HLC Wellness Briefing
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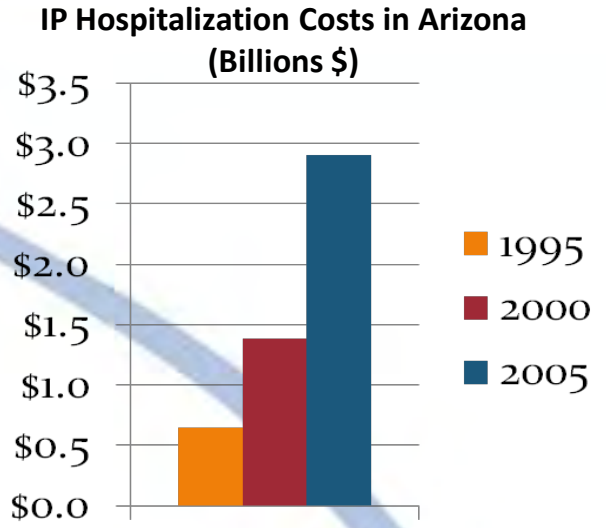
The Diabetes Epidemic

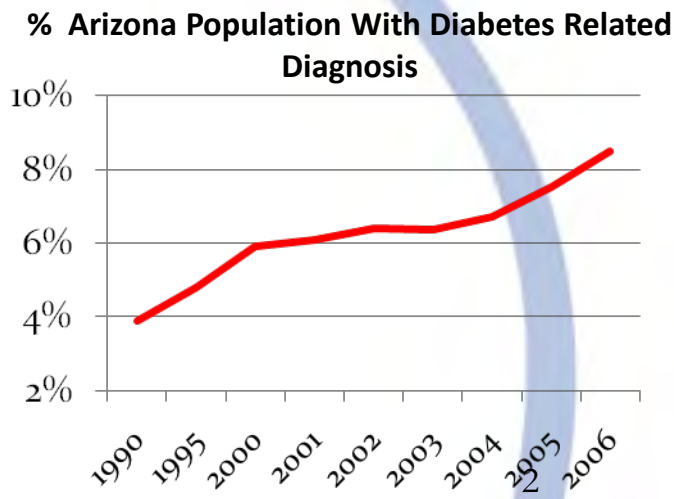
According to the Arizona Diabetes Association, over the past decade diabetes has risen 40% and prevalence of obesity has risen 37%

Arizona is ranked 8th in the U.S for the incidence of diabetes where 40% of its residents are considered overweight and 23% obese

In 2006, the direct medical cost of diabetes in Arizona was $2.3 billion and the indirect cost associated with lost productivity was $1.1 billion totaling a $3.4 billion burden for the state and economy

Arizona trends exceed that of U.S. trends





BEATING DIABETES A SPECIAL REPORT

Southern Arizona: epicenter of an epidemic

Twin scourges of obesity and diabetes threaten region's children more than any others in U.S.

First of four parts

Food power

BEATING DIABETES A SPECIAL REPORT

Aggressive attack on body-racking disease

Second of four parts

Food power

Proactive Step to Health Care Reform

CMG Diabetes Disease Management Program
Diabetes Scorecard

Patient Grade	Annual Cost per Patient
A	$1,621
B	$3,405
C	$9,720
D	$21,003

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Scoring System

Compliance Grade	A	B	C	D
HbA1c	6-6.9	7-7.9	8-8.9	9+
Blood Pressure	<130/80	130-140/80-90	140-150/90	>150/90
LDL	<100	100-130	130-200	>200
Last visit to podiatrist	Within the last 1 year	Within the last 2 years	Within the last 3 years	Within the last 4 years
Neuropathy (Foot Exam)	0 No loss of protective sensation	1 Loss of protective sensation (no weakness, deformity, callus, pre-ulcer or hx of ulceration)	2 Loss of protective sensation (with weakness, deformity, callus, pre-ulcer or hx of ulceration)	3 History of plantar ulceration and/or amputation
Last visit to ophthalmologist	Within the last 1 year	Within the last 2 years	Within the last 3 years	Within the last 4 years
Retinopathy	0 Negative	1 Non-Proliferative Retinopathy	2 Proliferative Retinopathy	3 Blindness

Relative Weights	
HbA1c	40%
BP	20%
LDL	20%
Neuropathy & Last visit	10%
Retinopathy & Last Visit	10%

Grade	Score
A	100
B	80
C	60
D	40

Grade	Annual Cost
A	$ 1,621.00
B	$ 3,405.00
C	$ 9,702.00
D	$ 21,003.00

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Patient-Centered Health Care

CMG Diabetes Intervention Grid

- PCP Visits (EHR Diabetes Template)
- Diabetes Nurse Educator Visits
- Telehome monitoring for high-risk patients
- Dietitian Visits
- Diabetes Day Clinics for annual exams
- Diabetes Navigator (Promotora)
- Behavioral Health
- Web-based scorecard and care team intervention management (Ascension Transformation Div)
- Patient score drives the interventions per Carondelet Intervention Grid

