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In each issue of *Diabetes Resources* we have provided specific information about management for diabetes, including important tests and resources to help reduce complications associated with the disease. Information is included about the ABCs of diabetes: **A1C testing 2-4 times per year**, **Blood pressure screening at every visit**, and **annual Cholesterol testing**. Additional clinical information is also provided. **A dilated eye exam, sensory foot exam and screening for kidney disease are each recommended annually.** **Attention to these risk factors reduces the chance for cardiac, renal, eye and vascular disease secondary to diabetes.**

In support of the *New Mexico Adult Diabetes Practice Guideline 2010*, please see the reverse side of *Diabetes Resources* for recommendations for care including resources and tools that can help in your efforts to provide education and support among your patients with diabetes.

Check www.nmtod.org for organizations that have graciously provided funding for *Diabetes Resources*.

New Mexico Health Care Takes On Diabetes, a New Mexico non-profit corporation, is a broad coalition of New Mexico's diabetes care professionals, New Mexico Health Plans, the New Mexico Department of Health, and the New Mexico Medical Review Association, with technical and administrative support from the American Diabetes Association.

Diabetes Resources

Practical Information for New Mexico Health Care Professionals



A quarterly publication for clinicians caring for people with diabetes - Vol 14 No. 1, 2010

Diabetes Care: It Takes a Team

The Issue:

Most individual primary care practitioners do not have the time or the resources to meet the many needs of their patients with diabetes. These needs include education; behavioral interventions; nutrition and exercise counseling; medication management for diabetes, hypertension, and dyslipidemia; self-management support; health promotion; screening; and periodic examinations. It requires a team of coordinated, patient-centered diabetes care professionals to ensure that all of these needs are met.

Who is on the Diabetes Care Team?

The patient is at the center of the diabetes care team. He or she is responsible for the day-to-day management of diabetes both at home and at work. This requires knowledge, skill, and readiness to assume responsibility for diabetes care. Other team members support the patient, but the central role of the patient, family and personal support system should be emphasized. Diabetes management strategies should be guided by the patient's preferences, needs, environment, and values.

The professional members of the team support the patient by integrating their skills with those of the patient. In addition to the patient and his or her family, the core team members include the *primary care practitioner, nurse, and dietitian*, at least one of whom is a Certified Diabetes Educator (CDE). Depending on needs, setting, and available resources, other members may include a *pharmacist, podiatrist, ophthalmologist, optometrist, endocrinologist, health educator, social worker, community health worker, physical therapist, psychologist, podiatrist/orthotist, dentist/hygienist, nephrologist, and neurologist*. Regardless of team structure, one professional member must be designated as the *team coordinator* who oversees communication among team members, coordinates care and education, and ensures that accurate and timely information is available to all team members. To support the patient, team members may provide education, direct patient care, self-management support, advocacy, and population management. Possible activities include:

- ❖ Group patient education programs led by a nurse, dietitian, pharmacist and/or other team member
- ❖ Shared medical appointments led by the primary care practitioner or endocrinologist and a CDE
- ❖ The use of *Diabetes Conversation Maps*® facilitated by any trained team member
- ❖ One-on-one education, assessment, goal-setting, or action planning provided by a nurse, dietitian, pharmacist, health educator or other team member
- ❖ Telephone follow-up by a nurse or pharmacist after regimen changes
- ❖ Use of algorithms by nurse or pharmacist for medication management
- ❖ Use of registries to identify patients not meeting guidelines and/or due for monitoring or screening
- ❖ Case management outreach to patients who are not meeting guidelines or goals
- ❖ Support groups facilitated by a mental health professional or a social worker

Establishing a team first involves obtaining the support of organizational leadership and potential team members. An organizing committee should be convened to plan team processes and oversee implementation and assessment of the team approach. The National Diabetes Education Program provides guidance in establishing a team at: <http://betterdiabetescare.nih.gov/WHATteamcare.htm> and an illustration of team membership at <http://betterdiabetescare.nih.gov/teamcaregraphic.htm>.

