



VA SHARED MEDICAL APPOINTMENTS FOR PATIENTS WITH DIABETES:

*MAXIMIZING PATIENT & PROVIDER EXPERTISE
to
STRENGTHEN CARE MANAGEMENT*

A photograph showing four hands of different skin tones clasped together on a wooden table. The hands are arranged in a supportive grip, symbolizing teamwork and care. The lighting is warm and focused on the hands.

**GUIDE AND RESOURCES FOR
STARTING AND SUSTAINING SUCCESSFUL SMAs**

TRAINING MANUAL
December 2008

Development of this manual was supported in part by the Diabetes Mellitus QUERI, VA HSR&D

Contributors to the Development of this Manual:

Susan Kirsh, MD
Sharon Watts, ND, RN-C, CDE, NP
Kimberley Schaub, PhD
Gerald Strauss, PhD
Mary Ellen O'Day, PharmD, CDE
Scott Ober, MD, MBA
Gloria Taylor, RN, CDE
Elizabeth Kern, MD, MS
Renée Lawrence, PhD
David C. Aron, MD, MS

Acknowledgements:

We would like to acknowledge the support and guidance provided by Eve Kerr and other colleagues at the Diabetes Mellitus QUERI, VA HSR&D.

Contents

Executive Summary	5-6
Objectives of the Manual	7
1. An Overview of Shared Medical Appointments for Veterans with Diabetes: Why do group visits in the VA?	8-9
A. Benefits for Staff	8
B. Benefits for Patients	8-9
C. Balancing Trade-offs and Maximizing Opportunities	9
2. Group Visit and Patient Activation Model: Chronic Care Model as an Implementation Tool	10-12
3. Ready for Action	13-20
A. Securing Buy-In and Rally Stakeholders: Identifying a Physician Champion	13-15
Physician Champion	13
B. Planning Your Timeline	16
C. Initial Decisions	17
1) Team Members ~ Main Roles and Core Expertise for Each Session	17-18
2) Target Population	18
3) Session and Format Parameters	18
4) Other Considerations	20
4. Making It Happen	21-28
A. Identifying and Contacting Patients and Family Members (significant others)	21
B. Establishing an Agenda	22-25
C. Tools	25
D. Documentation and Billing	26
E. Guidelines and Decision Support	27
F. Challenges, Solutions and Trade-offs	27-28
5. Aligning Resources	29-38
A. Key Elements for Success	29-38
1) Multi-disciplinary Team Development (including Continuity of Team)	29
2) Motivational Interviewing: Setting the Tone for Patient-Centered Group Encounters	30-33
3) Nurturing Peer Support	34-36
4) Teaching and Encouraging Self-management	36
5) Registry for Identifying and Tracking Patients	37
6) Continuous QI/evaluation: Sustaining Progress and Staying Alert to Unintended Consequences	37-38
6. Challenges and Suggested Solutions for Conducting Group Sessions	39-41
A. Leading the Group	39
B. Roles and Group Processes versus Individual Needs	39
C. Common Challenges and Solutions	39-41
The Talkative Patient	39-40
The Talkative Provider	40
The Silent Patient	40
The Silent or Absent Provider	40
Managing Misinformation, Old Wives-Tales and Urban Legends	40
Comparisons (What Private Docs and VA PCPs Prescribe)	40-41

7. Assessing Progress: Measuring Outcomes	41-42
8. Conclusions	43-44
9. Supplemental Materials: Tools, References and Web-based Resources	45-58
Enrollment Letters:	45-46
Invitation letter	45
Birthday letter	46
Handouts:	47-54
Diabetes Care: The ABCs to Better Health	47
Remembering your ABCs	48
Reasons and Treatments for Hypoglycemia/VA Hospital Hypoglycemia 15-15 Rule	49-50
Causes of Low Blood Glucose	51
Diabetes Action Plan	52
Blood Sugar Targets	53
Pattern Management for Blood Sugars	54
Templated group note (images of screen)	55-56
Patient Satisfaction Survey	57
Resource for Providers: Steps For Analyzing Blood Glucose Patterns	58
Web-based Resources for Providers	58
Web-based Resources for Providers and Patients:	58
10. References	59-60
11. SMA: Easy Reference Summary Sheets, Reminders and Check-list	61-68
Diabetes Shared Medical Appointment Schedule Overview	62
Medical Record Progress Notes	63-66
SMA Team Check-List	67
Reminders for Conducting Shared Medical Appointments	68

Executive Summary

Diabetes Shared Medical Appointments (SMAs) are a novel approach to improvement in a chronic illness that's complexity can be seen in multiple aspects of a patient's life. Engaging patients in a team approach with several peers to support behavior change has been an effective tool for us to improve many aspects of care for patients with diabetes at our VA site. We have done so in the context of the primary care clinic with the conceptual framework of the chronic care model. We have achieved success in doing so as evidenced by the improvements seen for patients who have participated in SMAs since we began them in 2005. Our preliminary findings (based on 44 SMA participants and 35 comparison patients) were published in *Quality and Safety in Health Care* (2007, see next page for a brief summary). Updated information for 334 patients documented a mean change in A1c of $-.9$ (± 1.9), $p < .001$. The pre-SMA mean for this group was 9 (± 2.1) and the post-SMA was 8.4 (± 1.7).

This manual compiles the processes that have facilitated our own implementation with some attention to challenges that have needed to be addressed. For further details in addition to this manual, see Kirsh et al (2008). We hope you find this easily adaptable to your local environment.

Change is often challenging and accompanied by uncertainty. Be reassured that there are a growing number of SMA success stories, including our own experiences at the Cleveland VAMC. On the following page we share some findings from various studies.

