CARE TRANSFORMATION COLLABORATIVE RHODE ISLAND

pcmh kids patient-centered medical home

ADVANCING INTEGRATED HEALTHCARE

Welcome
Improving Care of People with Diabetes Through Team-Based Care

Best Practices in Team-Based Care | September 20, 2022

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Care Transformation Collaborative of RI

CTC-RI Conflict of Interest Statement

Session presenters have no financial relationships with a commercial entity producing healthcare-related products used on or by patients.

If CME credits are offered, all relevant financial relationships of those on the session planning committee have been disclosed and, if necessary, mitigated.

Objectives & CME Credits

- Summarize the findings of the CTC quality improvement project to decrease diabetes related emergency department and inpatient utilization
- Explain how the quality improvement project identified opportunities for improving interprofessional collaboration in diabetes management
- Demonstrate patient care improvement for patients with diabetes through team-based care

Claim CME credit here: https://www.surveymonkey.com/r/Team-Based-Care-CME-evaluation

The AAFP has reviewed 'Advancing Comprehensive Primary Care Through Improving Care Delivery Design and Community Health,' and deemed it acceptable for AAFP credit. Term of approval is from 03/18/2022 to 03/18/2023. Physicians should claim only the credit commensurate with the extent of their participation in the activity. NPs and RNs can also receive credit through AAFP's partnership with the American Nurses Credentialing Center (ANCC) and the American Academy of Nurse Practitioners Certification Board (AANPCB).

TEAM-BASED DIABETES CARE

- Diana G. Mercurio, BSPharm, CDCES, CDOE, CVDOE
  RIPCPC/Integra
- Jessica M. Ryan, PharmD, BCACP
  Thundermist Health Center

OBJECTIVES

Summarize	Explain	Demonstrate
• Summarize the findings of the CTC quality improvement project to decrease diabetes related emergency department and inpatient utilization	• Explain how the quality improvement project identified opportunities for improving interprofessional collaboration in diabetes management	• Demonstrate patient care improvement for patients with diabetes through team-based care

RIPCPC/INTEGRA

RHODE ISLAND
PHYSICIANS CORPORATION
PRIMARY CARE

integra

RIPCPC/INTEGRA CTC QUALITY IMPROVEMENT PROJECT GOALS

1

Implement a workflow to prevent unnecessary utilization of ED/IP services for diabetes-related acute complications

2

Establish consistent messaging by all of the care team members and use standardized, updated patient education materials

3

Reduce unnecessary utilization of ED/IP diabetes-related problems

SUMMARY OF FINDINGS

The most prevalent cause of preventable ED/IP use was related to medication choice/dose in our population

22 preventable ED/IP hypoglycemia utilizations were identified:

- 14 were related to oral sulfonylurea use in older adults with A1c <7%
- 8 were attributed to insulin dose or type

RISK STRATIFICATION

Patients were identified who were overdue for in-person primary care visit and/or overdue for labs

Patients identified who have A1c above goal are stratified to NCM or pharmacist team

Developed a report with analytics/EMR team to proactively identify vulnerable patients (Defined this as patient >64 years old who have a sulfonylurea on current medication list)

IMPLEMENTATION

Created new position: Clinical Program Development and Operations Manager

Developing evidence-based clinical pathways in collaboration with Medical Management, Pharmacy and Quality Committee as well as the Medical, Nursing and Pharmacy Directors

Established more clearly defined roles for the care team (nursing, pharmacy, behavioral health)

Care management redesign

Developing disease state management competencies

Establishing library of patient education materials to establish consistent messaging with validated information

Performing routine chart audits

ADDRESSING THE OLDER ADULT WITH PATIENT SPECIFIC GOALS

Target Blood Sugar Levels in Older Adults Over 65

Health Status	A1C	Fasting Blood Sugar	Bedtime Blood Sugar
No or few chronic conditions, cognitively functional	7.5% or less	90-130 mg/dL	90-150 mg/dL
Multiple chronic conditions, mild to moderate cognitive impairment	8% or less	90-150 mg/dL	100-180 mg/dL
Living in a long-term care facility, end-stage chronic illness, moderate to severe cognitive impairment	8% to 9%	100-180 mg/dL	110-200 mg/dL

