Team Effort

Supporting Diabetes Care with a Team-Based Approach

2020-2022 Cardiovascular Disease & Diabetes Network Leadership Team

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Introduction

Diabetes is a major health concern in the United States. Many American adults currently live with diabetes or are at risk for getting it. Diabetes significantly adds to the level of difficulty with effective care, complications related to medication management, nutrition, exercise, oral and skin care among other issues.

Interdisciplinary teamwork is an important model for delivering appropriate and effective health care to individuals with diabetes. Working as a cohesive team in healthcare enables the practice of collaboration and effective communication to expand beyond the traditional roles within each discipline, allowing decisions to be made towards a common goal.

Teamwork is an important intervention for a few reasons:

- clinical care is becoming more advanced and specialized, which allows staff to provide additional services as well as learn new methods
- working together helps to increase patient safety by reducing number of errors
- when teamwork is centered on solid communication, patients and their families feel more satisfied with their healthcare and truly feel taken care of

Between 2020 – 2022, the Cardiovascular Disease & Diabetes Network Leadership Team collaborated to interview seven professionals and one patient to collect information in an effort to share that information with those that are looking to understand more about the various roles in the health care system and how they are all a part of the diabetes management team.

Interviews with a wide variety of health care providers and a patient follow.

Health Educators

Shannon Roussy, Sea Mar Community Health Centers

Can you describe your training and educational background?

BS in Healthcare admin, BA in Spanish, Master's in Public Health with certificates in Epidemiology and Health Education Promotion

Who do you see as your team?

Everyone at the clinic, including the Providers, Medical Assistants and Care Coordinators, Registered Dieticians, Phlebotomists, and front desk staff.

How do you interact with the members of your team, and what are the roles and communication lines?

Shannon sees herself as an in-person type communicator. She spends the start of each day in a 30-minute morning huddle where the team goes through all patients for the day, triaging each on their needs and wants.

As part of the triaging, decisions are made on prioritizing who the patient needs to see most, so they are not seeing 3 different providers in the same appointment.

As you consider best practices, what do you see as promising practices in your team as you work with individuals with diabetes to improve outcomes?

Shannon considers offering services every time patients come in as well as offering health education at every chance to be best practices. She expresses that even if patients don't take the opportunity at the time, she notes “you just never know if it might be the day, they're ready.”

In improving outcomes for new diagnoses, providers should be strongly encouraging patients to speak to a health educator and ancillary providers early on.

How are you billing/documenting the work that’s being accomplished?

Shannon’s team uses EPIC (an electronic medical record system), and they have specific templates that they use for different diagnoses. Each diagnosis has a series of questions to ask to provide standard care. This information is contained in the electronic health record. A Social Determinants of Health (SDOH) screening shows up in a “snapshot” page in EPIC with problems list, health info, etc.

Where do you see the future of diabetes going in your field including any upcoming changes?

Shannon discussed the importance of always encouraging a more holistic approach. The population of patients seen at Sea Mar have lower income and literacy levels than the general population. Shannon teaches patients how to cook vegetables and tries to ask questions around how the patients budget/grocery shop. She is one of 22 health educators, and each site provides programs according to the needs of their patients. She works in Grays Harbor at the Aberdeen Clinic, and once a week in the Elma Clinic.
Community resources are essential. One example is Food Lifeline in which patients are given a grocery bag of food, provided cooking tips and education about what's in the bag. Health educators really try to incorporate social determinants of health and try to ask questions about what supports the patient has/refer to resources as appropriate. We also discussed a Food Insecurity Nutrition Incentive (FINI) grant where patients get access to $10 vouchers (Department of Health and Safeway collaborate) and patients can get 4-6 vouchers/month for fresh fruits and vegetables depending on the size of their families.

How is your organization measuring patient activation (engagement/measurement) in terms of readiness for change?

Health educators place a great deal of emphasis and training on motivational interviewing to see where patients are at with engagement, and how often follow up should occur.

How do you close the loop or refer to a Diabetes Prevention Program?

The Aberdeen Sea Mar Clinic doesn't have a specific Diabetes Prevention Program (DPP) as the County in Grays Harbor offers this, and duplication of services is avoided. However, referrals are done internally. Televisions in the lobby display information, and there are flyers in the waiting rooms and clinic rooms. As health educators, tracking and follow up occurs with a significant number of patients that don't finish DPP programs. We also have a REACH Diabetes program (Racial Ethnic Approach to Community Health).

Dieticians

Danae Shelley, Sea Mar Community Health Centers

Can you describe your training and educational background?

Danae went to a 4-year accredited college and majored in dietetics. She was accepted into an internship program through Louisiana Tech University. Now that she is a dietician, she completes at least 75 hours of continuing education credits every five years to stay current in her field.

What is a Registered Dietician?