WARNING

*Shared Medical Appointments are a shift in health care delivery method for patients with chronic conditions. The default is often to lecture to patients and to see them every 2 or 3 months. In Shared Medical Appointments you **don't lecture** and once the patients have the **self-management skills** you let them go – the patients still have their primary care providers they see regularly. Shared Medical Appointments are a supplement, not a replacement.*

Some Findings from Various Studies

Kirsh et al (2007) used a quasi-experimental design with concurrent, but non-randomized controls to evaluate the impact of SMAs for patients with diabetes. The intervention group included patients who participated in SMAs from 5/06 through 8/06). At the initial visit, 83.3% had A1c levels > 9%, 30.6% had ldl-cholesterol levels > 130 mg/dl, and 34.1% had SBP \geq 160 mm Hg. Levels of A1c, ldl-c and SBP all fell significantly postintervention with a mean (95% CI) decrease of A1c 1.4 (0.8, 2.1) ($p < 0.001$), ldl-c 14.8 mg/dL (2.3, 27.4) ($p = 0.022$) and SBP 16.0 mm Hg (9.7, 22.3) ($p < 0.001$). There were no significant differences at baseline between control and intervention groups in terms of age, baseline intermediate outcomes, or medication use. The reductions in A1c % and SBP were greater in the intervention group relative to the control group: 1.44 vs -0.30 ($p = 0.002$) for A1c and 14.83 vs 2.54 mm Hg ($p = 0.04$) for SBP. Ldl-c reduction was also greater in the intervention group, 16.0 vs 5.37 mg/dl, but the difference was not statistically significant ($p = 0.29$).

Wagner and colleagues (2001) at the W. A. MacColl Institute for Healthcare Innovation in Seattle, Washington, did a system-wide randomized trial. Primary care practices were randomized within clinics to either a chronic care diabetes group or usual care. Patients received baseline and follow-up assessments (12 and 24 months) and the intention-to-treat analysis at 24 months showed that the SMA group had received significantly more recommended preventive procedures and helpful patient education. These patients, compared to usual care patients, had slightly more primary care visits. However, they had significantly fewer specialty and emergency room visits. The number of group sessions attended was consistently related to A1c levels.

A team headed by Trento (2002) at the University of Turin, Italy, conducted a randomized clinical trial of 112 patients with non-insulin treated type 2 diabetes managed by either group education visits or by individual consultation and education. Over 5 years, A1c increased in the control patients but not in the group visit patients. Patients in the group visits also experienced a decrease in BMI and increase in HDL-cholesterol. They also found that quality of life, knowledge about diabetes and health behaviors improved with group care but worsened in the controls.

Based at the Medical University of South Carolina, Clancy and colleagues (2007) undertook a 12-month randomized controlled trial of 186 patients with diabetes in group visits with traditional, usual patient-physician care. While there were no differences regarding A1c, BP and lipid levels, group visit patients exhibited greater concordance with diabetes process-of-care guidelines.

Objectives of the Manual

The main objectives of this manual/toolkit are to summarize the necessary guidelines, information, tools and resources for starting and conducting successful shared medical appointments for veterans with diabetes. We provide a brief overview of the background and added value of shared medical appointments to the care options available at VAMCs and then discuss the implementation process, including a discussion of the key elements to success that we have identified. Finally, we also provide appendices with examples of materials useful for initiating shared medical appointments and tracking relevant information in the VA.

It is important to keep in mind that this manual is meant to help you design a SMA for your patients with diabetes. Every setting differs and therefore the manual/toolkit is meant to provide guidelines and suggestions as you design your SMA. We hope this manual assists your implementation of a diabetes SMA through summarizing our implementation experiences, including identification of factors related to our success.

We are always seeking to improve the presentation and the materials. As such, we would appreciate hearing from you: Susan.Kirsh@va.gov

1. An Overview of Shared Medical Appointments for Veterans with Diabetes: Why do group visits in the VA?

Diabetes is a national problem that has reached epidemic proportions. Its management complexity threatens to overwhelm the acute care-oriented health care systems and challenge the resources of current and future individual primary care providers. While medical training has increasingly addressed chronic care management, quality care necessitates education approaches that go farther. Chronic care management needs approaches that educate, sensitize, support and help nurture an activated patient and prepared proactive health care team. Shared medical appointments (SMAs) constitute a promising improvement strategy to help address the complexities and demands of managing chronic health conditions and there is evidence in support of this approach including our own experience here at the VAMC Cleveland. (Kirsh, et al 2007) The format remains appealing in an environment of growing demands and limited resources.

The Veterans Health Administration in 2005 mandated shared or group medical appointments as a means to improve clinic efficiency and quality of care. Both local and national Advanced Clinic Access meetings endorsed this methodology for decreasing waiting times, improving patient outcome measures and minimizing cost. Additionally, shared medical appointments offer an opportunity to utilize non-physician providers to their fullest potential. The VA has recognized the important role non-physicians play in improving care for patients, especially patients with chronic illnesses, such as diabetes.

Based on the chronic care model, Shared Medical Appointments are patient medical appointments in which a multi-disciplinary/multi-expertise team of providers sees a group of patients (8-20) in a 1.5 to 2 hour visit. Chronic illnesses, such as diabetes, especially lend themselves to this approach. Some materials have been made available for use by those planning SMAs in the VA and elsewhere (Masley et al. Family Practice Management, June 2000, Vol. 7, No. 6, p33-7). While the general structure and processes for conducting SMAs have been established that recognize inter-related decisions, there is a lack of specificity to guide making setting-specific decisions that help ensure success. Each setting has its own unique strengths and challenges and one goal of this manual is to help you make local adjustments to SMAs and to your setting. SMAs for patients with diabetes must make sense for your setting without compromising the key elements necessary for obtaining benefits for patients and providers.

A. Benefits for Staff

Benefits of this method when integrated appropriately can include a strong sense of teamwork and camaraderie as different providers contribute to the care of an individual patient, each offering unique skills that another provider may not possess. Also, if a consistent group of staff members exists and members embrace the team concept, the system redesign associated with SMAs helps to create a very supportive environment with high staff satisfaction. Staff team members feel that very high quality patient care is delivered in SMAs where group discussion/motivation and individual titration sessions are utilized. Team members are valued by different disciplines to a larger degree than when working separately in a large clinic. In addition, spread of provider expertise amongst each other is observed, benefitting all staff. It is very rewarding to see challenging high-risk patients become better self-managers, teachers and motivators for other patients, and have improved clinical outcome measures after participation in SMAs.

