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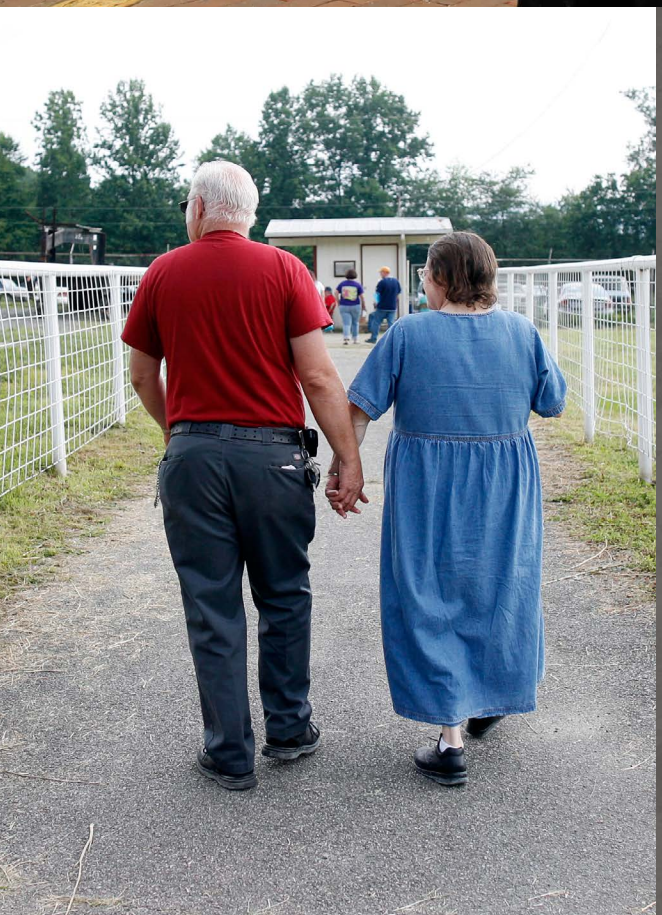

TEXAS

Enhancing Diabetes Care through Personalized, High-Touch Case Management

Rio Grande Valley Accountable Care Organization

Center for Health Policy at BROOKINGS

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TEXAS

Enhancing Diabetes Care through Personalized, High-Touch Case Management

Rio Grande Valley Accountable Care Organization Health Providers, LLC, Texas
Provider Type: Accountable Care Organization
Patients Served Annually: 8,500 Medicare beneficiaries
Program Name: The RGV ACO Diabetes Program: Different Strategies with a Common Goal

EXECUTIVE SUMMARY

The Rio Grande Valley (RGV) Accountable Care Organization (ACO) uses a wide array of strategies to help their patients with diabetes – approximately 45% of their patient population – better manage their condition. The diabetes initiatives aim to support patients to understand their disease, undergo lifestyle changes, and systematically employ diabetes management approaches. All practices utilize care coordinators, who reach out to patients with uncontrolled diabetes as often as every other day. In these regular contacts, the care coordinator can check-in with the patient to see how they are doing and make any medication adjustments necessary. Other initiatives include weekly uncontrolled diabetes clinics, where diabetics can see a nutritionist after their provider visit, and a central Diabetes Education Center that provides additional support to practices and their patients.

The RGV ACO's diabetes strategies are used for patients with an HbA1c greater than eight and, although the ACO aims to reach out to 100% of this patient population, physicians reach out to approximately 80% of these patients. Of those targeted, approximately 70% participate in at least one of the ACO's diabetes strategies, almost 50% of whom achieve good blood sugar control. Across the RGV ACO as a whole, almost 77% of patients with diabetes have good blood sugar control and, in addition, the percentage of patients in the ACO with comprehensive control of their disease (a composite of ACO quality measures 22-26) increased from the national average of 23% in 2012 to 49% in 2014, which is well above the 90th percentile nationally.

