Behavioral Health Integration for Chronic Disease Management of Depression and Diabetes

Joseph Parks, M.D.
National Council Behavioral Health Medical Director

integration.samhsa.gov
Today’s Moderators

Madhana Pandian
Associate

Deann Jepson, M.S.
Co-facilitator
Slides for today’s webinar will be available on the CIHS website:

www.integration.samhsa.gov

In the About Us/Innovation Communities 2017 tab
To participate

Use the chat box to communicate with other attendees

Use the question box to send a question directly to Dr. Parks.
Disclaimer: The views, opinions, and content expressed in this presentation do not necessarily reflect the views, opinions, or policies of the Center for Mental Health Services (CMHS), the Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), or the U.S. Department of Health and Human Services (HHS).
Setting the Stage

Dr. Katie Stuckmeyer
Compass Health
Metabolic and Diabetes Screening and Strategies to Improve Treatment Adherence

Katie Stuckmeyer D.O.
Compass Health
Why Screen?

- Patients with depression are more likely to develop metabolic syndrome and type 2 diabetes
- Patients with Diabetes are 2x as likely to have depression
- Comorbid depression in patients with Diabetes is a predictive factor for the number of and severity of Diabetic complications
- Patients with SMI are dying 25 years earlier, particularly from cardiovascular disease, diabetes and cancer.
Psychotropics

- Psychotropic medications, including antidepressants, mood stabilizers, and antipsychotics, have shown to potentiate metabolic issues such as insulin resistance secondary to significant weight gain.

- For patients taking higher risk medications, closer monitoring for prediabetes/diabetes, weight gain, hypertension, and dyslipidemia will lead to improved outcomes.
Metabolic Syndrome

Defined as 3 or more of the below 5 parameters.

Blood glucose ≥100 (or taking hypoglycemic)
HDL <40 (men) or < 35 (women)
Triglycerides ≥ 150 (or taking lipid lowering agents)
Waist circumference >40 in (men) or > 35 in (women)
Blood pressure ≥ 130/85 (or taking anti-hypertensive)
Diabetes Screening- ADA

All patients should be screened at age 45 and repeated at least every 3 years if normal. Can screen with fasting glucose, a1c, glucose tolerance test.

**Testing should be considered at an earlier age or be carried out more frequently if diabetes risk factors are present**

- family history of diabetes
- overweight or obesity
- habitual physical inactivity
- belonging to a high-risk ethnic or racial group
- previously identified pre-diabetic or glucose intolerance
- Hypertension
- Dyslipidemia
- history of GDM or delivery of a baby weighing >9 lbs
- conditions associated with insulin resistance – acanthosis nigricans and pcos

Testing may be considered in children and adolescents who are overweight or obese and have two or more risk factors
Screening in Patients with Depression/SMI

- History of depression, current depression, and antidepressant medication use are risk factors for the development of type 2 diabetes, especially if the individual has other risk factors such as obesity and family history of type 2 diabetes.

- There is no consensus screening protocol for patients with SMI or diagnosis of depression.

- ADA and APA coordinated to develop consensus metabolic monitoring guideline for patients on atypical antipsychotics
### ADA/APA Consensus Guidelines for Atypical Antipsychotic Monitoring

<table>
<thead>
<tr>
<th></th>
<th>baseline</th>
<th>4 wks</th>
<th>8 wks</th>
<th>12 wks</th>
<th>Quarterly</th>
<th>Annually</th>
<th>Every 5 yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Personal/Family Hx</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weight (BMI)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Waist Circ</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fasting Glucose</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fasting Lipids</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Metabolic Screening/Diabetic Screening

Consider annual metabolic screening of all patients with depression, including those meeting SMI criteria and on antipsychotics.