A Registered Dietician (RD) is a food and nutrition expert who helps translate the science of nutrition into practical solutions for healthy living. RD's use their nutrition expertise to help individual make unique, positive lifestyle challenges. They also act as an advocate for advancing the nutritional status of Americans and peoples around the world.

We spoke with Danae, a Registered Dietician at a Sea Mar Community Health Centers, a healthcare system in Western Washington focusing on the Latino and low-income population. As a dietician in the primary care/community nutrition realm, Danae works with a variety of other disciplines, which make up the diabetes team.

Diabetes Care Team in the Outpatient Medical Setting

It starts with the Health Care Provider (HCP), who makes the initial referral to the Registered Dietician (RD) when they identify a need in a person who has a diagnosis of diabetes.

Another member of the care team would be the Care Coordinator, who interacts with the patients with chronic illnesses during their medical visit and tries to connect them with services and resources that would help them, such as diabetic shoes, prescription assistance programs and meeting with the RD.

One of the final team members is the Health Educator (HE). The HE is typically a person that meets with patients and provides education and health promotion programming to decrease barriers and improve health. Their focus, like the RD, is chronic disease prevention and management. The HE can conduct education on certain conditions in case the DE is out of the clinic or occupied. They also do community outreach, and lead group education, for those patients who would benefit from this.

Danae and the members of her team often use a warm handoff during the visit to introduce the patient to the RD. Typically, she can interact face to face. She shares an office with the Care Coordinator, Health Educator, so they can collaborate easily.

Communication among the Diabetes Care Team

Having the medical team all in the same building really helps with communication and patient coordination. If a patient is in the clinic for a medical appointment and has an immediate need, such as a new diagnosis of diabetes or new prescription of insulin, the HCP or their medical assistant can connect with the RD right away to do a warm handoff, preventing the patient from leaving the clinic without the education they will need.

If Danae is not within the clinic, the main way other team members can get a hold of her is through messages via the EPIC EMR (Electronic Medical Record) system. The medical clinic also has an instant message service, Skype for Business, which allows staff to communicate instantly with each other, whether they are in the same clinic or different clinics.

In regard to how the systems' network of dietitians communicates regarding new standards of practice and additional updates, they participate in monthly conference calls as well as bi-annual in-person trainings. They also communicate via email, sending out questions, resources, and requests for advice on various patient situations.

Promising Practices to Improve Outcomes in Patients with Diabetes

1. *Interdisciplinary Teamwork*

Having increased communication among team members is certainly a practice that will help improve the outcomes of patients with diabetes. When everyone on the team is working toward the same goal, patients feel like they are heard, which will lead to them taking ownership of their own health. It is important for all members of the medical team to understand their role in the team and identify in what ways they are similar yet know what sets them apart and how their specific role is unique and important to the patient's health.

Within the healthcare system that Danae works at, she can connect patients who are at risk for developing diabetes to the DPP. The programs are at various sites and offer services in English and Spanish, to meet the needs of the patients. If Danae interacts with a patient that would benefit or is interested in the DPP, she is able to make a referral to the Health Educator or contact the Health Educator directly to have them reach out. Interdisciplinary communication is key.

2. *Appropriate Billing and Coding when it comes to Documentation*

Most insurances only cover medical nutrition therapy for diabetes, obesity, and chronic kidney disease stages 1-4, however more insurance companies are starting to accept other diagnosis for reimbursement, such as pre-diabetes and hypertension. The billing department submits charges and works with the RDs in regard to any denials. For outpatient counseling, the nutrition referral is a central element. For a claim to be submitted successfully, the reason for referral needs to be related to nutrition. We also need to make sure we have an up-to-date referral. If the referral is greater than one year old or the RD will be seeing a patient for a new diagnosis, a new referral needs to be placed.

To help with reimbursement, the diagnosis associated with the billing code needs to match up with the nutrition referral diagnosis. If the RD has a referral for diabetes but they include hypertension with the encounter, there is risk for denial.

At the clinic where Danae is employed with, the RDs use the ADIME method of charting – which stands for Assessment, Diagnosis, Intervention and Monitoring and Evaluation. This sets up a great framework for the RD to conduct their nutrition-focused assessment, determine their nutrition diagnosis as well as document what they educated the patient on, and what are the goals established for the next appointment.

3. *Consistent Goal Setting and Self-Management Centered Around the Patient*

When a patient is seeing a variety of providers including RD's, HCP's, and Mental Health Counselors, it is easy for each discipline to set their own goals and expect the patient to meet them. This can lead to the patient having several goals and habits they are trying to work on which may be overwhelming.

During the patient's appointment, the RD uses motivational interviewing techniques to help the patient develop their own self-management goals. Danae says that, when possible, they try to keep the goals consistent among multiple providers, in order to minimize the number of goals the patient has to work on.

At follow-up appointments for patients with diabetes, the RD will check on their progress toward their goals and address any barriers that the patient may have encountered. If patients are actively checking their blood sugars, the RD will assess the blood sugar logs and discuss any changes that may need to occur.