B. Benefits for Patients

Patients may benefit from the one-visit access to multiple disciplines or areas of expertise (disease and medication management, nutrition, and behavioral/motivational experts). Patients also benefit from the

experience of other patients participating in the group (peer support): With team guidance, patients learn from each other about solutions to tackle the day-to-day challenges in a way that is impossible to achieve in traditional clinic visits. Finally, the patients gain a sense of control and usually experience improved health. We have found high patient satisfaction among participants.

PCPs: Feel a sense of additional support when working with the many challenges and complexities that are evident in daily management of patients with diabetes. Providers facilitating and staffing the SMA engage in a high sense of camaraderie and teamwork in getting even challenging patients to improve their own care.

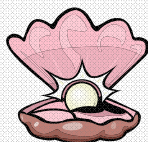


Pearls of Wisdom

Patients: Get support and strategies from other patients and can feel a high degree of care from a “team of providers.”

C. Balancing Trade-offs and Maximizing Opportunities

As is true with all new paths, there is a balancing act as implementation unfolds. It is important to keep in mind that SMAs can be staffed by a variety of different types of teams for success. Physicians, nurse practitioners and/or pharmacists are needed for medication titration but the number and combination of medication changers will vary. While it may be easy to fall in the trap of thinking ideally about all the disciplines that should be represented, it is more important to think about the expertise or skill sets needed as a core for each session and how to create such expertise by harnessing local resources.



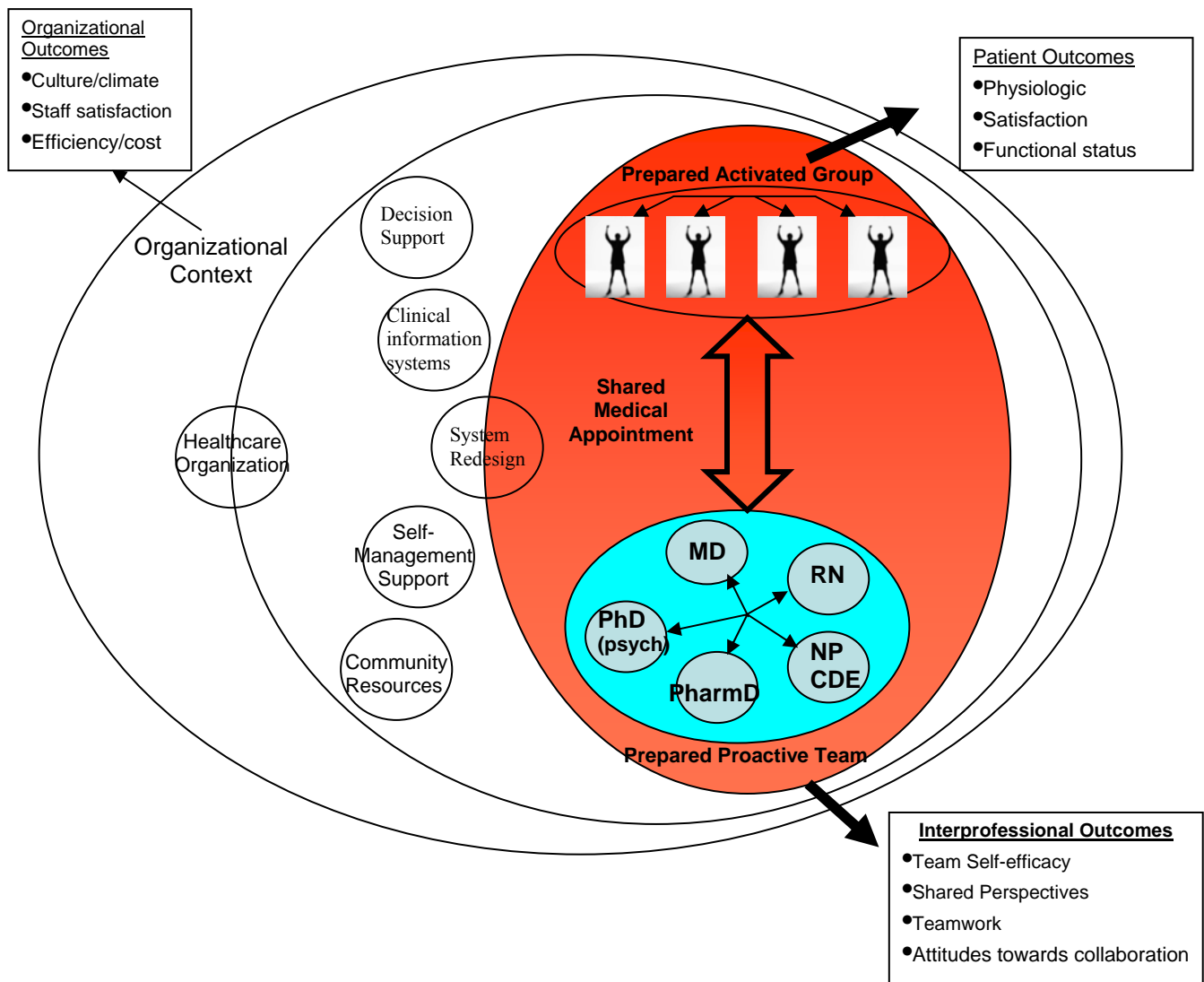
Pearl of Wisdom: SMA is a novel approach that has yielded improved patient outcomes while allowing staff to form an interdisciplinary team approach to care.

2. Group Visit and Patient Activation Model: Chronic Care Model as an Implementation Tool

Core concepts of the Chronic Care Model (CCM) of disease management provide a useful framework for thinking about how to maximize resources and goals while establishing group shared medical appointments in your local setting. In particular, the CCM emphasizes the integration of an informed proactive team and an engaged patient while at the same time appreciating the contextual layers of a health care system.

