~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 credit/hours.

- Conflict of Interest (COI) and Financial Relationship Disclosures:
  - Presenter: Laura Smith, RN, BSN, Baylor Scott and White/Health Texas Provider Network
  - Presenter: Edith Munoz, RN, BSN, Baylor Scott and White/Health Texas Provider Network

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  - Participants will be notified by speakers if any product is used for a purpose other than for which it was approved by the Food and Drug Administration.

~LEARNING OBJECTIVES~

- Define the role of the RN Care Manager in the clinic setting.
- Recognize how RNs prioritize self-care behaviors using a team-based care approach.
- Explain how risk stratification is used in the outpatient setting to improve patient outcomes.
RN Care Manager – Registered Nurse skilled in patient assessment and care coordination.

- Provides chronic disease management, education and tools necessary to make healthy lifestyle choices and adapt healthy behaviors.
- Helps patients transition from inpatient to outpatient care.
- Supports and influences patients and their families in decision making and self-care.
- Collaborates with care teams to coordinate care for high-risk/susceptible patients and families.
- Collaborates with patient and medical care teams to identify needs and expedite appropriate, cost-effective care.


"Warm Handoff" Referrals: Appointment scheduled for chronic disease management while patient is attending office visit with Provider, Social Worker, Pharmacist.

Assess patient’s concern about health and readiness to make behavior/lifestyle changes. If interested: a brief intake is completed; follow up appointment is scheduled. If uninterested, document decline of service and notify Provider.

EPIC Referrals: Patient contacted via care call to discuss order received for Chronic Disease Management. If patient expresses interest in Chronic Disease education, appointment is scheduled for office visit with RNCM. If patient is uninterested in receiving chronic disease education, referral is closed and Provider is notified.

RN Care Manager Workflow

1. Identify Barriers to Self Management/Problem Solving
   - Discuss possible solutions. Address any questions/concerns the patient may have. Address any health system navigation needs.
   - Confirm follow up appointment. Document education/goals in EPIC. Communicate with Provider and other care team members as needed.

2. Review Chronic Disease Self-Management Behavior Goals
   - Blood glucose changes, blood pressure monitoring, Heart Failure Action plan, Asthma Action plan, COPD action plan.

3. Telephonic Appointment
   - Address how patient is feeling using MI techniques: reflective listening, affirmation, eliciting change talk using open-ended questions.
   - Discuss any change in medications since last visit. Assess need for medication refills.
RN CARE MANAGER
DIABETES MANAGEMENT PROTOCOL

Discuss Diabetes (Type 1 or Type 2) diagnosis
Medication Reconciliation
Provide self-management education and support based on assessment of knowledge, needs, and preference
Facilitate setting self-management goals. Review and adjust as needed.

RN CARE MANAGER
INSULIN TITRATION PROTOCOL

RN Care Manager Basal Insulin Titration Standing Delegated Order

RN Care Managers utilize evidence-based practice guidelines in an expanded role of intensive disease management.
Basal insulin titration allows the RN Care Manager to facilitate high quality diabetes care through timely basal insulin adjustments.
Optimal diabetes management requires an organized, systematic approach and the involvement of a coordinated team of dedicated health care professionals working in an environment where PATIENT-centered high quality care is a priority.

Diabetes must be managed by BSW referring Provider
Patient must be diagnosed with Type 2 Diabetes and on basal insulin ONLY (Glargine [Lantus/Toujeo/Basaglar], Detemir [Levemir] or Degludec [Tresiba]).
Can not have hypoglycemia <70mg/dL at least 2 weeks prior to initiation of protocol.
Must have access to a blood glucose meter and agree to engage in recording fasting blood glucose levels for seven consecutive days.
RNCM will call and assess the patient and discuss care management with Provider prior to starting the insulin titration.
Increase dosage of insulin no more frequently than once every seven days until fasting glucose target is attained.
RN CARE MANAGER
INSULIN TITRATION PROTOCOL

- RNCM will follow up with patient weekly to adjust basal insulin and fasting blood glucose readings are maintained at goal.

- Once the patient is in maintenance phase (defined as no change in insulin dosage for two consecutive weeks), the RN will start to taper the frequency of outreaches, starting at two weeks, then at the frequency the patient desires for disease management.