4. *Increased use of Continuous Glucose Monitors (CGMs) and Insulin Pumps*

Danae believes that in regard to promising practices, she would like to see an increased use of insulin pumps and Continuous Glucose Monitors (CGM's). Insulin pumps were originally used primarily for patients with Type 1 Diabetes, however there are pumps on the market that are specifically designed for patients with Type 2 Diabetes. More state insurances are starting to cover some of the costs of insulin pumps and CGMs. Prescriptions for CGMs and Pumps are submitted to the CGM/Pump Company directly, a pharmacy or a Durable Medical Equipment company.

Despite current requirements that are needed for patients to receive a CGM or an insulin pump, Danae believes this equipment is becoming easily accessible. By having a CGM, patients can get a real-time idea what their blood sugar is and where it will be I the next 30-60 minutes. Many CGMs are connected with a software that allow the medical provider, Registered Dietician, Diabetes Educator or other family members to be able to see blood sugar trends and what is happening during the day and even at night to help better tailor their diet and medication regimen.

The insulin pump allows for continuous basal insulin as well as allows customizable boluses and correction doses based on the meal being eaten and what the patient's blood sugar was.

Conclusion

The Registered Dietician is an integral part of the diabetes health care team. Nutrition and diet are integral in controlling blood sugar and connecting a patient with a Registered Dietician will help improve outcomes.

Clinical Pharmacists

Amanda Johnson, Providence Medical Group

Can you describe your training and educational background?

Amanda completed her undergrad studies at Washington State University and attended the University of Washington for pharmacy school with a focus on geriatrics. She then completed her Residency at Providence St. Mary Medical Center with a focus in hospital based ambulatory care. Amanda is currently employed as a Population Health PharmD (Doctor of Pharmacy).

Who do you see as your team?

Within the Inpatient Pharmacy Team, Amanda has the advantage of working under a dotted line with the Pharmacy Director, who started their ambulatory care services. She also works closely with the Transition of Care (TOC) and Medication Reconciliation Team in the hospital. They identify patients who she may be able to impact after discharge and vice versa.

Amanda also collaborates hand in hand with Providence's Population Health Team, which is multidisciplinary in nature, and provides numerous opportunities to collaborate on projects and patients. This allows for being able to hear different perspectives from all the team players, but she appreciates being able to be able to go back to her pharmacy team for like mindedness as well.

How do you interact with the members of your team, and what are the roles and communication lines?

The team uses Microsoft Teams messages and/or phone calls mostly. They send chart notes back and forth regarding official communication or referrals.
Within the Population Health Team, there are a variety of roles including four Registered Nurse Clinical Specialists, three Community Health Workers, a Clinical Pharmacist, and a staff with a Master's in Social Work. Amanda appreciates their ability to work together without hierarchy.

As you consider best practices, what do you see as promising practices in your team as you work with individuals with diabetes to improve outcomes?

Amanda sees interdisciplinary care as key. They hold care conferences about their more complex patients and share opinions/ideas about best care. It has taken all those ideas for some patients to get motivated and improve. This works well because all staff work together collaboratively with the patient.

There is standard pharmacist billing for in-person visits, but the team also uses Chronic Care Management (CCM) and Principal Care Management (PCM) billing.

Amanda shared that a DM project is being piloted with two of their pharmacy residents. The goal is to proactively identify (using population health reports) patients who have an A1C >10 and then see them in the pharmacotherapy clinic. Patients go through six visits over three months and then assessed for improvement. The goal is more rapid control and follow up with PCP (Primary Care Provider). They are hoping that this will drive revenue and increase DM (Diabetes Mellitus) outcomes locally.

Community Pharmacists

Claire Rutledge and Stacey Frede, Kroger Health Fred Meyer Pharmacy

Can you describe your training and educational background?

Claire went to pharmacy school and completed her Community Residency Internship through Fred Meyer in Oregon and Washington. She is currently in Vancouver, WA working in ambulatory and transitional care within a DPP.

Stacey completed her Doctor of Pharmacy degree through the University of Cincinnati, completed a Residency Program, and stayed on with Kroger Health. She took on a corporate position and helped advance as well as create new clinical programs as a board-certified ambulatory care pharmacist.

Who do you see as your team?

Claire sees everyone she works with as part of her team, including the technicians at the pharmacy and is greatly appreciative of the team bond. She also values the participants in the DPP's and Presenter Leaders throughout the nation as part of the team.

Stacey described that the Kroger health teams within the 2800 supermarkets are helping people live healthier lives and hold the perspective that “food is medicine”. Across the 220 small clinic locations, staff members in the grocery stores, dieticians, and Nurse Practitioners help serve patients with acute and chronic care needs. There are over 400,000 employees within the team in different roles working closely with one another to improve patient care.

