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The Journey Begins

What does it take for a person to successfully lose weight and prevent diabetes? In Fergus Falls, MN, the journey for individual patients begins with behind the scenes work in the healthcare system. In May 2016, Lake Region Healthcare (LRH) was awarded Community Wellness Grant (CWG) funding to work with PartnerSHIP 4 Health (PS4H), local public health and community partners in Becker, Clay, Otter Tail and Wilkin counties, to address prediabetes among its patient population.

In collaboration with PS4H, LRH reviewed current practices and best practices, and then targeted areas for improvement. The following 4 improvements had the biggest impact on the prediabetes initiative:

1. Updating prediabetes lab values (A1C and fasting glucose) to match CDC guidelines.
2. Adding prediabetes diagnosis to patients with an A1C in the prediabetes range. This was probably the simplest change with the biggest impact. We went from 298 prediabetes diagnoses in 2016 to 718 prediabetes diagnoses in 2017. Once becoming aware of the diagnosis, the provider encourages the patient to make lifestyle changes and referred to clinic-based resources to help them from converting to diabetes.
3. Developing a “one stop shop” referral document for our medical providers to raise awareness of clinic and community resources as well as how to refer a patient to a resource.
4. Developing a pre-visit planning document that is completed before every wellness visit to give the medical provider a quick overview of what type of testing may be needed for the patient.

According to Nathan Hoff, LRH Operations Process Analyst and chair of the CWG initiative, “LRH focused on supporting physicians and providers in treating patients with comorbid or complex medical issues. The biggest challenge for us was developing tools that bring value to the clinic interaction.”

Using the new identification strategy, LRH providers discovered that many patients had prediabetes and desired support to head off diabetes. Having been awarded PS4H CWG funds to offer the Diabetes Prevention Program (DPP) and Lifestyle Medicine, providers had ready-made internal resources for patients.

Two additional elements that support this prediabetes initiative include group visits and a new EHR:

- PS4H introduced LRH to the concept of Group Visits for Prediabetes and Hypertension, and LRH hopes to add this option to their clinic services.
- In the Fall of 2018, LRH converts to a new EHR which will provide a robust reporting and tracking system.

The Results

According to Dr. Erin Peterson, “The simple changes made on our lab reports highlighting the diagnostic ranges for FBG and A1c drove the identification of patients with ‘prediabetes’, opening the door to impactful discussions about the role for healthy lifestyle to prevent and treat disease. The ‘prediabetes’ diagnosis makes patients appreciate more urgently the need to follow through and implement lifestyle changes and flags these patients in my practice, so I am more likely to review and discuss healthy lifestyle at each visit.

Developing and expanding our DPP program has given me, as a physician, a very valuable tool for addressing my prediabetic patients' needs. I am seeing my ‘prediabetic’ patients generally embrace to a much higher degree the principles of healthy eating and more active life style. I am seeing a noticeable increase in my patients' willingness to participate in (and even request referrals to) our Lifestyle Medicine Program and DPP.”

April 2018

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