Diabetes Care Path Example

BHC Workshop, Jefferson City
March 13th 2013
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Care Path Population

• Adult Patients with Diabetes diagnosis treated by Primary Care team.
PCP role

- Conducts exam
- Reviews/adjusts medications
- Evaluates patient’s knowledge of disease.
- Insulin education and teach back
- PCP discusses medical treatments and interventions in regards to DM, Heart Disease, Kidney Disease, etc. with patients and charts recommendations in record.
- Refer to Behavioral Health Consultant
Medical Assistant role

- Completes tasks as assigned by PCP.
- Gives patient glucose meter (if needed)
- Reviews medication/insulin/BS checking instructions given by PCP
- Advises PCP or BHC of any specific question patient has regarding diabetes or self-management
- MA notifies BHC of patient availability.
- Monitoring samples & supplies
BHC role

• Explanation of Care Path for persons with Diabetes
• Assess emotional and behavioral impacts to self-management; e.g. adjustment to diagnosis, adherence issues, depression
• Provide behavioral health interventions
• Set achievable goals to improve adherence to treatment plan
BHC role

• Inform patient of US Diabetes Conversation Map sessions as available
• Uniform Goal sheet for Diabetic patients regarding self care
• Inquire about other services received at CMHC
• BHC contacts other CMHC provider (if applicable) to inform them of patient’s participation of Care Path & current goal towards disease management.
BHC role

- Review goals and objectives
- Discuss barriers and successes
- Further patient education regarding disease if needed
- Discuss progress and changes to patient’s goals with PCP and CMHC provider when applicable
Patient Care Specialist Role

• Completes tasks and referrals as assigned by PCP.
Structure

• Automatic referral to BHC for patients with a previous or new Diabetes diagnosis.

  ✓ MA will notify BHC of patients with A1C > 7 if finger stick obtained during office visit.

  ✓ BHC will obtain a report on A1Cs obtained from IT on a quarterly basis. This report will be used to help determine which Track patients would qualify for.
Target Goals

- Has DM focused visit every 3-6 months
- BP goal of $<130/80$, TRIG $<150$, HDL $>40$ (men) $>50$ (women), LDL $<100$
- Advise to quit tobacco at every visit/offer to help patient with quit plan when ready
- Receives annual eye exam
- Receives dental exam every 6 months
Target Goals

• Annual foot exam & reports knowledge of daily self foot exams
• Maintain A1C of <7
• 20-30 minutes of physical activity 5 days/week
• Psychosocial Health does not impact daily functioning or Diabetes self-management
• Social system does not result in significant barriers in patient’s ability to adhere to health plan
Possible tracks within Care Path

- Tracks determine frequency of Primary Care Team contact
  - Track 1 – A1C <7*
  - Track 2 - A1C >7*
Frequency

Track 1

Office Visits

- Every 3-6 months
  - PCP conducts exam and orders appropriate tests/lab work
  - BHC will meet with patient to discuss progress/concerns regarding DM management

Phone consult with BHC

- One month after clinic visit
  - Review progress towards goals to address barriers and successes
Frequency

Track 2

Office Visits

• MONTHLY

✓ PCP conducts exam and orders appropriate tests/lab work
✓ BHC will meet with patient to discuss progress/concerns regarding DM management

Phone consult with BHC

• 2 Weeks after visits

✓ Review progress towards goals to address barriers and successes
Tools/Ideas to Integrate into Care Path

- 10 minute educational/topical videos for patients to view at clinic
- Group visits for Diabetic patients (scheduled as group, PCP involvement)
- Discuss protected email account for Primary Care Team for patients to send Glucose results & other self-monitoring information
- Addition to website re: DM management & materials
- Pedometers
- Available openings for dental services
- One day a month offer onsite visit with Dietician
- Quarterly onsite visit with Podiatrist