Together 2 Goal®

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

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WEBINAR REMINDERS

- 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

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TOGETHER 2 GOAL® INNOVATOR TRACK CVD COHORT

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SOCIAL MEDIA MOVE

- On May 1, we will no longer post on our AMGAFhealth accounts.
- Follow @theAMGA on Facebook and Twitter to stay connected with us!

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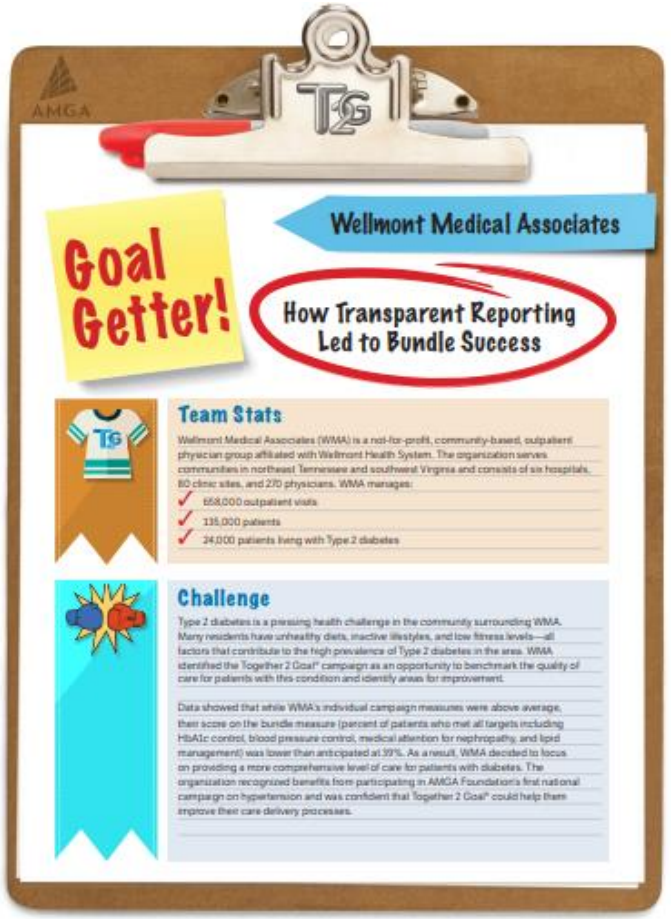
BALLAD HEALTH IS A GOAL GETTER!

- 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



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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

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Improving Diabetes Outcomes through RN Targeted Patient Management

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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

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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

Sentara Medical Group

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

Improving Diabetes Outcomes through RN Targeted Patient Management: Case Study #1

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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

