# Diabetes Care Path Example

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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