Together2Goal
AMGA Foundation
National Diabetes Campaign

Monthly Campaign Webinar
April 19, 2018
TODAY’S WEBINAR

• **Together 2 Goal® Updates**
  – Webinar Reminders
  – Together 2 Goal® Innovator Track CVD Cohort
  – Social Media Move
  – Ballad Health is a Goal Getter!

• **The Role of the Nurse in Diabetes Care**
  – Mary M. Morin, RN, NEA-BC
  – Yvonne Durham, RN, RN-BC
  – Tina Zachary, RN, EP-C, ACSM

• **Q&A**
  – Use Q&A or chat feature
• Webinar will be recorded today and available the week of April 23rd
  – www.Together2Goal.org
• Participants are encouraged to ask questions using the “Chat” and “Q&A” functions on the right side of your screen
• On May 1, we will no longer post on our AMGAFhealth accounts.

• Follow @theAMGA on Facebook and Twitter to stay connected with us!
BALLAD HEALTH IS A GOAL GETTER!

• Congratulations to Ballad Health (formerly Wellmont Medical Associates)!

• Learn how transparent internal reporting led to a dramatic increase in their bundle performance.

www.together2goal.org
TODAY’S FEATURED PRESENTERS

Mary M. Morin, RN, NEA-BC
Vice President, Nurse Executive
Sentara Medical Group

Yvonne Durham, RN, RN-BC
Integrated Care Manager
Sentara Medical Group

Tina Zachary, RN, EP-C, ACSM
Ambulatory Staff Nurse
Sentara Belleharbor Family Medicine
Sentara Medical Group
Improving Diabetes Outcomes through RN Targeted Patient Management

AMGA Together 2 Goal

Yvonne Durham, RN, RN-BC, Integrated Care Manager
Sentara Medical group
Tina Zachary, RN, ACSM-EP
Sentara Belleharbor Family Medicine
Sentara Medical Group
April 19, 2018
Introduction of Presenters and Overview

Mary M. Morin, RN, NEA-BC
Vice President, Nurse Executive
Sentara Medical Group
Objectives

• Describe **RN-led strategies** implemented to improve patient outcomes in a targeted population of patients with Type 2 Diabetes
• Share patient case studies and the impact of RN-led strategies in **improving outcomes** in patients with Type 2 Diabetes
• Compare and contrast **patient outcome data** in the targeted population of patients with Type 2 Diabetes
• Share **lessons learned** in the engagement and management of a targeted population of patients with Type 2 Diabetes
Yvonne Durham, RN, RN-BC
Integrated Care Manager
Sentara Medical Group
Tina Zachary, RN, EP-C, ACSM
Ambulatory Staff Nurse
Sentara Belleharbor Family Medicine
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Improving Diabetes Outcomes through RN Targeted Patient Management: Case Study #1
Case Study #1

- PCMH meeting SMG Riverwalk Family Medicine Practice in 2015
- Large number of Type 2 Diabetics
- Discussed need to focus on identification, tracking outcomes and progress
- Focus: referral to ICM for patients with A1Cs between 6.4%-15%
- Implemented monthly group sessions for education and support
- 2-6 participants/session
Case Study #1

- 54 year old male diagnosed with Type 2 Diabetes
- A1C = 15.4%
- Employed full-time
- Lives with wife and son
- Provider referred to ICM for diabetes education
- Completed thorough chart review prior to initial contact
- Conducted telephonic engagement and clinical assessment
Group Sessions

• Held Monthly
• 2-3.5 Hours
• 2-6 Participants
• Free of Charge
• Variety of Topics
Case Study #1

• Patient eating diet high in carbohydrates and drinking sweet drinks (tea, soda)
• Receptive to learning how to better manage his diet and getting his family involved
• Attended 1st session with his wife and son
• Education focused on how to use the Sentara Diabetes Took Kit, other educational resources, and recipes
Case Study #1

• ICM contacted patient and his spouse on a monthly basis
• Transitioned to a call every 3-4 months and saw patient during routine office visits
• Positive outcomes: **OCT 2017 A1C = 6.4% (9% decrease)**, feels better, has more energy, has lost weight (including spouse), and able to “enjoy life more”
• Patient feedback: grateful for education, will “never go back to his old way of eating again,” shared his experience with other patients at a holiday lunch in DEC 2016, and “You all care”
Strategies

- Patient Identification
- Provider Engagement
- Patient Engagement
- Data Measures
- Interventions
- Timeline
Report Card

<table>
<thead>
<tr>
<th>Test</th>
<th>Goal</th>
<th>Date</th>
<th>Value</th>
<th>Ref Range</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>HgbA1c</td>
<td>(Predicts problems from diabetes)</td>
<td>10/04/2017</td>
<td>6.4</td>
<td>4.8 - 5.9%</td>
<td>Final</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>(Predicts heart disease)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goal: LDL less than 100 (optimal less than 70)</td>
<td>LDL CALCULATION</td>
<td>10/04/2017</td>
<td>107</td>
<td>50 - 99 mg/dL</td>
<td>Final</td>
</tr>
<tr>
<td>Goal: HDL greater than 45</td>
<td>LDL CALCULATION</td>
<td>10/04/2017</td>
<td>107</td>
<td>50 - 99 mg/dL</td>
<td>Final</td>
</tr>
<tr>
<td>Goal: Triglycerides less than 150</td>
<td>Triglyceride</td>
<td>10/04/2017</td>
<td>103</td>
<td>40 - 149 mg/dL</td>
<td>Final</td>
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<tr>
<td>Microalbumin urine</td>
<td>(Predicts kidney disease)</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>Normal is less than 17 mcg/mL</td>
<td>MICROALBUMIN RANDOM</td>
<td>03/27/2017</td>
<td>52.0</td>
<td>0.1 - 17.0 mcg/mL</td>
<td>Final</td>
</tr>
</tbody>
</table>
Patient Outcomes Data

