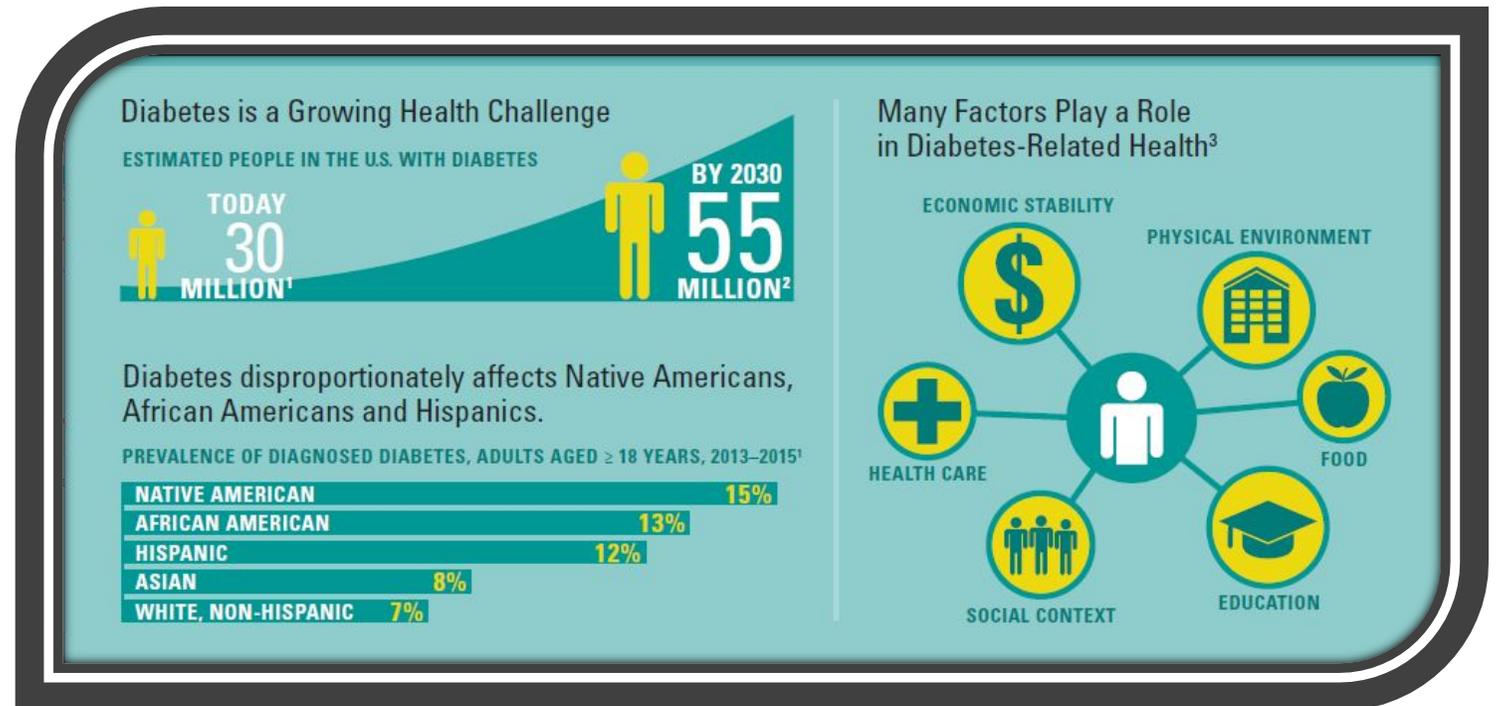


Integrated
Patient-Centered
Diabetes Care:
A Shared Vision

Raichell Dorland-Roan MS, RDN, LN, IBCLC

Diabetes: Our Nations Most Expensive Health Condition

- 1 in 4 Health Care Dollars
- 26% Increase
- Medical Expenditures 2.3 X Higher





Diabetes: Quality Gap

Keys to Better Diabetes Care

- Patient-Centered Care
- Self-Management
- Patient Empowerment
- Team-Based Care
- Continuous Quality Improvement