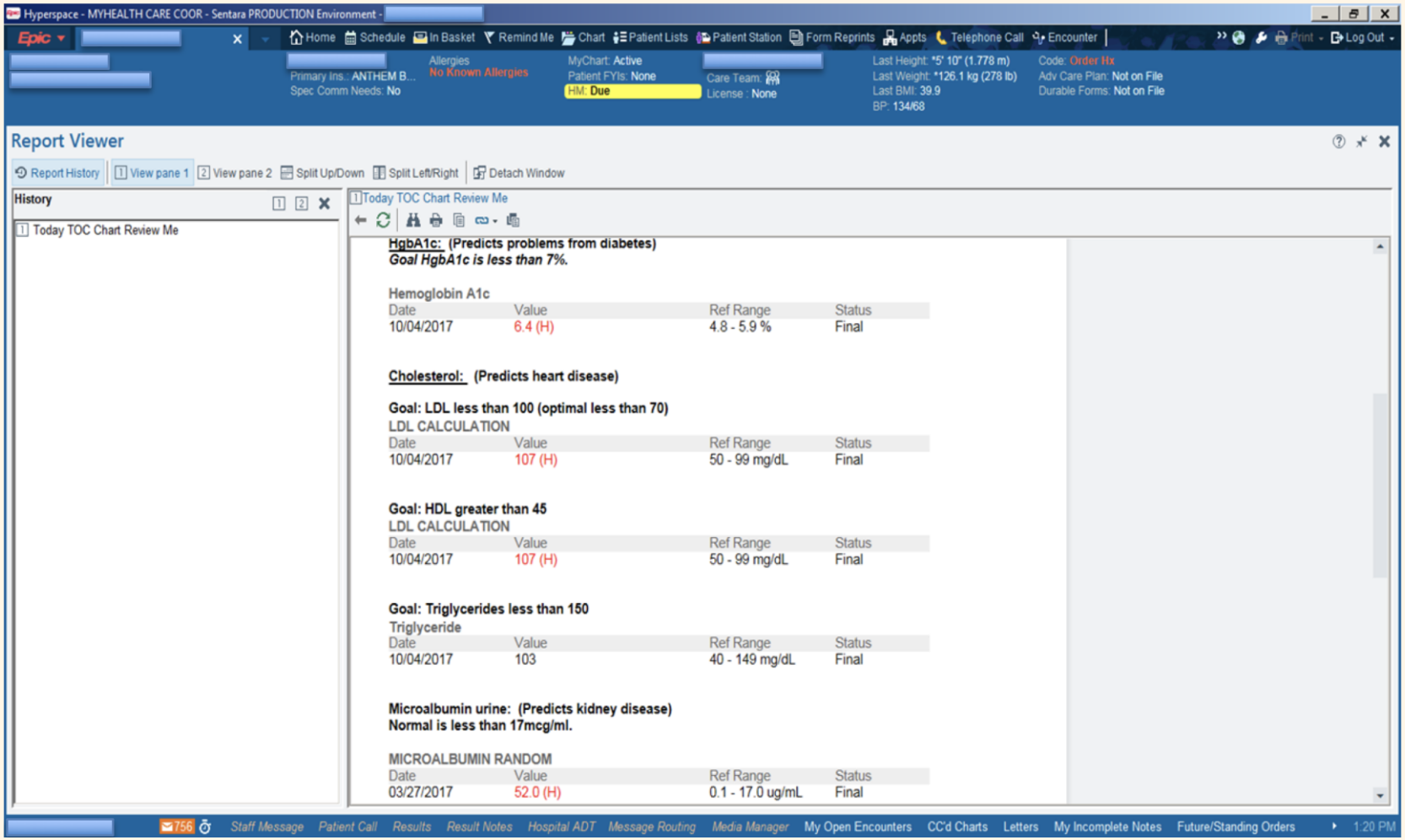
Case Study #1

- 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"