CMHC HCH program - Met Screen
- Annual screening recommended on all participants in the program that includes monitoring bmi, waist circumference, fasting glucose or a1c, blood pressure and lipids.
<table>
<thead>
<tr>
<th>Lab Test</th>
<th>Date</th>
<th>Test Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBC</td>
<td>9/13/16*</td>
<td></td>
</tr>
<tr>
<td>CMP/GLUCOSE</td>
<td>8/17/16*</td>
<td>79</td>
</tr>
<tr>
<td>HgA1C</td>
<td>8/17/16*</td>
<td>5.4</td>
</tr>
<tr>
<td>LDL</td>
<td>9/13/16*</td>
<td>59</td>
</tr>
<tr>
<td>TRIG</td>
<td>8/17/16*</td>
<td>42</td>
</tr>
<tr>
<td>MICRO/CREAT RATIO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TSH</td>
<td>8/17/16*</td>
<td>1.59</td>
</tr>
<tr>
<td>UA</td>
<td>8/17/16*</td>
<td></td>
</tr>
</tbody>
</table>

**Immunizations**

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>FLU</td>
<td>9/23/16</td>
</tr>
<tr>
<td>PNEUMO (DUE PPV 23)</td>
<td>5/3/16</td>
</tr>
</tbody>
</table>

**Exams**

<table>
<thead>
<tr>
<th>Exam</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>FOOT EXAM</td>
<td>4/20/17</td>
</tr>
<tr>
<td>EYE EXAM</td>
<td></td>
</tr>
</tbody>
</table>

**Diagnostics**

<table>
<thead>
<tr>
<th>Diagnostic</th>
<th>Date</th>
<th>Test Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>COLONOSCOPY-Rpt 5YRS</td>
<td>2/20/14</td>
<td></td>
</tr>
<tr>
<td>FIT NEG POS</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Provider Test Action:**

- LAST VISIT: 3/13/17
- MISC:
- 9/13/16 AND 8/17/16 LABS SCANNED (PER PSYCH)
Pre-diabetes

Diagnostic Criteria
Fasting glucose
- 100-125mg/dL = impaired fasting glucose
Glucose Tolerance test
- 140-199mg/dL = impaired glucose tolerance
A1c
- 5.7-6.4%

Treatment
- Weight reduction
- Increased physical activity
- Medical nutrition therapy
- Consider medications that lower the risk of developing dm in this group (metformin, acarbose)
Diabetes Diagnosis

Criteria for Diabetes Diagnosis: 4 options

FPG ≥126 mg/dL (7.0 mmol/L)*
Fasting is defined as no caloric intake for ≥8 hours

2-hr PG ≥200 mg/dL (11.1 mmol/L) during OGTT (75-g)*
Using a glucose load containing the equivalent of 75g anhydrous glucose dissolved in water

A1C ≥6.5% (48 mmol/mol)*
Performed in a lab using NGSP-certified method and standardized to DCCT assay

Random PG ≥200 mg/dL (11.1 mmol/L)
In individuals with symptoms of hyperglycemia or hyperglycemic crisis
ADA New Diabetes Guidelines

New guidelines have a comprehensive approach

Multidisciplinary team-based approach –
  - Diabetes educators, dieticians, nurses, medical assistants, PCP

Routine screening for depression

Treatment includes
  - Lifestyle modifications, Pharmacologic interventions, Monitoring blood glucose at regular intervals (3-6 mo) and adjusting medications accordingly
  - Treatment of blood pressure, lipids, weight loss, anticoagulation with aspirin.
  - Management of hypoglycemia
“Good news.
Your cholesterol has stayed the same,
but the research findings have changed.”
Diabetes Complications Screening and Prevention

- Lipid panel at time of diagnosis and every 5 years if not on a statin, increased frequency if indicated (at least annually if abnormal) and for medication monitoring
- Annual albumuria (ma/cr) screening and GFR,
- Dilated eye exam (at dx in type 2 within 5 yrs in type 1, if normal can rpt 2yrs, any retinopathy rpt at least annually) - many use annual exam
- Annual foot exam with monofilament
- Blood pressure monitoring at every visit with goal of <140/90
- Dental exam at time of diagnosis and with recommended follow up
- Age appropriate Cancer screening
- Aspirin consideration
- Update recommended vaccines for diabetics based on age
- Lifestyle modifications
  - Referral to dietician at diagnosis and as needed, ADA diet counseling, wt loss counseling as indicated. Physical activity counseling
Goals