How do you interact with the members of your team, and what are the roles and communication lines?

Claire worked very closely with her co-resident in 2020 emphasizing the importance of open and consistent communication. Information that was closely communicated include scheduling, discussing progress of projects, brainstorming topics, as well as frequent emailing and phone meetings with the Residency Director. This would then trigger additional research where Claire and her co-resident presented the follow-up materials together. This kept them engaged and invested.

Stacey had the opportunity to work one on one with pharmacists and gathered feedback on projects and programs. She was also part of a team responsible for the execution of ideas and plans developed. Regular communication channels with the regional and division managers have been built in with the company along with existing developed training programs. Depending on the specific line of business, newsletters were also released on a regular basis.

As you consider best practices, what do you see as promising practices in your team as you work with individuals with diabetes to improve outcomes?

As with most areas, communication and stressing the importance of proper documentation is placed at the forefront. It is very important that the pharmacy can relay information and answer patient questions as well as keep the rest of the medical team abreast of the patient progress when appropriate. It is vital to keep everyone on the same page to avoid discrepancies. When pharmacists are included in the care team to document patient’s weight, activity levels and blood sugar values, it promotes consistent tracking and improves visibility.

According to Claire, having a Diabetes Prevention Program (DPP) will be a promising practice in the future. She has also noticed more individualized care in the world of pharmacy. Another promising practice is having community pharmacists involved more in a telehealth environment, which allows flexibility for patients, increasing access to pharmacy services.

How are you billing/documenting the work that is being completed?

Claire states that when doing DPP, they can document attendance, weight and activity levels in their DPP portal. In the documentation, the pharmacist enters the description of the patient

visit and service level to electronically submit and seek reimbursement based on their documentation. An online portal called Impact Diabetes is also used for documentation. Impact Diabetes is a project that was launched in 2010 and was the first national diabetes self-management program. The goal of Impact Diabetes is to transform health care delivery in local communities and improve patient outcomes.

In terms of billing, Kroger/Fred Meyer received a grant from the American Pharmacists Association (APhA) Foundation and the Center for Disease Control and Prevention (CDC). They can see patients and provide this service free of charge, which further helps address access and minimize gaps in diabetes care. They also work with self-insured employer group contracts.

Where do you see the future of diabetes going in your field including any upcoming changes?

An upcoming change Stacey sees for the future of diabetes in regard to pharmacy is a change to a digital accommodation program.

Claire added that soon, many providers will work with pharmacists more closely, which will provide the opportunity for additional collaboration to improve patient outcomes. She shared a story about a class participant that had lowered her A1C from over 6% to a low 5% with diet and exercise. This was primarily due to the involvement in the diabetes programs.

How is your organization measuring patient activation (engagement/measurement) in terms of readiness for change?

In the community pharmacy practice setting, pharmacists encourage patients to make a yearlong commitment with the DPP. Various tools are used to make sure that patients are aware of the commitment, benefits of the program and its flexibility. As part of the program, the coaches are trained in motivational interviewing, and it helps determine the patient's readiness with a built-in scale used in some of the materials. The participant meets with their coach early in the program to ensure patient buy-in and engagement. The administrators of the program receive regular reports to track the participant's progression in real-time, along with seeing how many lessons the patient has viewed, and if the patient is tracking their weight and meals at home.

As a part of the pharmacy residency program, the pharmacists received a coaching certification, like that of Certified Diabetes Health Educators. In the community setting, pharmacists focus on the use of Motivational Interviewing (MI). By using MI, pharmacists can gauge where or not the patient is able to make a change. Some patients decide that they aren't quite ready for a change and will decide to re-enroll later. Others can realize their readiness for change and are able to get their numbers lowered by consistent effort.

How do you close the loop or refer to a Diabetes Prevention Program?

Unfortunately, as a community pharmacist, Stacey says this can be difficult because pharmacists aren't typically included in the primary care provider's agenda. Pharmacists do their best to help patients become aware of DPP's, although many patients do self-refer.

At the start of every class, a recap from the last class is completed, and there is a check-in with the participants to discuss barriers and successes. At the end of each class, key messages are highlighted, questions are answered, and resources are given.

Internally, the pharmacy residents keep in communication via an email chain. On a weekly basis, they are reviewing patient progress and ensuring everyone is on the same page. They also loop in the district manager or the corporate office to provide a brief overview of participants' progress.

Dentists

Dr. John Deviny – Retired Dentist

Can you describe your training and educational background?

A graduate of the University of Washington School of Dentistry in 1974, Dr. Deviny spent his professional career equally divided between general dentistry private practice, dental education, and community oral health. Most recently he was one of the host dentists of the Arcora Foundation SmileMobile, a mobile dental program that addresses the access needs of patients in rural locations around the state of Washington.