Specifically, the Chronic Care Model, including the self-management training model, provides a framework of 6 interrelated structural components – *health care organization, decision support, clinical information systems (registries), delivery system redesign (such as group shared medical appointments), self-management support which can include engaging family support, and community resources* – to utilize as the foundation for improved chronic care delivery and management (Figure 1).

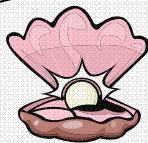
Figure 1: An illustration of a Shared Medical Appointment based on the Chronic Care Model.



The key components of the chronic care model are seen on the left as they interact with the group of patients and the team of providers. The red oval represents shared medical appointments as the system redesign component of the chronic care model with the activated patients and the prepared proactive team members who are present at the time of the visit. It emphasizes how the other 5 components play a role in the system redesign.

SMA's can supplement and augment the diabetes care given by primary care providers in one-on-one clinic visits and does not replace the primary care provider/patient relationship regardless of whether the PCP is part of the SMA team or not. The SMA team of providers is in communication with the primary care provider regarding any changes to the patient's regime via electronic notes.

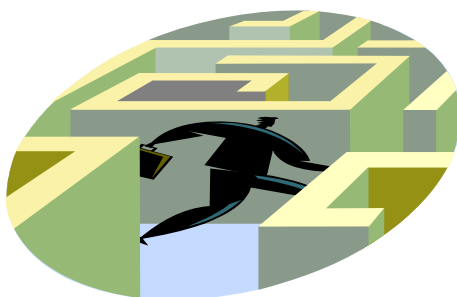
While the CCM provides a framework, it is worth emphasizing the dimensions and practices we identified for successful SMA's in the VA Health Care System. Table 1 provides such an overview. As can be seen in Table 1, elements or ingredients related to successful implementation and sustainability cut across the various components of the CCM model. These key elements will be covered in Section 5.



Pearl of Wisdom: The chronic care model is a useful tool to conceptualize the system redesign and how the other components of the model support the implementation and sustainability to this model of care.

Table 1. Application & Enhancement of Chronic Care Model to SMAs in the VA Health Care System

CCM Components	Enhanced Dimensions and Practices for SMAs
<p>1. Self-management support: Provide methods and opportunities for patients to be empowered and prepared to manage their health conditions and health care</p>	Tools and information utilized in group format for teaching self-management
	Health topics covered during patient-led discussion to enhance self-management
	Multi-disciplinary team and continuity of team
	Patient-centered group dynamics
	Peer support (helps with problem solving for self-management)
	Reinforced by team members
	Motivational interviewing
<p>2. Decision support: Enhance and promote evidence-based clinical care that recognizes patient preferences</p>	Embedded guidelines into notes
	Template for entering notes
	Multi-disciplinary team overlap
<p>3. Delivery system design: Promote proactive delivery of clinical care and support of self-management within the system</p>	Debriefing huddle after each session (Continuous QI/Evaluation) and continuity of team
	Registry to review and plan
	Multi-disciplinary team with roles and tasks defined and overlapping
	Individual patient (one-on-one) sessions at end
	Cross-training and spread of care practices back to (other) PCPs
<p>4. Community Resources & Policies: Identify and mobilize community-based resources to help meet health care management needs of patients</p>	Significant others invited and encouraged to participate
	Peer support group structure with possibilities for linking outside of group
<p>5. Organizational support: Leadership at all levels provides mechanisms to enhance care and Improvements</p>	Personnel time committed for multi-disciplinary team to participate
	Resources and infrastructure (e.g., designated space and staff, and endorse guidelines and registry)
	Continuous QI/Evaluation (feedback and goal-setting)
<p>6. Clinical information systems: Organize and utilize data to promote efficient and effective care</p>	Documentation (consistent with evidence-based guidelines)
	Utilize a diabetes registry or cube for identifying patients



3. Ready for Action

Figure 2 overviews initial issues that need to be addressed and provides decisions made in our local context. We found these to be the most effective approach after several iterations of planning, doing, checking/studying and acting, and thus highly recommend them as a starting point for making decisions for your local setting.

A. Securing Buy-In and Rallying Stakeholders: Identifying a Physician Champion

It is important to obtain buy-in and support from all stakeholders -- from administration to patients and their family members because change is always challenging, especially change that involves system redesign. Although we believe that this requires a team approach and multiple champions, we have found a physician champion to be one important component of successful system redesign. This may reflect the specific nature of the intervention (i.e., multidisciplinary team that includes a physician) as well as the context – a clinic staffed by many physicians. Although our team approach flattens the hierarchy within the team, we also recognize the reality of the context. Again, it is important to recall that it is the solid core of the team that will keep moving the process forward and therefore the champion is not alone in the process. However, it still is useful to have one person identified as a champion. A champion of this process is essential to initially, and then intermittently in the future, garner resources for the SMA.

PHYSICIAN CHAMPION: We strongly recommend that a physician be the champion or the primary champion among a team of champions. We suggest a physician champion because it is important to have someone who can leverage support at various levels and who has a solid understanding of the diabetes population and care challenges. A physician is particularly ideal given the fact that SMAs are a change in the format of delivering patient care. Physician leaders are often more successful in a shorter time frame for achieving system redesign regarding direct patient care issues: making a case to administration, getting things moving, obtaining initial resources, and dealing with administration to rally additional resources for new needs that arise. Similarly, physicians are often in a better position to arrange for outcome data to be made available so that the team can gauge its success on those dimensions.

It is important to remember that the physician doesn't have to be visible at all the appointments or oversee the day-to-day management or even be in charge of the team. The team remains central to the success of the SMAs but like all changes, needs a liaison with enough status and pull to get support and resources.

ADMINISTRATION SUPPORT: At the outset it is important to obtain or reaffirm administration support. In the VA we are fortunate because SMAs have been recognized and prescribed as an

important management option. Local administration support still is essential and proceeds better if some initial planning and decisions have been made and played out to demonstrate feasibility.

