



Team Care Approach for Diabetes Management

A team approach to diabetes care can effectively help people cope with the vast array of complications that can arise from diabetes. People with diabetes can lower their risk for microvascular complications, such as eye disease and kidney disease; macrovascular complications, such as heart disease and stroke; and other diabetes complications, such as nerve damage, by:

- Controlling their ABCs (A1C, blood pressure, cholesterol, and smoking cessation).
- Following an individualized meal plan.
- Engaging in regular physical activity.
- Avoiding tobacco use.
- Taking medicines as prescribed.
- Coping effectively with the demands of a complex chronic disease.

Patients who increase their use of effective behavioral interventions to lower the risk of diabetes—and treatments to improve glycemic control and cardiovascular risk profiles—can prevent or delay progression to kidney failure, vision loss, nerve damage, lower-extremity amputation, and cardiovascular disease. This in turn can lead to increased patient satisfaction with care, better quality of life, improved health outcomes, and ultimately, lower health care costs.

The challenge is to broaden delivery of care by expanding the health care team to include several types of health care professionals.

Collaborative teams vary according to patients' needs, patient load, organizational constraints, resources, clinical setting, geographic location, and professional skills.

PPOD and the Team Approach. You and other PPOD providers play an integral role in the team care approach to diabetes care. When you are educated about the complications of diabetes care issues in your own and other PPOD disciplines, you can better recognize symptomatic concerns warranting timely referral and reinforce annual screening recommendations that are proven to lower the risk of serious complications for diabetic patients.

Below you will find information and resources to promote this comprehensive, team-based diabetes care for patients. A multidisciplinary team approach is critical to success in diabetes care and complications prevention. Evidence indicates that a team approach:

- Can facilitate diabetes management.
- Can lower the risk for chronic disease complications.¹
- Helps educate about ways to reduce risk factors for type 2 diabetes in your patients' family members.

Patient Case Example

A dentist needs to schedule a patient for several procedures and asks about the timing of the patient's morning insulin. The patient is confused about his complicated medication regimen and asks, "Should I just skip all medicines that day until after you work on my teeth?" The dentist phones the patient's pharmacist to arrange a consultation.

The pharmacist collaborates with the primary care clinician to develop an individualized medication schedule and advises the patient and his dentist on medication usage on the day of the procedure.



Health Care Team for People With Diabetes. There are many other possible members of the health care team in addition to physicians (e.g., primary care, endocrinologist, obstetrician-gynecologist, ophthalmologist). This team could include (but is not limited to):

- Pharmacists
- Podiatrists
- Optometrists
- Dental care professionals
- Primary care physicians
- Physician assistants
- Nurse practitioners
- Dietitians
- Certified diabetes educators
- Community health workers
- Mental health professionals

Other Valuable Team Members. Clinical care teams can be augmented by including the resources and support of community partners such as:

- School nurses
- Trained peer leaders

Nontraditional approaches to health care can expand access to team care and, if used effectively, can build team care practices. These approaches include telehealth, shared medical appointments, and group education. For instance, pharmacist-directed telehealth programs have improved outcomes in blood pressure and diabetes medication management. There are also opportunities to partner with primary care providers in shared group appointments (SGAs). These shared group visits allow time for learning and integration of new knowledge and skills. A literature review showed that SGAs build synergy between health care providers and patients while using group interactions to increase knowledge and self-care skills.^{2,3,4}

All of these team members play important roles in the delivery of care for people with diabetes. When you work together using a team care approach, you can:

- Minimize patients' health risks through assessment, intervention, and surveillance.
- Identify problems early and initiate timely treatment.

Key Messages All Health Care Providers Can Reinforce

- Emphasize the importance of metabolic control and the control of other cardiovascular risk factors such as the [ABCs](#).
- Promote a healthy lifestyle that includes physical activity, healthful eating, and coping skills.
- Explain the benefits of diabetes comprehensive team care.
- Recommend routine checkups to prevent complications: a dental exam, a comprehensive foot exam, and a complete dilated eye exam.
- Reinforce self-exams for foot care and dental care, and others as appropriate.
- Recognize the danger signs for foot and dental problems and seek help from a health care provider.
- Promote the pharmacist's role in drug therapy management.

The [What to Discuss With Patients](#) section of this Guide provides further explanation of the diabetes management messages that providers can relay to patients.

