

# Building an Effective Collaborative Care Team to Address Diabetes

Source: *ADA Standards of Medical Care in Diabetes*

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# Disclosures

- Nothing to Disclose

# Learning Objectives

- Tailor treatment of diabetes for cultural, environment and social context
- Identify the importance of community resources and collaborative care for diabetes management
- Summarize the importance of individual treatment based on individual preferences, social context, prognoses, and comorbidities

# Diabetes and Population Health

- Clinical practice guidelines are key to improving population health
- For optimal outcomes – diabetes care must be individualized for each patient
- Ensure patient preferences, needs, values guide all clinical decisions

# Care Delivery Systems

- 33-49% of patients still do not meet targets for A1C, blood pressure, or lipids.
- Only 14% of patients meet targets for all A1C, BP, lipids, and nonsmoking status.
- Progress in CVD risk factor control is slowing.
- Substantial system-level improvements are needed.
- Delivery system is fragmented, lacks clinical information capabilities, duplicates services & is poorly designed.

# Chronic Care Model (CCM)

**The CCM includes Six Core Elements to optimize the care of patients with chronic disease:**

1. Delivery system design
2. Self-management support
3. Decision support
4. Clinical information systems
5. Community resources & policies
6. Health systems

# Strategies for System-Level Improvement

- Care team should prioritize timely and appropriate intensification of lifestyle and/or pharmacologic therapy for patients who have not achieved metabolic targets.
- Strategies for intensification include:
  - Explicit and collaborative goal setting with patients
  - Identifying and addressing language, numeracy, and/or cultural barriers to care
  - Integrating evidence-based guidelines and clinical information tools into the process of care
  - Soliciting performance feedback, setting reminders, and providing structured care
  - Incorporating care management teams

# Strategies for System-Level Improvement

The National Diabetes Education Program (NDEP) maintains an online resource to help health care professionals design and implement more effective health care delivery systems for those with diabetes:

[www.BetterDiabetesCare.nih.gov](http://www.BetterDiabetesCare.nih.gov)



## Health Professionals

Game Plan for Preventing Type 2 Diabetes +

Guiding Principles for the Care of People With or at Risk for Diabetes

Practice Transformation -

- Why Transform
- Defining Quality Care
- Team-Based Care
- How to Assess Your Practice
- Techniques for Improving the Quality of Care
- Diabetes Care Standards
- Information Systems
- Diabetes Practice Changes: Tools and Strategies
- Approaches to Affect Specific Outcomes
- Approaches for Specific Populations
- Diabetes and Patient Safety

## Practice Transformation for Physicians & Health Care Teams

This resource is designed to help physicians, health professionals, and health care administrators across the country adapt to the changing system of health care delivery around diabetes. Practice change is essential to effectively manage diabetes, prevent its serious complications, and delay or prevent type 2 diabetes. This content is based on current, peer-reviewed literature and evidence-based clinical practice recommendations.

## Understand Current State and Future of Diabetes Care

Find out how redesigning diabetes care delivery can benefit your practice and learn ways to coordinate with the team to improve care.



### Why Transform

Why health professionals and practices should consider redesigning diabetes care delivery.



### Defining Quality Care

To define quality in diabetes care and provide information on current diabetes-specific programs to improve care, which are often coupled with financial incentives.



### Team-Based Care

To introduce concepts and models of team-based care and provide useful resources for integrating these elements into practice.

# Support Patient Self-Management

- Implement a systematic approach to support patient behavior change efforts, including:
  - High-quality diabetes self-management education and support (DSMES)
    - Clinical content & skills
    - Behavioral strategies (goal setting, problem solving, etc.)
    - Engagement with psychosocial concerns
  - Addressing barriers to medication taking

# Diabetes and Population Health: Recommendations

- Ensure treatment decisions are timely, rely on evidence-based guidelines, and are made collaboratively with patients based on individual preferences, prognoses, and comorbidities. **B**
- Align approaches to diabetes management with the CCM, emphasizing productive interactions between a prepared proactive care team and an informed activated patient. **A**

# Diabetes and Population Health: Recommendations (2)

- Care systems should facilitate team-based care, patient registries, decision support tools, and community involvement to meet patient needs. **B**
- Efforts to assess the quality of diabetes care and create quality improvement strategies should incorporate reliable data metrics, to promote improved processes of care and health outcomes, with simultaneous emphasis on costs. **E**

# Health Inequities And Social Context

# Health Inequities

- Health inequities related to diabetes and its complications are well documented and are heavily influenced by social determinants of health
- Social determinants of health are not always recognized and often go undiscussed in the clinical encounter
- Creating systems-level mechanisms to screen for social determinants of health may help overcome structural barriers and communication gaps between patients and providers.