RN CARE MANAGER
HEART FAILURE PROTOCOL

- Discuss HF diagnosis
- Review HF action plan
- Medication reconciliation
- Set and review HF goals

RN CARE MANAGER
ASTHMA/COPD PROTOCOL

- Discuss Asthma/COPD diagnosis
- Review Asthma/COPD action plan
- Medication reconciliation/peak flow assessment
- Set and review Asthma/COPD goals
PROVIDER FEEDBACK

“RN care managers provide us invaluable resources for our patients. They have helped identify socioeconomic barriers and given resources and encouragement to our patients to achieve optimum health.”

Alexander Vilaythong, M.D.
Medical Director
Baylor Community Care at Fort Worth

CARE TEAM ROLES

CHRONIC DISEASE MANAGEMENT

- RN Care Manager (RNCM)
  - Work closely with provider and CHW for referrals
  - Close follow-up of patients with chronic diseases (Diabetes, HF, COPD, Asthma, and HTN)
  - Review plan of care
  - Use motivational interviewing to assist with lifestyle modifications and setting SMART goals
  - Medication review / database
  - Provider recommendations
  - Assist with SQL program
- CHW (Community Health Worker)
  - Work with Provider and RNCM for close follow-up of patients with chronic diseases
  - Case Messages (text)
  - Home visits with CCN

CARE TEAM ROLES

BEHAVIORAL HEALTH / CCN

- Social Worker (SW)
  - Behavioral Health services
  - Resources
  - Bi-weekly or monthly group sessions
- CCN (Community Care Navigator)
  - Schedule non-patient care hospital
  - Monitor and progress with CHW
  - Assist with resources
CARE TEAM ROLES
PHARMACY TEAM
- Pharmacist
  - Medication review/education
  - Medication adjustments (collaboration agreements)
  - Insulin titration
- Pharmacy Tech
  - Medication education
  - Medication reconciliation

TEAM BASED CARE HUDDLES
- RN led
- Meet weekly or every other week.
- Focus on patients with frequent ER/hospital visits
- Goal: Reduce hospitalizations

<table>
<thead>
<tr>
<th>Team</th>
<th>Key Care Activities</th>
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<tbody>
<tr>
<td>Provider</td>
<td>Risk Stratification, 12 AM Admission and Tracking, Meeting Notes</td>
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<tr>
<td>RN Care Manager</td>
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<tr>
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<td>Risk Factors, Multiple Facility Management</td>
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<tr>
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TEAM BASED CARE HUDDLES – CONTINUED
RN care managers are at the core of our integrated care team. Our RN has to balance an individual’s care plan while understanding their unique social determinates barriers. RN care managers and integrated team-based care are the foundation for population health in the future.

Jeff Zsohar, M.D.
Internal Medicine/Pediatrics
Medical Director
BSWH Community Care Clinics

CASE TEAM
HYPERTENSION MANAGEMENT
- Patients with current diagnosis of Hypertension
- Patients with elevated BP without diagnosis of Hypertension
- Blood pressure checks, medication adjustments, education, and follow-up

CASE STUDY 1
- 46 year old male newly diagnosed with diabetes
- Pt referred to clinic by CON
- Initial visit February 2018
  - A1C 14%
  - Provider and RNCM saw at initial visit
  - Patient with anxiety and many stressors, but highly motivated
CASE STUDY 1

- RNCM
  - Appointments between provider visits.
  - Medications review, lifestyle modifications, and support.
  - Blood pressure follow-up appointment due stress.

- Social Worker
  - Behavioral health
  - Depression / Anxiety
  - Healthy coping

CASE STUDY 1

- A1C levels
  - 2/11/18 = 14.0
  - 5/15/18 = 6.8
  - 8/13/18 = 5.6
  - 11/13/18 = 5.7
  - 3/13/19 = 5.8

CASE STUDY 2

- 58 year old female diagnosed with diabetes X 17 years.
  - A1C at initial visit with RNCM = 11.3
  - Hospitalized with e-coli/bacteremia complicated by aspiration pneumonia
  - A1C improved to 7.7
  - Family and work stressors led to increased A1C 9.4
  - SW & RNCM followed patient closely
  - She is now part of the bi-weekly SW group sessions.
  - Most recent A1C = 6.2
CASE STUDY 2

- HbA1C levels:
  - 8/21/17: 11.3
  - 1/11/18: 7.7
  - 4/18/18: 7.7
  - 7/25/18: 7.7
  - 10/26/18: 9.4*
  - 12/7/18: 7.5
  - 3/1/19: 6.2

INTEGRATED CARE STRATEGIES

- Risk stratification approaches - Taking Medications/Monitoring
  - Continuous Quality Improvement Project (PlanDoStudyAct).
  - Established as an interdisciplinary approach to support patients with hyperglycemia and hypertension.
  - Significant improvements in chronic disease self-management seen within 2-3 months (depending on patient’s attendance to frequent office visits for education/support regarding medication administration and lifestyle modifications).
  - Positive feedback from Providers and patients.