Now mostly retired, he is enjoying the opportunities to volunteer with charity dental programs locally and in Zihuantanejo, Mexico, where he helped establish an annual cross-cultural partnership for charity care of children and adults.

He is presently a volunteer with the Olympia Union Gospel Mission (OUGM) dental clinic where he led the formation of a partnership with his private practice colleagues to treat the less fortunate upon referral to their offices. His interests and previous speaking experiences include local anesthetic administration, child and maternal oral health, community partnerships, financial intelligence and responsibility, and the value of mindful creativity in living fully. Community dental care is instrumental to him.

He shared that patients who are seen at the Union Gospel Mission Dental Clinic lack the financial ability and/or access to private practice dental services. The focus of the volunteers and staff is the relief of severe oral pain and infection. Extractions are usually necessary as the only reasonable or affordable option. In limited cases, depending on volunteer availability and patient needs, more comprehensive treatment such as cleanings and restorations can be scheduled.
At this point he considers his “team” to be a group of fellow volunteer oral health professionals.

As you consider best practices, what do you see as promising practices in your team as you work with individuals with diabetes to improve outcomes?
Key points included helping to educate dentists and inform and update about the integration of dentistry and medicine. He sees dentists/medicine as having a co-relationship and feels it’s important for dentists to identify treatment for individuals who suffer from diabetes and periodontal disease, and for medical personnel to understand the role periodontal disease plays in diabetes. It was also expressed that increased access to care has the potential to greatly improve diabetes outcomes.

Good oral home care can help keep periodontal disease under control. Dentists and dental hygienists can play a large part in demonstrating correct brushing and flossing techniques, as well as discussing diet and A1C levels.

Where do you see the future of diabetes going in your field including any upcoming changes?
Dr. Deviny shared that in considering periodontal disease, undiagnosed diabetes, and BMI’s (Body Mass Index), he would hope to see an improved relationship between dentistry and medicine, especially in the form of increased collaboration.

Small Research Study:
Dr. Deviny described a small research study currently underway at the OUGM Dental Clinic where select Medicare-eligible patients with diabetes/pre-diabetes who had been treated for toothaches reappointed into a program to receive periodontal disease treatments. They were followed for 6 months, and pre and post A1C readings were taken. At the end of the 6 weeks, there was a reduction of 0.4% in the patient’s A1C levels. He recognized that this was a small study but was hopeful that there would be more studies like this in the future.

Behavioral Health Provider

Marissa Braun – Currently working in Community Mental Health as a Case Manager

Can you describe your training and educational background?

Marissa has a Master's in Social Work from the University of Minnesota, with a Health, Disabilities and Aging Concentration as well as Clinical Mental Health Concentration

Who do you see as your team?

Mental Health Counselors, Psychiatric ARNP's (Advanced Registered Nurse Practitioners), Psychiatrists, and Caregivers at Adult Family Homes. Marissa also collaborates with Behavior Support Specialists, physicians, and Home and Community Services Case Managers

How do you interact with the members of your team, and what are the roles and communication lines?

As part of Marissa's role as a Case Manager in her day-to-day work, she has weekly team meetings for consultation, and monthly meetings with Home and Community Services for clients with behavioral health needs.

In regard to clients who have a diagnosis of diabetes, Marissa calls and speaks with physicians or their assistants as necessary. She also coordinates care through the EPIC system. Marissa works closely with her clients to write out the different questions they have regarding diabetes to discuss with their medical providers. She finds that obtaining Releases of Information (ROI's) to talk directly with the provider's offices is useful.

As you consider best practices, what do you see as promising practices in your team as you work with individuals with diabetes to improve outcomes?
Marissa sees the importance of educating mental health professionals on the signs and symptoms of diabetes, including hyper/hypoglycemia.

How are you billing/documenting the work that is being completed?
Marissa's employer provides billing codes for her to use. She typically uses case management codes. She then documents in chart notes and treatment plans.

How is your organization measuring patient activation (engagement/measurement) in terms of readiness for change?
This is done through treatment planning – identifying the steps the patient is ready to take and reflecting back on these steps at the 6-month mark.
Another important aspect of measuring patient activation involves the use of SMART goals with patients (Specific, Measurable, Achievable, Relevant, and Time-Bound).

How do you close the loop or refer to a Diabetes Prevention Program?
Marissa ensures that patients are established with a Primary Care Provider and have a positive relationship with them. She encourages all patients with mobility issues to get set up with physical therapy, and patients who struggle with their weight to become established with a nutritionist.

Certified Diabetes Educator

Jessica Baker, Dietitian, Diabetes Care & Education, DSHS/ALTSA

Training and Educational Background

Jessica has a Master's in Nutrition from Bastyr University and has been a Registered Dietician for nearly 14 years. She is also a Certified Diabetes Care and Education Specialist, and to sit for that exam, an active healthcare license as well as 1,000 hours of diabetes education over four years was required. To maintain those licenses, she must complete 75 hours of education every 5 years.