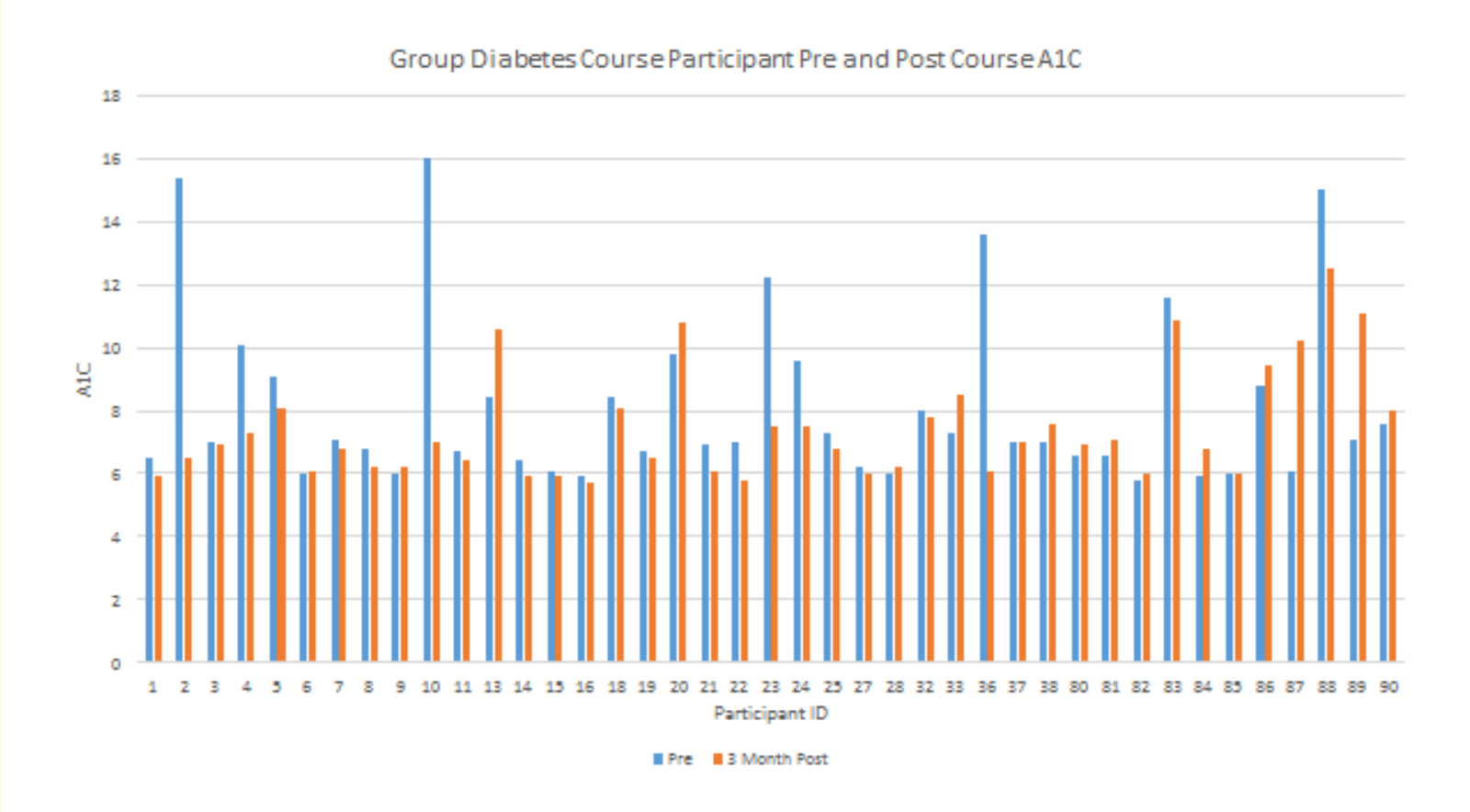
Strategies

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

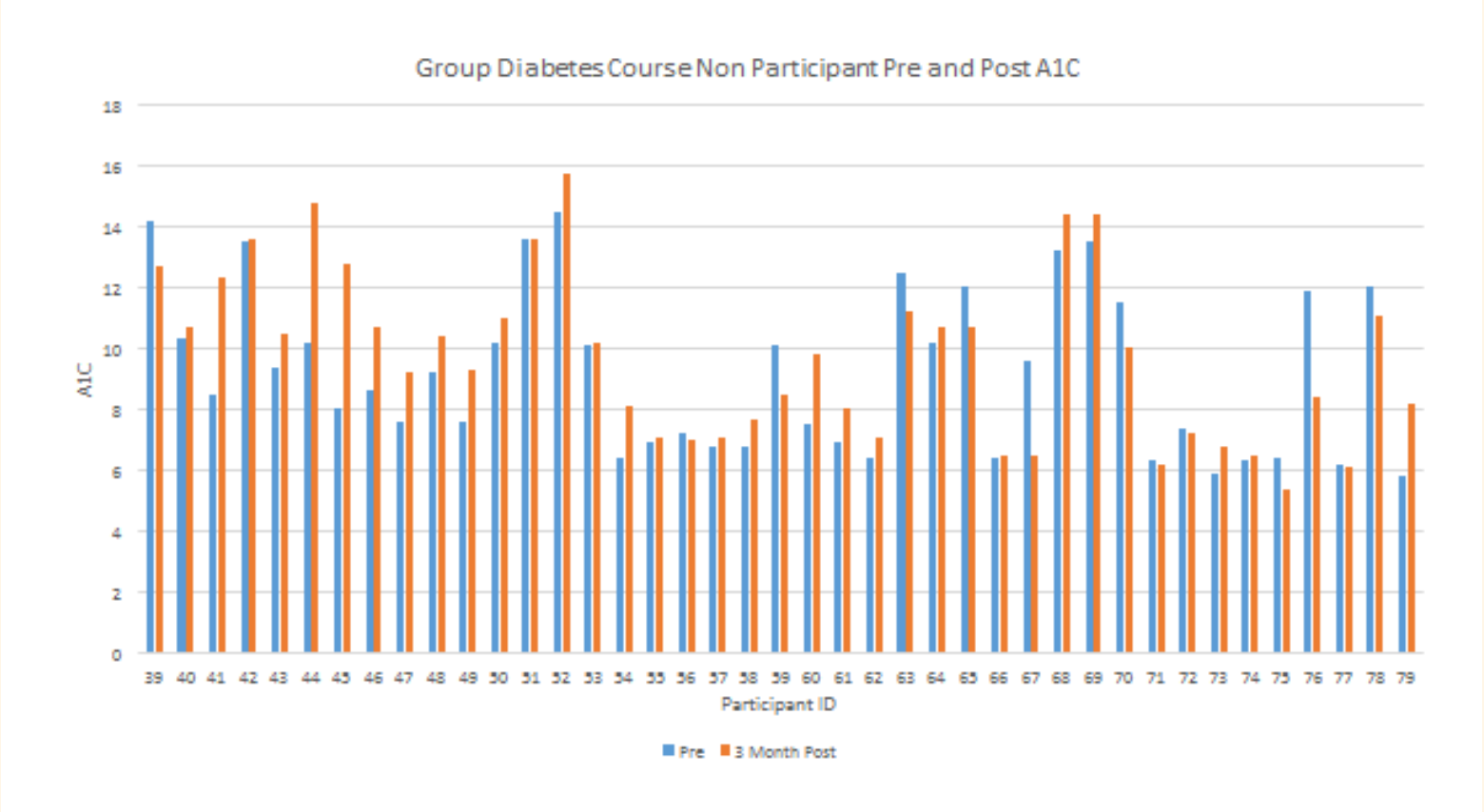
Report Card


Hyperspace - MYHEALTH CARE COOR - Sentara PRODUCTION Environment -
Epic
Home Schedule In Basket Remind Me Chart Patient Lists Patient Station Form Reprints Appts Telephone Call Encounter
Print Log Out
Primary Ins.: ANTHEM B...
Spec Comm Needs: No
Allergies
No Known Allergies
MyChart: Active
Patient FYIs: None
HM: Due
Care Team:
License : None
Last Height: *5' 10" (1.778 m)
Last Weight: *126.1 kg (278 lb)
Last BMI: 39.9
BP: 134/68
Code: Order Hx
Adv Care Plan: Not on File
Durable Forms: Not on File
Report Viewer
Report History
View pane 1
View pane 2
Split Up/Down
Split Left/Right
Detach Window
History
Today TOC Chart Review Me
Today TOC Chart Review Me
HgbA1c: (Predicts problems from diabetes)
Goal HgbA1c is less than 7%.
Hemoglobin A1c
Date Value Ref Range Status
10/04/2017 6.4 (H) 4.8 - 5.9 % Final
Cholesterol: (Predicts heart disease)
Goal: LDL less than 100 (optimal less than 70)
LDL CALCULATION
Date Value Ref Range Status
10/04/2017 107 (H) 50 - 99 mg/dL Final
Goal: HDL greater than 45
LDL CALCULATION
Date Value Ref Range Status
10/04/2017 107 (H) 50 - 99 mg/dL Final
Goal: Triglycerides less than 150
Triglyceride
Date Value Ref Range Status
10/04/2017 103 40 - 149 mg/dL Final
Microalbumin urine: (Predicts kidney disease)
Normal is less than 17mcg/ml.
MICROALBUMIN RANDOM
Date Value Ref Range Status
03/27/2017 52.0 (H) 0.1 - 17.0 ug/mL Final
756
Staff Message
Patient Call
Results
Result Notes
Hospital ADT
Message Routing
Media Manager
My Open Encounters
CC'd Charts
Letters
My Incomplete Notes
Future/Standing Orders
1:20 PM

