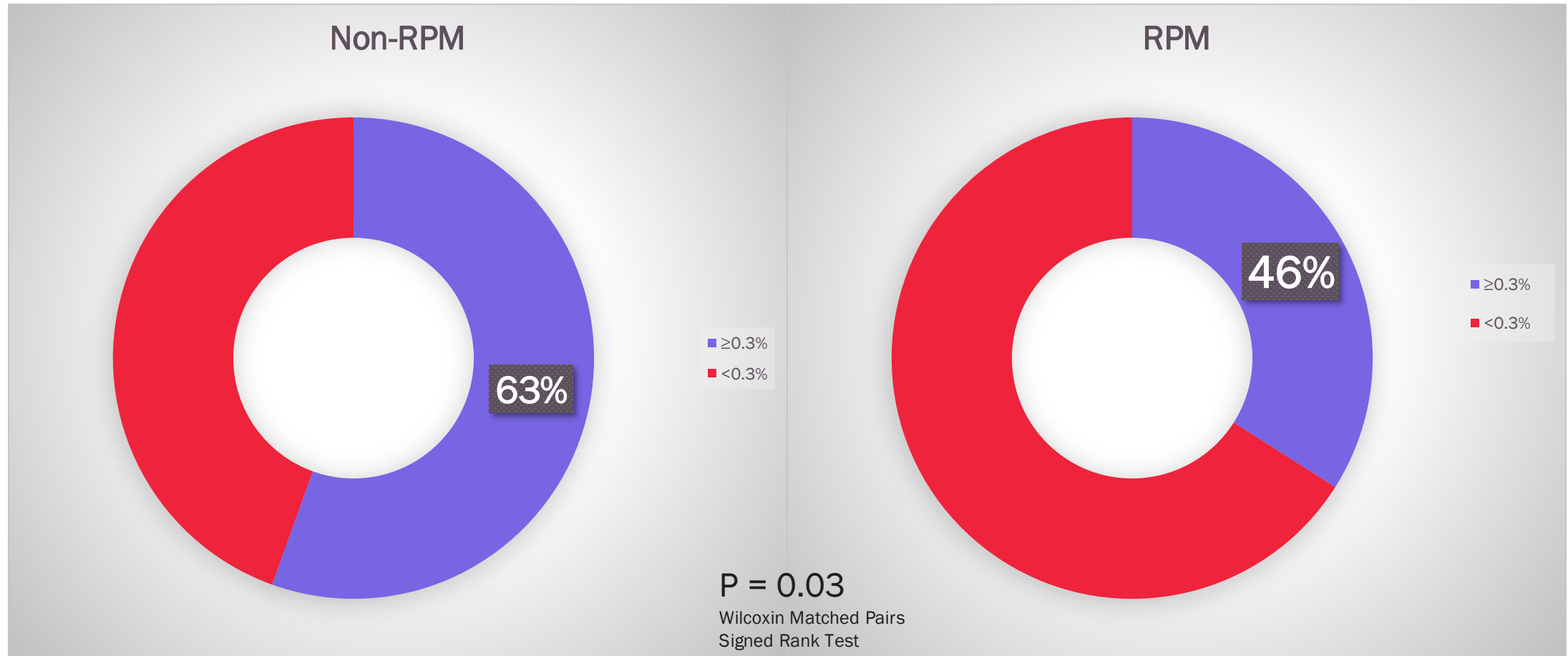
Who We Are and What We Do

- The Rising T1DE Alliance (Rising T1DE) was launched in 2020 through a \$8.5 million grant from The Leona M. and Harry B. Charitable Trust to Children's Mercy Hospital Kansas City to rapidly innovate and scale quality improvement efforts in diabetes care.
- We leverage Data Integration, Data Science and QI capabilities to test, validate and deploy new Innovative Care Models for Patients with Diabetes.
- Rising T1DE is now disseminating its technology and expertise across the country with new alliance members including Lurie Children's, Cincinnati Children's and the University of Kansas Medical Center among others.

How We Do It



Proportion with A1c Rise $>0.3\%$ comparison to propensity score-matched cohort



CMICS VBC Program Payment Framework Overview

The Chronic Condition VBC Program provides two value-based payment mechanisms:

1. Infrastructure Payment:

- Aim of supporting resources a specialty division needs to provide whole person, integrated, coordinated care
- Support care coordination, care management and/or other care model resources to help target, manage, and deliver necessary care and services (e.g. remote patient monitoring) to high or rising risk patients.

2. Value Based Care (VBC) Investment Opportunity:

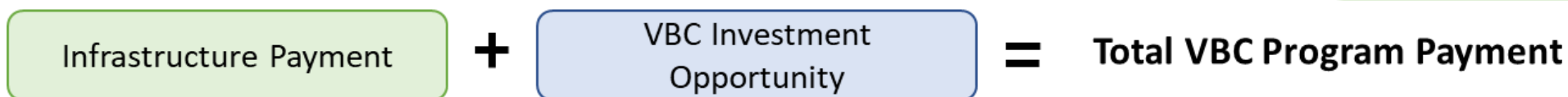
- Aim of rewarding accountability and performance for clinical quality, cost, and utilization measures that improve health outcomes
- Performance targets are transparent & finalized prior to Measurement Year
- 50% of VBC Investment Opportunity is based on Quality Performance & 50% based on Cost / Utilization Performance

Quality Measures:

- 1 Required CMICS Measure (% CMICS Patients Receiving 1+ Interventions and/or ICS Care Management)
- 1 to 3 Meaningful, Nationally Recognized Measures Selected by Specialty Division

Cost & Utilization Measures:

- 2 Required CMICS Measures (ED Visits/1000 | Admits/1000)



Important: Infrastructure Payment will begin at 50% of overall payment but then expected to decrease over time to focus increasingly on health outcomes.



