How this Framework can help you:

This framework is designed to provide a standard set of strategies and tools specific to help you improve care provided in the ambulatory environment. The framework has a three tiered approach that we believe provides a foundation for improvement work resulting in effective adoption and sustainability. These elements include:

1. **Infrastructure**: this first section focuses on the role of the care team and highlights how to prepare for upcoming appointments, optimize the role of team members, address equipment needs or medical record needs as well as how to regularly monitor your results;

2. **Competencies**: this section identifies what trainings are available to build clinical and content knowledge for all members of the care team and the patient population. Whenever possible hyperlinks to web based handouts, tools or webinars are included.

3. **Additional Resources**: We recognize that healthcare alone may not meet all of a patient’s needs so this section includes medication and health care coverage as well as related community resources when applicable.

Need help implementing this Framework?

The MaineHealth ACO Improvement team can assist you with strategies and workflows in support of ACO initiatives. To learn more about what frameworks are available or for improvement support please contact Michele Gilliam, Director, Performance Improvement, at

MGilliam@mmc.org

or (207) 661-3804.
1. Infrastructure: Diabetes

☐ Identify Equipment Needs and Standardize (Hardware/Testing)
  ■ Point of Care for HbA1c and Nephropathy tests

☑ Pre-Visit Planning/Huddle
  □ Pre-visit check list
  □ Example of huddle tool
  □ Patient Pre-visit Workflow

☑ Define Care Team Roles
  □ Diabetic Office Visit Workflow
  □ Talking points about HbA1c testing

☑ EMR Tools
  □ EPIC CQM Guide
  □ Measure value sets and POC components for Diabetic Nephropathy

☐ Referral/Communication with Expanded Care Team
  ■ Specialty, Dietitian (RD/RDN) and Behavioral Health referral process
  □ Referral form & result request letter (samples)
- Regularly Measure Results (Sustainability)
  - MHACO Heat Map & Gap reports
  - Claims Based Clinical Closure Reports
  - Other (region/community/payer/practice specific)
  - KPI Examples for performance improvement
### Pre-Visit Planning Checklist

Patient: ____________________  Reason for Appt: ____________________  Appt Time: __________

#### Adult Prevention: Gap(s) in Care or Due Soon:
- BMI (ht & wt)
- Blood Pressure (if >140/90) pull last 3 BP
- Falls Risk (65+)
- Pneumococcal
- Flu Shot
- TDaP
- Tobacco Use/Counsel/Referral to MTHL
- Depression Screen
- Pap Smear
- DEXA Scan
- Colon Cancer Screen (50-75)
- Breast Cancer Screen (50-75)
- Outside Reports / Tests
- Advance Directive
- Outstanding Testing
- Hospital Admissions/ED Visits

#### Diabetic: Gap(s) in Care or Due Soon:
- HgbA1c
- Tobacco Use/Counsel/Referral to MTHL
- Micro albumin
- Outside Reports / Tests
- Eye Exam
- Foot Exam
- Depression Screen
- LDL
- Outstanding Testing
- Hospital Admissions/ED Visits

#### Cardiovascular Disease: Gap(s) in Care or Due Soon:
- Blood Pressure
- IVD / Aspirin
- HTN
- HF / Beta Blocker
- LDL
- Outside Reports / Tests
- Outstanding Testing
- Hospital Admissions/ED Visits

#### Controlled Substance: Gap(s) in Care or Due Soon:
- Controlled Substance Agreement
- UTOX
- PMP
- Outstanding Testing
- Hospital Admissions/ED Visits

#### Pediatric Prevention: Gap(s) in Care or Due Soon:
- BMI (ht & wt)
- 5-2-1-0
- Immunizations
- Tobacco Use/Exposure/Counsel/Referral to MTHL
- Blood Pressure
- Depression Screening
- MCHAT/ASQ
- Outside Reports / Tests
- Outstanding Testing
- Hospital Admissions/ED Visits

#### Pediatric Asthma: Gap(s) in Care or Due Soon:
- Severity
- Controller Med
- Action Plan
- Lung Function Test
- Tobacco Use/Counsel/Referral to MTHL
- ACT
- Outside Reports / Tests
- BMI (ht & wt)
- Outstanding Testing
- Hospital Admissions/ED Visits

#### Room Set Up Needs/General Notes:

**NOTES:**

**Rev 06.01.18**
Huddle Sheet

- What can we proactively anticipate and plan for in our work day/week? At the beginning of the day, hold a review of the day, review of the coming week and review of the next week. Frequency of daily review is dependent on the situation, but a mid-day review is also helpful.
- This worksheet can be modified to add more detail to the content and purpose of the huddles.

<table>
<thead>
<tr>
<th>Huddle Sheet</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice: __________________________________________ Date: __________________</td>
</tr>
</tbody>
</table>

**Aim:** Enable the practice to proactively anticipate and plan actions based on patient need and available resources, and contingency planning.

**Follow-ups from Yesterday**

<table>
<thead>
<tr>
<th>&quot;Heads up&quot; for Today: (include review for orders, labs, etc.; special patient needs, sick calls, staff flexibility, contingency plans)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meetings:</td>
</tr>
<tr>
<td><strong>Example:</strong> Identify and share with team patients with diabetes and an elevated A1c to ensure updated testing, foot checks, and patient education is provided at time of visit.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Review of Tomorrow and Proactive Planning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Meetings:</td>
</tr>
</tbody>
</table>
Diabetic Workflow

Day of Visit

Clinical staff pre-visit plan and identify gaps for visit

Patient Arrives

Checks in Completes paperwork

Clinical staff rooms patient and takes vitals

Did patient have any screenings done outside the office?

NO

Which screening/test are they missing?

