Learning Collaborative Presentation
Diabetes Group Visit

April 9, 2015
Community Priorities
Community Health Needs Assessment of Trenton, New Jersey

- Poverty and Obesity are positively correlated with diabetes
  - 36% of Trenton residents live 200% below the poverty level
  - 39% of Trenton residents are obese
  - 10% of US population has diabetes vs. 16% of Trenton
- Minority populations are at high risk for diabetes
  - 46% of Trenton residents are African American
  - 18% are Hispanic/Latino American
To sustain and grow our DSRIP program, we need MULTIPLE DISCIPLINES to continue to collaborate & participate.

Project work teams include senior leadership, physicians, nurses, care coordinators, IT support.

Various fields of expertise needed to improve diabetes outcomes in our patient population.
Ultimately, want to be vehicle to improve care for patients with diabetes, not just a revenue stream

Many challenges in our patient population
  ◦ Low health literacy
  ◦ Cultural/language differences
  ◦ Socio-economic challenges
  ◦ General mistrust of the medical community

Impetus for changes in our management of patients with diabetes – Implementation of Best Practices

Multidisciplinary staff engagement and collaboration critical for success
What is the Group Visit?

- Group Visits are conducted on site as well as off site
- Referrals generated from patient self-referral, healthcare provider referral, community referral
- Pre- and Post-questionnaires completed to assess for increased knowledge of diabetes self-management skills
- Patients establish goals that they will continue to work on after group visit completed
Who are our Participants?

Male 20, 47%
Female 23, 53%
Age groups

![Age distribution chart]

- over 65: 6
- 55-65: 14
- 45-55: 10
- 35-45: 7
- 18-35: 2

Series 1
Ethnicity

African American/Black 18, 44%
Hispanic 9, 22%
White 11, 27%
Other 3, 7%
My name is Rafael Fernandez, I have to say that after I have been in the program, I feel much better and my sugar levels completely controlled, with all the foods that have been presented to me and with the diet I am doing, really good. I give thanks to everyone who has worked with us in helping us reach our goal, my diabetics level are between 140 to the number of 130 and some at 120 another day, special thanks to the team.

Sincerely who loves you all with all my heart
Rafael Fernandez
May God Bless you
Graduation Class of August 2014

For more information, please contact the Diabetes Self-Management Director, Debra S. Birkenstamm, at (609) 599–5711 or dbirkenstamm@stfrancismedical.org
Lessons Learned....

- The social issues uncovered during our first Group Visit were overwhelming to the DSRIP Team:
  - Lack of trust in the medical community
  - Inability to navigate the Medicaid System
  - Lack of knowledge of community and hospital resources
  - Financial barriers
  - Lack of transportation to the group visit
From the data collected from the weekly program evaluation tool, the program curriculum was adapted to meet the needs of the participants:

- Length of program revised
- Nutritional Education was increased from 1 to 2 weeks, totaling 3 hours of instruction time
- The nutritionists included meal planning on a budget in their presentation
- A session was devoted to depression and stress management moderated by the APN and Social Worker
Internal versus External Group Visits

- Internal group visits are generated from our referral sources such as ED, Inpatient, and clinic

- External group visits are initiated through community partnership

- Rewards of External group visit
  - Building partnerships for the future
  - Educating the community of the SFMC clinical services
DSRIP DIABETES PATIENT FLOW PROCESS

ED – TREAT and RELEASE

PATIENT IS TRIAGED

PATIENT EXAMINED BY ED PHYSICIAN

History Of Diabetes / Diagnosis Of Diabetes

S W Refers to Diabetes Transition APN using AllScript

Admitted to Inpatient TRIAGED

H&P, Chief Complains / Nursing Assessment

Random Findings from Blood Work

Diagnosis of Diabetes

S W Refers to Diabetes Transition APN using AllScript Nursing Consult using Soarian

Evaluated in the Medical Clinic

Diagnosis of Diabetes

DIAGNOSTIC RESULTS

Patients referred for Group Visit PHYSICIAN

Diabetes Self-Management Team

Assessment of Patients Using Risk Stratification Tool

Recommend & Refer Educational Modalities

Schedule Clinic Appointments

Home Visit

Social /Medication Assistance Coordinate Home Visit Schedule For Group visit

Schedule For Group visit

Order Appropriate Tests & follow up

Other Assistance Coordinate Home Visit Schedule For Group visit
Group Visit Model

Group Visit
- Group Education
- Disease Management
- Self-Care Skills
- Food & Nutritional Counselling
- Physical / Fitness

Medical Management
- Endocrinologist Visit
- APN Assessment / Reassessment
- Tests / Examination
  - HbA1c
  - Foot Exam
  - Eye Exam
  - Lipid profile
- Refer to other specialties / Follow up at the Clinic

Provider Education
- Standards of Care for Management of Diabetes
- Review of Clinical Information BRIDGING ORDERS WRITTEN
- Clinical Outcomes review
- Review & Revise protocols
- Review of DSRIP measures & PI activities
DSRIP Achievements: Inpatient

- Implemented insulin pump protocol for inpatients
- Established insulin drip protocol for hyperglycemia
- Redefined hypoglycemia threshold and treatment
- Redefined aspart supplemental scale administration guidelines
- Identified and attempt to rectify issues with inpatient DM nutrition
- Developed DM education handout for inpatient/outpatient use
DSRIP Achievements: Outpatient

- Weekly DM clinic with Endocrinologist and APN
- Clinical Decision Support Initiative implemented to improve workflow and to break down barriers within the organization
  - Improve access of care
  - Decrease wait time
  - Avoid duplication of services
- Incorporate Lab Corp services into the clinic
Provider Education

- Ongoing Nursing Education
  - Insulin pump management
  - Insulin drip protocol
  - Inpatient DM management guidelines
  - Hypoglycemia management
  - Patient education handbook

- Ongoing Medical Education
  - Resident lectures
  - Resident endocrine electives
  - Diabetes Grand Rounds
  - Round table and topic discussions for providers
  - Case Studies
Challenges with Medication Access

- **Medicaid/NJ Horizon**
  - Generally good access to meds because patients can go to any pharmacy and get Rx filled as long as medication on formulary
  - **Challenge:** getting non-formulary meds covered

- **Medicare**
  - **Challenge:** finding out what is on the formulary list due to multiple types of plans
  - **Challenge:** getting non-formulary meds covered

- **Charity Care**
  - **Challenge:** prescribing meds other than generic metformin or sulfonylurea (NO AFFORDABLE INSULIN OR OTHER BRANDED CLASS OF DRUGS, limited to Shop Rite or Walmart)
  - **Challenge:** access to affordable test strips and glucometers
Take Charge of Your Diabetes
Patient Teaching Guide

- Developed in-house for our patient population to be utilized for inpatients and outpatients
- Professional patient teaching tool created by internal team
- Clear and simple language used to ensure the diabetes concepts readily understood
- Standardized information to be used in all hospital settings
- In-servicing professionals in multiple disciplines so that the education is consistent
Challenge: Identification of project partner
DSRIP has been an important project at St Francis Medical Center and has shed light on multiple areas for improvement

- The need for individual improvement, on both the provider and patient level
- The need for hospital improvement, in both the inpatient and outpatient hospital setting

With our DSRIP inspired multiple interventions, we strive to increase hospital and community awareness of this chronic disease