PART 1: BACKGROUND

State Profile

Texas, with a population of almost 27 million, is both ethnically and socioeconomically diverse.[1] Hispanics and individuals over the age of 65 account for an ever increasing proportion of the state population.[2] Located in the Southern tip of Texas, the Rio Grande Valley is a microcosm of the larger issues found within the state. Hidalgo County in central Rio Grande Valley is one of the poorest counties in Texas.[3] Highlighted in two 2009 *New Yorker* articles by Atul Gawande,[4,5] the Medicare per capita cost in this county is above $12,300 annually, significantly higher than the national average of $8,874. In parts of Hidalgo County like the Mid-Valley, the annual per capita cost is closer to $14,000. Contributing to this high annual cost is the relatively high number of dual eligible Medicare-Medicaid beneficiaries, which make up approximately 42%-45% of the patient population.

In 2012 diabetes was the 7th most common cause of mortality in Texas.[2] Mortality rates of diabetes increase along the southern border of the state, reaching as high as 28.6 deaths per 100,000, compared to 21.0 deaths per 100,000 in the rest of the state.[2] Prevalence similarly increases in this area; within the central Rio Grande Valley, diabetes prevalence is 29%. Among Medicare beneficiaries in the area, this is even higher, at 45%.[6]

The RGV ACO Payment Model

The Rio Grande Valley Accountable Care Organization Health Providers, LLC (RGV ACO) was established in 2012 as part of the Medicare Shared Savings Program (MSSP). When established, the ACO consisted of six independent primary care practices and included 11 physicians.[3] It currently includes 13 practices with a total of 18 physicians and several nurse practitioners and physicians assistants.[3] The RGV ACO is responsible for 8,500 Medicare beneficiaries, just under half of whom are dual eligible for Medicare and Medicaid.[3] Although the RGV ACO is a Medicare ACO, the participating practices have a range of payers. Medicare beneficiaries, including those in Medicare Advantage plans, make up approximately 60% of the patient population. The remaining population is approximately 20% commercial insurance, 10% Medicaid, and 5% uninsured.

Under the MSSP model, the RGV ACO is responsible for all care provided to a prospectively assigned population of beneficiaries. The organization participates in the two-sided risk model: if the RGV ACO meets or exceeds a minimum savings rate of 2%, it is eligible to share up to 60% of the savings depending on quality performance measures, including measures related to diabetes treatment and outcomes. However, if costs exceed the set benchmark, the RGV ACO shares in losses up to 5% of the ACO's benchmark the first performance year, 7.5% the second year, and 10% the third year. Savings and losses are calculated by comparing per capita expenditures to a risk-adjusted benchmark determined by the Centers for Medicaid and Medicare Services (CMS). Thus, if the practice is able to reduce costs significantly below the benchmark while improving quality, it can receive additional payments to sustain reforms in care that would otherwise not be reimbursed well if at all under fee-for-service Medicare.

PART 2: INNOVATIONS IN CARE

RGV ACO Diabetes Care Plan

The mission of the RGV ACO is to "[improve] the quality of life and health [of patients] through the effective practice of patient-centered preventative care."[7] With this mission, the RGV ACO focuses on prevention of uncontrolled disease and of complications for those living with diabetes. The RGV ACO hopes to accomplish these aims by better engaging patients through a number of initiatives that provide increased and multifaceted communication and education with patients. Overall, these initiatives aim to 1) support patients to understand their disease; 2) encourage appropriate lifestyle changes; 3) systematically employ diabetes management approaches; and 4) connect patients with poorly controlled diabetes to additional support.

Each individual physician's office has a diabetes program, although the intensity of these programs vary. Some large offices have an 'uncontrolled diabetes mellitus clinic' once a week for patients with an elevated glycosylated hemoglobin level, (i.e., over 8%) with a nutritionist technician available to see these patients before or after their provider appointments. The nutritionist goes to each office half day every week. Additionally, a call center utilizes medical assistants, care coordinators, and care coaches to make phone calls as often as every other day to patients with uncontrolled diabetes. These patient contact points enable providers to adjust patients' medications between office appointments and increases patient engagement.

