Disclosures

- I have NO financial relationships with any commercial interests, manufacturers, and/or proprietary entities
- In my role with the activity I have agreed to abide by the content validation statements in regards to this discussion
Part I: Integrative Diabetes Care in the Primary Care Setting Learning Objectives

- To understand how to effectively implement coordination of care in a primary care setting

- To use team based care to effectively implement quality patient centered care
Thank you for coming today to promote November’s diabetes awareness month campaign: This is Diabetes

This is how we reach our goals:

1. EDUCATION
2. AWARENESS
3. EMPOWERMENT
4. SUPPORT

1 in 11 Americans has diabetes today.

Every 23 seconds, someone in the U.S. is diagnosed with diabetes.

86 million Americans are at risk for diabetes.

Diabetes causes more deaths than AIDS and breast cancer combined.

#ThisIsDiabetes
Diabetes & Population Health at AHP

Arcadia Analytics Dashboard

- 41 Primary Care Practices
- 10 Distinct EMR Vendors
- 303 Physicians
- 431,735 Patients being measured
Case Presentation

Mr. W, 49 year old male with:

Problem List
- Astigmatism
- Refractive Error
- External Hemorrhoids
- Serum Enzyme Levels - ALT (SGPT) Elevated
- Schizophrenia
- Hyperlipidemia
- Benign Essential Hypertension
- Diabetes mellitus
- Morbid obesity
- Retinal dystrophy
- Rectal bleeding
- Internal hemorrhoids s/p hemorrhoidectomy 12/5/13
- Peripheral neuropathy
- Depressive disorder, not elsewhere classified
- Mass of left lower leg
- Daytime somnolence
- OSA (obstructive sleep apnea)
- Mycosis
- Open leg wound
- Encounter for counseling for care management of patient with chronic conditions and complex health needs using nurse-based model
- ERRONEOUS ENCOUNTER--DISREGARD
- Folliculitis right lower leg
- Venous stasis ulcers of both lower extremities
- Venous stasis

Medications

Outpatient Medications
- cholestyramine (QUESTRAN) 4 G packet
- hydrocortisone (PROCTOSOL HC) 2.5 % rectal cream
- insulin glargine (LANTS) 100 UNIT/ML injection vial
- insulin syringe-needle U-100 (MONOJECT ULTRA COMFORT SYRINGE) 29G X 1/2" 1 ml
- Empagliflozin 25 MG TABS
- valsartan (DIOVAN) 80 MG tablet
- metFORMIN (GLUCOPHAGE) 1000 MG tablet
- blood glucose (ONE TOUCH) test strip
- Liraglutide (VICTOZA) 18 MG/3ML injection
- pravastatin (PRAVACHOL) 40 MG tablet
- penicillin v potassium (VEETIDS) 500 MG tablet
- ARIPiprazole (ABILIFY) 15 MG tablet
- ONE TOUCH ULTRA BLUE test strip
- Elastic Bandages & Supports (MEDICAL COMPRESSION STOCKINGS) MISC
- insulin lispro (HUMALOG KWIKPEN) 100 UNIT/ML injection pen
- acetaminophen (TYLENOL) 500 mg tablet
- hydrocortisone 1 % cream
- insulin pen needle (BD ULTRA-FINE PEN NEEDLE MINI) 31G X 5 MM
- metoprolol (TOPROL-XL) 25 MG 24 hr tablet
- ibuprofen (ADVIL,MOTRIN) 600 MG tablet
- Jobst anti-embolism relief stocking extra-large 30-40 mmHg
- lidocaine (XYLOCAINE) 2 % jelly
- docusate sodium (DOCQLACE) 100 MG capsule
- CPAP machine
- polyethylene glycol (GLYCOLAX,MIRALAX) powder packet
- ONE TOUCH LANCETS MISC
HbA1c from 1/4/11-4/28/13
What would you do for this patient?

- Take 5 minutes to discuss with 1-2 people around you as to what you would do to try and help improve his care.
What did you come up with?

- Who is on your team?
What does it take to provide diabetic care at Primary Care offices?

- Need to do outreach to get diabetic patients into the office
- Once scheduled need to do pre-visit planning
- Need to huddle to discuss the sessions work with the team
- Need to check-in patients and give them documentation and verify demographics, etc.
- Need to room them and identify their current concerns
- Need to check vital signs and review gaps in care
Diabetic Care at Primary Care offices continued…

- **Set Agenda**
  - Is diabetes on their list of things to discuss?

- **Do medication reconciliation**
  - Check on adherence
  - Check on understanding of medication use
  - Check on side effects of treatment

- **Close gaps of clinical care**
  - Foot exams
  - Check on and order Immunizations
  - Repeat blood pressures if elevated when roomed
  - Review Blood sugar readings/journal
  - Point of care testing of HbA1c, random blood glucose level
  - Identify if other labs are needed
  - Check on eye exam/retinopathy screening
Diabetic Care at Primary Care offices continued yes there’s more!

- Make medical decisions on the next steps in their care
  - Are they controlled or uncontrolled?
  - Why are they uncontrolled?