CMICS VBC Program Payment Overview

CMICS Chronic Care VBC Program: Example Program Payment Overview

Potential VBC Investment Opportunity: \$75,000 | VBC Infrastructure Funding: \$75,000 (Actual Value TBD | Example Only)

Performance Measures	Baseline Performance	Target	Data Source	% of Investment Opportunity	Potential Payment
Clinical Quality Performance					
% of CMICS VBC Patients Receiving 1 or More Intervention(s)	85.0%	89.3%	Division/CMICS	12.5%	\$ 9,375
Clinical Quality Metric #2	75.0%	78.8%	Division/CMICS	12.5%	\$ 9,375
Clinical Quality Metric #3 (Optional)	90.0%	94.5%	Division/CMICS	12.5%	\$ 9,375
Clinical Quality Metric #4 (Optional)	68.0%	74.8%	Division/CMICS	12.5%	\$ 9,375
Total Clinical Quality Performance				50.0%	\$ 37,500
Cost & Utilization Performance					
Inpatient Admission Rate (Monthly Admits / 1000)	TBD	TBD	CMICS	25.0%	\$ 18,750
ED Rate (Monthly ED Visits / 1000)	TBD	TBD	CMICS	25.0%	\$ 18,750
Total Cost & Utilization Performance				50.0%	\$ 37,500
Total VBC Investment Opportunity (Performance Dependent)				100%	\$ 75,000
Total VBC Infrastructure Funding (Current % Guaranteed: 100%)					\$ 75,000
Total VBC Funding Opportunity					\$ 150,000

**3 Overall Funding Tiers
Established Based on Chronic
Condition Total Annual Cost**

\$200,000 | \$25 Million + Annual Total Cost

\$150,000 | \$15-25 Million Annual Total Cost

\$100,000 | \$5-15 Million + Annual Total Cost

Total Annual VBC Funding
Expected to Remain the Same But
Guaranteed Infrastructure
Funding will Shift Toward
Performance Dependent Funding

CMICS Chronic Care Value Based Care Program 2024 Overview: Diabetes

Report Refreshed On: 08/22/2024

Performance Measures	2024 Rate	2024 Target	Gap to Target	% of VBC Opportunity	Potential VBC Payment	Current VBC Payment
Clinical Quality Performance 2024 Rate is Rolling Year Ending June 2024						
% of CMICS VBC Patients Receiving 1 or More Intervention(s)	14.5%	18.6%	4.1%	12.5%	\$9,375	\$0
Median A1C Level	8.1	7.8	0.3	12.5%	\$9,375	\$0
% of Patients with Median A1C Levels Above 9.0%	32.1%	30.0%	2.1%	12.5%	\$9,375	\$0
% of Patients with 1 or More DKA Admissions in Last 12 Months	8.6%	6.8%	1.8%	12.5%	\$9,375	\$0
Total Clinical Quality Performance				50.0%	\$37,500	\$0
Cost & Utilization Performance 2024 Rate is YTD 2024						
Inpatient Admission Rate (Monthly Admits / 1000)	8.4	10.4	Meeting Target	25.0%	\$18,750	\$18,750
ED Rate (Monthly ED Visits / 1000)	14.4	15.0	Meeting Target	25.0%	\$18,750	\$18,750
Total Cost & Utilization Performance				50.0%	\$37,500	\$37,500
Total VBC Investment Opportunity (Performance Dependent)				100.0%	\$75,000	\$37,500
Total VBC Infrastructure Funding (Guaranteed)					\$75,000	\$75,000
Total VBC Funding Opportunity / Earned					\$150,000	\$112,500



Required CMICS VBC program performance metrics.

Metrics selected by specialty division and finalized based on mutual CMICS/division agreement.

Important: If 3 of 4 quality metrics are exceeding target, 100% of the clinical quality VBC payment can be earned if 1 of the 3 measures is the CMICS required measure.

Scorecard	Quality	Quality Detail	Admissions	Admission Detail	ED Visits	ED Visit Detail	ED/Admit Eligible Patients	Quality Grids	Utilization Grid
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Resources Available

- CMICS Chronic Condition Value Based Care Program Manual
- CMICS Chronic Condition Value Based Care Program Slide Deck
- Example: Chronic Condition Program (Diabetes) Terms Slide Deck (Measure Definitions & Targets)



** Supporting Your
Research & Duplicate
Process ***

Please feel free to use content to develop and/or inform specialty VBC programs specific to your market!

Contact Information: Luke Harris (laharris@cmh.edu)
Dr. Mark Clements (maclements@cmh.edu)



Implementation of Type 1 Diabetes Transition Clinic and Visit Checklist

Jordan Ross, MD

Med/Peds Endocrinology Fellow, PGY-8

University of Tennessee Health Science Center

Background

- Lack of unified approaches to transitional care as patients with chronic medical conditions age out of childhood/adolescence
 - Diminished health-related outcomes after transitioning to adult care
- Transition programs increase adolescent satisfaction with care
- Emerging standards of care
- Goals:
 - Improve the ability of youth and young adults to manage their own health care and effectively use health services
 - Provide an organized process to facilitate transition preparation, transfer of care, and integration into adult health care