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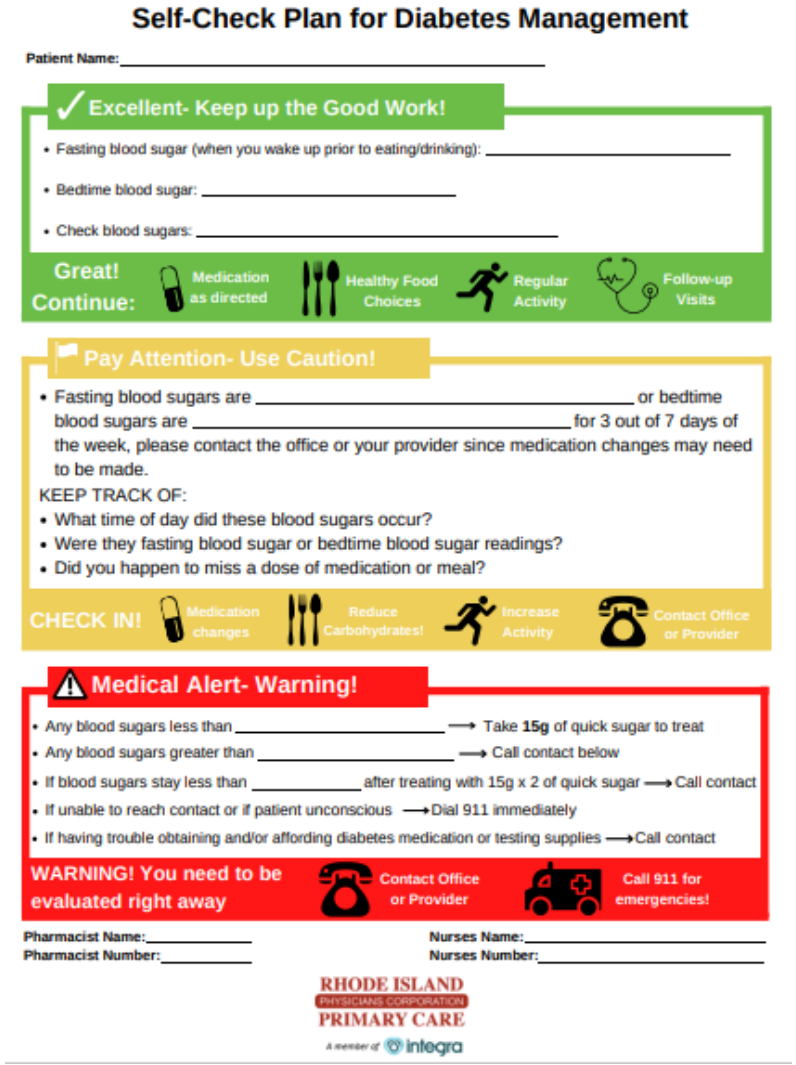

Self-Check Plan for Diabetes Management

Patient Name: _____

✓ Excellent- Keep up the Good Work!

- Fasting blood sugar (when you wake up prior to eating/drinking): _____
- Bedtime blood sugar: _____
- Check blood sugars: _____

Great! Continue: Medication as directed; Healthy Food Choices; Regular Activity; Follow-up Visits

Pay Attention- Use Caution!

- Fasting blood sugars are _____ or bedtime blood sugars are _____ for 3 out of 7 days of the week, please contact the office or your provider since medication changes may need to be made.

KEEP TRACK OF:

- What time of day did these blood sugars occur?
- Were they fasting blood sugar or bedtime blood sugar readings?
- Did you happen to miss a dose of medication or meal?

CHECK IN! Medication changes; Reduce Carbohydrates!; Increase Activity; Contact Office or Provider

⚠ Medical Alert- Warning!

- Any blood sugars less than _____ → Take **15g** of quick sugar to treat
- Any blood sugars greater than _____ → Call contact below
- If blood sugars stay less than _____ after treating with 15g x 2 of quick sugar → Call contact
- If unable to reach contact or if patient unconscious → Dial 911 immediately
- If having trouble obtaining and/or affording diabetes medication or testing supplies → Call contact

WARNING! You need to be evaluated right away — Contact Office or Provider; Call 911 for emergencies!

Pharmacist Name: _____ Nurses Name: _____
Pharmacist Number: _____ Nurses Number: _____

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CASE STUDY: RPH/NCM COLLABORATION

DAWN LANDRY, BSN, NCM

- Background: KV is a 76-year-old cis-female with PMH of type 2 DM with hyperglycemia, hypothyroidism, benign essential HTN, mixed hyperlipidemia, malignant neoplasm of left breast, Arias-Stella phenomenon, urge incontinence, and colon polyps
- 7/20/22: pharmacist appointment for medication management of diabetes. Dose of semaglutide (Ozempic) adjusted and personal Freestyle Libre CGM system reviewed with sensor placement; patient able to return demonstration
- 7/21/22: patient contacts pharmacist with problems with sensor at home. RPh not able to meet with patient, confirms NCM will be in practice and co-ordinates with patient and NCM for in-person meeting
- NCM meets with patient; addresses sensor issue; continues CGM teaching and completes a care plan

CASE STUDY: RPH/NCM COLLABORATION CONT.