- If uncontrolled what is needed to improve their control?
  - Dietary changes?
  - Medication adherence?
  - More education on the disease?
  - Education to family and friends to help with changes
  - Financial problems to getting all of the above done
  - To get the patient to “own” their disease
Diabetic Care at Primary Care offices continued and this is it, or is it?

- Make a care plan
- Identify self management goals
- Follow up
Lot’s to do!

How are you doing with coordinating diabetic care in primary care?
Your poll will show here

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or
Open poll in your web browser
Your poll will show here

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Why should we use teams to implement care in primary care settings?

- High functioning primary care teams are staffed with a variety of non-physician members who:
  - Have the time
  - Are trained to address the patient family’s needs
  - Can all share their perspective, skills, expertise around patient care issues for the ultimate benefit of the patient

- They allow each member the opportunity to work up to their level of training
How did we get here?

- Patient Centered Medical Home (PCMH) accreditation
- Improved access and communication
- Care coordination and integration
- Focus on quality and safety
What’s the point?

- Teams are the wave of the future in healthcare.
- Patients and families get better care when it’s coordinated.
- Each role (clinician, care manager, behavioral health therapist, pharmacist, social work) is an important piece of a primary care team, and each offers a unique and necessary skill set.
- Everyone is happier and healthier when they’re on teams that work well.
Your ideal Diabetes care “dream” team

- Patient
- Care Manager/Health Coach
- Pharmacist
- Certified Diabetes Educator
- Clinical Psychologist
- Registered Nurse
- Registered Dietician
- Clinician

* Slide created by Tziporah Rosenberg, Karen Mahler, and Nabila Ahmed-Sarwar
Highland Family Medicines - Diabetes Care Team

- Care Managers/Registered Nurse
- Medical Assistants
- Clinicians
- Suite Nurses
- Clinical Psychologist
- Social Worker
- Clinical Pharmacist/CDE

*Slide created by Tziporah Rosenberg, Karen Mahler, and Nabila Ahmed-Sarwar*
What does efficient coordination of diabetes care look like?

1. Dealing with emotional aspects of the disease, such as anger, fear, frustration, and depression (stay tuned for Part 4!)

2. Managing the disease (taking medications, following a diet, engaging in physical activity, self-monitoring, stay tuned for Part 2!)

3. Maintaining one's daily life while living with chronic illness (stay tuned for Part 3!)

What do we need to make our team efficient?

- Various forms of expertise in chronic disease management & treatment
- Skills to manage the condition and to maintain functioning (include problem solving skills)
- Motivation and buy in
- Confidence in one's ability to successfully execute specific tasks
- Adequate environmental support to initiate and sustain behavioral changes
- Effective management of feelings
CASE REPORT FOLLOW UP- Mr. W 5/1/, 6/5/2013–First step was to have him attend a Diabetic Group visit

Progress Notes
S: Pt. presents for diabetic group visit. The visit included an exercise lead by the behavioral health team and review of an educational or patient self-management topic led by MD residents and faculty on the topic of new discoveries in diabetes management. The patient then met individually with me while an interactive session with the remainder of the group was conducted by the behavioral health team.
3/10 and 3/24/14 – Pharmacist/CDE

- Helped with meds and copays
- Provided education and teaching on meds
- Dietary education

Assessment/Plan:

1. Cough/ACE-inhibitor induced: Improved, recommended patient discontinue benzonatate therapy and monitor to see if cough worsens once therapy is discontinued.
2. Hypertension: BP at goal < 140/80 per ADA guidelines. Tolerating beta-blocker therapy well, continue current therapy and monitor BP and HR at next visit.
3. Diabetes: Patient is not at goal A1c<7%, current therapy of max dose insulin secretagogue, max dose insulin sensitizer, high dose biguinide, and basal insulin appropriate. Basal insulin dose split twice daily may not be providing maximal effect, recommended patient inject 72 units in two separate injections (total= 144 units) every morning rather than split between AM and PM. Encouraged physical activity by adding in an additional 15 mins of movement/walking into evening. Dietary modification to reduce portion size encouraged. Barrier to compliance with lifestyle modifications likely secondary to readiness to learn and understanding of disease process.
Clinical Pharmacist/CDE

- Identify uncontrolled patients
  - Assess pharmacotherapy
- Formal and informal consults
- Provide disease state and medication education
- Monitor and adjust therapies
  - Customize to patients lifestyle
Care management and SW assistance

- Started in Summer 2014
- Help with work accommodations
- Call to work for food choicing
- Mother attending visits and watching him takes his meds
- Treatment for his LE ulcers and wound care
- Help with DriveOn for licensure renewal
Medical Assistants/Front End staff

- Keeping the ball rolling
- Data and quality coordination
- Inreach
- Outreach
Clinicians

- Engaged with behavioral health support
- Community engagement to other facilities
Take Away Points

- Primary care teams, especially patient-centered ones, are primed to include various clinicians.

- Clear expectations, roles, and agendas are critical.

- Being a good team member is finding the right balance.
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