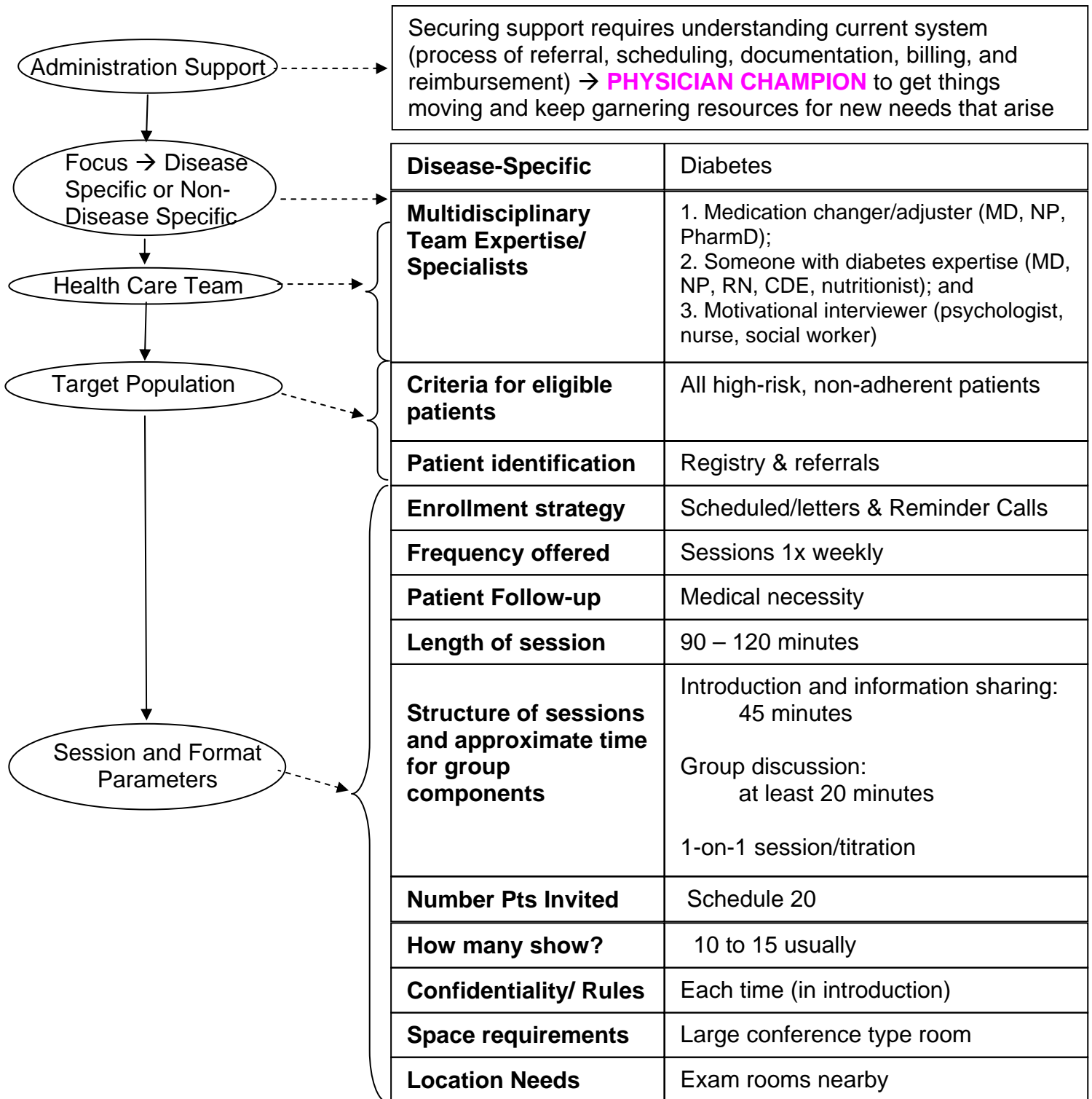
PROVIDER AND STAFF SUPPORT: Starting with the high-risk patients provided us with the opportunity to obtain initial buy-in from providers and other staff because many recognized that the traditional approaches were not working for these patients. Again, support at the national level of prescribing SMAs as a legitimate management option was helpful. We found that most of the doubts came from uncertainty about whether it is worth the resources and lack of familiarity. We were able to address these by sharing published findings and providing the opportunity for non-team members to observe and participate in a SMA. Once local patients with their success stories were experienced, SMA buy-in was self-perpetuating.

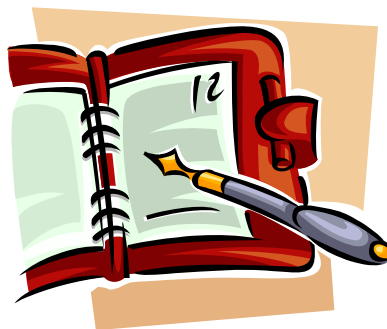
PATIENT AND FAMILY SUPPORT: Securing provider and staff support helps with approaching and encouraging patients and family members about the new care option. While we use the registry to identify potential patients, we recognize that patients and family members may seek reassurance from their primary provider. We send an introductory letter and follow-up with a reminder phone call. Here also, once success is experienced, patients provide a source of buy-in for other patients, family members, and back to their primary providers (who then are more likely to refer/encourage other patients to participate).



Pearl of Wisdom: SMA success is highly dependent on obtaining support from administration and team members that will be providing care to work through issues that arise. A *physician champion* is necessary to initiate the change in process and to help sustain it.

Figure 2. Developmental Phases and Example of Decisions Made to Help Guide Implementation of SMAs for Patients with Diabetes

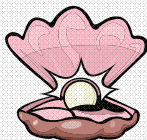




B. Planning Your Timeline

It is easy to underestimate the time needed to plan and coordinate a SMA. After securing leadership support, one of the first decisions will focus on the team so that other decisions reflect the team working together. We suggest weekly meetings occur until initial decisions have been finalized (see next section below). Consistent with others' recommendations, we suggest that you begin planning and coordinating at least two months before the first SMA. This provides ample time to finalize decisions including identifying space and a time slot. About one month prior to the SMA, team meetings can become less frequent and focus on reviewing potential patients that have been identified, materials that will be used/needed, and documentation procedures. We suggest sending letters to patients two weeks prior to the session with a reminder phone call 1 to 2 days prior to the SMA. It is important to remember that for the first several sessions, some aspects may not run as smoothly as desired, but once a process is in place that works (e.g., who and when patients are identified to be invited, who sends letters, who does the reminder calls), less time is needed for coordination efforts.