In 2013, the Diabetes Education Center was established and certified by the American Diabetes Association (ADA) to provide additional support to patients and practices. The ADA provides standards for management, utilization, and training. At the center, patients are seen by certified diabetes educators who help them better understand their disease and encourage lifestyle changes, such as improved diet and increased physical activity. Patients with uncontrolled disease are assigned to a nutritionist in order to receive additional support. In addition to work with patients, the Diabetes Education Center trains the medical assistants who work as care coordinators in each office. Medical assistants complete 16 hours of training before taking an ADA certification test, which is retaken yearly. This 'train the trainer' initiative aims to

ensure the standardized application of best practices in diabetes management at each practice within the ACO. Finally, the Center hosts diabetes walks to promote diabetes awareness throughout the community.

In addition, the RGV ACO utilizes technological tools to improve care for patients with diabetes. If any parameters are out of range, a chart alert is provided so providers and medical assistants know to address these issues in each visit. In some of the more successful clinics, providers follow a checklist that includes blood pressure, HbA1c, LDL-cholesterol, smoking status, and the use of aspirin in the case of ischemic vascular disease. Medical assistants write the results at the top of each progress note before providers enter the room. Where utilized, this technique has decreased the likelihood of missing a measure during the encounter. The RGV ACO also helps patients control their blood sugar with new medications that have become available in the last few years. This growth in treatment options for patients with diabetes is particularly useful for the RGV ACO because of their diverse patient population. Finally, the RGV ACO offers bariatric surgery for morbidly obese patients with diabetes.

PART 3: CHARACTERIZATION OF ACCOUNTABLE CARE AT THE RGV ACO

This case study applies the five pillars of the Global Accountable Care Framework to showcase the RGV ACO's Diabetes Care Plan. The Framework pillars, outlined in Table 1, include: population, performance, continuous improvement, payments and incentives, and care coordination.

Table 1: The Five Pillars of Accountable Care and Key Innovations in RGV ACO

Conceptual Pillar	Definition	Key Success Factor at RGV ACO
Population	A defined group of patients for which providers are responsible	Patients with a diagnosis of uncontrolled diabetes and newly diagnosed patients
Performance Measures	Targeted outcome measures for the population that are patient-based and meaningful	Diabetes-focused clinical outcomes to monitor and measure outcomes tied to payments.
Continuous Improvement	Feedback to observe outcomes and performance while also learning from comparison	Through the centralized collection of ERH data, providers routinely review their performance on the diabetes-focused and other patient-based measures and adapt accordingly.
Payments and Incentives	Aligned payments and rewards for improved outcomes that matter to patients	Shared savings payments are tied to savings on overall costs and performance in quality measures, including diabetes treatment and outcome measures
Coordinated Care	Care coordination across providers (clinical and non-clinical) to achieve patient-level outcomes	A multi-dimensional patient-focused model that uses a team-based approach to care to coordinate care across providers through a site-based care coordinator, a centralized EHR system, and adherence to best practices in diabetes including the diabetes mellitus checklist.

Population: What population group is included in the model?

Of the 8,500 patients attributed to the RGV ACO, approximately 45% have diabetes. Associated providers are advised to identify all patients with an HbA1c greater than eight and newly diagnosed patients to participate in at least one of the diabetes strategies. In addition, patients with diabetes new to a provider are targeted for the program. Once a patient has been identified, a medical assistant or care coordinator makes them an appointment for the call program or Diabetes Care Center. Patients with higher HbA1c scores receive more intensive targeting such as calls from a diabetes coach every few days.

Although the RGV ACO suggests that physicians attempt to engage 100% of the patients outlined above, currently physicians across the ACO are reaching out to approximately 80% of the desired patient population. In the most successful practices, outreach is closer to 95% of this population. Of the patients targeted by physicians, approximately 70% participate in at least one of the diabetes strategies. The majority of patients

engage in the strategies provided through their local physician's office; only approximately 17% of patients are seen at the Diabetes Education Center. Even with this impressively high overall program participation rate, only approximately 50% of these patients are able to successfully translate this engagement into control of their diabetes.