Hospital utilization for adolescents with T1DM

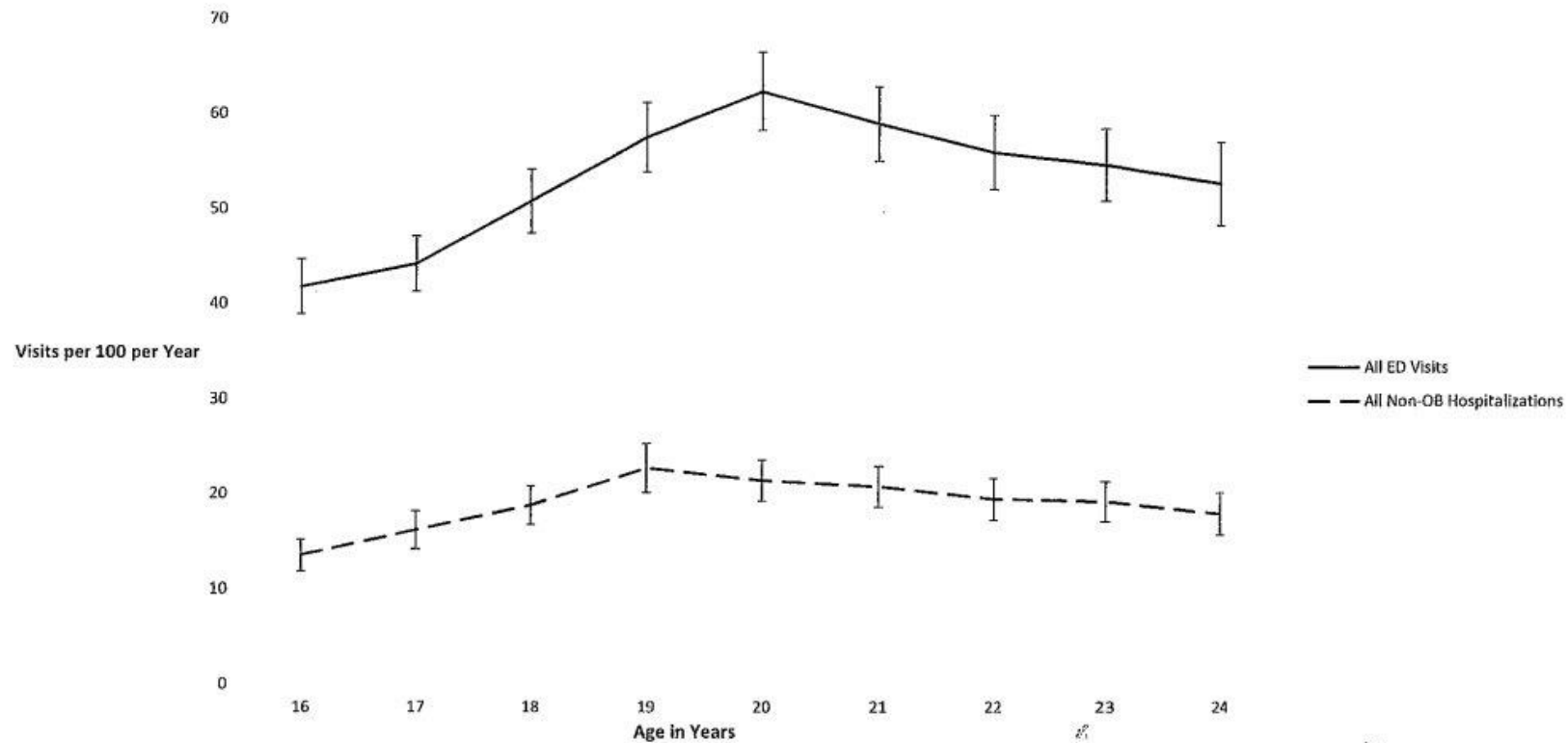


Figure 2—Overall emergency department (ED) visits and nonobstetric (non-OB) hospitalizations by age. Depicted are marginal adjusted rates (visits per 100 per year) by age for ED visits and non-OB hospitalizations, with adjustment for sex, U.S. region, ACG morbidity score, race/ethnicity, and neighborhood income/education.

Core elements of transition

SIX CORE ELEMENTS™ APPROACH AND TIMELINE FOR YOUTH TRANSITIONING FROM PEDIATRIC TO ADULT HEALTH CARE www.gottransition.org