Promoting Team Interaction

Below are some tools and resources you can use to promote interaction among PPOD professionals and other providers:

- The National Diabetes Education Program's (NDEP) [Redesigning the Health Care Team](#) illustrates how teams can work together effectively. Examples from the peer-reviewed literature and case studies that show the diversity and effectiveness of health care professional teams working with people who have diabetes include:
 - » Community-based primary care providers who involve a pharmacist and dietitian in implementing treatment algorithms, nurse and dietitian case managers, and educators who help to improve patients' weight loss and A1C values.
 - » A nurse practitioner-physician team that manages patients with diabetes and hypertension.



- » Health care professionals who use telehealth to improve eye care, nutrition counseling, and diabetes self-management education.
- » Pharmacists who work with company employees who have diabetes and their physicians to improve clinical measures and lower health care costs.
- » Trained community health workers who bridge the gap among traditional health care teams to improve access to diabetes health care, complications assessment, and education in underserved communities.
- » Podiatrists and other health care professionals who help reduce lower-extremity amputation rates in foot care clinics.
- » Dental and eye care professionals who help prevent and manage diabetes complications.
- NDEP’s comprehensive [*Diabetes Head to Toe Checklist Examination Report*](#) was developed by the NDEP Health Care Providers Stakeholders’ Group (comprised of physicians, nurses, physician assistants, and diabetes educators), and the PPOD Providers Stakeholders’ Group (comprised of providers in all four of the PPOD fields—pharmacy, podiatry, optometry, and dentistry)—to foster collaboration. The groups developed the checklist to support coordination of care and to recognize the following variables:
 - » Coordination will help ensure patients understand and can implement the intended treatment plan and can identify drug and disease management and psychosocial problems in a timely manner.
 - » Coordination of care presents many challenges when delivered by multiple providers in a variety of settings.
 - » PPOD professionals are often a primary point of care for people with type 2 diabetes. You have an important role in ensuring that diabetes care is continuous and patient-centered.

The checklist was pilot-tested by a range of health care providers and was found to be useful in a real-world clinical setting. They indicated that they were likely to change their practice to more of a team approach, incorporating the members of the team, or to adopt a referral approach. The providers also reported that the checklist helped them educate their patients about how preventive care can decrease the risk of diabetes complications. Further, 30% indicated that the checklist has useful application in electronic medical record/electronic health record systems.

Additional Resources

[Redesigning the Health Care Team: Diabetes Prevention and Lifelong Management](#)

NDEP

Find out how to form and implement a multidisciplinary team to provide effective care for people with diabetes in all clinical settings. This guide provides insights on how to practice a proactive, planned, patient-centered, and population-based approach to care.

[Practice Transformation for Physicians and Health Care Teams](#)

NDEP

This website discusses the meaning of team care, what is required to form a coordinated care group, and the advantages that can result from this model.

[Diabetes HealthSense: Resources for Living Well](#)

NDEP

This website has resources on many topics, such as managing weight, coping with stress and emotions, being active, and eating healthy.

[How to Use Telehealth in Diabetes Management](#)

Canadian Diabetes Association

The Canadian Diabetes Association 2013 guidelines strongly recommend using telehealth as part of a disease management program. This website offers a case study and information about using telehealth to improve access to expert diabetes care.

References

1. [Redesigning the health care team: Diabetes prevention and lifelong management](#). NIH Publication No. 11-7739 NDEP-37. Bethesda, MD: National Diabetes Education Program; Revised June 2011.
2. Ridge T. Shared medical appointments in diabetes care: A literature review. *Diabetes Spectrum* 2012; 25 (2):72-75.
3. McFarland M, Davis K, Wallace J, Wan J, Cassidy R, Morgan T, Venugopal D. Use of home telehealth monitoring with active medication therapy management by clinical pharmacists in veterans with poorly controlled type 2 diabetes mellitus. *Pharmacotherapy*. 2012; 32(5):420-6.
4. Margolis K, Asche S, Bergdall A, Dehmer S, Groen S, Kadmas H, Kerby T, Klotzle K, Maciosek M, Michels R, O'Connor P, Pritchard R, Sekenski J, Sperl-Hillen J, Trower N. Effect of home blood pressure telemonitoring and pharmacist management on blood pressure control: A cluster randomized clinical trial. *JAMA*. 2013; 310(1):46-56.