Allow for more preparation time than seems necessary as issues such as room and space arrangements can be challenging since most of us are already feeling short on such commodities in our work settings. The more the team members work together and debrief about ways to improve the flow, the smoother the process will become and the sessions will continue to improve.



Pearl of Wisdom: It takes longer than anticipated to get this running, so be patient and be flexible. It is worth it!



C. Initial Decisions

In general, the components of SMAs include identification of: a targeted population, a healthcare team, methods to identify patients and track patient outcomes, and techniques and processes for conducting the visit.

C. 1. Team Members ~ Main Roles and Core Expertise For Each Session: Reports in the literature indicate variation in the size of the teams: The actual size of the team can vary ranging from 2 members (1 RN and 1 physician) to 6 or so members. The composition of the team can also vary and reflect different options for fulfilling expertise requirements (for example, a nutritionist may not be available, but a local certified diabetes educator (CDE) has the necessary knowledge of the interface between diabetes and diet). One or more medication changers need to be present at each session. We recommend at least 3 providers be involved at each session (although it need not always be the same three people), with each one primarily fulfilling one of the three main roles. Table 2 provides an overview. The three main roles are further defined by the core or critical expertise that we have found necessary to have present at each session for successful diabetes SMAs.

MODERATOR: The moderator takes main responsibility for running the group session. The core expertise that is needed is motivational interviewing skills, which includes techniques to create a patient-centered discussion. There are a number of potential staff members who could be a moderator. Since settings may not have any one on staff currently who is skilled in motivational interviewing, this manual provides information and examples to train someone. The moderator helps guide the group session so that the discussion can be derived from patient questions or educational topics. It is important to recognize that even though the flow of the discussion is derived from patients and their issues, the moderator and team help ensure that all patients get basic education on physiologic goals, familiarity with medications used in diabetes to achieve goals, complications of diabetes as well as hypoglycemia. The advantage in this context is that the

moderator and team build on the discussions so that the information is pertinent to the patient and permits other patients to discuss and make suggestions.

PROVIDER: Medication changers include MD, NP, RN with MD support, pharmacists. These team members wait about 20 to 30 minutes for the group education (and/or longer depending on how many patients there are and the nature of the discussion) and then begin to pull patients into individual rooms for a personalized medication review, titration as needed and written plan based on the process and intermediate outcome measures. This takes between 5 and 15 minutes ideally. In our local site, the provider is usually the one to complete the note addressing A1c, blood pressure, cholesterol, aspirin use, foot examination, eye examination and self-management goal. Consults are placed as needed with a written treatment plan and list of medications for the patient upon discharge. Patients may or may not rejoin the group after the individual session. Input from other team members is done during this time as needed via such mechanisms as pulling another member in for a quick consult, asking and relaying information back to patient. Input from other team members is done during this time as needed via such mechanisms as pulling another member in for a quick consult, asking and relaying information back to patient.

DIABETES EXPERT: The CDE can be a nurse, PharmD, physician (who is not an endocrinologist), nutritionist or someone who is more of a content expert. We have found that there are several reoccurring themes for patients and their families particularly surrounding food/nutrition related issues for the patient with diabetes (e.g., carbohydrate counting, food preparation, salt intake issues, budget and food).

C.2. Target Population: Identification of patients is a key initial decision. Patients may include those from one specific primary care provider or all primary care providers. SMAs may be used for patients with well controlled conditions to improve access or targeted to those with poorly controlled conditions, or a mixture of the two. The VA has a diabetes registry which can efficiently and effectively identify patients in the target population. Depending on goals of the SMA, the targeted population needs to have a pool greater than 500 for a once weekly clinic. This will likely ensure 5-15 patients per clinic session. You may want to focus on populating your SMAs with patients who have diabetes and high blood pressure or high ldl, if your patients have relatively good A1c. Getting the most out of your SMA in terms of outcomes depends on your population's needs.

C.3. Session and Format Parameters: In Figure 2, we have summarized our recommended approach for starting but recognize some parameters will be a function of other factors. For example, offering SMAs for patients with diabetes once a week would be ideal to quickly get as many patients involved in SMAs as possible, however, that may not be feasible.

The visit itself begins with the group format where introductions and information sharing occurs, followed by a more open group discussion which also has an educational component. The group discussion facilitates peer support, one of the keys to success in chronic disease management. The last component of the visit is the clinical component (examination and management) where medication titration is done if necessary. The group discussion should be done to facilitate peer support, one of the keys to success in chronic disease management. Medication titration and a patient plan can be done in the presence of the whole group or separately.

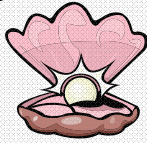
Table 2. Core roles, possible team members who could fill those roles, and suggested distribution of responsibilities