8/3/22: NCM appointment: patient able to change sensor with only minimal verbal cues from NCM; nutritional education provided

Ongoing: RPh and NCM working collaboratively for CGM data review. NCM focus on lifestyle management of diabetes (nutrition/ activity) with referral back to RPh to review need for medication changes

CASE STUDY (NCM/BH TEAM/RPH COLLABORATION)

LARRY LUCENA,MS BH CLINICIAN
NICOLE NADICH, BSW BH TEAM SUPERVISOR

- Background; JJ is a 60-year-old cis-male patient. PMH includes Type 2 DM, OSA, acute ischemic stroke, essential hypertension, Peronei disease, mood disorder, testosterone deficiency, and hyperlipidemia.
- NCM and Pharmacist involved in ongoing care of patient managing his medical issues
- 3/29/22: patient not taking any of his medications and has been generally non-adherent for the last several years. Current A1c elevated at 11.1%
- 4/14/22: Pharmacist note states patient has SDOH needs and would benefit from engagement with behavioral health clinician, social work and nurse care manager.

  Patient stated to pharmacist that he “would like a socially acceptable way to die” . Pharmacist verified that he did not have a plan in place to harm himself but did make sure BH clinician was aware.

CASE STUDY: BH/NCM.RPH COLLABORATION CONT.

- 4/15/22: BH team becomes very involved with patient care
- BSW helping patient with guidance for where he can get legal help and other SDOH needs
- BH Clinician immediately begins to establish relationship with patient
- 7/28/22: Patient's progress compounded by PCP, Dr. P, retirement and BH clinician assisted with transfer to new PCP, Dr. G
- BH Clinician continues to meet with patient weekly
- NCM from Dr. P's office coordinated ongoing NCM care with NCM at Dr. G's office
- Patient was able to establish care with neurologist at NeuroHealth in Warwick
- BH team currently in process of referring pt to more intensive outpatient mental health program to further address psychiatric and SDOH needs

Thundermist!

HEALTH CENTER

THUNDERMIST DIABETES TEAM-BASED CARE

Nurse	• A1c < 9% • Diabetes education
Nurse Care Manager	• A1c > 9% • Diabetes education
Clinical Pharmacist	• No A1c cut-off • Medication management and diabetes education • Referred by provider, RN, or NCM. If RN/NCM referred, provider authorizes referral

THUNDERMIST CTC QUALITY IMPROVEMENT PROJECT: PLAN AND OUTCOME

Problem	Aim	Goal	Outcome
• Per 2019 APCD data, Thundermist had a 7.5% rate for ED visits and 2.4% rate for hospitalizations compared to RI APCD of 3.6% and 1.4%, respectively • 69% (699/1013) of patients had an A1c < 9% as of 4/2021	• **Primary Aim:** Decrease ED visits and hospitalizations due to short-term and long-term diabetes complications by 25% using team-based care by 4/2022 • **Secondary Aim:** Achieve A1c < 9% for 73% of patients using team-based care by 7/2022	• To optimize pharmacy services and team-based care for patients with diabetes and a history of ED visits or hospitalizations for short-term and long-term complications	• 3/2019 to 9/2021: 102 ED visits/ hospitalizations (63 unique patients) • 9/2021 to 4/2022: 54 ED visits/ hospitalizations (37 unique patients) • As of 4/30/2022, 75% (840/1,119) of patients had an A1c < 9%

THUNDERMIST CTC QUALITY IMPROVEMENT PROJECT: METHOD

Patient Engagement

- Patient identified by medical assistant (MA), nurse (RN) or nurse care manager (NCM) for ED visit or hospitalization for diabetes-related complication
- MA/RN/NCM automatically refers patient to PharmD for appointment
- PharmD books appointment. If patient declines or is unable to be reached, complete chart review instead

Pharmacist Interventions

- Review ED visit or hospitalization with patient to identify potential cause(s) and/or barrier(s)
- Recommend guideline directed therapy
- Recommend hypoglycemia treatment and continuous glucose monitor, if appropriate
- Educate on when to seek emergency care
- Update Problem List to reflect ED visit or hospitalization diabetes diagnosis

Outcomes

- Communicate recommendation(s) with provider
- Determine if 1 time referral or continue co-management
- Outreach to support staff for barriers identified (Social Services, Community Health Team, NCM, Behavioral Health)