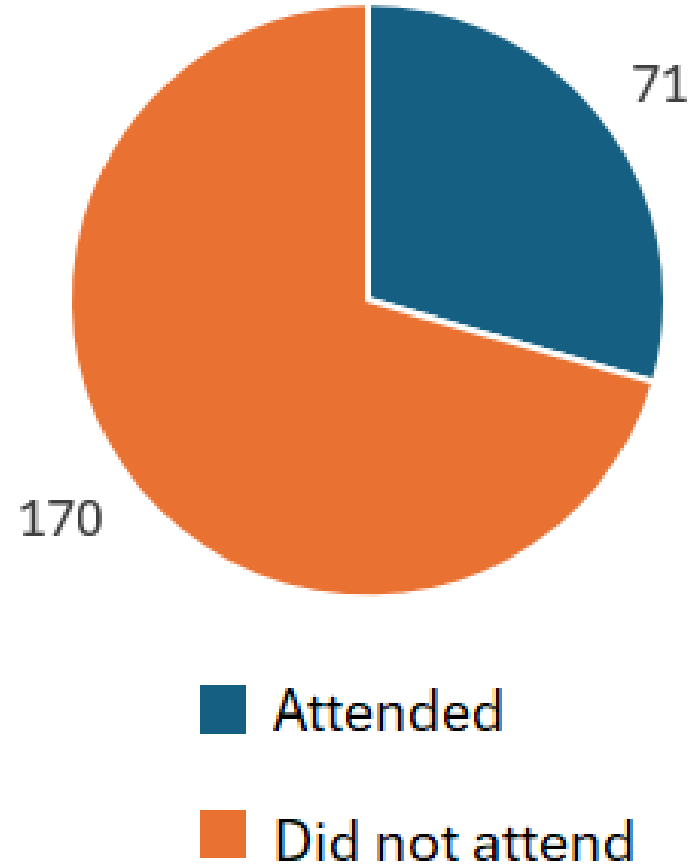


Implementation of transition clinic

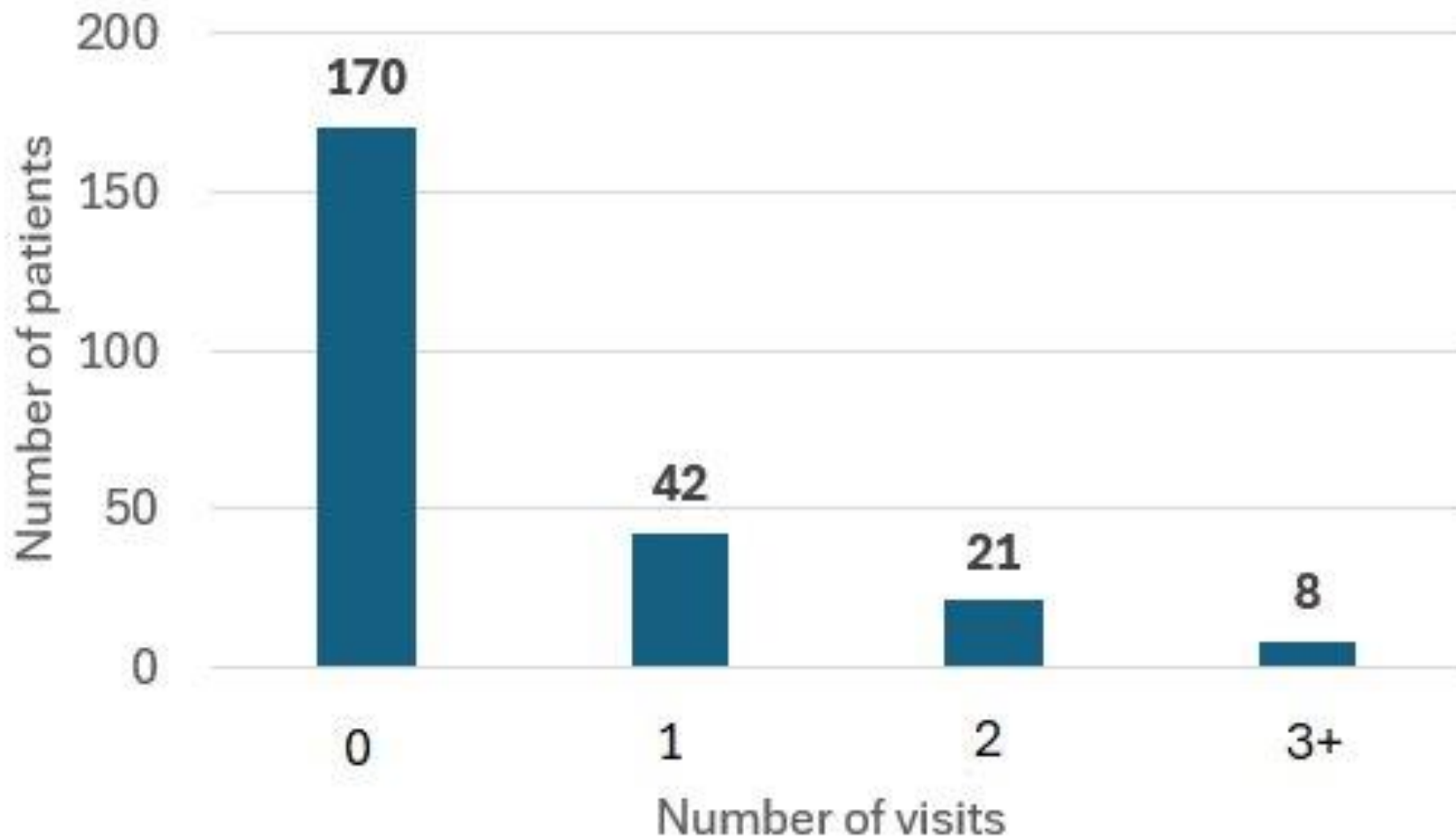
- Internal referral of any adolescents with T1DM (typically no younger than 15 years)
- Visit every six months, alternating quarterly visits with the adolescent's primary endocrinologist
 - Two half-days a month started in 2018 with Dr. Anne Wynn
 - Increase to four half-days a month in September 2023
- Orientation to clinic with booklet

Data set

- Patients with T1D seen in the pediatric endocrinology department for clinic between 7/1/23 and 6/30/24
 - Age at least 16 years
-
- 29.5% of patients attended transition clinic



Number of transition clinic visits per patient (July 2023-June 2024)



