Team Approach to Diabetes Management

Melanie Batchelor
Margot Blekfeld-Sztraky
Janice Lazear
ADA and AADE

• Diabetes is complex
• Team management endorsed as the ideal model for the delivery of care for people with diabetes
• The core membership should reflect the basic requirements of diabetes treatment: nutrition, medication, self-monitoring, and self-management.
Members of the Interdisciplinary Team

Team Members
- Educators
- Nurses
- Dieticians
- Providers
- Pharmacists
- Behavioral health specialists
- Case Managers
- School Nurses
- Dentists and hygienists

Team Members
- Podiatrists
- Exercise Physiologists
- Ophthalmologists
- Specialists
  - Maternal-child care
  - Gerontology
- Community Health Workers
The Diabetes Care Team

- Comprehensive diabetes care program
- Based on standards of care
- Evidence-Based
- Outcome focused
Redesigning the Health Care Team

Diabetes Prevention and Lifelong Management
Elements of the Interdisciplinary Team

- Shared leadership with common goals
- Shared professional identity
- Collaborative, rather than consultative relationships among members
- Shared leadership
  - Mutual problem-solving
  - Open communication
  - Team cohesiveness
Requirement for an Effective Team

- The commitment and support of organization leadership
- The active participation of the patient and health care professional team members
- Ways to identify the patient population via an information tracking system
- Adequate resources
- Payment mechanisms for team care services
- A coordinated communication system
- Documentation and evaluation of outcomes and adjustment of services as necessary

National Diabetes Education Program http://www.ndep.nih.gov/media/NDEP37_RedesignTeamCare_4c_508.pdf
Advantages of a Team Approach

• Reduces risk factors for T2DM
• Improves diabetes management
• Lowers the risk for chronic complications
Delivery Care Models

Chronic Care Model

- The health system-culture, organizations, and mechanisms to promote safe, high-quality care
- Delivery system design for clinical care and self-management support, including team care
- Decision support-based on evidence and patients’ preferences
- Clinical information systems to organize patient and population data
- Self-management support to enable patients to manage their health and health care
- Community involvement to mobilize patient resources
The Medical Home Model

- Team approach with the patient at the center
- Prevention
- Health information technology,
- Coordination of care
- Shared decision making among patients and their health care team
The Healthy Learner Model

- Extends the Chronic Care Model to include school nurses
- The goal is to maintain student health in the school setting
- Leadership involving communities and school districts
Successful Teams

- Patient/family central team member
- Healthcare professionals
  - Complementary skills
  - Common goal and approach
  - Composition of teams may vary
Nontraditional approaches used by teams

Increases Access to Care

- Telehealth
- Group Education
- Shared Medical Appointments
Team Care Accomplishments

Team care improvement was found to improve one or more of the following:

- Glycemic, lipid, and blood pressure control
- Patient follow-up
- Patient satisfaction
- Risk for diabetes complications
- Quality of life
Six Team Building Steps

Ensure the commitment of leadership
- Meet with primary care providers
- Administrators
- Payment specialists
- Include key stakeholders in planning
Identify Team Members

- Invite potential team members to commit to being a member of the team
- Clarify roles
- Ensure mutual respect
- Establish a common vision
Identify the Patient Population

- Demographics
- Diabetes types
- Complications
- Health care utilization patterns
Assess Resources

- Space
- Equipment
- Supplies
- Support staff
- Education materials,
- Support groups
- Follow-up services
- Community resources
- Funding/payment mechanisms
- Home care services
Assemble Tools

- standards of care
- Treatment guidelines
- protocols
- Algorithms
- education materials
- flowcharts
- Standing orders
- Chart stickers, and other recording and reminder systems
Develop a System for Coordinated, Continuous High-quality Care

• Define the team:
  • Philosophy
  • Goals
  • Objectives

• Information system
  • Identification
  • Data collection
  • Ongoing assessment
  • Monitoring performance measures
    • A1C, blood pressure, lipids
    • Patient satisfaction
    • Quality-of-life indicators
Determine the Structure and Scope of Services

Screening
Preventative services
Medical care
DSME
Counseling services
Case management
Community Outreach
Evaluate Outcomes and Adjust as Necessary

- Databases - evaluate the outcomes of team care
  - Audit findings
  - Utilization data
  - length-of-stay
  - Emergency room visits
  - Total dollars spent can help evaluate outcomes of team
  - Quality measures
  - Patient satisfaction
Maintaining a Successful Team

- Promote patient satisfaction, quality of life, and self-management
- Promote a community support network
- Maintain team coordination and communication
- Provide follow-up
- Use health information technology
Questions?