A1c less than 7% - most common goal
  - Shown to decrease micro and macrovascular complications and decrease mortality in type 1 diabetics

Less Stringent goal <8%
  - History of severe hypoglycemia, limited life expectancy, advanced micro/macrovascular complications, extensive comorbidity, long term diabetics in whom it has been difficult to achieve a1c targets

More stringent goal <6.5%
  - Short diabetes duration, long life expectancy-treatment with lifestyle or metformin only, no significant CVD complications
It takes a Village and Health Information Technology

Team based care models and data to identify care gaps and the most at risk patients

- In Primary Care, teams may include physician/nurse practitioner, RN, behavioral health specialist, medical assistant, dietician.
- RNs taking on significant roles with health coaching, and case management of chronic diseases
- Care is expanded beyond the 15-30min apt to include pre-visit, visit, post visit and between visit care
- Increased focus on the patient and self management support
- Population management using data bases and technology
Disease Registries

Population Management

- Monitor health parameters and treatment adherence
- Develop practice guidelines Identify modifiable risk factors and care gaps
  - Care coordinators identify care gaps and create individualized plans
- Identify high risk patients and high risk diseases for increased monitoring and interventions
- Track organizational or individual care teams performance and improve performance
Registry Examples

ProAct by CMT

Cyber Access- (Mo Healthnet)

Care Manager by Netsmart

DRVS by Azara

Disclaimer: These examples should not be construed as endorsement
<table>
<thead>
<tr>
<th>Agency Name</th>
<th>PatientID</th>
<th>Patient Name</th>
<th>Attribute Name</th>
<th>Attribute Value</th>
<th>Attribute Date Taken</th>
<th>OptOut</th>
<th>Mox</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crider Health Center, Inc.</td>
<td></td>
<td></td>
<td>BP Systolic</td>
<td>130</td>
<td>04/26/2016</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Crider Health Center, Inc.</td>
<td></td>
<td></td>
<td>HDL</td>
<td>63</td>
<td>04/19/2016</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Crider Health Center, Inc.</td>
<td></td>
<td></td>
<td>Height</td>
<td>65</td>
<td>04/26/2016</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Crider Health Center, Inc.</td>
<td></td>
<td></td>
<td>LDL</td>
<td>73</td>
<td>04/19/2016</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Crider Health Center, Inc.</td>
<td></td>
<td></td>
<td>Pregnant</td>
<td>No</td>
<td>04/26/2016</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Crider Health Center, Inc.</td>
<td></td>
<td></td>
<td>Smoker</td>
<td>Yes</td>
<td>04/26/2016</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Crider Health Center, Inc.</td>
<td></td>
<td></td>
<td>Total Cholesterol</td>
<td>155</td>
<td>04/19/2016</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Crider Health Center, Inc.</td>
<td></td>
<td></td>
<td>Triglycerides</td>
<td>78</td>
<td>04/19/2016</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Crider Health Center, Inc.</td>
<td></td>
<td></td>
<td>Weight</td>
<td>140.4</td>
<td>04/26/2015</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Crider Health Center, Inc.</td>
<td></td>
<td></td>
<td>Antipsychotic Use</td>
<td>Yes</td>
<td>04/08/2016</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Crider Health Center, Inc.</td>
<td></td>
<td></td>
<td>Blood Glucose</td>
<td>108</td>
<td>04/08/2016</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Crider Health Center, Inc.</td>
<td></td>
<td></td>
<td>BP Diastolic</td>
<td>80</td>
<td>04/08/2016</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Crider Health Center, Inc.</td>
<td></td>
<td></td>
<td>BP Systolic</td>
<td>130</td>
<td>04/08/2016</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Crider Health Center, Inc.</td>
<td></td>
<td></td>
<td>HA1C</td>
<td>0</td>
<td>04/08/2016</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>Crider Health Center, Inc.</td>
<td></td>
<td></td>
<td>HDL</td>
<td>71</td>
<td>04/08/2016</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Crider Health Center, Inc.</td>
<td></td>
<td></td>
<td>Height</td>
<td>60</td>
<td>04/08/2016</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Crider Health Center, Inc.</td>
<td></td>
<td></td>
<td>LDL</td>
<td>76</td>
<td>04/08/2016</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Crider Health Center, Inc.</td>
<td></td>
<td></td>
<td>Pregnant</td>
<td>No</td>
<td>04/08/2016</td>
<td>No</td>
<td></td>
</tr>
<tr>
<td>Crider Health Center, Inc.</td>
<td></td>
<td></td>
<td>Smoker</td>
<td>Yes</td>
<td>04/08/2016</td>
<td>No</td>
<td></td>
</tr>
</tbody>
</table>
## Care Manager