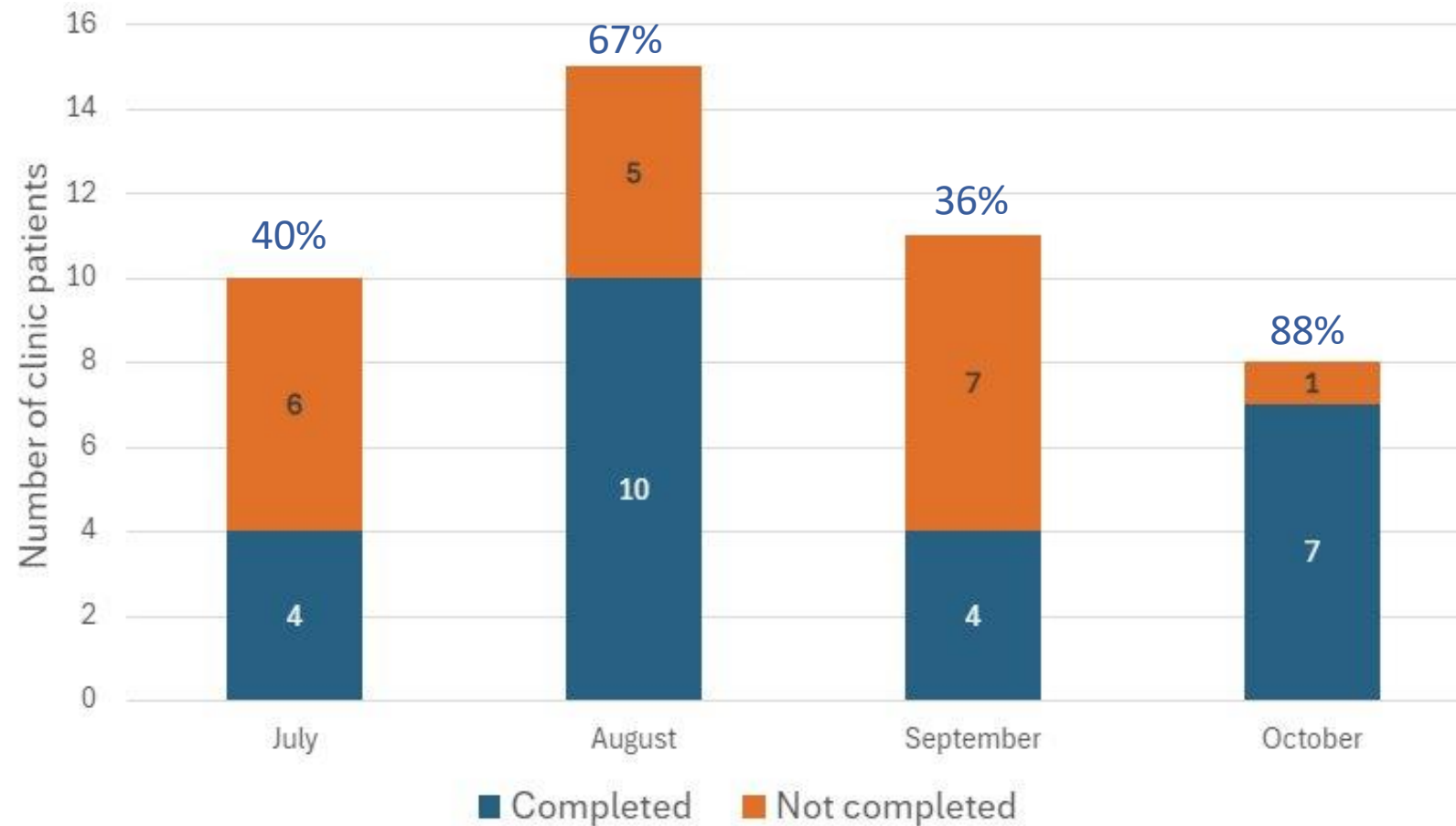
Transition Visit Checklist

- Highlight key tasks and educational topics to cover throughout the patient's transitional period
- Update the list throughout the transition period
- Able to adapted for use outside of transition clinic or by the endocrinology team in between transition clinic visit

Transition clinic program checklist

- Transition Policy given
- Transition Booklet given
- Driving
- Knowing medications (list) and dangers of rationing
- Review important numbers/refs for CGM/pump technology questions
- Sexual Activity and Pregnancy with Diabetes
- Alcohol/substance use
- College Diabetes Network
- FMLA and workplace rights
- Health insurance
- Expectations for adult endocrinology team
- Graduation Packet

Transition checklist implementation



Future directions

- Define institutional metrics for measured improved in transition clinic attendance/retention
- Encode a T1D transition registry and a transition checklist form into Epic
- Tie the transition checklist content discussion to TRAQ/READDY

Team

- Blake Adams, BSN: endocrinology nurse / transition QI team member
- Grace Nelson, MD: T1D QI faculty mentor
- Jordan Ross, MD: endocrinology fellow / transition QI team member
- Anne Wynn, MD: transition clinic physician
- Kayla Zimmerman, BA, BS: medical student / transition QI team member



Implementing High-Risk Programs at Four Pediatric Endocrinology Clinics in the T1D Exchange QI Collaborative

Ori Odugbesan November 11, 2024

Background

- HbA1c >9% is associated with a higher risk of diabetes-related complications such as DKA
- Although diabetes technology has improved glycemic management, its use varies by population. CGM users have lower HbA1c compared with non- CGM users
- Non-Hispanic Blacks have higher rates of HbA1c, and lower rate of technology use compared to non-Hispanic White
- Disparities exist in access and health outcomes among PwD
- These highlights the need to address the challenges to achieving glycemic outcome equitably.

Study Objective

- To Evaluate the effectiveness of a multidisciplinary team and patient-centered approach in reducing HbA1c levels in high-risk PwT1D population

Study Design & Study Location

- Multicenter QI study
- Population: PwT1D HbA1c levels >9%
- Program is named to promote a positive and supportive environment and to avoid labeling participants as 'high-risk'
 - Hassenfeld Children Hospital, NY- "Wellness Program"
 - Baylor College of Medicine, TX- "Extra Care Program"
 - University of Colorado Denver Anschutz Medical Campus, CO- "Extra Care Program"
 - SUNY Upstate Medical University, Syracuse NY- "DREAMs Program"
- Patients followed closely and monthly HbA1c data was shared with the coordinating center



Intervention Strategies

- Interventions are patient-centered:
 - Focus on patient education, empowerment, and active participation
 - Regular follow-ups to assess progress and modify interventions
 - Tailored education on diabetes management and lifestyle changes
 - Addressing barriers to patient engagement and adherence
 - Medication adjustments when needed
 - Individualized care plans based on unique needs
 - PhQ-9 screening
 - Community Health Worker outreach to families
 - Pump training & CGM education classes

Center 1

Global Aim: Initiate a Wellness Program for youth who had an HbA1c >9% at their last visit

QI initiative Protocol

- Each person was paired with a CDCES
- CDCES or RN called to confirm their next appointment or schedule an appointment if none was scheduled
- WP participants had weekly contact with CDCES for 6 weeks and then attended a 6 week follow up (options for contact: text, call, remote visit, in-person, etc.)
- Through shared decision-making, individualized interventions were initiated including ;weekly CDCES check-in plan, support to increase use of diabetes technology, behavioral health/psychosocial supports, provide diabetes education/handouts
- The Problem Recognition in Illness Self-Management (PRISM) tool

Center 1:

Results of Wellness Program

- Population reviewed for WP eligibility = 464
- 82 (17.6%) youth had HbA1c >9% as of August 2021 and were eligible for WP

WP population:

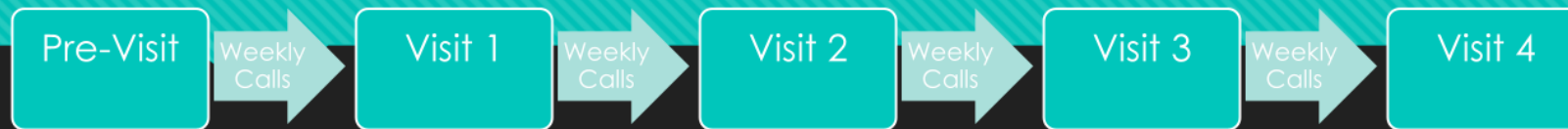
- median age = 14 years (total population = 14 years)
- 70.2% self-identified as non-White (total population = 31.4% non-White)