The RGV ACO focuses on engaging beneficiaries who are already diagnosed with diabetes. However, each practice also has individual efforts to engage pre-diabetics. Although there is not an ACO directive regarding this patient population, monthly quality assurance meetings identify best practices and speakers are brought in to discuss management and other topics related to identifying pre-diabetic patients and preventing their progression.

Performance Measures: What are the types of measures that are used in the model?

As diabetes is one of the key priorities for the whole of the RGV ACO, the organization uses the 33 ACO measures required as part of the MSSP for their performance measures. The shared savings component of their payment is linked to success on these measures. Specific to the care of diabetes patients, the RGV ACO reports the following:

- ACO 22: Hemoglobin A1c Control (HbA1c) < 8 percent
- ACO 23: Low Density Lipoprotein <100mg/dL
- ACO 24: Blood pressure < 140/90
- ACO 25: Tobacco Non-Use
- ACO 26: Aspirin use in the case of concomitant ischemic vascular disease
- ACO 27: Hemoglobin A1c Poor Control (HbA1c) >9 percent

In addition to these measures, three of the larger practices in the RGV ACO (accounting for 4,500 patients) are certified by the National Committee for Quality Assurance (NCQA) for diabetes management. Additional performance measures are used for this certification but are not yet ACO-wide. The measures related to diabetes for NCQA certification include the following:

- Hemoglobin A1c (HbA1c) testing
- HbA1c poor control (>9.0%)
- HbA1c control (<8.0%)
- HbA1c control (<7.0%) for a selected population
- Eye exam
- LDL-C screening
- LDL-C control (<100 mg/dL)
- Medical attention for nephropathy
- Influenza Vaccination
- Pneumococcal Vaccination
- Assessment of tobacco use
- Assistance with tobacco cessation

The health information technology (IT) software utilized by the RGV ACO provides a patient registry that generates feedback on each ACO participant's quality metrics. Each office functions through a cloud- or office-based electronic health records (EHR) system. There are several different EHRs used across the ACO. The RGV ACO developed a population management system that identifies relevant metrics from each provider's EHR system, pulls them to a central point in the cloud, and provides data regarding monthly performance by providers. The ACO is in the process of switching to a commercially available platform. Care

coordinators and group leaders are asked to review their performance associated with quality measures at least monthly.

Continuous Improvement: What system is in place for performance improvement?

Data is collected through health IT software and analyzed to identify areas for improvement. Each practice is able to see how it compares against all other practices within the ACO. The availability of this data has led to changes. For example, to address failed treatment recommendations, practices extended appointment times in order to coordinate with care managers, diabetes educators, and others as needed to review and update the patient care plan and discuss ways to support patient adherence. In an effort to improve patient experience, the RGV ACO has sought feedback directly from patients since the ACO's establishment and altered practice elements accordingly. For example, many patients voiced concern about long wait times. Practices performed an initial assessment to ensure that critical cases were seen faster, which decreased wait times. In addition, practices ensured that waiting rooms more welcoming for those patients that did have to wait by providing beverages and a more welcoming front desk staff.

To improve upon the MSSP Quality Measures, the RGV ACO distributes the latest version of *"ACO Program Analysis Qualitative Performance, Standards Narrative Measure Specifications"* annually. In addition, the ACO conducts monthly Quality Assessment Process Improvement (QAPI) meetings reviewing the quality measures in detail. The ACO also educates team leaders on an ongoing basis about provider engagement and best practices of high performance organizations. Participating physicians and care coordinators are provided flash cards that contain an abstract of the quality measures. In addition, these professionals receive emails regarding evidence-based topics including patient engagement and activation as well as best practices to decrease 30 days readmissions. Also, high-performing providers share best practices and coach new participants to the ACO. Finally, the RGV ACO acts to increase providers' awareness regarding cost of care.