Role and Core Expertise	Possible Team Members to Fill the Role	Responsibilities
MODERATOR <i>Motivational Interviewer</i>	<i>Psychologist</i>	Facilitate discussion related to various aspects of patients' chronic disease
	<i>Certified Diabetes Educator (CDE)</i>	Answer clinical questions that arise during patient discussion
	<i>Clinical Nurse</i>	Give recommendations to providers as to which order patients should be taken back for their individual physical exam
	<i>Dietician</i>	Provide, or consult, mental health service for smoking cessation classes, weight loss counseling, depression, PTSD, insomnia, erectile dysfunction
	<i>Pharmacist</i>	Provide, or consult, nutrition service for carbohydrate counting
		Provide, or consult, pharmacy service for pill box counseling, medication reconciliation (especially new consults), prescription renewals/refills
		Obtain vitals, and assist with check-in process, if necessary
		Assist patients with completion of symptom questionnaire, if indicated
PROVIDER <i>Medication Changer</i>	<i>MD/NP/PA</i>	Complete individual patient physical exam if needed (often isn't needed), assess functional capacity to engage patient in exercise program
	<i>Clinical Nurse</i>	Discuss patients' symptoms, adverse drug reactions, and follow-up on patient response to symptom questionnaire, if needed
	<i>CDE</i>	Complete medication reconciliation
	<i>Pharmacist</i>	Adjust patient specific pharmacotherapy, if appropriate and as indicated
		Schedule follow-up appointments, as clinically appropriate
		Provide patient option to return to the group for continued discussion or check-out
		Record provider and patient goals for therapy and treatment plan for documentation into the patient's chart (documentation usually occurs during individual patient visits). Partial or complete progress note documentation of the subjective, objective, assessment and plan (SOAP) for each patient.
		Complete take home instruction sheet for the patient
Content (Diabetes) Expertise	<i>MD/NP/PA</i>	May call patients out for individual consult (e.g., regarding diet)
	<i>Clinical Nurse</i>	Can help with documentation
	<i>CDE</i>	<i>Note that documentation of the assessment and plan can be an individual effort ~or~ a collaborative effort with the team after the clinic visit.</i>
	<i>Dietician</i>	
	<i>Pharmacist</i>	Understand medical terminology, or have clinical background experience
	<i>Psychologist</i>	Assist with group facilitation

C.4. Other Considerations: The room and its set-up should help facilitate the group process and the flow. We have found that a conference room with a table works well because the set-up reinforces a group exchange: chairs are in a circle or oblong arrangement around the table with additional chairs on the perimeter. A table for the group is useful but not critical. The table allows for the patients to arrange the papers and printouts they're given and to jot down goals that are set during the session.

It might also be helpful to have a small table with a computer in the room to have access to additional information as needed for patients and for charting. We recommend keeping this at a minimum since use of computers might disrupt the flow of the session and group discussion.

It's important to find a room that accommodates the size of group invited and is located near exam rooms or other areas where individual one-on-one sessions could be conducted.



Pearl of Wisdom: Key personnel and skills needed to implement successful SMAs include: a moderator who can facilitate a group with motivational interviewing, a provider who can adjust medications, and a diabetes content expert which can be any number of health care professionals.



4. Making It Happen

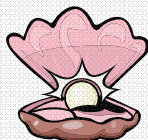
A. Identifying and Contacting Patients and Family Members (significant others)

Once the criteria have been established, the registry can be used to identify potential participants. Potential patients are screened for other issues or conditions that would suggest SMAs might not be appropriate. We apply the following exclusions to participation in the SMAs and traditional education classes: an inability to speak English, a diagnosis of dementia or other cognitive impairment, a psychiatric diagnosis of schizophrenia/psychosis and the patient is not stable, and any behavioral problem which interferes with group participation and discussion.

The letter of invitation is sent about two weeks prior to the SMA session the patient is invited to. An example of a letter is provided in the appendices. A reminder phone call (when possible) is done one or two days prior to the session. Both the letter of invitation and the reminder phone call clarify that significant others are also invited to attend.

Originally, at our local site, we discussed use of the *Happy Birthday Report Card* as a means to further identify patients on the month of their birthday. However, we have been able to populate the clinic without utilizing this strategy to date. We include a copy of this letter in the appendices in case you have difficulty enrolling and/or want to use another format for contacting and encouraging patients to participate.

The team is involved in review as needed at the beginning but once the process has been established, the identification and contacting processes can be undertaken by one individual.



Pearl of Wisdom: Letters pulled from a registry inviting patients to come is the easiest form of contact. See resource materials.

B. Establishing an Agenda

Prior to SMA session: Electronic review of patient charts is conducted. Specifically, data is electronically gathered to assess need for labs prior to visits and if patients have been appropriately triaged to the SMA. For example, patients who have an A1c < 8 and who are > 7.5 are referred to self-management classes. Patients who need insulin initiation are identified and discussed with the RN who assists patients with insulin starts in order to make this process more efficient during the clinic visit.

During SMA session: Patients are checked in at the site of the group visit, not at nursing station (blood pressure is obtained; foot screen, if needed), and given copies of most recent labs including values for A1c, ldl-c and blood pressure. Box 1 lists what is included on the handout of patient specific data, along with other tools.

SIT, DON'T STAND: It is important for the team members to be seen as equal members in the group. Sitting rather than standing helps with this since most lecturers stand and people tend to look toward the person standing as the leader.

CONFIDENTIALITY: Note that the beginning of each session contains information/reminders about confidentiality.

INTRODUCTIONS: The way the session is introduced is very important to help set the tone. We begin the actual session with introductions so that the emphasis is on everyone present and everyone's voice is recognized at the outset. Go around the room and ask everyone that is present (patients, family members and health care team members) to briefly introduce him or herself and share how long he/she has had diabetes and if on insulin. This also helps the care team who may not be familiar with all the patients at the session.

Introductions can also be altered to help steer the process of information sharing beyond the basic information of how long someone has had diabetes and whether he/she is on insulin. For example, if during prep time you recognize that many of the participants need to start insulin, you could ask people to share their biggest fear of starting insulin and/or what was their biggest fear, for those already on insulin. As another example, if you know that many participants are struggling with understanding carbohydrates, you could ask participants to also mention their favorite low carb food. Such alterations help get the discussion moving in the direction that you initially want it to go. Remember to be flexible as the issues the patient wants to discuss need to surface and be part of the process.

ENGAGE THE PATIENTS: Discussion then begins with asking an open-ended question, and the moderator, and other team members, ensure that relevant educational topics are discussed and that goals are established during the discussion. Box 2 overviews the topics. Note that the topics focused on and the approach to discussing the topics are designed to teach better self-management skills. That is, the topics reinforce the self-management support component of the Chronic Care Model: provide methods and opportunities for patients to be empowered and prepared to manage their health conditions and health care. The handout we use that summarizes the ABCs to better health for patients with diabetes is provided in the appendices. The handout includes the goal and a column where the patient enters his/her current level for each measure, and items to evaluate confidence in setting and achieving self-management goals.