Group Diabetes Course Participant Pre and Post Course A1C

A1C

Participant ID

Pre 3 Month Post
Patient Outcomes Data

Group Diabetes Course Non Participant Pre and Post A1C

Participant ID

Pre  3 Month Post
Patient Outcomes Data

Mean A1C Pre and Post Group Diabetes Course by Time

- Pre A1C
- 3 Month Post A1C

Participant vs Non Participant
Patient Outcomes Data

Mean A1C Pre and Post Group Diabetes Course by Participant Status

A1C

Participant
Non Participant

Pre A1C  Post A1C

0  2  4  6  8  10  12
Lessons Learned

• Group visits improve patient adherence to diet and meds
• Participants provide support to each other and share (e.g. recipes, resources)
• Patients have better attendance if they do not have to travel far from home or work – location matters
• Cost matters (meetings, resources, supplies)
• Regular, consistent contact (telephonic, face-face) promoted ongoing patient and family engagement
• Provider buy-in and referral to ICM is essential
• Patients more likely to participate if the provider explains why they would benefit
Lessons Learned

• Patient identification and engagement is critical
• Family engagement promotes better patient adherence
• Data monitoring and tracking is powerful (“Report Card”)
• Participants do not always show – forget or have transportation issues – need to send reminders and address transportation issues before the scheduled meetings
• Participants are motivated by “snacks” provided at meetings
• Marketing and promoting sessions facilitates self-referrals
Future Plans

• Poster Presentations: AAACN May 2018

• Obtain Certified Diabetes Educator (CDE) in 2018

• Continue with group session and expand outreach
Improving Diabetes Outcomes through RN Targeted Patient Management: Case Study #2
Case Study #2

- Patient identification and engagement
- RN collaboration with provider to increase patient engagement, knowledge, and support towards improving outcomes
- Goal to lower A1C and encourage exercise/increase activity
- Discovered a few patients had knowledge deficits
Case Study #2

Patient Blue
• 73 year old female, lives alone, no support network, knowledge deficit concerning how to use newer insulin pen

Patient Red
• 56 year old male, busy life, no exercise and lacked education on how to manage diabetes via eating and exercise

Patient Green
• 53 year old male, works rotating shifts, busy lifestyle, no exercise program
Strategies

• Called patients bi-weekly or monthly
• Provided education to patients in office and over phone
• Developed patient-centered action plans using smart goals that are specific and attainable
• Educated on nutrition and exercise
• Hosted diabetes education and support classes
• Provided encouragement, and offered coaching and guidance
• Delivered feedback to Providers on patient progress and revised plan of care
• Sent out congratulation and motivational cards
Group Sessions

• Sessions Offered: Two sessions
• Length of session: 2-3 hours
• Number of participants: 6 - 10 patients
• Topics: Managing Diabetes, and Diabetes & Healthy Eating
• Cost: Free to Sentara Patients
• Location: Sentara Belle
Action Plan

- Established Smart Goals with patient
- Review with Provider and receive feedback
- Discuss barriers and developed strategies to overcome barriers with patients
- Scheduled follow-up via phone
Action Plan
Example of Smart Goals for Pt Green

Specific:
Long Term Goal: To decrease A1C from 9.4 to below 8.0
Short Term Goal:
To increase exercise 3-4 days per week 45-60 minutes of cardiovascular exercise each session
Improve eating by decreasing simple carbohydrates and increasing vegetables during lunch and dinner 4-5 meals per week

Measureable:
Q 3 months measure A1C
By measuring weight (1-2 pounds per week) or BMI

Attainable:
“If I join a gym and commit to exercising I know I will make changes”
“If I can change my eating I know my A1C will be eventually decrease”

Relevant:
“Yes, I know I need to make improvements”

Time Bound: “Within 3 months I should see changes, this is acceptable”
Motivational Card

All team members and Providers sign acknowledging progress!
Patient Outcome Data: A1C

- Patient 1: 10 (7/6/2016), 6.8 (3/15/2017), 12.1 (10/20/2016), 8.6 (2/17/2017), 9.4 (10/31/2016), 7 (5/10/2017)
- Patient 2: 10 (7/6/2016), 6.8 (3/15/2017), 12.1 (10/20/2016), 8.6 (2/17/2017), 9.4 (10/31/2016), 7 (5/10/2017)
Lessons Learned

• Persistence is rewarded
• Positive outcomes: reduction in A1C and verbal expression of patient satisfaction
• More time is needed to commit to the program
• Knowledge deficits, especially working with learning disabilities such as psychological disorders, mental retardation and memory impairment, can pose significant barriers
Lessons Learned

• Need to enhance knowledge on how to educate and motivate patients with knowledge deficits
• Collect feedback from patients on regular intervals
• Improve data collection
• Empower patients to take more ownership of their diabetes
Future Plans

• Develop a “mindfulness” diabetes program
• Develop individual exercise programs patients can do at home or at their fitness facility
• Incorporate grocery store tours, and cooking classes
Next Steps

• 3-year Strategic Action Plan focused on Type 2 Diabetes (primary), pre-diabetes (secondary), and undiagnosed
• Medication Management: Uncontrolled (> 9 A1C) on Antidiabetic Medication(s) and Engaged; RN-PharmD Insulin Protocol (designed after SASC); Rx Guidelines
• Evidenced-Based and Best Practices
Questions?
• **Date/Time:** Thursday, May 17
  2-3pm Eastern

• **Topic:** Quality Improvement and the Together 2 Goal® Bundle

• **Presenters:** AMGA Analytics and Featured Guests from Premier Medical Associates and Mercy