<table>
<thead>
<tr>
<th>Client DMH</th>
<th>Last Na First Name</th>
<th>Gender</th>
<th>Age</th>
<th>Date Vitals Taken</th>
<th>Systolic Result</th>
<th>Diastolic Result</th>
<th>Lab Taken Di A1c Result</th>
<th>Lab Taken Di LDL Result</th>
<th>Nurse Care Manager</th>
</tr>
</thead>
<tbody>
<tr>
<td>P</td>
<td>Paul</td>
<td>Male</td>
<td>69</td>
<td>2016-12-08</td>
<td>148</td>
<td>90</td>
<td>2016-10-18</td>
<td>9.8</td>
<td>2016-10-18</td>
</tr>
<tr>
<td>Q</td>
<td>Lisa</td>
<td>Female</td>
<td>53</td>
<td>2016-09-29</td>
<td>145</td>
<td>85</td>
<td>2016-09-29</td>
<td>8.7</td>
<td>2016-09-29</td>
</tr>
<tr>
<td>N</td>
<td>Jessica</td>
<td>Female</td>
<td>29</td>
<td>2016-04-11</td>
<td>122</td>
<td>87</td>
<td>2016-03-30</td>
<td>10.7</td>
<td>2016-03-30</td>
</tr>
<tr>
<td>W</td>
<td>Mildred</td>
<td>Female</td>
<td>43</td>
<td>2016-08-12</td>
<td>130</td>
<td>87</td>
<td>2016-08-12</td>
<td>8.4</td>
<td>2016-07-15</td>
</tr>
<tr>
<td>X</td>
<td>Amanda</td>
<td>Female</td>
<td>32</td>
<td>2016-03-15</td>
<td>158</td>
<td>95</td>
<td>2016-03-15</td>
<td>8.5</td>
<td>2016-03-15</td>
</tr>
<tr>
<td>E</td>
<td>Charles</td>
<td>Male</td>
<td>48</td>
<td>2015-12-21</td>
<td>113</td>
<td>90</td>
<td>2015-12-21</td>
<td>7.8</td>
<td>2015-12-21</td>
</tr>
<tr>
<td>R</td>
<td>David</td>
<td>Male</td>
<td>31</td>
<td>2016-10-17</td>
<td>129</td>
<td>84</td>
<td>2016-10-17</td>
<td>10.6</td>
<td>2016-04-07</td>
</tr>
<tr>
<td>Q</td>
<td>Dorothy</td>
<td>Female</td>
<td>51</td>
<td>2016-06-29</td>
<td>138</td>
<td>64</td>
<td>2016-04-26</td>
<td>7</td>
<td>2016-01-06</td>
</tr>
<tr>
<td>P</td>
<td>Angel</td>
<td>Female</td>
<td>34</td>
<td>2016-09-13</td>
<td>130</td>
<td>84</td>
<td>2016-07-28</td>
<td>10.3</td>
<td>2016-07-28</td>
</tr>
<tr>
<td>M</td>
<td>Tina</td>
<td>Female</td>
<td>46</td>
<td>2016-03-09</td>
<td>138</td>
<td>81</td>
<td>2016-03-09</td>
<td>9.2</td>
<td>2016-06-07</td>
</tr>
<tr>
<td>N</td>
<td>Cynthia</td>
<td>Female</td>
<td>57</td>
<td>2016-04-20</td>
<td>144</td>
<td>100</td>
<td>-</td>
<td>-</td>
<td>2016-05-19</td>
</tr>
<tr>
<td>V</td>
<td>Heather</td>
<td>Female</td>
<td>40</td>
<td>2015-10-15</td>
<td>142</td>
<td>87</td>
<td>-</td>
<td>-</td>
<td>2015-10-15</td>
</tr>
<tr>
<td>U</td>
<td>Amy</td>
<td>Female</td>
<td>42</td>
<td>2015-11-09</td>
<td>116</td>
<td>76</td>
<td>2015-12-10</td>
<td>5.6</td>
<td>2015-12-10</td>
</tr>
<tr>
<td>T</td>
<td>Mogola</td>