At 6 months:

- 32 of 82 WP youth (39%) had an HbA1c <9% (graduated)
- Mean post-program HbA1c level of graduates = 8.2+/-0.6% (median=8.4% [6.5-8.9])
- Interventions of WP graduates included:
 - initiation of Control-IQ
 - increased diabetes education/management
 - behavioral health intervention/additional psychosocial care in place
 - increased communication

Center 2

Curriculum for Rolling Admissions



RN DCES

- Confirm First Appt Date/Time
- Review of Program & Expectations
- Licensed Master SW and Child Life Specialist meet with patient in person
- Notify QI Team
- MyChart setup & usage

MD/APP + DCES LMSW/CCLS (as necessary)

- Keep BG Log and/or Downloading of Devices
- Setting SMART goals
- Nutrition Education
- Introduce Tech if indicated
- Obtain A1c (preferably at admission)

DCES + LMSW/CCLS (as necessary)

- Ketone Testing/Sick Day Guideline
- Low Blood Sugar Management
- Nutrition Education
- Review Blood Glucose

DCES + LMSW/CCLS (as necessary)

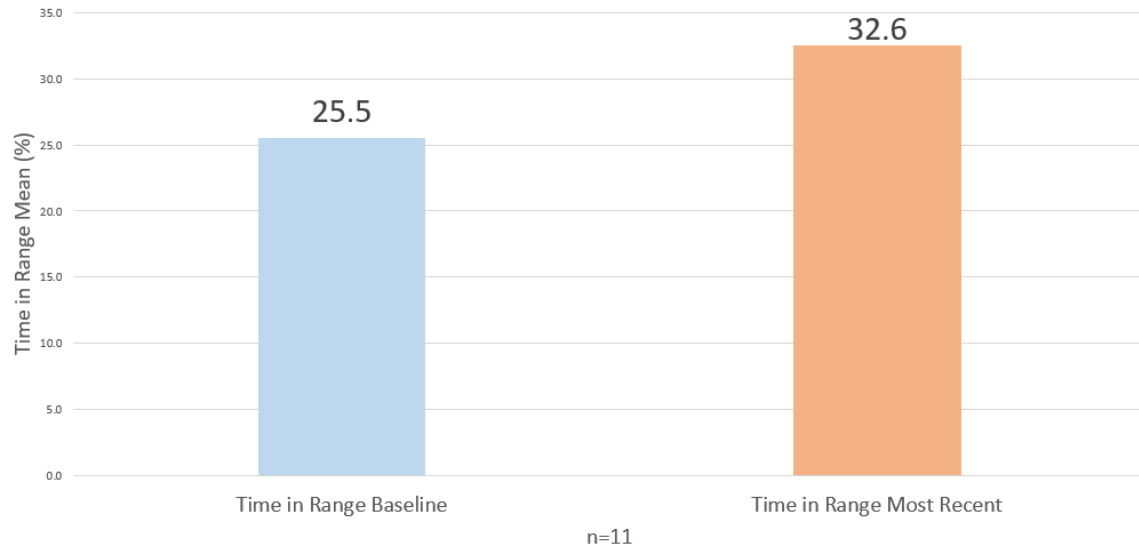
- Sport and Exercise Management
- Technology
- Achieving a greater independence at school
- Nutrition Education
- Establishing Routines
- Review Blood Glucose

MD/APP + DCES LMSW/CCLS

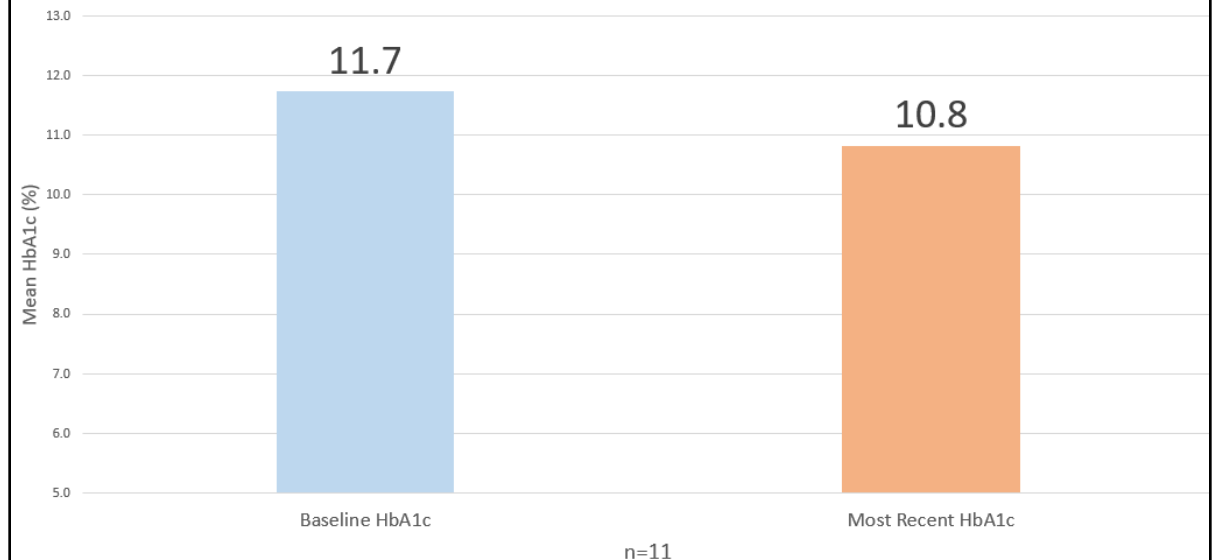
- How to identify blood sugar patterns and make changes
- After Hours Game
- Review the preview topics as needed
- Review Blood Glucose

Improvement in HbA1c & Time in Range

Baseline & Most Recent TIR of Current DREAMS Cohort



Baseline & Most Recent HbA1c of Current DREAMS Cohort



Center 3

- For patients with HbA1c>9% who are also lost to FU
- Collected data on barriers among participants and addressed identified barriers
- Provided resources and additional follow-up
- Provide diabetes education

What is EXTRA CARE+?