Who do you see as your team?

In Jessica's previous work at a Managed Care Organization, her team consisted of Diabetes Educators, Case Managers, Community Health Workers, Pharmacists, Primary Care Providers, as well as Management and other support staff.

How do you interact with the members of your team, and what are the roles and communication lines?

Jessica worked within an Interdisciplinary Care Model. The primary team member working with an individual was the Case Manager, and that staff member would make referrals into

the Health Coaching Program. Those individuals would be discussed at Interdisciplinary Rounds with other healthcare professionals. As any needs arose, the Case Manager would reach out to various providers. Custom built assessments were created within a platform called JIVA and referrals could be viewed within this system.

As you consider best practices, what do you see as promising practices in your team as you work with individuals with diabetes to improve outcomes?

The Health Coaching Program described above was designed to last for three months. Within that time period, individuals were contacted bi-weekly or monthly. Jessica found that the more frequently individuals were contacted, the better support they had. She also found that there was great success when individuals were set up with continuous glucose monitors.

How are you billing/documenting the work that is being completed?

Jessica shared that all documentation at the MCO she was employed at was entered into JIVA. If individuals were enrolled members of the insurance company, all healthcare services were free of charge to them. Billing was not something Jessica was involved in, though she aware of behind the scenes “stratification reports” that would give a risk number to an individual, indicating outreach to individuals was necessary based on gaps in care, the complexity of the individual’s diagnoses, missing HEDIS measures, etc.
Custom built assessments would generate care plans based on the information entered by the staff, which would allow for comparison over the length of the program. For example, A1C scores could be compared, as well as participation in treatment (such as seeing a provider for an eye exam).

How is your organization measuring patient activation (engagement/measurement) in terms of readiness for change?

Jessica shared she was excited to discuss this topic. One thing she participated in with her former team was building readiness for change into each component of the assessments within the Health Coaching Program. Based off the answers the individuals provided, staff would know whether individuals were highly engaged/motivated to work on weight loss, increasing activity levels, etc. This would dictate where the primary focus would be placed and would be monitored at each follow up.

How do you close the loop or refer to a Diabetes Prevention Program?

Jessica shared that if there was benefit for an individual to participate in a Diabetes Prevention Program, this could be discussed with the Case Manager, and the Primary Care Provider could be consulted.

Optometrist

Dr. Amenda Chou, O.D.

Can you describe your training and educational background?

Dr. Chou graduated from UC Berkeley School of Optometry in 2002. She is a Doctor of Optometry; primary level eyecare.

Who do you see as your team?

Dr. Chou expressed that in her field the team mainly consists of her patients, their PCP's, Diabetes Educators, Endocrinologists, and Retinal Specialists. The health professionals named are trained to recognize the complications of diabetes.
(Note: Retinal Specialists provide surgical care to treat ocular complications of the eye from diabetes).

How do you interact with the members of your team, and what are the roles and communication lines?

Dr. Chou has her own practice, but communication lines involve collaboration with the patients' PCP's when there are other health diagnoses involved such as high blood pressure.

She states that optometrists are usually one of the first medical providers to identify diabetes in a patient, and she works hard to emphasize to her patients the importance of preventive care. She genuinely appreciates providers who work hard to emphasize eye care. She primarily communicates through written fax and records.

As you consider best practices, what do you see as promising practices in your team as you work with individuals with diabetes to improve outcomes?

Dr. Chou strongly believes in the concept that communication is key. She listens carefully to her patients and understands the importance of relaying all necessary information to the specialists involved in her patient's care. She emphasized that collaboration with Retinal Specialists is something that she views as a promising practice.

How are you billing/documenting the work that is being completed?

Dr. Chou stated that she bills insurance directly on provider portal websites when applicable and verifies payments on the Estimation of Benefits insurances send back. There is also a clearing house that assists in submitting claims electronically called OfficeAlly.

Where do you see the future of diabetes going in your field, including any upcoming changes?

Dr. Chou reflected on the importance of giving patients more education, especially in terms of emphasizing the importance of routine and preventive care. She enjoys listening to patients as they discuss their visits with their assigned PCPs, especially when they give accounts of how they are working on their A1Cs. She states that she can often tell how comfortable patients are with their diabetes, or how comfortable they feel with their PCPs, and notices that patients who are more positive and proactive are often more engaged with their PCPs. She notices that those patients genuinely recognize the importance of eye care, podiatry, health education, etc.

Dr. Chou also was enthusiastic about the use of high-quality remote imaging to improve access for patients needing advice on ocular issues.

How is your organization measuring patient activation (engagement/measurement) in terms of readiness for change?

Dr. Chou expressed that the best indicator of readiness for change are patients who are well aware of their A1C levels. She is uncertain why, but she notices that a great deal of the population she sees does not check their blood sugars on their own, and she recognizes that this can be a barrier to care.