PLAN DO STUDY ACT PROJECT

First Visit: Face-to-Face (REQUIRED)
- Establish care and rapport with patient.
- Discuss medical history of Diabetes and/or HTN.
- Discuss DMP/HTN education and lifestyle modifications.

Subsequent Visits
- Weekly to biweekly telephone or face-to-face visits.
- Joint or separate visits with RN/CM and PharmD.

Established care and rapport with patient.
Discuss medical history of Diabetes and/or HTN.
Discuss DMP/HTN education and lifestyle modifications.
Plan Do Study Act Project

PharmD/Pharm tech/RNCM/CHW Visit:
- Assess medication taking skills, including administration techniques.
- Review BG and BP readings.
- Physical assessment (e.g., signs).
- Titrate and update medications (Pharm/RNCM only); consult Provider for needed adjustments.
- Review lifestyle modifications.
- Create SMART goals.

Provider Feedback:

"Partnering with the RN care manager in our clinic has been extraordinarily helpful to patients as well as providers. The RN helps coach patients through lifestyle changes to improve their health as well as taking care of medications. Teams share information to make the best decisions for our patients. Sharing the care of patients with Laura extends my capacity and ensures patients get the best care possible. I wouldn’t want to do my job without my RN care manager."

Erin Kane, M.D.
Medical Director, Community Care Navigation
Chronic Disease Champion
Worth Street Clinic
PATIENT SATISFACTION

“Thank you very much for taking care of me. If I don’t take care of my health, then no one else will. Thank you again for being there for me.”
- 60 y/o HM

“I really appreciate you spending time with me to get my sugars controlled. This clinic is like my family. Thank you very much.”
- 63 y/o HW

INTEGRATED CARE STRATEGIES

Risk stratification approaches: Healthy Eating/Being Active

CASE STUDY 3

- 54 year old female with Type 2
- Diagnosed with Type 2 x 10 years
- A1C 14% at initial visit with RN
- Provider referred patient to PDSA program (RN and Pharm) – patient given glucometer and test strips during intake visit.
- DM Medication: Metformin 1000 mg twice daily
- Barriers: Unable to afford medications, increased eye pain, trouble planning meals, unable to exercise due to weather
- Pharm visits: discussed medication management, possible initiation of new DM meds, BG monitoring (fasting and post-prandial readings). 1st visit average FBG: 209 mg/dL average PP: 186 mg/dL
CASE STUDY 3
- RNCM interventions (4): reviewed meal planning (avoiding skipping meals), increasing physical activity and behavioral health (PHQ 2 positive), SMART goal setting.
- Follow up A1C (3 months): decreased to 7.6%; FBG: 144 mg/dL, PP: 139 mg/dL, 5 lb weight loss.

CASE STUDY 4
- 60 year old male with Type 2
- Diagnosed with Type 2 x 20 years
- A1C 14% at initial visit with RNCM
- Provider referred patient to PDSA program due to patient needing assistance with taking medications and lifestyle modifications
- DM Medications: Metformin 1000 mg twice daily; Novolog 70/30 20 units twice daily
- Medical History: Bipolar disorder going to outpatient mental health facility for treatment; hyperlipidemia
- Barriers: limited support system, mental illness, no medications x 3 years; limited insight regarding medication and lifestyle management
- Pharm visits: insulin titration (if applicable), BG monitoring and smoking cessation. 1st visit average FBG: 350 mg/dL, average PP: 258 mg/dL.
- RNCM interventions: lifestyle modifications, discuss barriers, SMART goal setting.
- Follow up A1C 1st 3 months A1C decreased to 7.5%
- A1C increased back to 14% due to stressors, poor medication taking skills and unhealthy meal planning; re-introduced to program.
- After 6 months with program A1C decreased to 6.7%; FBG average: 120 mg/dL, PP average: 145 mg/dL.