The BDC is launching a new program for those who need extra support from their diabetes team.

WHAT TO EXPECT:

Your extra care team will

- Check your shared CGM data weekly for data drop offs
- Help troubleshoot supply and device issues
- Connect you with a Diabetes Educator upon request to look at device trends and make adjustments
- Coordinate transportation and assist with other barriers

Scan this code to enter your info and join our program!

We can't wait to work with you!

MEET YOUR PATIENT NAVIGATOR TEAM:

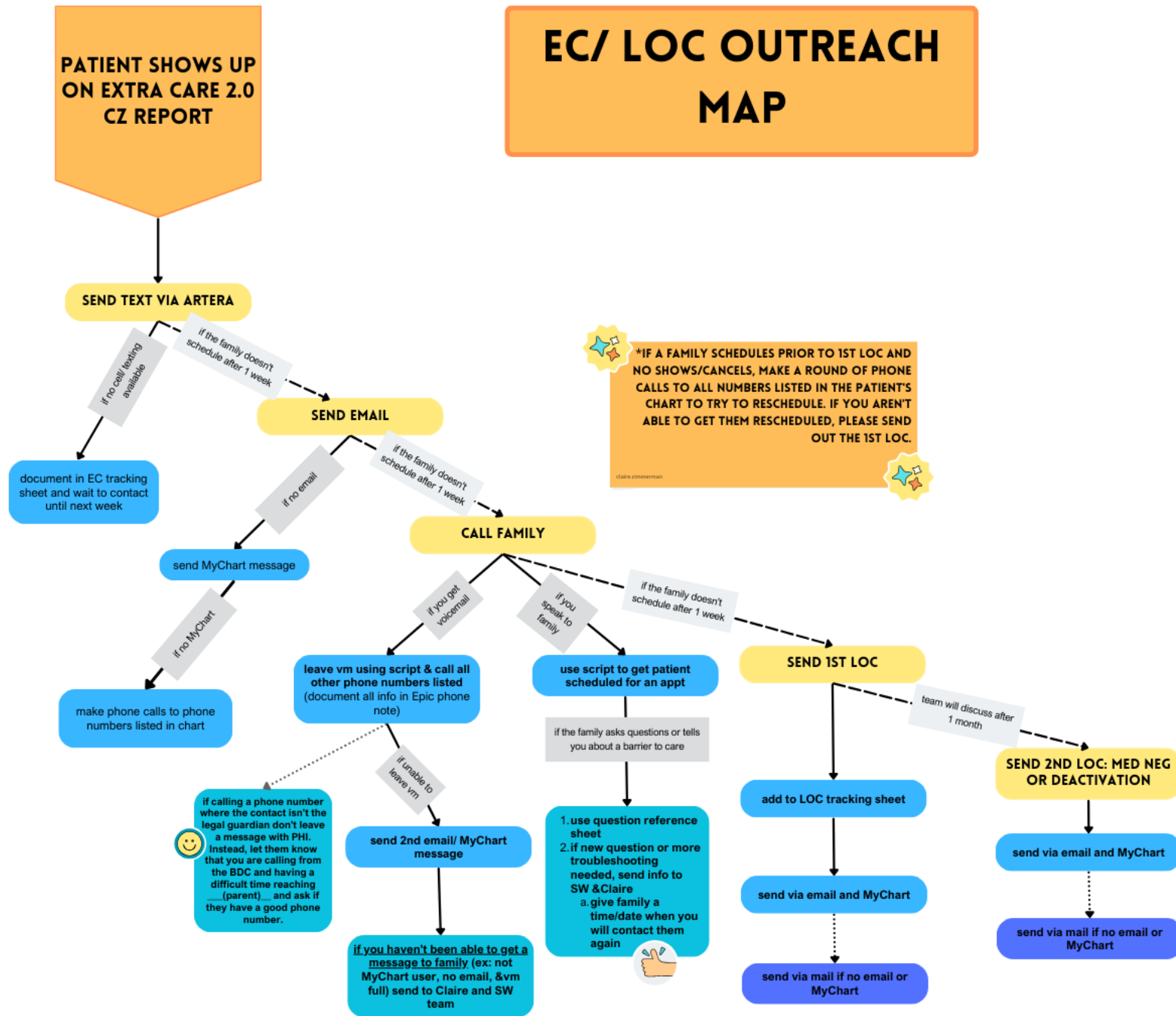
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EC/ LOC OUTREACH MAP



Center 4

Risk score calculates at 1 year but takes into account DKA in past 2 years.
So this is to exclude kids with high risk score with just initial diagnosis DKA

Moderate risk score but has had a DKA outside their diagnosis DKA

Type 1 Diabetes HELLO Cohort
(Help for youth with ELevated glucose Levels to improve Outcomes)
RI-DKA > 2.5
OR
2+ DKA in the past year

Type 1 Diabetes REACH Cohort
(REsources And Care to improve Health outcomes)
RI-DKA > 7
plus 2 Years from Diagnosis
OR
RI-DKA > 2.5 plus DKA in past year (365 days)
plus 1 year from Diagnosis
OR
2 or more DKA in past year (365 days)
regardless of risk score and date of diagnosis

Dismissed from Cohort if:

- Family Declined
- Transfer to Adult or Outside TCH
- Unable to Contact

Enrolled in Wrap Around Services by High Risk Team:

- Monthly Phone Check-In (See Epic form for further details)
 - If needed, sooner appointment given.
- If admitted for DKA, two week post-admission phone call.
- Appointment Reminders
- Seen by High Risk SW and Nurse at Each Appointment

Step down services if no DKA episode for 12 months following enrollment or 6 months if initial reason for enrollment was pump malfunction or if risk score improves due to a change in caregiver:

- Appointment Reminders
- Seen by High Risk SW and Nurse at Each Appointment

Graduate if no DKA episode for 6 more months following step-down:

- Seen by High Risk SW and Nurse at for Annual SW Visit

Reactivate if:

- TBD

Change in HbA1c Overtime (3 PwT1D)

More frequent visits

Component	4 wk ago	2 mo	4 mo	7 mo	10 mo
Ref Range & Units	(7/11/24)	(5/30/24)	(4/11/24)	(1/8/24)	(10/2/23)
Hemoglobin A1C	11.6	10.7	14.0	13.3	>14.0
<=5.6 %	▲	▲	▲	▲	▲

Component	9 d ago	1 mo	2 mo	4 mo	9 mo	1 yr ago
Ref Range & Units	(7/31/24)	(6/25/24)	(5/15/24)	(3/15/24)	(11/3/23)	(7/28/23)
Hemoglobin A1C	12.5	11.2	>14.0	>14.0	>14.0	>14.0
<=5.6 %	▲	▲	▲	▲	▲	▲

Example of summer visits every month!
The kids and parents were so proud of their progress!

Component	4 d ago	1 mo	2 mo	3 mo	7 mo
Ref Range & Units					
Hemoglobin A1C	12.7	13.1	12.2	12.0	>14.0
<=5.6 %	▲	▲	▲	▲	▲

Extra Care Success Story

8/12/2024	6/17/2024	5/6/2024	4/1/2024	2/28/2024	1/31/2024	1/3/2024	11/17/2023	10/27/2023	9/27/2023	8/25/2023	7/28/2023	12/7/2022	8/26/2022
9.1 ▲ 📄	8.5 ▲ 📄	7.9 ▲ 📄	9.0 ▲ 📄	9.3 ▲ 📄	8.6 ▲ 📄	9.1 ▲ 📄	10.9 ▲ 📄	10.9 ▲ 📄	12.2 ▲ 📄	11.8 ▲ 📄	>14.0 ▲ 📄	>14.0 ▲ 📄	>14.0 ▲ 📄

Becky, Amelia and Jessika have been working with **L.B.** since July 23. She was depressed and severe diabetes burnout. She previously didn't come to regular appointments for years. Becky (CDCES) met with her in July 23 and then **L.B.** came every 4-6 weeks to clinic and her A1c went down!

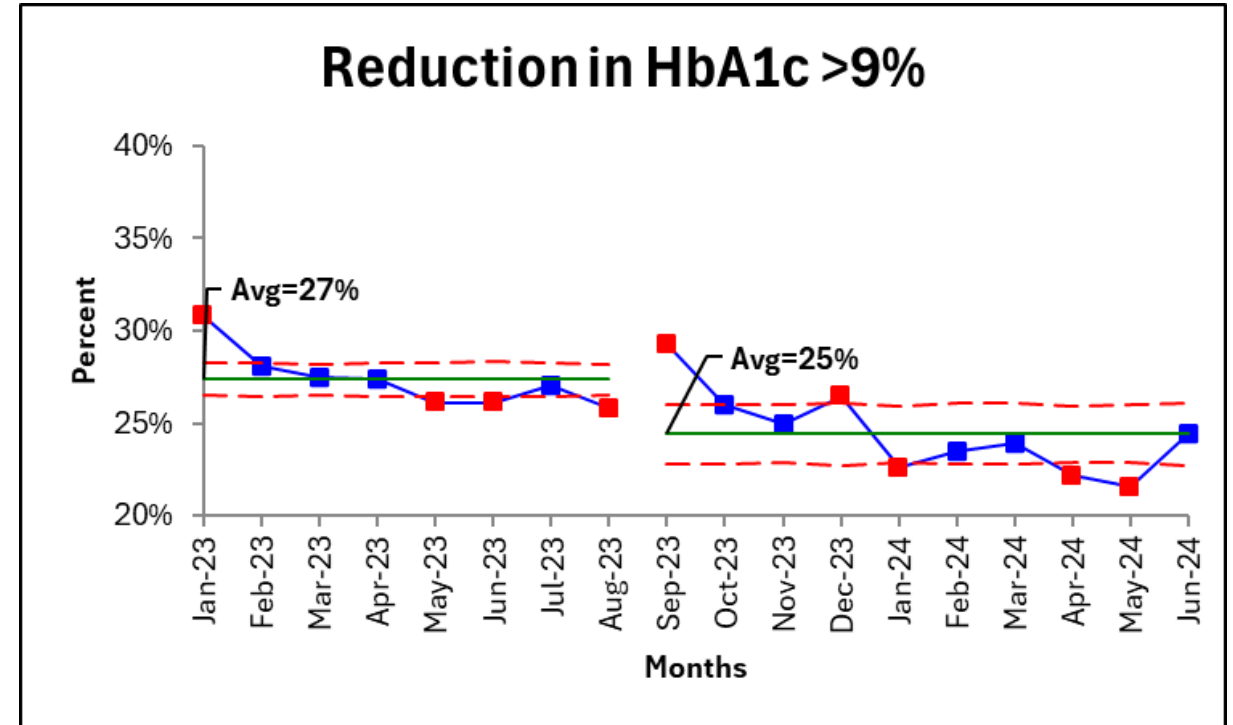
During this time, **L.B.** was kicked out of mother's home when she turned 18 in February and went to live with her ex-stepfather. She still managed to graduated high school.

In the spring and summer, **L.B.** and Becky worked on her financial aid and junior college application. **L.B.** was accepted and received the full Pell Grant amount! Becky was able to locate a foundation that bought **L.B.** a new computer and items for her dorm!

Just this past week and a year later, we were together at her appointment and called college housing and **L.B.** finally got a dorm room! **L.B.** will be moving next week to start a new life!

Participating Center Result

- HbA1c levels >9% at participating centers decreased by 2% from baseline over 18 months.
- The consistent follow-up, personalized care plans, addressing barriers to patient engagement, were key factors contributing to the improvement in HbA1c.



Conclusion

- Multidisciplinary and patient-centered care can significantly reduce HbA1c levels in people with diabetes
- This approach is helpful in providing equitable care as patients needs are different
- Approach is practical and can be expanded to other diabetes care settings