HbA1c Nephropathy

Diabetic Eye Exam

Confirm preferred specialist

Outreach to specialist, schedule exam

Send referral form & results letter to specialist to ensure results returned

Set reminder to follow up on results (eg. 2 weeks after test date)

YES

Note where and follow up with lab/specialist to obtain results

Provider Exam and education

Places orders if needed (Lab or POC, if available)

Patient checks out and makes follow-up appointment
Talking to Patients about A1C Testing

Talking with your patients about A1C testing will probably result in them having some questions. We are supplying you with some frequently asked questions and answers regarding A1C testing that we have pulled together as a resource for patients. When care team members use consistent language to answer the patients’ questions, it helps increase patient comprehension. The MaineHealth Learning Resource Center has helped us craft these answers to make sure that the literacy level is appropriate for the majority of our patients.

What is an A1C test?
An A1C test is a simple blood test that measures the amount of sugar stuck to red blood cells (RBCs) in the body. RBCs stay in the body for 2-3 months. By measuring the amount of sugar stuck to RBCs, the A1C test shows us how much sugar was in the blood over the last 2-3 months.

How is A1C different than the blood tests done at home with a finger stick?
An A1C is different than the daily blood sugar tests done at home. Here is how they are different:

- The daily test done at home shows how much sugar is in the blood at that time. A1C shows an average of how much sugar was in the blood over an extended period of time.
- The patient does not have to be fasting when having an A1C test done. This is because the A1C measures blood sugar over time; while the daily test done at home only shows blood sugar at that moment. So one meal won’t make the A1C result change. (For example: going to a birthday party and eating pizza and birthday cake once will affect the results of the daily test, but will not change the A1C result because the party was a one-time occurrence and the patient does not have that much sugar in his/her blood most of the time).
- A1C measures blood sugars at all times of the day. The daily test done at home only shows blood sugar at that moment. If a patient has high blood sugars right after eating but only does fasting tests, then the patient might never know that the blood sugars high after eating.

What is the target A1C range?
A provider can help figure what someone’s personal target A1C should be. There are several things to consider when deciding someone’s target A1C level, including age and any other health conditions. For most adults, the American Diabetes Association recommends the goal target of an A1C less than 7%.

When someone reaches their target A1C level, then we can say that the diabetes is “in control.”
Why do patients need an A1C test?
Testing A1Cs are important. Results from the test tell the health care team if the current diabetes treatment plan is working or if the plan needs to be changed.

Why do patients need to stay at target A1C levels?
A patient knowing their target level and staying at it is an important part of living well with diabetes. Staying at target A1C level can lower the chances of developing other health problems that can be caused by diabetes, like eye disease or kidney disease.

Is the A1C test always right?
There are some health conditions that might affect how accurate the A1C test is. These conditions include:

- Pregnancy
- Sickle cell anemia or iron deficient anemia
- Thalassemia
- Heavy bleeding after having a blood transfusion
- Having a hemoglobin variant (this is sometimes found in people from African, Mediterranean, or Southeast Asian descent)

What can patients do to get their A1C in target range?
- Eat a healthy diet
- Get physical activity
- Take medicines as prescribed and instructed by health care team
  - Remind the patient that if for some reason the patient cannot or does not want to take the prescribed medication the patient should notify their health care team right away
- Test blood sugars as instructed
- Lower stress

For more information, visit www.mainehealth.org/diabetes or contact chronicdiseaseadmin@mainehealth.org
Diabetes Hemoglobin A1C Poor Control (>9.0%)

An HbA1C of ≤9.0% must be achieved for patients with diabetes in order to meet this measure.

If a result is not documented at least annually, the patient will be included in the measurement reporting as ‘not in control’.

Medicare Shared Savings Program (MSSP ACO27)
– Begins 18th birthday and ends 75th birthday

Meaningful Use (eCQM122)

Order the Test – Clinical Support

Per standing orders protocol, order a HbA1C test for all patients with diabetes who have not had at least one within the past 12 months. More frequent testing can be ordered if appropriate.

Testing can be done either point of care (POC) or at an external lab.

Resulting the Order – Clinical Support

The critical result is the HbA1C which must be documented in the patient’s chart.

If the result is received from an external lab, use the QM Results Console activity to document HbA1C.

If the result is POC, use Enter/Edit Results for documenting HbA1C.
Diabetes Eye Exam

Patients with diabetes Type 1 or Type 2 are required to have a dilated retinal eye exam performed every two years (if normal).

If the patient has diabetic retinopathy (abnormal), the eye exam must be performed at least annually.

Medicare Shared Savings Program (MSSP ACO 41) – Patients between ages of 18-75 with Type 1 or Type 2 diabetes who had a retinal eye exam performed.

Meaningful Use (MU eCQM131)

Note: Best practice for Pediatric Patients ages 10-17 with Diabetes.

Report Review - Provider

- Review the paper eye exam report.
- Note at top right of document whether result is Normal (No Retinopathy) or Abnormal (Retinopathy) for the dilated diabetic retinopathy exam.

Resulting the Order – Clinical Support

The diabetic eye exam result must be documented in the patient’s chart.

If it is not received electronically, manually enter the eye exam as Normal (No Retinopathy) or Abnormal (Retinopathy) in the QM Results Console activity.

Note: If exam is Abnormal, Health Maintenance screening default will change to 1 year.

Click test tube to the left of ‘Diabetic Retinopathy Eye Exam Report Summary’ and document Abnormal or Normal.

Health Maintenance Modifier – Clinical Support

Choose a Health Maintenance Modifier if the screening interval of every 2 years does not apply. This does not exclude the patient from the measure.

Step 1: Go to Health Maintenance activity
Step 2: Select Edit Modifiers
Step 3: Choose the correct interval and accept
Diabetes Foot Exam

Patients with diabetes must have a diabetic foot exam annually.

Meaningful Use (MU eCQM123) – Patients 18 -75 with Type 1 or Type 2 diabetes

**Option 1: Foot Exam – Provider**

*When performing a visual, pulse, and sensory foot exam in your office:*

Go to the Notes activity and document foot exam in your note using the SmartPhrase .DMFOOTEXAM

**IMPORTANT:** Insert .DMFOOTEXAM directly in the NOTE of Notewriter.
The smartphrase .DMFOOTEXAM does not work in ANY comment field. It will not store a value to the SmartData element if it is used in NoteWriter comment.