In addition, individual practices are strongly encouraged, and financially supported by the RGV ACO, to become Patient Centered Medical Homes (PCMHs). The RGV ACO believes that PCMHs are a key transformation tool to create an integrated structure that aligns with the ACO's goals. In addition, this structure provides a more effective way to track clinical data and improved outcomes. So far, three practices in the RGV ACO have become level-3 PCMHs and one practice has become a level-2 PCMH.

Payment and Incentives: How are financial and non-financial incentives used in the model?

In its first year, the Rio Grande Valley ACO spent approximately $1.2 million on operations related to infrastructure and development needed to establish itself as an ACO. The RGV ACO's centralized EHR solution and registry capacity is partially reflected in that figure. Total costs dedicated to the EHR amount to more than $500,000 and are still ongoing. The annual operating cost of the Diabetes Education Center is $120,000.

The RGV ACO program is expected to be financially sustainable as a result of MSSP. As a part of the MSSP, the RGV ACO is accountable for overall savings for its population while maintaining quality performance on 33 ACO quality measures. During the first year of the MSSP, ACOs were not assessed based on their performance on the 33 measures, but were instead required only to report data for all measures and all participating providers. As a smaller ACO, the RGV ACO is not eligible for the value-based modifiers based on quality metrics. However, the RGV ACO is hoping for these modifiers to be available to smaller organizations in the next few years.

Under the two-sided MSSP model, the RGV ACO bears financial risk if spending exceeds 2% of the assigned benchmark and only shares in the savings above the 2% benchmark if it meets certain thresholds in quality after the first year. Up to 60% of savings or losses are shared with Medicare. Expenditure benchmarks are calculated based on Medicare Part A and Part B FFS beneficiaries that would have been assigned to the ACO in the three preceding years, weighted at 60%, 30% and 10% for years 3, 2, and 1 respectively. The RGV ACO

believes that becoming a PCMH can lead to larger savings on the ACO program through supporting further initiatives such as 24/7 availability that decreases emergency department utilization.

The RGV ACO elected to participate in the Advance Payment program in MSSP, which allows the ACO to receive a portion of its anticipated shared savings in advance. Final shared savings are calculated and reconciled retrospectively. This program has allowed the RGV ACO to invest in its health IT and other redesign transformations at the outset. One quarter of the funds are used to assist the ACO as a whole with operational expenditures such as hiring additional key staff for case management. The remaining three quarters is allotted to participating practices to support PCP bonuses, hiring practice-specific staff, and increased provider earnings. Primary care professionals receive around 70% of the three quarters allotted to participating practices. In addition, these shared savings go to repay the advance shared savings payments.

Care Coordination and Transformation: What types of changes in practice are used to achieve care transformation?

Communication with patients, particularly those with missed appointment, poor disease control, or those that were at risk for complications, is all coordinated through on-site care coordinators. To alleviate some of the difficulty for patients and their caregivers, the providers with the RGV ACO offer same-day appointments to those in need as well as evening and weekend hours. The ACO also offers planned follow-up calls or home visits for patients rather than requiring in-office follow-up visits. In addition, all providers speak Spanish and many share cultural backgrounds with their patient population.

Each ACO participant office has specific access to claims-derived reports on its assigned beneficiaries. The internal care coordination team as well as the Board of Managers oversees the status of every participant office through the use of these reports. It is expected that the lead providers work with each care coordinator to focus on high-cost, high-risk patients. For the purposes of targeting care management, high cost patients are defined as the 10% who account for approximately 50% of spending. High cost patients receive more intensive care management support by a nurse practitioner, physician assistant, a vocational nurse, or a care coordinator. Some of these care managers are shared among practices. The care manager may conduct a home visit to monitor the patient's health and identify deteriorations early so as to avoid unnecessary hospitalizations. These home visits focus on patient self-care techniques and support behavioral changes. Additionally, care mangers provide patients with an opportunity to receive health advice from a trusted source rather than visiting the emergency department.