<td>Female</td>
<td>34</td>
<td>2016-08-04</td>
<td>130</td>
<td>80</td>
<td>2016-04-26</td>
<td>5.7</td>
<td>2016-04-26</td>
</tr>
<tr>
<td>O</td>
<td>Nathaniel</td>
<td>Male</td>
<td>62</td>
<td>2016-12-13</td>
<td>162</td>
<td>90</td>
<td>2016-08-01</td>
<td>6.2</td>
<td>2016-12-13</td>
</tr>
<tr>
<td>D</td>
<td>Christina</td>
<td>Female</td>
<td>50</td>
<td>2016-07-19</td>
<td>145</td>
<td>80</td>
<td>2016-06-24</td>
<td>6.9</td>
<td>2016-06-24</td>
</tr>
<tr>
<td>Z</td>
<td>Debra</td>
<td>Female</td>
<td>56</td>
<td>2016-10-03</td>
<td>102</td>
<td>61</td>
<td>2016-09-08</td>
<td>6.6</td>
<td>2016-09-08</td>
</tr>
<tr>
<td>Y</td>
<td>Donna</td>
<td>Female</td>
<td>57</td>
<td>2016-06-29</td>
<td>116</td>
<td>66</td>
<td>2016-07-14</td>
<td>5.7</td>
<td>2016-07-14</td>
</tr>
<tr>
<td>B</td>
<td>Erica</td>
<td>Female</td>
<td>36</td>
<td>2016-02-04</td>
<td>110</td>
<td>85</td>
<td>2016-02-04</td>
<td>6.4</td>
<td>2016-02-04</td>
</tr>
<tr>
<td>I</td>
<td>Rachel</td>
<td>Female</td>
<td>43</td>
<td>2015-10-01</td>
<td>110</td>
<td>73</td>
<td>-</td>
<td>-</td>
<td>2015-10-01</td>
</tr>
<tr>
<td>L</td>
<td>Christina</td>
<td>Female</td>
<td>48</td>
<td>2016-10-06</td>
<td>133</td>
<td>85</td>
<td>2016-07-08</td>
<td>5.5</td>
<td>2016-07-08</td>
</tr>
<tr>
<td>Y</td>
<td>Jean</td>
<td>Female</td>
<td>54</td>
<td>2016-04-25</td>
<td>110</td>
<td>70</td>
<td>2016-01-25</td>
<td>6.1</td>
<td>2016-02-02</td>
</tr>
<tr>
<td>T</td>
<td>Sheila</td>
<td>Female</td>
<td>48</td>
<td>2016-07-22</td>
<td>118</td>
<td>84</td>
<td>2016-02-05</td>
<td>6.8</td>
<td>2016-02-05</td>
</tr>
<tr>
<td>S</td>
<td>Wanada</td>
<td>Female</td>
<td>50</td>
<td>2016-03-02</td>
<td>126</td>
<td>75</td>
<td>2016-03-02</td>
<td>6.3</td>
<td>2016-03-02</td>
</tr>
<tr>
<td>A</td>
<td>Lacey</td>
<td>Male</td>
<td>49</td>
<td>2016-07-21</td>
<td>-</td>
<td>-</td>
<td>2016-02-11</td>
<td>5.4</td>
<td>2016-02-11</td>
</tr>
<tr>
<td>S</td>
<td>Timothy</td>
<td>Male</td>
<td>37</td>
<td>2016-01-05</td>
<td>136</td>
<td>82</td>
<td>-</td>
<td>-</td>
<td>2016-01-05</td>
</tr>
<tr>
<td>#</td>
<td>Description</td>
<td>%</td>
<td>Managed Population</td>
<td>Goal</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>--------------------------------------------------</td>
<td>----</td>
<td>--------------------</td>
<td>-------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Asthma Medication Adherence (Adult)</td>