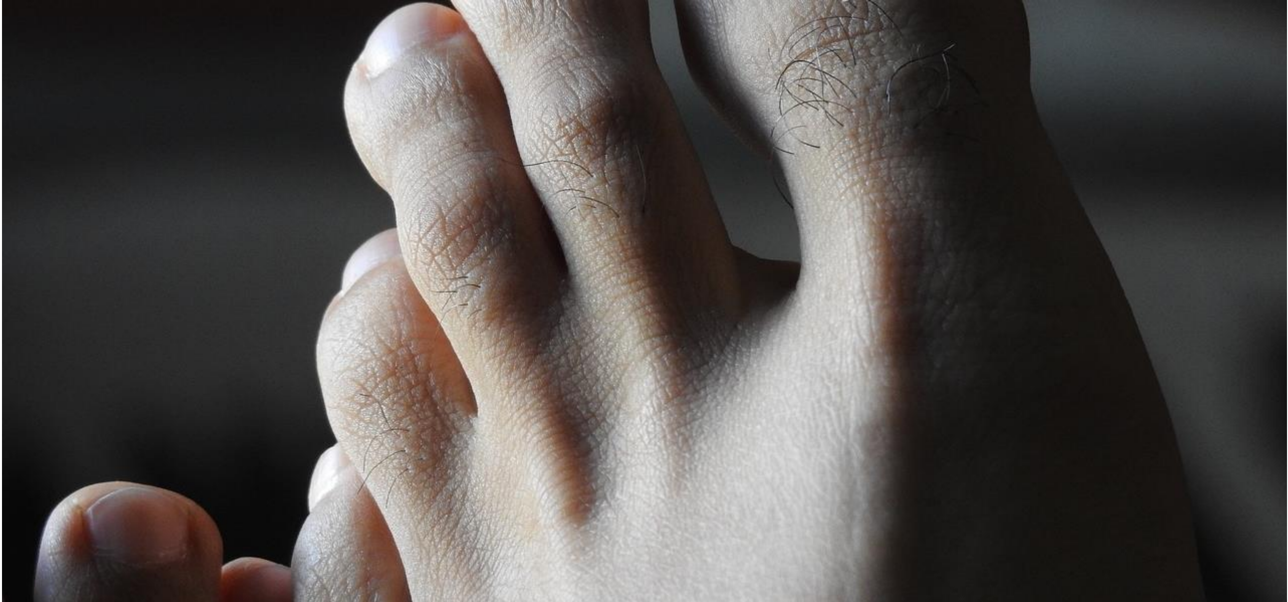
How do you close the loop or refer to a Diabetes Prevention Program?

Dr. Chou re-emphasized the importance of preventive care and the need for health education, as well as the need for improved health care accessibility. She discussed how this is true for underserved populations such as Native American communities. She discussed her work at the Tulalip Reservation and recalled how prevalent diabetes was in that community. She also relayed that educating children should be a key priority, in terms of discussing the importance of watching what they eat and the need for a healthy diet. She stated that by the time children mature to adults, it is so much harder to make lifestyle changes.

She summarized our discussion with an emphasis on communication and education, as well as the importance of sharing the latest understanding of diabetic treatment methodology in different fields.

Podiatrist

Huy Dang, Doctor of Podiatric Medicine



Can you describe your training and educational background?

Dr. Dang completed four years of podiatry/medical school in Chicago and completed an additional three-year residency program at Tacoma General Hospital, focusing on foot and ankle reconstructive surgery. He currently works as the only podiatrist at Foot and Ankle Associates in Centralia, Washington.

Who do you see as your team?

Dr. Dang shared that he works closely with his “core team” which includes numerous Medical Assistants and front desk staff, as well as a scribe to work in the moment as much as possible and keep processes streamlined.

How do you interact with the members of your team, and what are the roles and communication lines?

The Foot and Ankle Clinic where Dr. Dang practices is very busy. He often sees 60 patients daily. On the regular, he and the team would need to communicate quickly on topics including the need for diabetic shoes, infections, labs from the hospital, and amputations. His interactions with the team are typically face to face, but he also accesses Microsoft Teams, when necessary, as well as their electronic health records. Dr. Dang also stated that his office tries to send the first visit notes to the patient’s PCPs, as well as when there are important updates, which would be when an A1C has drastically increased, or when there is a need for surgery.

As you consider best practices, what do you see as promising practices in your team as you work with individuals with diabetes to improve outcomes?

Dr. Dang expressed that improved communication is the key. He believes that sometimes “it takes a village” to improve patient compliance. He reflected on the fact that many times individuals with chronic diabetes can have cognitive difficulties, and that education must be reiterated by multiple providers. Everyone must work together, especially when concurrent health problems (such as high blood pressure, high cholesterol, etc.) are in the mix. The staff at his front desk play an important role in reaching out to patients about missed appointments and determining possible barriers to care. Dr. Dang also expressed the importance of primary care interaction.