The RGV ACO uses a hybrid health IT model to help coordinate care. This model integrates information from each practice's federally implemented EHR and ACO related clinical information. In addition, a centralized data repository leverages capabilities related to beneficiary management, population registries, care coordination, and quality assurance as well as performance improvement, reporting, and tracking. The centralized data repository also tracks cost and utilization. To protect patient information, each practice undergoes yearly HIPAA training. The centralized data repository is fully isolated from internal and external users behind a multilevel unified thread management (UTM) security infrastructure. In addition, a third party secure messaging application is used for interoffice communications.

The RGV ACO Results

Quality results on six of the ACO quality measures pertaining to diabetes, as well as the all-or-nothing composite measure based on five of those measures, can be seen in Table 2. The RGV ACO showed improvement above the national average in 32 out of the 33 Quality Measures. In addition, the RGV ACO made significant improvement on a number of those measures from 2012 to 2013. Preliminary data for 2014 shows further improvement. Patients in comprehensive control of their disease (Diabetes Mellitus (DM) Composite) rose from 23% in 2012 (matching nation average) to 49.17 in 2014 and top performing practices in the group are currently reaching 70% in DM Composite. Nationally, practices reaching 37% DM Composite

are in the 90th percentile. In addition, the percent of beneficiaries whose HbA1c is in poor control (>9) has dropped to less than 5% in the top performing practices, while the national average is around 20%.

The RGV ACO also reduced the per capita costs of care for its Medicare beneficiaries by 14% through reducing hospital admissions, readmissions and implementing home health care.

The joint efforts of the RGV ACO's leaders have helped encourage behavior change in providers and staff, as well as in Medicare beneficiaries. The two-sided risk MSSP model acts to provide an added sense of urgency not only to benefit from the shared savings, but also to avoid incurring shared losses. This model gave providers and their staff a heightened sense of responsibility to execute innovative changes that benefit their patients and their offices to improve outcomes.

Table 2: The RGV ACO's Key Results of Diabetes Measures for years 2012 to 2014

Measure	Baseline	Year 1 of ACO 2012	Year 2 of ACO 2013	Year 3 of ACO 2014
ACO-22: Hemoglobin A1c Control (HbA1c) < 8%	70.34%	69.18%	74.96%	76.83%
ACO-23: Low Density Lipoprotein <100mg/dL	60.02%	65.92%	76.71%	75.83%
ACO-24: Blood pressure < 140/90	71.84%	71.58%	82.14%	84.33%
ACO-25: Tobacco Non-Use	61.09%	68.15%	93.52%	93.67%
ACO-26: Aspirin Use	47.44%	75.82%	97.64%	93.09%
Composite Measure of ACO 22-26 (Patients that passed all 5 components of composite measure)	**22.99%**	**23.29%**	**48.34%**	**49.17%**
ACO-27: Hemoglobin A1c Poor Control (HbA1c) >9%	19.68%	17.81%	14.19%	12.83%

PART 4: THE FUTURE ACCOUNTABLE CARE AT THE RGV ACO

The new strategies for diabetes care employed by the RGV ACO aim to help patients understand their disease and encourage maintenance of lifestyle changes through coordinated care across the network of ACO providers. Although the RGV ACO has had many successes improving care for this patient population, implementing their various diabetes initiatives was not without challenges. These challenges included:

- Information technology upgrade to integrate independent practices
- Cultural shifts for physicians to embrace accountable care
- Engaging Patients in their Treatment
- Support from and integration with local hospitals

Challenges and Policy Solutions

Challenge 1: Information Technology Upgrade to Integrate Independent Practices

Redesigning independent primary care practices to form an integrated ACO required a higher level of information technology competency. Although many practices within the RGV ACO had existing EHR systems, the use of a number of different EHRs that did not easily share data or compute comparable performance measures made aggregating data among these independent practices challenging.

To address the issue of aggregating EHR records, the RGV ACO leadership built their own system that collected data from each practice's EHR and formed a central repository. Analyses from this repository are available to practices with a lag of one to two months. The data can be accessed by a lead physician in the practice and care coordinators via a password protected website. The RGV ACO is now in the process of moving to a stronger, faster commercial population management platform. However, due to limited

resources, this type of practice redesign has occurred at a slower pace than leaders of the organization would like.