Option 2: Foot Exam Performed Previously or Elsewhere - Clinical Support

If a visual, pulse, and sensory foot exam was performed previously or elsewhere:

Step 1: In the Health Maintenance activity, select DM: FOOT EXAM, and click the Override button. In the pop-up window, choose a reason and enter the date of exam.

Step 2: Scan the foot exam report to the patient’s chart. Scan document type is ‘Consultation Report’.

Patient is Not a Candidate

If applicable, document when a patient is not a candidate for a foot exam:

Step 1: Go to Plan activity and add a bilateral foot or bilateral leg amputation diagnosis if not previously documented.

Step 2: In the Health Maintenance activity, click the Edit Modifiers button and select DM: Foot Exam: Not a Candidate or Not a Candidate: Bilateral Foot Amputation, and accept.

This will prevent the foot exam reminder from appearing in the Health Maintenance activity as due or overdue.
Diabetes: Urine Protein Screening – Clinical Support

Patients with diabetes must have a urine protein screening (microalbumin) at least yearly.

Note: Urine Protein Screening (Microalbumin) is not required if the patient is already on ACE Inhibitors or ARBs.

Meaningful Use (MU eCQM134) – Patients age 18 -75 with diabetes who were screened for nephropathy OR had evidence of nephropathy during the calendar year.

Best practice for Pediatric Patients ages 10-17 with Diabetes.

Ordering the Test – Clinical Support

- Order a urine micro albumin test for patients with diabetes not on an ACE or ARB.
- POC order does not satisfy this measure as it is not a microalbumin/creatinine ratio.

Resulting the Order – Clinical Support

The critical result is the urine micro albumin to creatinine ratio.

Resulting is complete when:

An electronic result is received in In Basket and Chart Review OR

A paper result is received. Check for an open micro albumin order.

a) If there is an open order, go to Enter/Edit Results and record the value with the result date.

b) If there is no open order, manually record the value in the QM Results Console activity and the result date.

The scanned document type is “lab result”. Document and Scan Result to an External Order in Epic
Diabetes Low Density Lipoprotein (LDL) Management

Document Cholesterol - Fasting Low Density Lipoprotein (LDL-C) Test for patients with Diabetes

**Meaningful Use (MU eCQM163)** - patients 18-75 years of age with diabetes whose LDL-C was adequately controlled (< 100 mg/dL) during the calendar year.

**P** Ordering the Test - Provider

Order a fasting LDL-C test for all patients with Diabetes who have not had at least one within the past 12 months. More frequent testing can be ordered if appropriate.

**C** Resulting the Test – Clinical Support

Resulting is complete when:

a) An electronic result is received in In Basket and Chart Review OR
b) A paper result is received. Check for an open LDL-C order.
   - If there is an open order, go to Enter/Edit Results and record the value with the result date.
   - If there is no open order, manually record the value in the QM Results Console activity along with the result date.

Refer to the following link for documentation on how to scan properly:

[Document and Scan Result to an External Order in Epic](#)

The scanned document type is “lab result scan”.
2019 MHACO Heat Map Measure Value Set and Point of Care Components

Diabetic Nephropathy Screening:

- **Denominator:** All patients with diabetes ages 18-75, with a visit within the last year.

- **Numerator:** Patients in the denominator that are on an ACE/ARB or diagnosed with nephropathy for “evidence” or have a nephropathy screening (micro albumin creatinine ratio) for “screening.”
  
  **Exclusion:** Patients whose hospice care overlaps the measurement period.

- **2019 MHACO Target:** 93%

- Screening for nephropathy includes a microalbumin/creatinine ratio lab or evidence of nephropathy includes being on an ACE/ARB or having a diagnosis in one of the following value sets:
  
  - "Diagnosis: Diabetic Nephropathy" using "Diabetic Nephropathy (2.16.840.1.113883.3.464.1003.109.12.1004)"
  
  - "Diagnosis: Glomerulonephritis and Nephrotic Syndrome" using "Glomerulonephritis and Nephrotic Syndrome (2.16.840.1.113883.3.464.1003.109.12.1018)"
  
  - "Diagnosis: Hypertensive Chronic Kidney Disease" using "Hypertensive Chronic Kidney Disease (2.16.840.1.113883.3.464.1003.109.12.1017)"
  
  - "Diagnosis: Kidney Failure" using "Kidney Failure (2.16.840.1.113883.3.464.1003.109.12.1028)"
  
  - "Diagnosis: Proteinuria" using "Proteinuria (2.16.840.1.113883.3.526.3.1003)"

- **Components:**

<table>
<thead>
<tr>
<th>Component ID</th>
<th>Desc</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td>2006133</td>
<td>MICROALBUMIN/CREATININE RATIO UR (MANUAL ENTRY)</td>
<td>Microalbumin</td>
</tr>
<tr>
<td>2003899</td>
<td>MICROALBUMIN/CREATININE RATIO UR (MANUAL ENTRY)</td>
<td>Microalbumin</td>
</tr>
</tbody>
</table>

- POC order POCP2 – POC MICROALB AND CREAT URINE – result MICROALBUMIN/CREATININE RATION RANDOM UR
Information from Eye Care Specialist

Return findings to: Physician Name:__________________________________________
Practice Name:__________________________________________________________
Fax #:___________________ Phone #:_________________

Patient’s Name: ___________________________ Date of Birth:__________
HbA1c Test Date: _________ Result:_________ Other Info:_____________________

Date Seen:_________ Optometrist/Ophthalmologist:________________________________
Practice: ___________________________ Office Phone:________________________

Findings:

Visual acuity: OD________ OS________
☐ No Diabetic Retinopathy
☐ Mild Nonproliferative Diabetic Retinopathy
☐ Moderate Nonproliferative Diabetic Retinopathy
☐ Severe Nonproliferative Diabetic Retinopathy
☐ Proliferative Diabetic Retinopathy

Other findings:
☐ Glaucoma
☐ Cataracts
☐ Other: _________________________________________________________________

Follow-up planned:
☐ Other Treatment: ________________________________________________________
☐ Referral for therapy made to:_____________________________________________
☐ Schedule re-check in 3-6 months
☐ Schedule re-check in 6 months
Diabetes Self-Management Education/Training and Medical Nutrition Therapy Services Order Form

Patient Information

Patient's Last Name ________________________________ First Name __________________ Middle __________________

Date of Birth ______ / ______ / ______

Gender: □ Male □ Female

Address __________________ City __________________ State ______ Zip Code ______

Home Phone ______ Other Phone ______ E-mail address __________________

Diabetes self-management education and training (DSME/T) and medical nutrition therapy (MNT) are individual and complementary services to improve diabetes care. Both services can be ordered in the same year. Research indicates MNT combined with DSME/T improves outcomes.