Conversation Map is a registered trademark of Healthy Interactions, Inc.

Did you know?

Nurses, pharmacists, and other nonphysician health care professionals using detailed algorithms working under the supervision of physicians have demonstrated the greatest reduction in A1C and blood pressure.

- American Diabetes Association's Standards of Care for 2010

Resources for Clinicians

The following resources are FREE and can be downloaded from the New Mexico Health Care Takes On Diabetes website at www.nmtod.org. For further information contact Charm Lindblad, Executive Director, at 505.796.9121 or toll-free 1.866.796.9121.

American Diabetes Association (ADA) Education Recognition Program*

—The ADA certifies education programs that meet the National Standards for Diabetes Self-Management Education. One criterion for ADA recognition is that education be provided by a team of health care professionals with expertise in diabetes care including certification as a diabetes educator (CDE). For practitioners who do not have access to a team of diabetes care experts, a recognized education program can be an excellent resource and may offer the opportunity for creation of a team. To find an ADA-recognized education program in your area, go to: http://professional.diabetes.org/erp_zip_search.aspx

American Association of Diabetes Educators (AADE)—It is important that at least one member of the diabetes care team be a CDE, BC-ADM, or diabetes educator with 15 hours of continuing education. If you do not already work with a CDE, you can find a list of CDEs in New Mexico on the AADE website:

www.diabeteseducator.org/DiabetesEducation/Find.html. Keep in mind that not all CDEs are AADE members, so there may be CDEs in your area who are not found on this website. There is an AADE list-serve, so AADE members may be able to help you find non-AADE members and other resources in your community.

National Diabetes Education Program (NDEP)—The NDEP has numerous publications related to diabetes care and prevention; the following focus on team care:

- ❖ *Team Care: Comprehensive Lifetime Management for Diabetes*
- ❖ *Working Together to Manage Diabetes: A Guide for Pharmacists, Podiatrists, Optometrists, and Dental Professionals, 2007*. This resource reviews the roles of multi-health care disciplines as they participate in the diabetes care team and promotes a collaborative effort in the treatment of a person with diabetes. This resource is available at:
www.ndep.nih.gov/publications/PublicationDetail.aspx?PubId=113
www.ndep.nih.gov/publications/PublicationDetail.aspx?PubId=26
- ❖ *Working Together to Manage Diabetes: Poster, 2007*
www.ndep.nih.gov/media/ppod_poster.pdf
- ❖ *We need one more very important person on our team: Poster*
<http://betterdiabetescare.nih.gov/pdfs/patientposter.pdf>
- ❖ *Diabetes Community Partnership Guide*
www.ndep.nih.gov/publications/PublicationDetail.aspx?PubId=121
- ❖ *Better Diabetes Care – What We Want to Achieve Through System Changes*
<http://betterdiabetescare.nih.gov/WHATteamcare.htm>

University of New Mexico—Join the University of New Mexico Project ECHO (Extension for Community Health Outcomes) Clinic in making meaningful outcomes improvements for patients with diabetes in rural areas and /or medically underserved areas. Project ECHO helps providers and clinics by partnering to provide consultation, co-management of patients and resources. For more information about Project ECHO contact 505-272-6169 or eharding@salud.unm.edu.

**Education Programs Recognition/Certification: ADA, AADE and IHS certify/recognize programs that meet the National Standards for DSME. Accreditation/recognition supports the provision of quality DSME, is essential for reimbursement, and offers public acknowledgment of accomplishment. All accrediting bodies encourage a team approach, with qualified instructors that include at least an RN, RD, or pharmacist. AADE put forth Practice Guidelines for DSME addressing the process, delivery and competencies of care by team members.*

Websites—The editorial committee has identified a select number of websites that we think you will find informative. To access these websites, please visit the New Mexico Health Care Takes On Diabetes website.*

**Please note that these websites do not necessarily represent the views of New Mexico Health Care Takes On Diabetes. They are listed for your reference and convenience. NMHCTOD does not evaluate websites for content accuracy or application to any clinical situation.*

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