Benefits of Team Care

A team approach can provide short- and long-term benefits from improved glycemic control, including:

- Short-term cost savings from[3]:
  - Shorter hospital stays
  - Reduced rate of hospital readmission
  - Reductions in disabilities and associated costs
- Long-term benefits from intensive treatment of diabetes patients over time, which has reduced risk for[3]:
  - Retinopathy by **21%**
  - Cataract extraction by **24%**
  - Microvascular endpoints by **25%**
  - Albuminuria by **33%**

Take These Steps to Form a Team[3]

1. Gain commitment from organization leadership
2. Gain support from key providers
3. Identify team members and their roles and responsibilities
4. Identify the patient population and stratify according to intensity of services needed
5. Assess available resources
6. Develop a system for coordinated quality care

"Properly implemented diabetes team care is cost-effective and the preferred method of care delivery, particularly when services include health promotion and disease prevention..."[3]

National Diabetes Education Program

References:

1. American Diabetes Association. Standards of Medical Care in Diabetes—2009. *Diabetes Care*. 2009;32(1):S13-S61.
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3. Centers for Disease Control and Prevention. *Team Care: Comprehensive Lifetime Management for Diabetes*. Atlanta, GA: U.S. Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, National Center for Chronic Disease and Health Promotion; 2001. NDEP-36. www.ndep.nih.gov/media/TeamCare.pdf. Accessed July 13, 2009.

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Empowerment for the Future

For Health Care Organizations and Providers

Taking a Team Approach to Diabetes Care

Diabetes

Taking a Team Approach to Diabetes Care

> *"[O]ptimal diabetes management requires an organized, systematic approach and involvement of a coordinated team of health care professionals."*[1]
>
> American Diabetes Association
> Standards of Medical Care in Diabetes—2009

The Need for Improving Diabetes Care

The American Diabetes Association (ADA) has indicated that only 37% of adults with diagnosed diabetes have achieved an A1C of <7%.[1] In addition, only 7.3% of people with diabetes have achieved all 3 treatment goals of A1C <7%, blood pressure <130/80 mm Hg, and total cholesterol <200 mg/dL.[1]

Primary care physicians have provided up to 95% of diabetes care, but they cannot do all that is required, such as[2]:

- Telephone management of glycemia
- Ongoing education and behavioral interventions
- Risk factor reduction
- Health promotion
- Periodic examination for early signs of complications
- Medication regimen review and counseling

Therefore, the ADA recommends that collaborative multidisciplinary teams provide ongoing care for people with diabetes and empower patients to appropriately self-manage.[1]

Patient-Centered Functions of a Diabetes Care Team[2]

1. Support patient self-care efforts and achievements

- Educate about the disease process
- Promote problem-solving skills
- Identify resources to promote self-care

2. Establish short- and long-term diabetes care goals

3. Prescribe and implement a plan for achieving goals

- Medication
- Exercise
- Diet
- Behavior modification

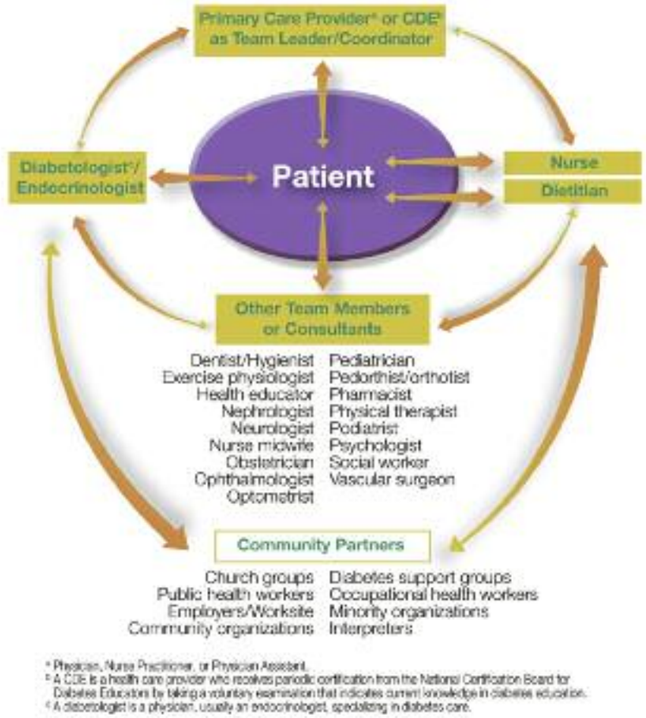
4. Screen for diabetes complications

- Identify risk factors
- Refer to appropriate specialists

Define the Diabetes Team[3]:

- An ideal core team consists of a primary care provider (PCP), a nurse, a dietitian, and a physician specialist such as an endocrinologist
  - At least 1 team member should be a certified diabetes educator (CDE)
  - The PCP is team leader/coordinator or should name the CDE as team leader/coordinator
- Other team members will vary based on the patient's needs:
  - Podiatrists
  - Pharmacists
  - Psychologists
  - Social workers

The Diabetes Interdisciplinary Team[3]



Setting Up Team Care[3]

Develop coordinated quality care using the list below to determine the structure and scope of the team program or service.

1. Initial team visit

- Medical history and physical examination
- Laboratory evaluation
- Risk factor assessment
- Nutritional and physical activity assessments
- Educational and psychosocial needs assessments

2. Intervention

- Self-management education
- Collaborative setting of metabolic and self-care goals
- Ongoing contact between patient and team
- Referral to specialists as necessary

3. Ongoing team care

- Assessment of progress toward goals and self-management
- Identification of barriers to self-care
- Problem solving, including adjustments in therapy and self-care goals

4. Annual planned team visit

- Annual visit for complications examination
- Reassessment of medical, nutritional, educational, and psychosocial needs
- Revisiting metabolic goals