Diabetes Self-Management Education/Training (DSME/T)

Check type of training services and number of hours requested

☐ Initial group DSME/T: □ 10 hours or ____ no. hrs. requested
☐ Follow-up DSME/T: □ 2 hours or ____ no. hrs. requested
☐ Telehealth

Patients with special needs requiring individual (1 on 1) DSME/T

Check all special needs that apply:

☐ Vision □ Hearing □ Physical
☐ Cognitive Impairment □ Language Limitations
☐ Additional training □ additional hrs requested _________
☐ Telehealth □ Other _________

DSME/T Content

☐ Monitoring diabetes □ Diabetes as disease process
☐ Psychological adjustment □ Physical activity
☐ Nutritional management □ Goal setting, problem solving
☐ Medications □ Prevent, detect and treat acute complications
☐ Preconception/pregnancy management or GDM
☐ Prevent, detect and treat chronic complications

Medicare coverage: 10 hrs initial DSMT in 12 month period from the date of first class or visit

Medical Nutrition Therapy (MNT)

Check the type of MNT and/or number of additional hours requested

☐ Initial MNT □ 3 hours or ____ no. hrs. requested
☐ Annual follow-up MNT □ 2 hours or ____ no. hrs. requested
☐ Telehealth □ Additional MNT services in the same calendar year, per RD

Additional hrs. requested _________

Please specify change in medical condition, treatment and/or diagnosis:

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

Medicare coverage: 3 hrs initial MNT in the first calendar year, plus 2 hrs follow-up MNT annually. Additional MNT hours available for change in medical condition, treatment and/or diagnosis.

Definition of Diabetes (Medicare)

Medicare coverage of DSMT and MNT requires the physician to provide documentation of a diagnosis of diabetes based on one of the following:

• A fasting blood sugar greater than or equal to 126 mg/dl on two different occasions;

• A 2 hour post-glucose challenge greater than or equal to 200 mg/dl on 2 different occasions; or

• A random glucose test over 200 mg/dl for a person with symptoms of uncontrolled diabetes.


Other payors may have other coverage requirements.

Signature and NPI ___________________________ Date ______ / ______ / ______

Group/practice name, address and phone: ___________________________

Revised 8/2011 by the American Association of Diabetes Educators and the Academy of Nutrition and Dietetics.
2. Clinical Competencies: Diabetes

☐ MA/RN - MH_Training@mmc.org
   ____ MH Medical Assistant Training- Fundamental
   http://www.mh-edu.org/d/xvq7vf/1Q
   ____ MH Medical Assistant Training – Advanced
   http://www.mh-edu.org/d/4vqth5/1Q
   ____ MH Care Manager Training
   https://www.surveymonkey.com/r/CMTtraining2018

☑ Provider

   ✔ Medication Titration Examples
   ✔ Project ECHO

☑ Staff & Patient - MH MPX - https://customerlogin.mpxonline.com/mainehealth

   ✔ Living Well with Diabetes
   ✔ Blood Sugar Logs
   ____ Nephropathy Education https://www.kidney.org/atoz/content/diabetes

☐ Shared Decision Making Tools

   ✔ ADA Medication Algorithm
   ✔ Diabetes Action Plan

☐ Build Staff Training Into Annual Competencies and New Staff Orientation
Long Acting Insulin Titration Standing Order

**Purpose:** The Long Acting Insulin Titration Standing Order is developed for the Registered Nurse Care Manager or Pharmacist to support the patient and/or caregiver in successfully and safely titrating long acting insulin in the home environment.

**Procedure:**
1. Provider initiates Long Acting Insulin Titration Standing Order in electronic health record by placing the referral: AMB REF TO CARE MANAGER LONG ACTING INSULIN REF19657
2. Qualifying patients (must meet all 5 bulleted criteria):
   a. Patient is 18 years of age and older
   b. Current hemoglobin A1c is greater than 8 (resulted within the prior last 30 days)
   c. Patient (or caregiver) is able to integrate education and skills of disease management and insulin titration as evidenced by teach back with pharmacist or RN Care Manager
   d. Patient (or caregiver) agrees to perform required self-monitoring of blood sugars, and tracks via log for reporting purposes to pharmacist or RN Care Manager
   e. Patient (or caregiver) must be able to maintain contact, at minimum every 3 to 7 days, with primary care office in order to safely and effectively engage in insulin management
3. Contraindications to patient participation include, but are not limited to:
   a. Patients with Type 1 Diabetes
   b. Based on clinical assessment of patient (ex. Active infection, acute change in comorbidities, steroid therapy, etc)
   c. Active cognitive impairment (unless insulin titration is managed by patient’s caregiver)
4. Prior to initiation of protocol the following must be completed:
   a. RN Care Manager or pharmacist must complete Long Acting Insulin Titration Protocol Competency to demonstrate understanding and proficiency in protocol procedures
   b. RN Care Manager or pharmacist to meet in-person with patient and/or caregiver. Identify patient using dual identification
   c. RN Care Manager or pharmacist to assess patient’s baseline understanding of diabetes disease and illness management and patient’s ability to adhere to required monitoring and communication with primary care practice office and staff
   d. RN Care Manager or pharmacist to provide education to patient and/or responsible caregiver regarding the following:
      i. Measuring Blood Sugar: Assess & confirm patient’s ability to self-monitor blood sugar
      ii. Hypoglycemia: including, but not limited to signs and symptoms, severe hypoglycemia and treatment of hypoglycemia
      iii. Hyperglycemia: including, but not limited to signs and symptoms, severe hyperglycemia and treatment of hyperglycemia
iv. Insulin Administration: Proper insulin preparation, administration technique, and needle disposal

v. Titration: including, but not limited to insulin dose changes and the following
   - Indications to notify provider, RN Care Manager or pharmacist
   - Indications to notify seek emergency medical treatment or 911