# Tailoring Treatment for Social Context

- Food Insecurity
- Homelessness
- Language Barriers
  - Non-English speaking/low literacy

# Food Insecurity

- Food Insecurity is the unreliable availability of nutritious food and the inability to consistently obtain food without resorting to socially unacceptable practices
- 14% of the US population is Food Insecure
  - In LA County, 30% of people at <300% FPL are food insecure
- Rates are higher among African American and Latino populations, low-income households, and homes headed by a single mother



# Food Insecurity: Treatment Considerations

- Increased risk for uncontrolled hyperglycemia
  - Steady consumption of inexpensive carbohydrate-rich processed foods, binge eating, financial constraints to filling of diabetes medication
- Increased risk for severe hypoglycemia
  - Inadequate or erratic carbohydrate consumption following administration of sulfonylurea or insulin

# Homelessness

- Homelessness often accompanies additional barriers to diabetes self management, including
  - Food Insecurity
  - Literacy
  - Numeracy deficiencies
  - Lack of insurance
  - Cognitive dysfunction
  - Mental health issues

# Homelessness

Patients with diabetes who are homeless need

- Secure places to store diabetes supplies
- Refrigerator access if on insulin

# Language Barriers

- Providers who care for non-English speakers
  - develop or offer educational programs and materials in multiple languages with specific goals of preventing diabetes and building diabetes awareness

# Language Barriers: National Resources

Center for Linguistic and Cultural Competency in Health Care at the Office of Minority Health

- The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care
  - The site offers a number of resources and materials that can be used to improve the quality of care delivery to non-English-speaking patients.

# Language Barriers

- ADA website fully translated to Spanish with click of a button **[diabetes.org](https://diabetes.org)**
- Living with Type 2 Program translated into Spanish **[diabetes.org/atdx](https://diabetes.org/atdx)**
- Downloadable patient ed handouts in several languages  
**[professional.diabetes.org/patiented](https://professional.diabetes.org/patiented)**

# Community Support

- Identification or development of community resources to support healthy lifestyles is a core element of the CCM
- Community health workers, peer supporters and lay leaders may assist in the delivery of DSMES services, particularly in underserved communities.

# Community Health Workers

- A frontline, public health worker who is a trusted member of and/or has an unusually close understanding of the community served
- CHWs can be part of a cost-effective, evidence-based strategy to improve the management of diabetes and cardiovascular risk factors in underserved communities and health care systems



# Agricultural/Migrant Workers

- Not directly addressed in ADA 2019 Standards, but much of that content applies
- Food Insecurity – given seasonality of work, many patients struggle financially in the winter
- Language Barriers – patients from Central America or Southern Mexico may only speak a local dialect
- Housing – many men or families may share a small unit

# Agricultural/Migrant Workers

- Documentation/Legal – may cause anxiety, reduce access, inhibit patients from signing up for benefits (“public charge” issue)
- Requirement for Multiple Visits – Models such as PCMH or CCM may not work well if multiple visits are required; patients may be afraid of losing their job if they miss too much work
- Regular Migration – disrupts access to providers, medications, labs

# Case Study

- 62 y.o. Spanish-speaking Hispanic male with unstable housing who is not consistently employed
- Lives with friends when he is able but otherwise living in his car. Has a BG meter but rarely checks his SMBG.
- **PMHx:** T2DM, HTN, HL and EtOH abuse
- **Labs:** BMI 28, last A1C 9.5, BP 145/95, LDL 132, elevated microalbumin/cr ratio
- **Meds:** metformin 1000mg bid, glipizide 20mg BID, HCTZ 25 mg

# Case Study

**More information:** Does not eat regular meals, often eats just one meal per day (sometimes stops by shelters but also frequents Taco Bell using 99 cent coupons). Income is variable.

- What is his A1c goal?
- What medications might you consider?
- Who should be on his care team?

# What next?

- Need to consider risks vs. benefits of glipizide and metformin in this patient with heavy EtOH use and infrequent oral intake
- Consider patient assistance programs for DPP-4 or GLP-1a. DPP-4i is less potent but oral whereas GLP-1a requires injection.
  - Could also consider adding once daily basal insulin to either of the above (vials are lower cost and do not need to be in the fridge once open, discard after 30 days)
- Additional risk factor control
  - Elevated BP and microalbumin ratio, so add ACE/ARB
  - Add statin for CV risk reduction
- **Care team support for housing, insurance, resources, nutrition education and substance abuse**
- Set SMG and follow with team-based care approach. Engage patient between office visits to check on progress and offer support

# Case Study 2

- 34 y.o. AA female who is a single mother of 2 school age children, non-smoker
- Unable to perform SMBG due to work. Often loses meter and/or test strips. Tries to come to office for visits when kids are in school so she doesn't have to bring them. Has trouble remembering appts and is often late.
- **PMHx:** T2DM, HTN, and hyperlipidemia
- **Labs:** BMI 32, last A1C 8.5, BP 128/82, LDL 94, normal microalbumin/cr ratio
- **Meds:** metformin 750mg bid, atorvastatin 40 mg, chlorthalidone 25 mg, paragard IUD

# Case Study 2

**More information:** living with various relatives and friends, + FI (kids eat mostly at school, but she skips meals to make sure that they have enough to eat). Difficulty storing and preparing food. Works 2 part time jobs; neither provides health insurance.

- Is she at goal?
- What medications might you consider?
- Who is on her care team? Who should be on her care team?

# What next?

- Could add glipizide since relatively short acting with largest meal
- Consider patient assistance programs for GLP-1 use since uninsured, liraglutide would offer additional weight and CV protection without hypoglycemia risk
- **Care team support for housing, insurance, resources, nutrition education for prepared foods**
- Set SMG and follow with team-based care approach. Engage patient between office visits to check on progress and offer support



# Tailoring Treatment for Social Context

## Key Recommendations:

- Providers should assess social context, including potential food insecurity, housing stability, and financial barriers, and apply that information to treatment decisions. **A**
- Refer patients to local community resources when available. **B**
- Provide patients with self-management support from lay health coaches, navigators, or community health workers when available. **A**

# Thank you