Patient-Centered Integrated Health Care



**Registered Dietitian
Nutritionist**



Primary Care Provider



Pharmacist



Nurse Educator

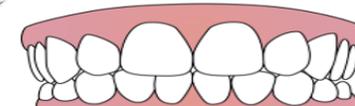


**Behavioral
Health**

Podiatrist

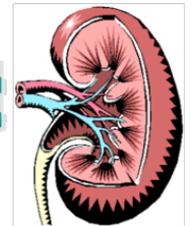


Eye Doctor



Dentist

Endocrinologist



The Three Phases of the Diabetes Care:

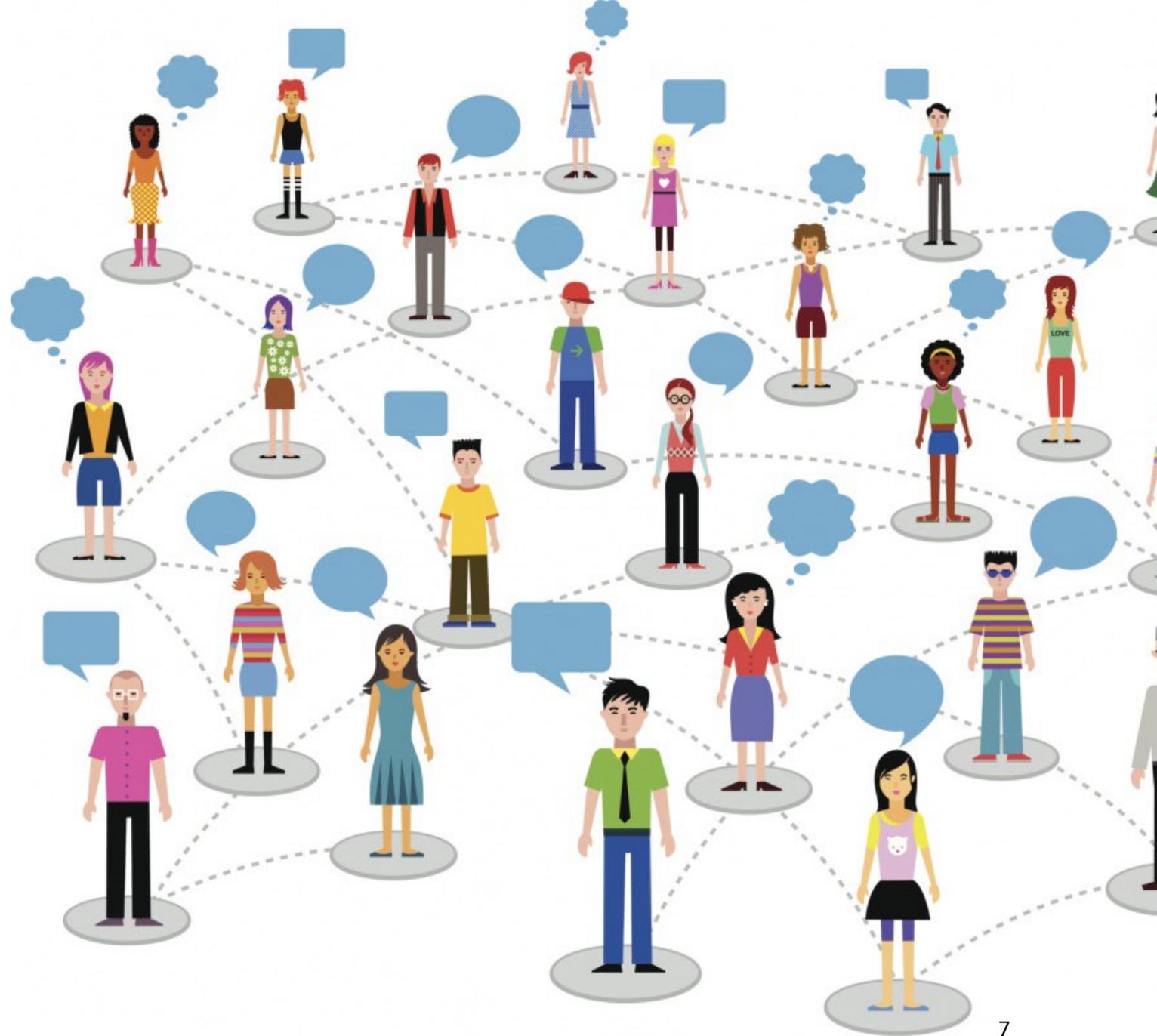
Phase 1–Pre-Visit Preparation

Phase 2–Intra-Visit

Phase 3–Post-Visit

Patient Engagement

- Shared Decision Making
- Resource Connections
- Empowerment
- Goals





Care Management: Assisting the Patient Who is Not at Goal

Community Partnerships



Community Culture Change



Resiliency



Diabetes Support Group(s)	Basic Diabetes Education	Comprehensive Diabetes Education/Treatment	Diabetes Prevention
<ul style="list-style-type: none"> • Facilitated by clinic staff • Focused on problem-solving and coping skills • Patient/Client led 	<ul style="list-style-type: none"> • Free to the community • Open to individuals with diabetes and family members/care takers • Focused on basic diabetes information and building a diabetes support network 	<ul style="list-style-type: none"> • Medical Nutrition Therapy • Diabetes Self-Management Education Training and Support (Individual and/or Group) • Clinical Pharmacist • Shared Medical Appointments • Consistent Messaging 	<ul style="list-style-type: none"> • CDC Diabetes Prevention Program • At risk screenings • Program referrals

Comprehensive Diabetes Program

Assessing Your Program

- How many prediabetic and diabetic patients does your clinic currently see?
 - How are prediabetic patients identified/diagnosed