5. Initiation of Protocol: upon patient or caregiver’s successful completion of education and teach back as determined by provider, RN Care Manager or pharmacist, the insulin titration protocol may be initiated
   a. Refer to Appendix A for process outlining insulin titration by RN Care Manager or pharmacist
   b. RN Care Manager or pharmacist will utilize designated electronic health record (EHR) “smartphrase” for documentation and must notify provider via EHR with every patient contact.
   c. The patient’s insulin dose will be updated in the medication list at every dose change interval
   d. Provider must be contacted if blood sugar is <70 mg/dL or > 450 mg/dL
   e. RN Care Manager or pharmacist must provide education to patient as outlined above, including goal morning and evening blood sugars, as applicable
      i. Goal morning blood sugars = 80 – 150 mg/dL
      ii. Goal evening blood sugars = 80 – 180 mg/dL
   f. Protocol requires RN Care Manager or pharmacist to be in touch with patient every 3 – 7 days until patient either reaches desired blood sugar levels or reaches total daily long acting insulin dose of 100 units and protocol is discontinued
   g. Protocol may be initiated for patients on short acting insulin. RN Care Manager or pharmacist will ONLY titrate long acting insulin

6. Discharge from Protocol:
   a. Attained Goal: once patient has achieved goal blood sugar readings, RN Care Manager or pharmacist will complete three additional follow-up telephone calls over the course of one month
      i. If goal sustained, patient will be referred back to provider for further management
   b. Failure to Participate: defined as three failed outreach attempts over the period of one month
      i. RN Care Manager or pharmacist will alert provider to failure to participate via EHR and discharge from protocol
      ii. Patient may have the opportunity to re-engage in protocol in future

**MMC Policy Reference:** Institutional Standing Physician Orders
Medication Order Interpretation/Dose Range Tape and Titration

Original Date: 7/1/16

Review Date(s): MMC Pharmacy & Therapeutics Committee, 7/8/16
The Long-Acting Insulin Standing Order is developed for the Registered Nurse or Pharmacist to support the patient and/or caregiver in successfully and safely titrating long-acting insulin in the home environment.

**Part 1: Once daily, long-acting insulin**

- Provider initiates Titration Protocol and places referral: AMB REFERRAL TO CARE MANAGER LONG ACTING INSULIN PROTOCOL (REF19657)
- RN/RPh places call to patient within 3 – 7 days.

**Question:** Is morning BG less than 70 or greater than 450?

- **Yes:** Contact Provider to assess for plan
- **No:** Remain on current insulin dose - Return back to Star for next call

**Question:** Is morning BG greater than 150? (3 consecutive days)

- **Yes:** Contact Provider to assess for plan
- **No:** Is Pt experiencing Hypoglycemia (BG less than 70)?

- **Yes:** Refer to Part 2 of Algorithm
- **No:** Is total daily dose of insulin greater than 60 units?

- **Yes:** Increase evening dose of insulin by 2 units - Continue steps in Part 1 - Titrate to dose specified by provider
- **No:** Onset Pt achieve morning BG goal of 80 – 150:
  - Complete 3 additional follow-up calls over the course of 1 month
  - If goal sustained, refer back to Provider for further management

**Stop Insulin Titration Protocol**

**Continue to titrate once daily dose**

- **Complete:** Continue telephone calls every 3 – 7 days
- **Alternate:** Phone calls between “Telephone Call A” and “Telephone Call B”

**Telephone Call A**

- Review morning BG readings
  - If BG > 150: Increase evening dose by 2 units
  - If BG < 150: Continue current night time dose
  - If BG < 70: Contact Provider for plan

**Important Guidance:**

- If Pt reaches goal morning BG, you may continue with sole titration of morning dose of insulin (Telephone call B)

**Telephone Call B**

- Review evening BG readings
  - If BG > 180: Increase morning dose by 2 units
  - If BG < 180: Continue current morning dose
  - If BG < 70: Contact Provider for plan

**Important Guidance:**

- If Pt reaches goal evening BG, you may continue with sole titration of evening dose of insulin (Telephone call A)

**Transition to twice daily dosing**

- Divide total daily dose by half
  - Administer 1/2 in the morning and 1/2 in evening
  - Continue testing morning BG before breakfast
  - Start testing BG before dinner (pt may choose to test before bedtime)

- Continue telephone calls every 3 – 7 days
  - Alternate phone calls between “Telephone Call A” and “Telephone Call B”

**Once Pt achieve goal evening BG of 80 – 150:**

- Complete 3 additional follow-up calls over the course of 1 month
- If goal sustained, refer back to Provider for further management

**STOP**

**Contact Provider for Next Steps**

- **Alternate phone calls between “Telephone Call A” and “Telephone Call B”**
- **Continue alternating Telephone Calls A and B until patient reaches 50 units twice daily or equivalent of total daily dose of 100 units**

**BG = Blood glucose**

**SC = Subcutaneous**

**Last Updated:** 4/06/18
Project ECHO

In the U.S. and around the world, people are not getting access to the specialty care they need, when they need it, for complex and treatable conditions.

Moving Knowledge, Not Patients

Through technology-enabled collaborative learning, ECHO creates access to high-quality specialty care in local communities.

Hub and spoke knowledge-sharing networks create a learning loop:

- Community providers (spokes) learn from specialists.
- Community providers learn from each other.
- Specialists (hub) learn from community providers as best practices emerge.