How are you billing/documenting the work that is being completed?

Dr. Dang stated that the Electronic Health Record system they use is called XMED. The scribe in his office is instrumental in keeping documentation accurate. He states that they bill right away, but that it’s also been very important to keep up on insurance policy changes from year to year.

Where do you see the future of diabetes going in your field, including any upcoming changes?

As Dr. Dang considered this question, he stated that he came from the Midwest where diabetes was rampant and poorly controlled, especially in the early 2000’s. It was not uncommon for patients to have A1Cs of 10 to 12. There were also a variety of providers who seemed more comfortable with patients having higher A1Cs, and this created opportunities for good discussion about what healthy A1C levels are. He also reflected on the need for increased patient engagement and expressed that getting patients to take responsibility for their own health is of utmost importance. He stated that it really comes down to the fact that there’s not a magic pill – the only one that can change a patient’s circumstance is themselves. We also touched on better access to glucose monitors and what a difference that could make in improved patient compliance.

How is your organization measuring patient activation (engagement/measurement) in terms of readiness for change?

Dr. Dang really assesses this by talking to the patients directly. He works closely with the Medical Assistants to focus on important issues such as wound care, A1C levels, and what social determinants of health may be impacting them. Dr. Dang noted that providing support for challenges, such as loss of housing, leads to more opportunities to discuss ways to improve a patient's health.

Patient Perspective

"Kari" (Patient name has been changed for privacy)

Kari shared that when she was first diagnosed with diabetes, it wasn't due to typical symptoms of high blood sugar. As a young woman in her 20's, she was struggling with recurring yeast infections, irregular periods, and her OB GYN (Obstetrician/Gynecologist) was testing for Polycystic Ovary Syndrome (PCOS), which is a hormonal disorder common among women of reproductive age. Her OB GYN suggested she have her blood sugar tested and referred to her to a primary care provider to look further into the issue. At that point in her life, she was inconsistent in seeking medical care, but this referral to her PCP led to a diagnosis of diabetes. From that point, her care team included her PCP, mental health provider, and local pharmacy.

Mental health is important for patients with a diabetes diagnosis, as is the understanding of the impact of ACEs (Adverse Childhood Experiences). Not all people with diabetes have ACEs, but it's at least as common as in the general population. Developing greater insight into ACEs can help patients discover relationships between their mental health, eating patterns, weight, and diabetes. It's important to have a non-judgmental provider to support patients in finding the best health practices for them.

Looking back, Kari wonders if smoking contributed to the onset of Type 2 Diabetes, and an awareness of the dangers of smoking in combination with diabetes motivated her to quit, although it took multiple quit attempts. Honest communication about those dangers in a non-judgmental way helped her to keep the risks in mind while moving through the stages of change.

Kari also spoke about how the importance of pharmacy support is. Care coordination and follow up is an opportunity for increased involvement for pharmacists, as there was a great deal of "tinkering with medications". Pharmacists should have paid time for patients that need and want it, and are essential in noting contraindications, etc.

Kari has seen dieticians and diabetes educators during big changes but expressed it would be great to have access to someone when she questions how to handle smaller things or go from "adequately treated" to "optimally treated". What if every person diagnosed with diabetes could self-refer to a diabetes educator if they felt they needed to? When patients have untreated low blood sugar, they have hunger that's tough to manage, and it's hard to stay in the caloric amount that's healthy. Reflecting on living with Type 2 Diabetes for more than 25 years, Kari believes self-referral would help people understand how to manage diet, hunger, and blood sugar.

One of the key takeaways that health professionals should never lose sight of: Compassion goes a long way in recognizing the patient as the expert in their own life.

Acronyms

ACES	Adverse Childhood Experiences
ADIME	Assessment – Diagnosis – Intervention – Monitoring – Evaluation
ARNP	Advanced Registered Nurse Practitioner
APhA	American Pharmacists Association
BMI	Body Mass Index
CCM	Chronic Care Management
CDC	Center for Disease Control and Prevention
CGM	Continuous Glucose Monitors
DM	Diabetes Mellitus
DPP	Diabetes Prevention Program
EMR	Electronic Medical Record
HCP	Health Care Provider
HE	Health Educator
FINI	Food Insecurity Nutrition Incentive
MI	Motivational Interviewing
OB/GYN	Obstetrician/Gynecologist
OUGM	Olympia Union Gospel Mission
PCOS	Polycystic Ovary Syndrome
PHARMD	Doctor of Pharmacy
PCM	Principal Care Management
PCP	Primary Care Provider
REACH	Racial Ethnic Approach to Community Health
RD	Registered Dietician
ROI	Release of Information
SDOH	Social Determinants of Health
SMART	Specific – Measurable – Achievable – Relevant – Time-Bound
TOC	Transition of Care