Challenge 2: Cultural Shift for Physicians to Embrace Accountable Care

The RGV ACO found that many physicians were wary of moving away from the status quo. Physicians have been practicing within the current payment and delivery system for a significant period of time and are well versed in how their practice fits within this structure. Therefore, many physicians were concerned about a different reimbursement model. To make matters more difficult, the financial support from the MSSP was not certain, and would not be provided until ten months after the year is completed. This delayed payoff to care improvement made provider buy-in even more difficult. In addition, providers were skeptical of the practice innovations with which they were expected to engage. Health education is a difficult endeavor with any patient. To help providers transitioning to this new model, ACO leaders have been spending more time coaching and engaging new providers. Now that a track record is accumulating, however, the RGV ACO is hoping that its growing history of success will help decrease future resistance to change. Clinical outcomes have shown important benefits to patients and data are reflecting improved care processes, and these impacts matter to the RGV providers.

Challenge 3: Engaging Patients in Their Treatment

There are a number of challenges in working with the patient population served by the RGV ACO, including high poverty rates, low literacy rates, low health literacy rates, unhealthy diets, and a high cultural tradition of using emergency departments for care management. Specifically, across the county, the average education level is sixth-grade, leading to patients requiring help in reading prescriptions and understanding the numbers before they can be advised on control strategies. In addition, since it is a single center in a centralized location, due to cost of transportation and geography, only approximately 17% of uncontrolled patients are able to utilize the Diabetes Education Center. Finally, many patients struggle with copayments for medications and so although a wider array of medications are now available, many patients must be given samples or stay on older, cheaper medications.

Challenge 4: Support from and Integration with Local Hospitals

Most alternative payment models aim to promote front-end care to keep patients out of hospitals and emergency departments; the RGV ACO is no different. Thus, in addition to general suspicion of new, unproven initiatives, hospitals also viewed the ACO as a threat their hospital bed occupancy. As such, the RGV ACO received pushback from local hospitals who were not pleased with the idea of an ACO in their county that may reduce their revenue by keeping patients out of the hospitals. However, with CMS' promotion of new payment models, local hospitals in the medical community are taking innovations more seriously.

Policy Implications

The RGV ACO credits much of its early success to strong leadership, physician engagement, and commitment to new approaches to diabetes and other care. These ACO leaders took the time to learn about the requirements and initiate the changes necessary to become an ACO. They meet frequently to execute initiatives assigned to their group. In addition, these leaders coach and engage other ACO participants and openly discuss performance. The RGV ACO believes that a high number of Medicare beneficiaries per physician groups allows for a more efficient utilization of resources. However, because practices see non-Medicare patients, the initiatives supported by the RGV ACO are having an impact on a greater share of the population than only those for whom the RGV ACO is accountable.

A key question is whether the historical high-cost history of the central Rio Grande Valley region enabled success in the MSSP. The RGV ACO's utilization data show that the high cost partially reflects the higher percentage of dual-eligible and end-stage renal disease patients. While there is some evidence that ACOs in

relatively high-cost areas are more likely to succeed, Medicare ACOs in both high and low cost areas have achieved shared savings.[9] Therefore, the RGV ACO believes that their success can be translated to other populations.

Next Steps

Next steps in the RGV ACO's Diabetes strategies include:

- Continue to review performance on diabetes care metrics and disseminate the most effective strategies throughout the organization. Specially, the DM checklist on each patient's encounter.
- Continue to build out the patient registry with additional data and more fully utilize it as a quality improvement tool. In addition, to integrate population management software able to deliver real time clinical data.
- Continue to financially support individual practices to obtain NCQA certification as PCMHs, to have a more uniform practice redesign throughout the organization.
- Purchase additional vans as needed to help patients get to appointments and overcome transportation/geographic barriers.
- Increase the number of certified diabetes educators in the organization and expand the diabetes education center "at your office" concept.

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