- What does your integrated care team look like: do you have behavioral health, pharmacy, patient resource coordinator, dietitian/diabetes educator and how many providers, nurses, medical assistants, etc. do you have?
- What are your current goals that pertain to diabetes or chronic disease care/treatment/prevention?
- What diabetes programming do you already offer?
- What resources do you have to support care in your community?
- Identify key partnerships to support diabetes care in your community.
 - What partnerships already exist?
 - What partnerships need to be established?



Thank you!



Resources

- <https://www.cdc.gov/diabetes/library/features/diabetes-stat-report.html#:~:text=34.2%20million%20Americans%E2%80%94just%20over,Asians%20and%20non%2DHispanic%20whites.>
- American Association of Diabetes Educators. (2015). CQI: Continuous Quality Improvement for Diabetes Education and Support Programs. Chicago: American Association of Diabetes Educators.
- American Diabetes Association. (2018, March). Economic Costs of Diabetes in the U.S. in 2017. Diabetes Care.
- Bojadziewski, T. a. (2011, April). Patient-Centered Medical Home and Diabetes. Diabetes Care, 1047-1053.
- CDC. (2018). Community Health Online Resource Center. Retrieved from CDC: https://nccd.cdc.gov/DCH_CHORC/
- Mitri, J. a. (2016, March). Measuring the Quality of Diabetes Care. Am J Manag Care, SP147-SP148.
- NIH. (2018). Community Partnerships. Retrieved from NIH: <https://www.niddk.nih.gov/health-information/communication-programs/ndep/health-professionals/practice-transformation-physicians-health-care-teams/diabetes-practice-changes/community-partnerships>
- Riddle, M. H. (2018, May). The Cost of Diabetes Care—An Elephant in the Room. Diabetes Care, 929-932. Retrieved from ADA Diabetes Care: <http://care.diabetesjournals.org/content/41/5/929>