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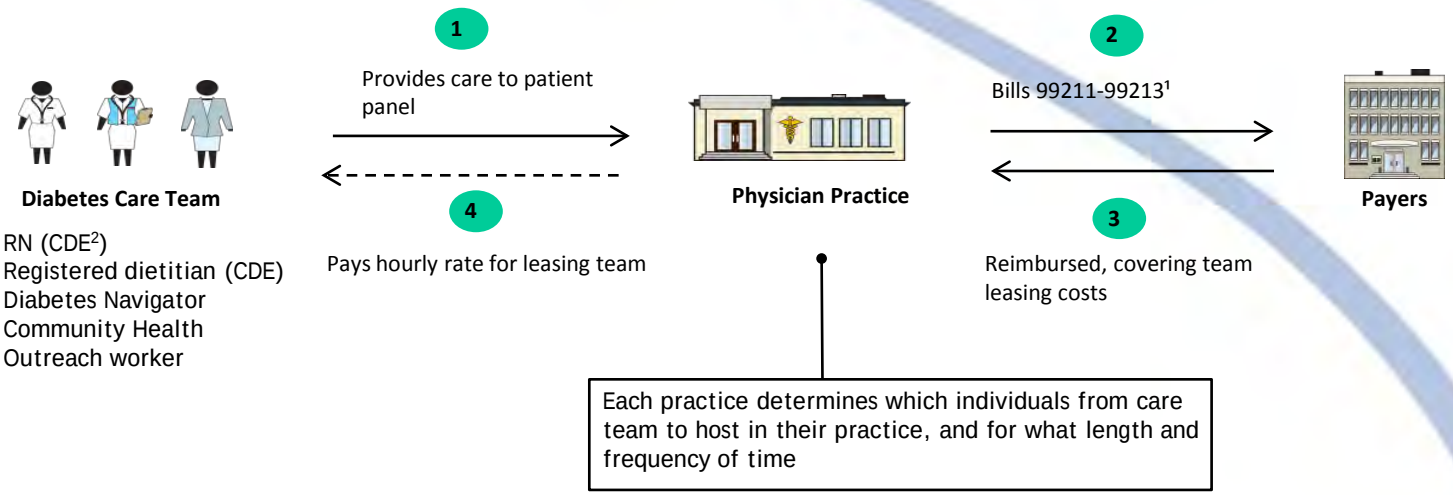
Distributing Cost of In-Practice Care Team Across PCP Network

Health Coach Rental Program Allows Practices In-Office Care Team Access

Diabetes Primary Care Team Lease Program



- RN (CDE[2])
- Registered dietitian (CDE)
- Diabetes Navigator
- Community Health Outreach worker

Case in Brief: Carondelet Health Network

- Four-hospital system based in Tucson, Arizona, part of Ascension Health
- Growing diabetes population prompts comprehensive outpatient diabetes strategy
- System leases diabetes team—health coach (community health worker), RN, and registered dietitian who are Certified Diabetes Educators—to practices, both employed and independent
- Diabetes team bills payers at an hourly fair market value rate

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Source: Health Care Advisory Board interviews and analysis.

Leveraging Non-Clinical Community Health Workers to Enhance Patient Engagement

Community Health Worker (Navigator) Enhances Patient Care, Coordination at Carondelet

Navigator Helps Manage System Contact with Patient

Helps manages patient data, disease registry

Schedules and coordinates patient contact with care team of RN and dietitian, PCP, specialists

Calls patient with appointment reminders, follow-up

Navigator Helps Patient Access Care Resources

Acts as peer contact, bridging socio-economic, language barriers

Assists patient interaction with diabetes care team

Helps patient navigate care management resources made available by health system

- Four-hospital system based in Tucson, Arizona
- Established Diabetes Care Center, offering a variety of care management services
- Diabetes teams, composed of RN, certified diabetes educator, and community health worker known as a navigator, leased to practices (owned and independent) to provide care management and connect patients to other Diabetes Care Center services
- Navigator coordinates patient's contact with care team, specialists, Diabetes Care Center services, helps bridge cultural and language barriers