Doing More for Patients

PATIENTS
- Right Care
- Right Place
- Right Time

PROVIDERS
- Acquire New Knowledge
- Treat More Patients
- Build Community of Practice

COMMUNITY
- Reduce Disparities
- Retain Providers
- Keep Patients Local

SYSTEM
- Increase Access
- Improve Quality
- Reduce Cost

Changing the World, Fast

NEW MEXICO
- Project ECHO started in NM and now has more than 300 community clinic sites
- 77,000 CME credits provided for free via ECHO-operated clinics

NATIONAL
- Operating in 30 states and growing
- 45 complex conditions

GLOBAL
- Operating 86 hubs in more than 13 countries and growing
- Goal of touching 1 billion lives by 2025

Are you part of the ECHO?

ChronicDiseaseAdmin@MaineHealth.org
MaineHealth, in partnership with MMP Endocrinology and Diabetes Center, is launching an “Endo Project ECHO.”

WHO?
- Spoke sites: Primary care providers and practices
- Hub site: MMP Endocrinology and Diabetes Center

WHAT?
- EndoECHO will focus on endocrinology and diabetes
- Each call will include a case review and a didactic component
- Didactic: Monthly curriculum will be provided to spokes prior to launch of the project
- Case Review: Spokes submit cases prior to the call to be peer reviewed and discussed on the call

WHERE?
- Anywhere! The virtual model allows you to participate from your practice or any location that is convenient for you
- Call in as a group in a practice or individually from your phone/computer

WHEN?
- Second Tuesday of every month from 7:30 a.m.–8:30 a.m.

For more information and to sign up as a spoke site:
Joan Ingram, Diabetes Program Manager
(207) 662-1548  ChronicDiseaseAdmin@MaineHealth.org
People with diabetes need to test their A1C levels often. What is an A1C test? Why does it matter for my health? Here are the answers to these and other frequently asked questions about A1C.

What Is an A1C Test?
An A1C test is a simple blood test that measures the amount of sugar stuck to the red blood cells (RBCs) in your body. RBCs stay in your body for 2-3 months. By measuring the amount of sugar stuck to your RBCs, the A1C test shows us how much sugar was in your blood over the last 2-3 months.

How Is An A1C Test Different Than the Blood Tests I Do at Home with a Finger Stick?
An A1C is different than the daily blood sugar tests you do at home because:

- The daily test you do at home shows you how much sugar is in your blood at that moment. The A1C shows an average of how much sugar has been in your blood over a longer period of time (2-3 months).

For example: Going to a birthday party and eating pizza and birthday cake once, will affect the results of your daily test. This won’t change your A1C results though, because this was a one-time event and you don’t usually have that much sugar in your blood.

How Do I Prepare for My A1C Test?
You just show up. You don’t have to fast (go without food) for this blood test. Many offices have point-of-care machines, meaning that you can do the A1C test and get results right at your doctor’s office. Other offices might send you to a lab to get your A1C test.
What Is My Target A1C Range?
Talk with your doctor about what your personal target A1C range should be. The American Diabetes Association says that an A1C of 7% or less is a good target for most people.

This might be a good target for you too. Your doctor might pick a different target for you, depending on your age and other health conditions you might have.

Why Is It Important to Reach My Target A1C Level?
When you reach your target A1C level, your diabetes is “controlled”. Reaching your target A1C is important. It can tell you and your health care team if your current diabetes treatment plan is working, or if the plan needs to be changed.

Staying at your target A1C can lower the chances of developing other health problems that can be caused by diabetes, (like eye or kidney disease).

How Can I Reach My Target A1C?
Your care team will help you get your A1C in target range or keep your A1C in target range. Also, here are some things that you can do at home:

- Eat healthy foods.
- Get lots of physical activity.
- Take your medicines as prescribed and instructed by your doctor. If for some reason you cannot or do not want to take your medicine, talk to your doctor right away.
- Test your blood sugars every day and keep a log.
- Lower your stress.

For more information visit:

www.mainehealth.org/diabetes

or contact:

chronicdiseaseadmin@mainehealth.org
Eye Care for Diabetes
Begin Taking Care of your Eyes Today

Did you know that diabetes can cause eye problems? If you have diabetes, here are a few things you should know about what you can do to help keep your eyes healthy.

What eye problems can diabetes cause?
Diabetes can cause eye problems like diabetic retinopathy (ret·i·nop·a·thy) and glaucoma (glau·co·ma).

- **Diabetic retinopathy** is damage to the small blood vessels in the back of your eye (the retina). The retina is very important because it collects the information you see and sends it to the brain. This damage can cause vision loss or blindness.
- **Diabetic glaucoma** is fluid pressure in your eye that can cause damage to the nerve that connects your eye to your brain. If the damage continues, glaucoma can lead to permanent vision loss within a few years.

How can I protect my eyes?
Here are some things you can do to help make sure that diabetes isn’t hurting your eyes:

- Get a regular eye exam. Loss of vision can be prevented and made less harmful if treated by your eye care professional, so it is important to see them regularly.
- Follow the ABC’s of diabetes care:
  - A for A1C: Keep your blood sugars in a healthy range for you.
    - My goal A1C is ________
  - B for blood pressure: Keep your blood pressure controlled and less than 140/90.
    - My goal BP is ____________
  - C for Cholesterol: Keep your LDL cholesterol controlled and less than 100.
    - My goal cholesterol is _______
- Quit smoking

What is a diabetic eye exam?

- An optometrist or ophthalmologist is an eye doctor who will do a special diabetic exam on your eyes to look for problems with your eye. Opticians are sometimes confused with these eye doctors, but opticians are people who make glasses and contact lenses and would not do this exam.
- Early on, you might not know if you have eye damage. This exam by your eye doctor is the only way to find out.
- If you wait to see an eye doctor until you have vision problems, it may mean the eye problems have gotten worse and treatment will be harder.
- Medical insurance often covers this eye exam, not vision insurance. Call your insurance provider to find out what is covered.

When do I need an eye exam?

