



Appalachian Diabetes Consultation

April 10, 2014

PROMISING PRACTICES

Project Title: Adaptive Care Teams for Diabetes

Presented by: Craig Robinson, Executive Director, Cabin Creek Health System

Purpose/Description: To create effective multidisciplinary primary care teams that join with patients to control their diabetes.

Key Components:

- Teams begin with the PCP and medical assistant nurse who serve a group of poorly controlled diabetics and includes a health coach, behavioral health consultant, and consulting pharmacist.
- The team is engaged prior to patient visit to prepare for the visit: prep includes collection and review of key clinical information, health coach call patient to check on current situation and, per patient approval, invite family member to visit, BHC scheduled to attend the visit with PCP.
- Address with the patient, technical issues, psycho-social issues, barriers to appropriate care, self-care action plan and hospital use.

Performance Metrics:

- Number of poorly controlled DM patients who receive PCP visits with at least 3 team members involved in the care before, during or after the visit.
- Number and rate of hospital admissions and ER visits in past 3 months compared to baseline year.
- Number and percent of poorly controlled diabetic patients who gain control - A1c is below 9%

Lessons Learned:

- Substantial evidence that both care management and behavioral health most effective when totally integrated with the primary care practice.
- Improvement DM outcomes related to patient's behavioral changes and change more likely when behavioral health issues such as depression are addressed, when patient and family understand the patient risks and are engaged in improvement