THUNDERMIST CTC QUALITY IMPROVEMENT PROJECT: RISK STRATIFICATION

Risk Group	Plan	Outcome
Housing Insecurity	Screening questions added to housing support specialists' appointments to identify patients with barriers to medication storage and/or access. Patients that screen positive will be referred to PharmD for review. Identify homeless shelters that have medication storage	**2** PharmD referrals with resolution of medication storage concerns Results pending reply from shelters
Group/sober home, rehab facility and day program participants	Discuss hyper/hypoglycemia policies with program staff. If program agrees, PCP will provide an order to amend the program's policy. Amendment will instruct the program to contact TCHC for triage prior to sending patient to ED.	**1** standing order for a Group Home **1** standing order for a Rehab Facility **3** individual orders at Day Programs **ED visits since implementation of orders: 0**
Co-existing substance use (SUD) or behavioral health (BH) disorders	If SUD/BH is the predominant problem/priority for patient, try to engage patient with behavioral health and/or discuss treatment, if appropriate	**17** patients: increased awareness to primary care and behavioral health providers

CASES #1

GROUP HOME POLICY AMENDMENT

- 53 yo male with DM2, HTN and schizophrenia residing at a group home
  - 3 ED visits in 2 weeks due to group home policy to send patient to the ED if BG > 350
  - Baseline A1c 8.1%
- Auto-PharmD referral identified ED utilization cause. Case discussed with RN at group home who agreed to a PCP order to amend their hyperglycemia policy
- Outcomes:
  - Zero ED visit since order implemented
  - RN at group home called when BG was > 350 and sent BG logs when appropriate which allowed for more frequent medication adjustment
  - A1c now controlled at 5.6%

CASES #2

HOUSING SUPPORT SPECIALIST MEDICATION ACCESS/STORAGE SCREENING

- 43 yo male with DM2, GAD, MDD, and HTN. Pt is homeless, living in a car
  - Hospitalized for DKA as a result of undiagnosed DM, was not actively engaged in primary care
  - Baseline A1c 12.2%, discharged on metformin and Lantus
- Auto-PharmD referral for DM post-hospital and referral from housing support specialist
- Outcomes:
  - Pt was unable to afford gas to get to the pharmacy resulting in medication non-adherence. Switched to medpacking delivery pharmacy to a family member's home. Remains adherent to treatment.
  - Pt unable to properly store insulin. Transitioned to oral medications only. A1c now controlled at 5.2%
  - Telemedicine improved engagement in care
  - Continues to work with HSS

THUNDERMIST CTC QUALITY IMPROVEMENT PROJECT: IMPLEMENTATION

- Implement automatic PharmD referrals after ED visit/hospitalization for diabetes into workflow
  - Added to MA, RN, NCM workflow
- NCMs and PharmD to continue updating Problem Lists to reflect diabetes diagnosis from hospitalization
- Providers to proactively amend group home policies for hyper/hypoglycemia to avoid initial ED utilization
- Providers to prescribe hypoglycemia treatment and continuous glucose monitors when appropriate
  - RNs trained for continuous glucose monitor visits
- Extend referrals for medication access/storage barriers to all sites regardless of diabetes status
  - Added to housing support specialist workflow

THUNDERMIST ENHANCED CARE MEETING

- Weekly meeting
- Team: nurse care managers, social services, community health team, housing support specialists, community based behavioral health clinicians, behavioral health case managers, home-based nurse practitioner, clinical pharmacist
- Discuss high risk, complex patient cases
  - Socioeconomic
  - Housing, transportation
  - High utilizers of ED
  - Adherence concerns

THUNDERMIST'S NEW INITIATIVE: STANDARDIZED NURSE TRAINING

Clinical Education Department

- Clinical Nurse Educator: Maryland Tarara, BSN, RN, CDOE

Goal

- Initial and ongoing diabetes training for all nurses
- Teaching material
  - Educational material for nurses
  - Standardized educational material for patients

QUESTIONS/OPEN DISCUSSION

Evaluation & CME Credits

Please complete a session evaluation! Claim CME credit here:

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Topics to look forward to in 2022

October 18: *Improving Care of People with Hypertension Through Team-Based Care*

November 15: *Best Practices in Lead Screening*

December 20: *Urinary Incontinence*

Mark your calendars **3rd Tuesday of the month at 8AM**


thank you
danke
謝謝
ngiyabonga
teşekkür ederim
gracias
merci
obrigado
dziękuję
bedankt
спасибо
Баярлалаа
рахмат
go raibh maith agat
mochchakkeram
sukriya
kop khun krap
terima kasih
grazie
arigatô
dakujem
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