<td>100%</td>
<td>2</td>
<td>100%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Blood Pressure Control for Diabetes (Adult)</td>
<td>69%</td>
<td>18</td>
<td>86%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Blood Pressure Control for Hypertension (Adult)</td>
<td>57%</td>
<td>4</td>
<td>67%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Body Mass Index Control (Adult)</td>
<td>No data to display</td>
<td></td>
<td>No data to display</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hemoglobin HbA1c Control for Diabetes (Adult)</td>
<td>54%</td>
<td>14</td>
<td>66%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>LDL Control for Cardiovascular Disease (Adult)</td>
<td>33%</td>
<td>1</td>
<td>33%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name</td>
<td>Age</td>
<td>MRN</td>
<td>Primary Payer</td>
<td>Most Recent Qualifying Enc</td>
<td>Provider</td>
<td>Location</td>
<td>Next App</td>
<td>Next Appointment Provider</td>
<td>Most Recent DM Diag</td>
</tr>
<tr>
<td>--------------</td>
<td>-----</td>
<td>-------</td>
<td>---------------</td>
<td>----------------------------</td>
<td>---------------</td>
<td>------------------------------</td>
<td>------------</td>
<td>--------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Mendoza, Lillie</td>
<td>50</td>
<td>849187</td>
<td>Medicare</td>
<td>4/13/2016</td>
<td>Unassigned Provider</td>
<td>Neighborhood Medical Center</td>
<td>8/2/2016</td>
<td>Unassigned Provider</td>
<td>4/10/2016</td>
</tr>
<tr>
<td>Maxwell, Gary</td>
<td>43</td>
<td>6130500</td>
<td>Aetna</td>
<td>11/2/2015</td>
<td>Unassigned Provider</td>
<td>Neighborhood Medical Center</td>
<td>8/2/2016</td>
<td>Unassigned Provider</td>
<td>9/7/2015</td>
</tr>
<tr>
<td>Palmer, Winston</td>
<td>10</td>
<td>7487331</td>
<td>Aetna</td>
<td>11/1/2015</td>
<td>Lynes, Lori</td>
<td>Neighborhood Medical Center</td>
<td>8/2/2016</td>
<td>Parker, Philip</td>
<td>12/6/2014</td>
</tr>
<tr>
<td>Dunn, Sara</td>
<td>15</td>
<td>5985198</td>
<td>Medicare</td>
<td>7/7/2016</td>
<td>Unassigned Provider</td>
<td>Neighborhood Medical Center</td>
<td>8/5/2016</td>
<td>Unassigned Provider</td>
<td>7/7/2016</td>
</tr>
<tr>
<td>Tran, Amos</td>
<td>80</td>
<td>6149257</td>
<td>Medicaid</td>
<td>2/10/2016</td>
<td>Unassigned Provider</td>
<td>Adult Health</td>
<td>8/4/2016</td>
<td>Unassigned Provider</td>
<td>7/12/2014</td>
</tr>
</tbody>
</table>
Patients with Diabetes

