Diabetes Protocol Pilot

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In support of care transformation within the
Patient Centered Medical Home,
Inspire Health Partners
is pleased to introduce
a draft care protocol
for the treatment of diabetic patients developed by
Slade Crowder, MD of **Sandcrest Family Medicine**

Three physician practices are piloting the protocol to manage the care of their diabetic population:

- Sandcrest Family Medicine
- Doctors Park Family Medicine
- Rau Family Medicine

Key components in this pilot are clearly defined roles within the office and all staff practicing at the top of their education or license. Involving medical assistants and nurses in pre-visit preparation and other visit related tasks allows the physician more time with the patient, improves efficiencies, and increases patient satisfaction. As part of this pilot, metrics will be tracked for six months to monitor for improvement in clinical outcomes, and in role definition practices.

This pilot leads the way for the development of additional disease protocols.

Be a part of the continued development of Inspire Health Partners by providing critical feedback on this pilot, adding your practice to the pilot or assisting in developing additional disease protocols.
Contact Natalie Thieret at NThieret@crh.org.

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HEALTHCARE IDEALS AT WORK

Diabetes Protocol Pilot

Pre-visit Planning

Care coordinator / coach will call patient approximately 1 week before appointment and remind them of appoint. He/she will:

- Confirm and document last eye exam
- Encourage patient to bring Blood Sugar logs, meter, medications, etc.
- Review Phytel system alerts with patient. Order any tests, or screenings as appropriate. May change f/u visit to HME as time and patient preferences permit
- For patients with last A1C > 7.0, offer yearly coaching session
- Order labs for upcoming appointment or add to already scheduled labs. This includes:
  - A1C if not done in > 3 months. If right at 3 months, order if last A1C > 6.5, or perform waived A1C
  - LDL if not done in > 9 months, or if last LDL > 100, or if statin therapy changed since last LDL value was completed
  - May continue with yearly LDL if not at goal but patient on Lipitor 80mg or Crestor 20mg or has statin allergy
  - CMP if not done in > 9 months or if statin therapy changed
  - TSH if diagnosis of hypothyroidism (on levothyroxine, armour thyroid) and not done in > 9 months. Repeat in 8 weeks if dosage changed
  - Urine micro albumin (preferred) or UA if not on ACE or ARB and not done in > 9 months
  - If patient wants other labs, coach feels other needed due to history, etc., confirm with provider
- Encourage patient to have labs done before visit to maximize utility of visit. Encourage (but do not require) fasting if doing a lipid panel
- If patient had outside labs / sees specialist, try to obtain results and enter into chart

Check In

- Confirm patient has portal account with active email address
- Remind patient that labs are available to be reviewed on-line

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Nurse

- While doing vitals, etc. ask patient if they brought medications, Blood Sugar logs, meter. Reinforce this behavior
- Check Phytel system alerts. Order any overdue services such as micro albumin, mammogram, colon cancer screening
- Confirm flu and pneumonia shots are current
- Schedule 3 month f/u appointment (this can be done when rooming patient or while provider is seeing patient. It should be automatic)
- Confirm current med list against patient's medications
- Ask patient to remove shoes and socks for foot exam
- If patient has already had labs for this visit, order labs for next visit
- Follow protocol as above; taking in to account labs will be completed in 3 months
- If patient has not had labs and is a Medicare patient or gets labs elsewhere, may order labs as per protocol above. If labs will be drawn here, allow provider to order as they will need to bill them

Provider

- Provider sees patient, ideally with all labs back and in chart, sugars / meter with patient
- Flu shot, pneumonia shot, etc. already completed. Shoes are off for foot exam.
- Urine micro albumin available to assess for need for ACE therapy, etc.
- Provider can add any additional labs, make changes to treatment, reinforce any coaching. Address other issues
- Try to set a goal with the patient that is measurable, such as "exercise 30 minutes 5 days per week" or "check blood sugar once daily" or "1 soda per day"
- Document goal in chart to reinforce at next visit

Discharge

- Give patient reminder of next appointment
- Remind about any orders/ labs
- Encourage use of portal to review labs
- Reinforce bringing meter/ logs/meds, etc., especially if patient forgot