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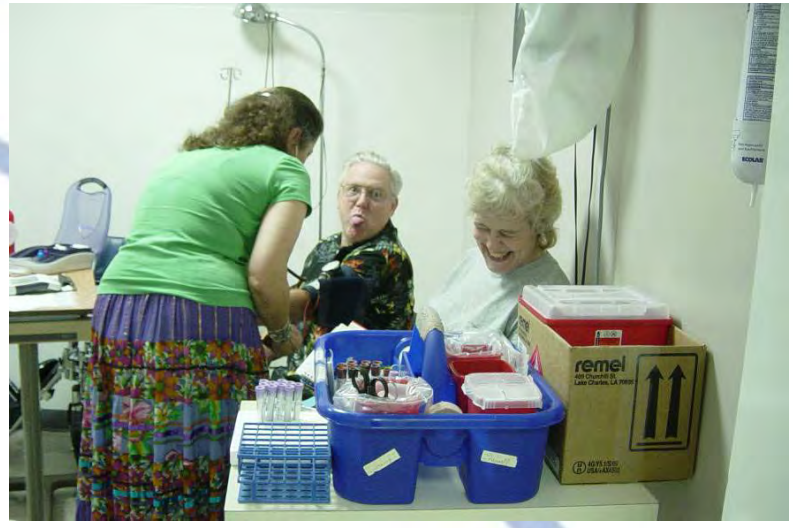
Source: Health Care Advisory Board interviews and analysis.

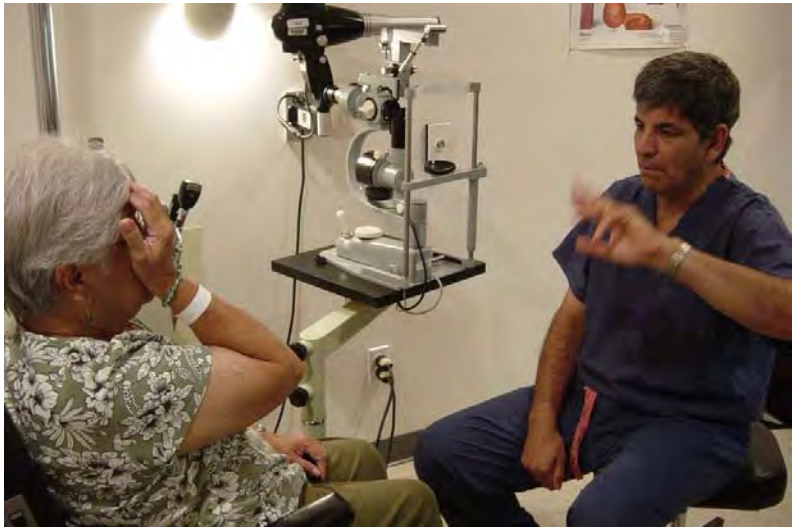
Diabetes Clinics with Health Plans

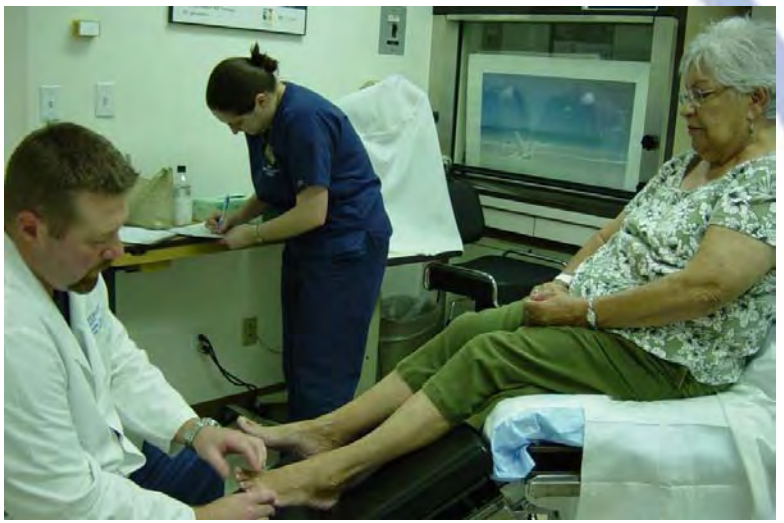
Annual Eye and Foot Exams

Medical Nutrition Therapy

Vital Signs and Labs







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Post-Program Confidence Levels

Self-Management Behavior	Jan 09 – Mar 09	Apr 09 – June 09	July 09 – Sept 09	Oct 09 – Dec 09
1. Can check blood sugars correctly	4.8	4.8	5.0	4.8
2. Make healthy food choices	4.4	4.4	4.5	4.4
3. Know which foods are carbs	4.4	4.5	4.6	4.5
4. Know about meds and side effects	4.4	4.2	4.5	4.4
5. Know how to exercise regularly & safely	4.4	4.7	4.8	4.6
6. Can find diabetes info and support	4.6	4.7	4.7	4.6
7. Know signs of low BG and what to do	4.6	4.5	4.7	4.6
8. Can check feet for problems/take care of feet	4.6	4.6	4.7	4.6
9. Can work with doctor to get complete, regular diabetes exams	NA	4.6	4.7	4.6

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Knowledge Assessment

Administered pre- and post-program

Multiple choice items

Item	% Correct Answers Oct 08 – Dec 08	% Correct Answers Jan 09-March-09
A1c Goal	79%	100%
Fasting BG goal	74%	100%
2 hr PP goal	93%	100%
BP goal	86%	100%
Care goal	97%	100%
AVE	87%	100%

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