- If everything is normal, the provider might tell you to get the exam every 2 years. You might need to get the eye exam every year if there are signs of damage.
Did you know that diabetes can cause eye problems? If you have diabetes, here are a few things you should know to help keep your eyes healthy.

**WHAT EYE PROBLEMS CAN DIABETES CAUSE?**
Diabetes can cause eye problems like diabetic retinopathy (ret•i•nop•a•thy) and glaucoma (glau•co•ma).

Diabetic retinopathy is damage to the small blood vessels in the back of your eye (the retina). The retina is very important because it collects the images you see and sends them to the brain. The damage can cause vision loss or blindness.

Diabetic glaucoma is fluid pressure in your eye that can cause damage to the nerve that connects your eye to your brain. If the damage continues, glaucoma can lead to permanent vision loss within a few years.

**HOW CAN I PROTECT MY EYES?**
Here are some things you can do to help make sure that diabetes isn’t hurting your eyes:

- **Get a regular eye exam.** Loss of vision can be prevented and made less harmful if treated by your eye care professional, so it is important to see them regularly.

- **Follow the ABC’s of diabetes care:**
  - **A** for A1C: Keep your blood sugars in a healthy range for you.
    
    **MY GOAL A1C IS ________**
  - **B** for blood pressure: Keep your blood pressure controlled and less than 140/90.
    
    **MY GOAL BP IS __________**
  - **C** for Cholesterol: Keep your LDL cholesterol controlled and less than 100.
    
    **MY GOAL CHOLESTEROL IS ________**

- **Quit smoking**
WHAT IS A DIABETIC EYE EXAM?

• It is a special eye exam that looks for problems related to your diabetes.

• This exam is different from a regular vision test.

• An optometrist or ophthalmologist is an eye doctor who will do a special exam on your eyes. Opticians are sometimes confused with eye doctors, but they are people who make glasses and contact lenses. An optician would not do this exam.

• Early on, you might not know if you have eye damage. This exam by your eye doctor is the only way to find out.

• If you wait to see an eye doctor until you have vision problems, it may mean the eye problems have gotten worse and treatment will be harder.

• Medical insurance often covers this eye exam, not vision insurance. Call your insurance provider to find out what is covered.

WHEN DO I NEED AN EYE EXAM?

• If everything is normal, the eye doctor might tell you to get the exam every 2 years. You might need to get the eye exam every year if there are signs of damage.
Antihyperglycemic therapy in type 2 diabetes: general recommendations.

### Start with Monotherapy unless:
- A1C is greater than or equal to 9%, consider Dual Therapy.
- A1C is greater than or equal to 10%, blood glucose is greater than or equal to 300 mg/dL, or patient is markedly symptomatic, consider Combination Injectable Therapy (See Figure 8.2).

#### Monotherapy

<table>
<thead>
<tr>
<th>Metformin</th>
<th>Lifestyle Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>EFFICACY*</td>
<td>high</td>
</tr>
<tr>
<td>HYPO RISK</td>
<td>low risk</td>
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<tr>
<td>WEIGHT</td>
<td>neutral/loss</td>
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<tr>
<td>SIDE EFFECTS</td>
<td>GI/lactic acidosis</td>
</tr>
<tr>
<td>COSTS*</td>
<td>low</td>
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</tbody>
</table>

**If A1C target not achieved after approximately 3 months of monotherapy, proceed to 2-drug combination (order not meant to denote any specific preference — choice dependent on a variety of patient- & disease-specific factors):**

#### Dual Therapy

<table>
<thead>
<tr>
<th>Metformin +</th>
<th>Lifestyle Management</th>
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</thead>
<tbody>
<tr>
<td>EFFICACY*</td>
<td>high</td>
</tr>
<tr>
<td>HYPO RISK</td>
<td>moderate risk</td>
</tr>
<tr>
<td>WEIGHT</td>
<td>gain</td>
</tr>
<tr>
<td>SIDE EFFECTS</td>
<td>hypoglycemia, edema, HF, fxs</td>
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<tr>
<td>COSTS*</td>
<td>low</td>
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</tbody>
</table>

**If A1C target not achieved after approximately 3 months of dual therapy, proceed to 3-drug combination (order not meant to denote any specific preference — choice dependent on a variety of patient- & disease-specific factors):**

#### Triple Therapy

<table>
<thead>
<tr>
<th>Metformin +</th>
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<tr>
<td>EFFICACY*</td>
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<td>HYPO RISK</td>
<td>low risk</td>
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<tr>
<td>WEIGHT</td>
<td>neutral</td>
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<tr>
<td>SIDE EFFECTS</td>
<td>GI, dehydration, fxs</td>
</tr>
<tr>
<td>COSTS*</td>
<td>high</td>
</tr>
</tbody>
</table>

**If A1C target not achieved after approximately 3 months of triple therapy and patient (1) on oral combination, move to basal insulin or GLP-1 RA, (2) on GLP4 RA, add basal insulin, or (3) on optimally titrated basal insulin, add GLP-1 RA or mealtime insulin. Metformin therapy should be maintained, while other oral agents may be discontinued on an individual basis to avoid unnecessarily complex or costly regimens (i.e., adding a fourth antihyperglycemic agent).**

### Combination Injectable Therapy
(See Figure 8.2)

American Diabetes Association Dia Care 2017;40:S64-S74
Diabetes Action Plan

my ACTION PLAN

Once you have set your goals, use this next step to take action.

Name ___________________________ Date ___________________________

☐ I have worked with another provider to set a goal.

take action

1. What I Will Do

Choose One Goal:
I will ____________________________

Examples: increase physical activity; take medications; make healthier food choices; reduce stress; reduce tobacco use.

Choose One Action:
I will ____________________________

Examples: walk more; eat more fruits and vegetables.

2. How Much / How Often

How much: ____________________________

Examples: 20 minutes.

How often: ____________________________

Examples: three times a week on Monday, Wednesday, Friday.

3. Confidence Level

Circle a number to show how sure you are about doing the activity.
Try to choose an activity that you are a 7 or above.