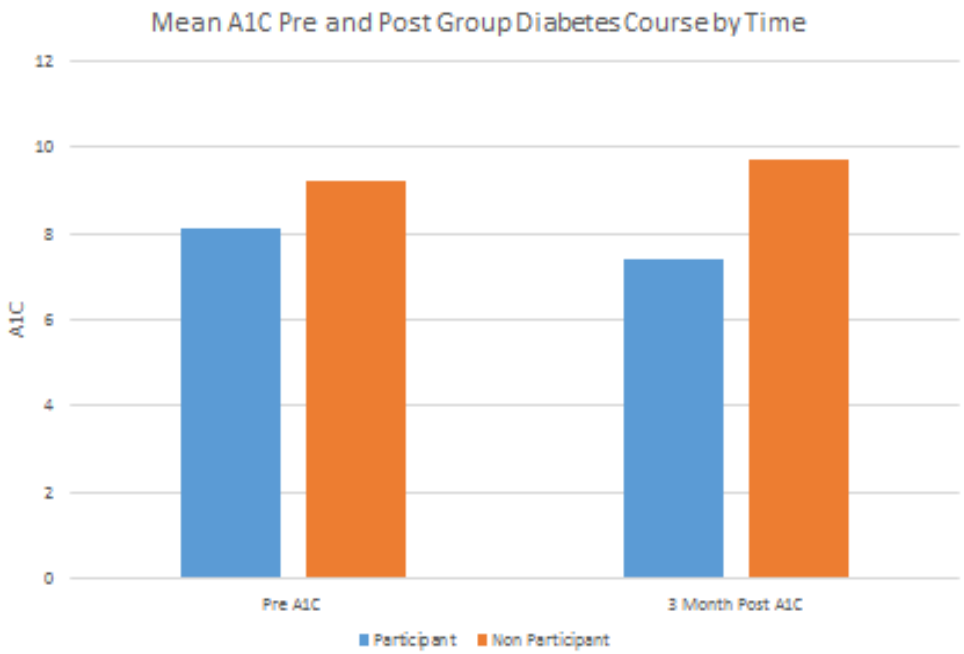
Patient Outcomes Data



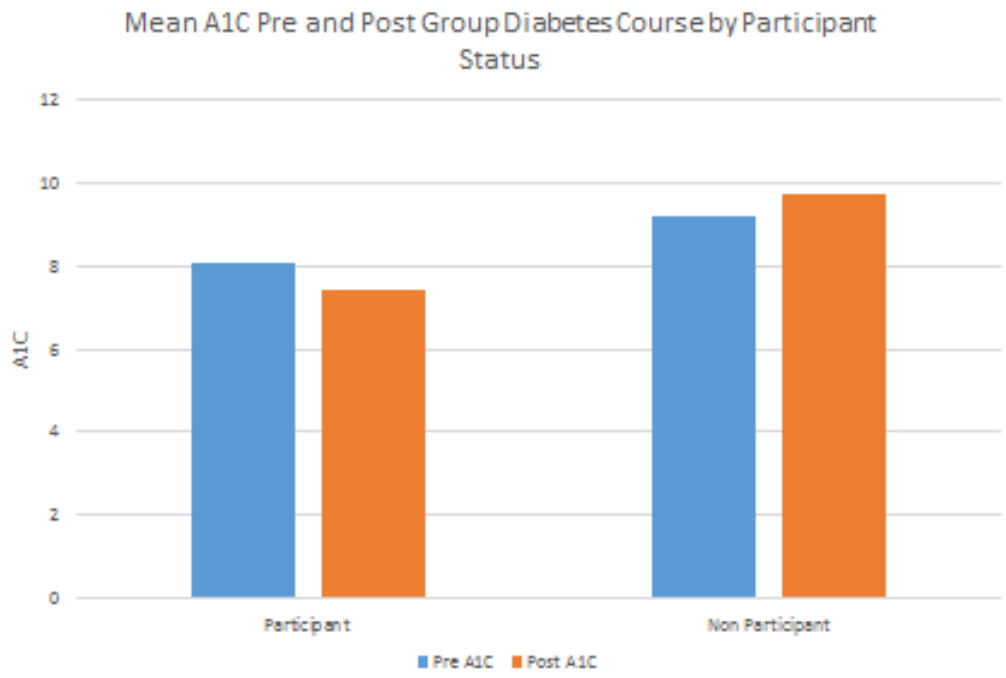
Patient Outcomes Data



Patient Outcomes Data



Patient Outcomes Data



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

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Tina Zachary, RN, ACSM-EP
Sentara Belleharbor Family Medicine
Sentara Medical Group

Improving Diabetes Outcomes through RN Targeted Patient Management: Case Study #2

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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 sessions

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”

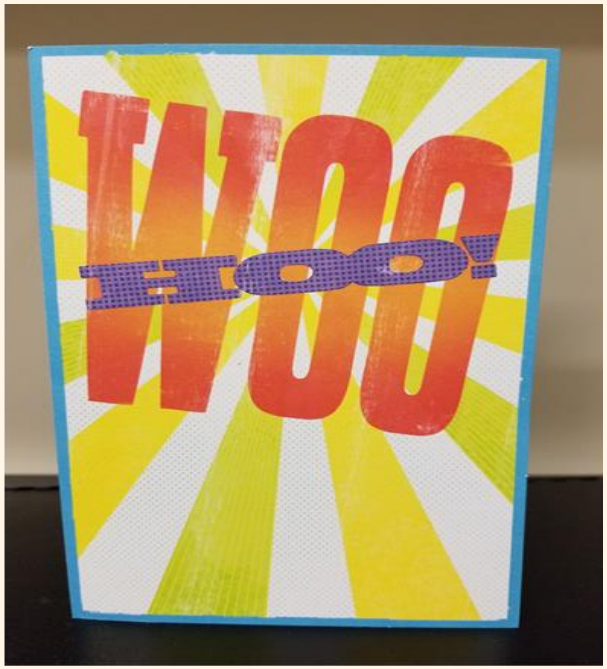
Relevant:

“Yes, I know I need to make improvements”

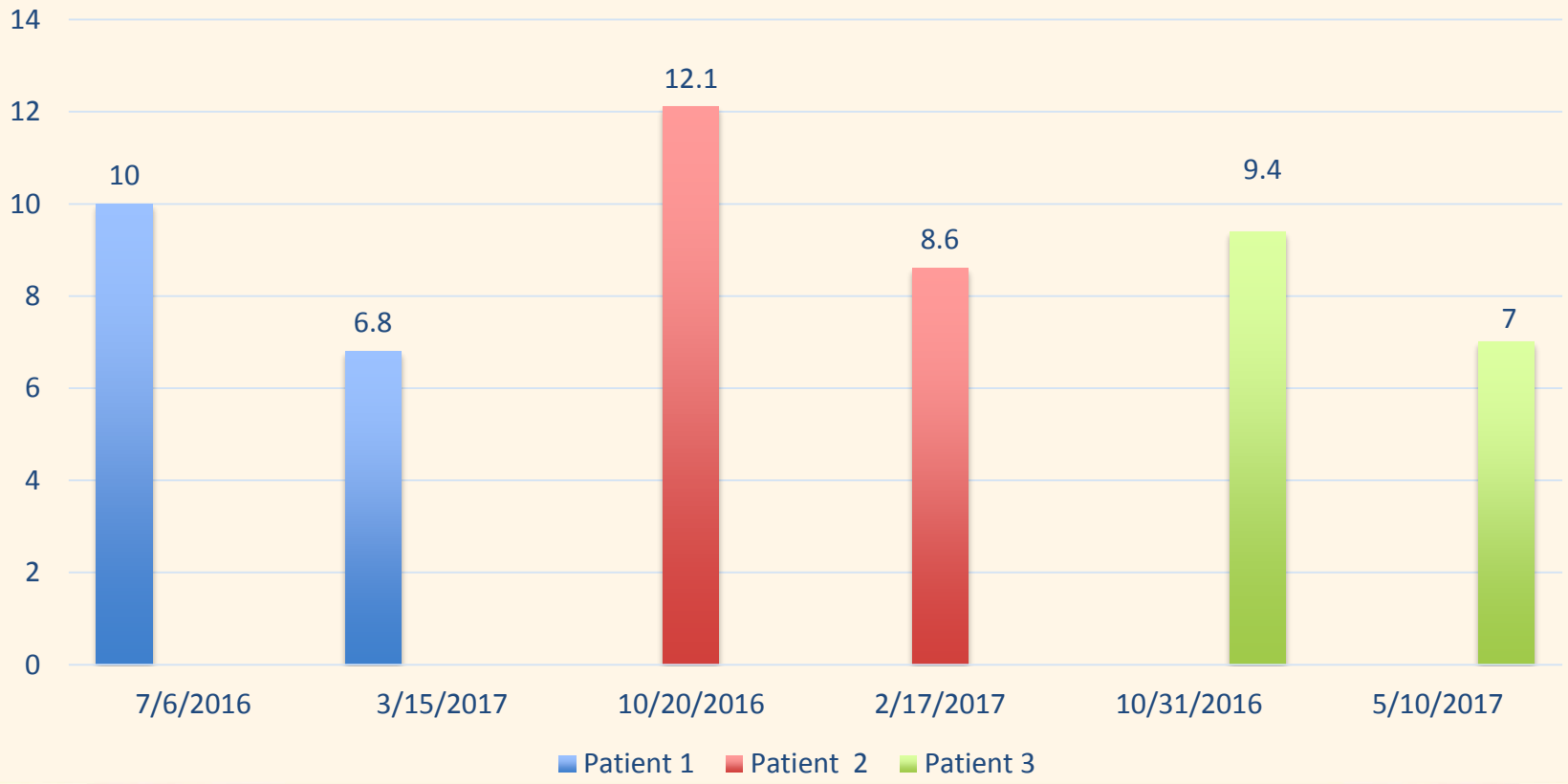
Time Bound: “Within 3 months I should see changes, this is acceptable”

Motivational Card

All team members and Providers sign acknowledging progress!



Patient Outcome Data: A1C



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?

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MAY 2018 MONTHLY WEBINAR

- **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

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