Disclosure to Participants

• Notice of Requirements For Successful Completion
  – Please refer to learning goals and objectives
  – Learners must attend the full activity and complete the evaluation in order to claim continuing education credits.

• Conflict of Interest (COI) and Financial Relationship Disclosures:
  – Presenter: Cecilia Sauter, MS, RD – No COI/Financial Relationship to disclose

• Non-Endorsement of Products:
  – Accredited status does not imply endorsement by AADE, ANCC, ACPE or CCR of any commercial products displayed in conjunction with this educational activity

• Off-Label Use:
  – Participants will be notified by speakers if any product used for a purpose other than for which it was approved by the Food and Drug Administration.

Disease Management: The Role of the Diabetes Educator

Objectives

• Describe the current changes in Healthcare
• Identify 3 differences between traditional care and chronic care management
• Describe 2 roles that the Diabetes Educator has in training Chronic Care Managers
International Comparison of Spending on Health, 1980-2010

Hidden Health Care System

Mary vs. John

Traditional Approach
- HCP directed
- Talking
- Telling
- Patient viewed as non-compliant
- Threats and persuasion used

Chronic Care Approach
- Patient Directed
- Listening
- Asking questions
- Patient working towards own goal
- Personal choice emphasized

What ELSE is broken?

Current Health Care System
Patient Centered Medical Home

Team approach
- Preventive services
- Treatment of acute events
- Treatment of chronic illness
- End of life issues

AHRQ: Definition of PCMH

- Comprehensive team-based care
- Patient-centered orientation
- Superb access to care
- Coordinated care
- Systems approach to quality and safety

Disease Management

Disease Management Components
- Identify the Population
- Evidence based practice guidelines
- Collaborative practice model
- Patient self-management education
- Evaluate process and outcomes
- Routine reporting/feedback loop

Diabetes Disease Management
- Medication Management
- Self-Management Support
- Care Coordination
- Transition of Care

Population Health Status

Care Coordination
Impact of Uncoordinated Care

Points of Transition

- Health Care System
  - Members from a care team
  - Patient care teams
  - Patient and professional caregivers
  - Across settings
    - PCP – Specialty – Inpatient – ED
  - Health Care Organizations

Self-Management Support

Education & Engagement

The Road to Success

CMS Multi-Payer Advanced Primary Care Practice Demonstration

- Maine
  - 22 practices → 42 (year 3)
- Michigan
  - 477 practices
- Minnesota
  - 159 practices → 340 (year 3)
- New York
  - 35 practices
- North Carolina
  - 54 practices
- Pennsylvania
  - 78 practices
- Rhode Island
  - 13 practices
- Vermont
  - 110 practices → 220 (year 3)
- TOTAL
  - 948 practices → 1,259
Michigan Primary Care Transformation Project (MiPCT)
- Improve care for patients with multiple chronic diseases

MiPCT Patient Population
- Most Complex
- Complex
- Mild-Moderate
- Healthy

MiPCT Required Training
- Self-Management Training
  - Required by moderate and complex care managers
- MiPCT training – Geisinger Model
  - Required only by the complex care managers
    - Basics of care management
    - Transition of care
    - Disease specific: CHF, COPD

The Diabetes Educator
- Self-Management Education
- Self-Management Support
- Care Management
- Disease Management
- Transition of Care

Self-Management Training Participants

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<thead>
<tr>
<th>Profession</th>
<th>Participants</th>
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<td>RN</td>
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Self-Management Training Set Up

- 1 session
  - 8 hour
  - Same day
- 2 sessions
  - 4 hour
  - 1 week apart
- 4 sessions
  - 2 hours
  - 1 week apart
  - 1 whole month
Self-Management Training Outline

- Traditional vs. Patient Centered
- Empowerment – 5 Step Model
- Emotional Concerns
- Skills

Empowerment

Helping patients discover and develop inherent capacity to be responsible for one's own care

Funnell M & Anderson R; Clin Diab: 22(3), 2004

Empowerment Approach

- 5 Step Model
  - Explore the problem
  - Clarify feelings
  - Develop a plan
  - Commit to action
  - Experience and evaluate the plan

Funnell M & Anderson R; Clin Diab: 22(3), 2004

Self-Management Training: Participants Outcomes

<table>
<thead>
<tr>
<th>Relevant to my practice</th>
<th>Will help me improve the patient care I provide</th>
<th>Has motivated me to learn more about patient empowerment</th>
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<tr>
<td>Strongly Agree</td>
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<tr>
<td>Somewhat Agree</td>
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<tr>
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<td>3%</td>
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Curriculum Training

MiPCT Preliminary Results
University of Michigan
- Reduction in readmissions
- Improved coordination of care
- Increased patient satisfaction
- Increased provider satisfaction

The Diabetes Educator

Thank you!

Questions?
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