1 2 3 4 5 6 7 8 9 10
Not sure at all  Somewhat sure  Very sure

My signature ____________________________

Healthcare provider signature ____________________________
Low Blood Sugars

At times, your blood sugar level may drop too low. This is called “low blood sugar” or HYPOglycemia. Levels below 70 mg/dl are too low and need to be treated right away!

Common Signs/Symptoms of Low Blood Sugar:
- Shaky, light-headed, or sweaty
- Weakness or headache
- Blurry vision
- Hungry
- Irritability or confusion
- Faster heartbeat than normal
- Anxiety
- Numbness or tingling around lips

Treating Low Blood Sugar:
If your blood sugar is below 70 mg/dL, you need to treat it right away by following the Rule of 15’s:

1. Eat or drink 15 grams of carbohydrates to raise your blood sugar level quickly. Examples include:
   - 4 glucose tablets or
   - 1/2 cup of fruit juice or regular soda or
   - 1 tablespoon of sugar or jelly or
   - 2 tablespoons of raisins or
   - 1 cup of skim or low fat milk

2. Wait 15 minutes. Retest your blood sugar level.
   - If it is still less than 70 mg/dl, treat again with Step 1. Retest in 15 minutes. Repeat this until your blood sugar is at a normal level.
   - Once your blood sugar is back in the healthy range, try to eat a small snack that has both carbs and protein. This could be nut butter and an apple, or cheese and crackers. If your next meal is more than 1 hour away, this snack will help to keep your blood sugar at a good level until then.

Common Causes of Low Blood Sugars
- More physical activity than usual
- Taking too much diabetes medicine or insulin
- Drinking alcohol
- Not eating enough food
- Skipping or delaying a meal

ABC’s of Diabetes Care

A for A1C: Keep your blood sugars in a healthy range for you.
B for Blood Pressure: Keep your BP less than 130/80.
C for Cholesterol: Keep your LDL cholesterol less than 100.

Reach Your Target Blood Sugar

- Eat healthy foods.
- Get lots of physical activity.
- Take your medicines as prescribed and instructed by your doctor. If for some reason you cannot or do not want to take your medicine, talk to your doctor right away.
- Test your blood sugars as instructed and keep a log.
- Lower your stress.
Test your blood sugar regularly throughout the day. Remember to always test your blood sugar before you eat a meal.

<table>
<thead>
<tr>
<th>Week of:</th>
<th>Breakfast blood sugar/ Medications</th>
<th>Lunch blood sugar/ Medications</th>
<th>Dinner blood sugar/ Medications</th>
<th>Bedtime blood sugar/ Medications</th>
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</table>
Here are some tips for staying healthy and controlling your blood sugar:

**ABC’s of Diabetes Care**

A for A1C: Keep your blood sugars in a healthy range for you.
B for Blood Pressure: Keep your BP controlled and less than 130/80.
C for Cholesterol: Keep your LDL cholesterol controlled and less than 100.

**Reach Your Target Blood Sugar**

- Eat healthy foods.
- Get lots of physical activity.
- Take your medicines as prescribed and instructed by your doctor. If for some reason you cannot or do not want to take your medicine, talk to your doctor right away.
- Test your blood sugars as instructed and keep a log.
- Lower your stress.

**Low Blood Sugar Treatment - Rule of 15’s**

If your blood sugar is below 70 mg/dL, you need to treat it right away by following the Rule of 15’s:

1. **Eat or drink 15 grams of carbohydrates to raise your blood sugar level quickly.**
   
   **Examples include:**
   - 4 glucose tablets or
   - 1/2 cup of fruit juice or regular soda or
   - 1 tablespoon of sugar or jelly or
   - 2 tablespoons of raisins or
   - 1 cup of skim or low fat milk

2. **Wait 15 minutes. Retest your blood sugar level.**
   
   - If it is still less than 70 mg/dL, Eat or drink 15 grams of carbohydrates to raise your blood sugar level quickly. Retest in 15 minutes. Repeat this until your blood sugar is at a normal level.
   - Once your blood sugar is back in the healthy range, try to eat a small snack that has both carbs and protein. This could be nut butter and an apple, or cheese and crackers.
   - If your next meal is more than 1 hour away, this snack will help to keep your blood sugar at a good level until then.
Test your blood sugar regularly throughout the day.
Remember to always test your blood sugar before you eat a meal.

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<th>Breakfast blood sugar</th>
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<th>Lunch blood sugar</th>
<th>Lunch diabetes medications</th>
<th>Dinner blood sugar</th>
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<th>Bedtime blood sugar</th>
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</tbody>
</table>
3. Additional Resources: Diabetes

☐ Additional Patient Resources


✓ Behavioral Health for Diabetes Management

____ Diabetes Self Management Classes (resources per region)
Behavioral Health for Diabetes Management

A Comprehensive Approach
Why refer to behavioral health

- People with diabetes are at a higher risk of developing symptoms of depression, anxiety, and an eating disorder.
- People with schizophrenia have higher rates of diabetes than the general public.
- Substance use can lead to the development of diabetes, and in patients with diabetes, substance use can negatively impact outcomes.
- Psychological distress presents two fold in people with diabetes compared to those without.
- Diabetes care and outcomes are negatively impacted by psychological distress.
Refer

**WHO to Refer**
- A1C over 9%
- Newly diagnosed
- High utilizer of medical services
- Comorbidities

**HOW to Refer**
- Tell patient you have a colleague who can assist them in managing diabetes
- Do a warm hand off to Behavioral health clinician
- Amb referral to behavioral health
What to expect from BH

• Clinician will use the diabetes distress scale to measure patient level of distress with disease

• Identify intervention pathway based on scale results
  - Emotional Burden
  - Physician related distress
  - Regimen related distress
  - Interpersonal distress

• Focus on health behaviors related to diabetes self management
  - Nutrition
  - Exercise
  - Medication adherence
  - Checking blood sugar
References

- S. MSHA Advisory. *Diabetes Care for Clients in Behavioral Health Treatment*
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- *Assessing Psychosocial Distress in Diabetes*
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