1,101
Qualifying Patients

Diabetes by A1c

- DM A1c < 7: 92 (8%)
- DM A1c 7 - 8: 34 (3%)
- DM A1c 8 - 9: 30 (4%)
- DM A1c > 9 or Untested: 936 (85%)

A1c > 9 or Untested Over Time

Controlled Diabetics (A1c < 7%)

MU Diabetes Scorecard

Measure | R | N  | D  | E
---|---|---|---|---
DM Eye Exam | 53% | 404 | 761 | 0
DM Foot Exam | 46% | 348 | 761 | 0
DM A1c > 9 or Untested | 75% | 573 | 761 | 0
DM A1c Tested (6 mo) | 22% | 171 | 761 | 0
DM A1c Tested (1 yr) | 48% | 385 | 761 | 0
DM Depression Screening | 8% | 12 | 761 | 0
Improving Care

Less than 50% of patients with type 2 diabetes in the U.S. achieve an A1c of less than 7%, approximately 2/3 die prematurely of cvd

ADA strategies for improving care (ADA Standards of Medical Care in Diabetes 2016)
- Patient Centered communication style that incorporates patient preferences, assesses literacy and numeracy and addresses cultural barriers should be used
- Treatment decisions should be timely and based on evidence based guidelines tailored to individual patient preference prognosis and comorbidities
- Care should be aligned with components of the Chronic Care Model, to ensure productive interactions between a prepared proactive practice team and an informed activated patient
- When feasible, care systems should support team-based care, community involvement, patient registries and decision support tools to meet patient needs
Treatment Adherence

- Simplicity
- Emphasize Choice and options
- Customize
- Repetition
- Monitoring
- Compassion
- Patience
- Access
"I have a question about my medication. Why is the couple in the commercial sitting outdoors in separate bathtubs?"
Medication Adherence

- Simplicity
- Tolerability
- Improved Communication
- Education
- Assess adherence
- Social Supports
At Risk

- Uninsured/Low Income
- Homeless
- Poor Literacy
- Food insecurities
Diabetic Medications

1st line
- Biguanides (Metformin) - Wt loss/neutral

2nd line (wt loss or neutral, low risk of hypoglycemia)
- DPP4 Inhibitors (Januvia, Onglyza, Tradjenta)
- GLP-1 Inhibitors (Victoza, Byetta, Bydureon, Trulicity, Tanzeum) – injectables
- SGLT2 Inhibitors (Invokana, Farxiga, Jardiance)

Next Tier (wt gain, inc risk hypoglycemia or other sig se)
- Sulfonylurias (glyburide, glpizide, glimeperide)
- TZD (Actos)

Insulins
- Long acting Lantus and Levemir, Ultra long acting, Tresiba, Toujeo
- Mealtime Humalog and Novolog, regular Intermediate - NPH
Provider Orientation/Training

- Behavioral health training, screening protocols, antidepressant protocols, access to psychiatry consultant
- Best practices on organizing complex medical appointments
- Comfortability with chaos
- Education on appropriate billing
- Team based Care
- Orientation on community resources
- Communication with other providers and family
- Basics of motivational interviewing
- Simplicity- small changes with encouragement and follow up
- Population mindset- data helps
- Self Care
- Low and very low health literacy patient education
Train An Army

Nurses

Medical assistants

Integrated health specialists

Dieticians

Behavioral health specialists

Scheduler

Receptionist

Family members
RE-CAP

- Screening for diabetes and metabolic syndrome in patients at increased risk
  - recommending at least annual in patients with depression, SMI, or on antipsychotics.
- Team based care with evidence based medicine for chronic diseases
- Population based care models- using patient and disease registries to identify patients with care gaps and outreaching.
- Patient centered medicine - understanding a patients experience and meeting them where they are
Questions?
References

Barrett, Eugene MD. Et al. Consensus Development Conference on Atipsychotic Drugs and Obesity and Diabetes.
Garcia-Perez, et al. Adherence to Therapies in Patients with Type 2 Diabetes. Diabetes Therapy. 2013
Raney, Lori MD, et al. Integrated Care: Working at the Interface of Primary Care and Behavioral Health. 2015
Next Learning Session

July 28, 2 – 3 p.m. ET

Presenter: Jeff Capobianco, Ph.D., LLP
Strategies to Maintain Gains, Support Momentum, and Sustain Adoption of the Innovation
Learn how Innovations Community participants are:

- Progressing toward goals
- Sustaining momentum, improving interventions, and garnering positive gains
- Establishing best practice models across the organization
Next Steps:

Continue to:

- work on your plan’s action steps with your team,
- meet with your coach on a regular basis, and
- plan for your 5 x 5 presentation.