MINIMIZE YOUR VOICE: The goal is to get the patients to share and problem-solve with and for each other. Your role is to help keep things on track and to engage patients. This may be hard and uncomfortable at first since many of us are used to doing presentations, covering materials, lecturing, etc. Team members can help each other with this transition: If you notice a team member is talking more than listening, help draw patients back in and discuss strategies during the debriefing session.

To Help with Group Flow, SMA Team Members should:



- SIT, DON'T STAND
- REMIND AND REASSURE ABOUT CONFIDENTIALITY AT OUTSET
- PERSONALIZE VIA INTRODUCTIONS
- ENGAGE THE PATIENTS
- MINIMIZE YOUR VOICE



Additional information and resources to help engage patients and minimize your voice while maximizing your potential to help patients change behaviors are provided in the sections on motivational interviewing and nurturing peer support.

Box 1: Tools and information utilized in group format for teaching self-management
<ul style="list-style-type: none"> <input type="checkbox"/> Blood sugar log <input type="checkbox"/> Glucometer and testing supplies <input type="checkbox"/> Current medication list <input type="checkbox"/> Pillbox <input type="checkbox"/> Patient specific data = vitals/labs and goals of therapy <ul style="list-style-type: none"> <input type="checkbox"/> HgbA1C <input type="checkbox"/> BP and pulse <input type="checkbox"/> Cholesterol panel <input type="checkbox"/> Kidney function <input type="checkbox"/> ASA use <input type="checkbox"/> Foot and eye care

Box 2: Health topics covered during patient-led discussion to enhance self-management
<ul style="list-style-type: none"> <input type="checkbox"/> What are the symptoms of hypoglycemia and hyperglycemia? <input type="checkbox"/> Diabetes care: The ABCs to better health <ul style="list-style-type: none"> <input type="checkbox"/> A1C <input type="checkbox"/> Blood pressure <input type="checkbox"/> Cholesterol <input type="checkbox"/> Diabetes kidney screening <input type="checkbox"/> Eye care <input type="checkbox"/> Foot care <input type="checkbox"/> Goals for self-management <input type="checkbox"/> Heat protection with aspirin and a statin <input type="checkbox"/> My provider asked me to follow an ADA diet; what can I eat? (Carbohydrates 101)

After sufficient discussion (i.e., the topics have been shared and discussed in a patient-driven format), medication changers/adjusters begin to take patients out individually for the one-on-one session. The other patients remain in the group session and the moderator continues to facilitate relevant discussions. Some patients return after their one-on-one session, others do not. We first pull out patients who have attended several previous SMAs or have time constraints and/or other commitments (e.g., need to get back to work).

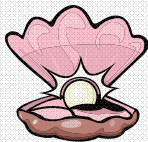
Immediately after SMA session: DEBRIEFING HUDDLE –The health care team, which reflects multiple disciplines/expertise areas, discusses the individual and group encounter portion of the patient visit. Additional collaboration happens that may lead to further recommendations for follow up care and/or charting in the medical record. Opinions and consensus occurs during these sessions. In addition, this provides an opportunity for assessing the overall process and goals (quality improvement focus for SMA). You may find that the amount of time needed for debriefing gets less over time, but it is important to continue debriefing, even if it is only 5-10 minutes, as a team. This helps to identify potential concerns or problems early regarding the process. It also provides time for touching base

about what is working well, sharing thoughts about recommendations for patients with special challenges, and for additional interprofessional cross-training and professional development as new evidence-based medicine practices emerge.

Also, allow more time after the initial sessions for debriefing as charting and other procedures may need to be discussed and fine-tuned for your own setting.

DEBRIEFING HUDDLE:

- *Helps consolidate the group as a team*
- *Allows for sharing of knowledge and cross-training*
- *Provides an opportunity to brainstorm & come up with strategies for difficult patients*
- *Creates a forum for supporting continuous quality improvement*



Pearl of Wisdom: Determine what education and flow works for your team. **DEBRIEFING** is important to review process, share insights, and discuss challenging patients.



SUMMARY OF PHASES AND CORE INGREDIENTS OF SHARED MEDICAL APPOINTMENTS



<i>ESSENTIAL PHASES</i>	<i>CORE INGREDIENTS (components or purposes)</i>
Check-in	Down load blood glucose meters Take blood pressures Check regarding basic foot, eye, etc. screens Give lab sheets (patient's data)
Introductions	Build familiarity and connections
Group Discussion	Develop peer support Motivate change via motivational interviewing Share information
Individual Patient (one-on-one) Sessions	Adjust medications as needed Review lab work
Debriefing	Build sense of team and fosters cross-training Permit brainstorming about patients Ensure continuous quality improvement

C. Tools

Box 1 (above) lists the tools that we use during the session to strengthen care management. We provide patients with **blood sugar logs** which they are asked to complete and bring with them for the next session. We also use several other handouts, including the **ABCs of Diabetes** handout, many of which are provided in the appendices. We bring **pillboxes** to the session and provide patients with those, along with instruction and patient discussion on how to maximize the use of this tool.



See Appendices for various tools we have found helpful.

D. Documentation and Billing

Documentation can accomplish several purposes:

- 1) documentation for reasons of patient care
- 2) documentation for workload credit
- 3) documentation for billing.

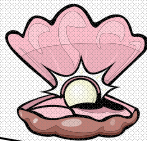
These purposes can be three separate issues or combined.

Documentation for Reasons of Patient Care. Initially documentation may be a particular challenge given this newer format in clinical care. We have found that use of templated notes helps to improve patient flow and increase ease of documentation. Templates can be used to embed guidelines to assist providers, link to consults and track progress as well as outcomes. The template can also be printed for the patient as an engagement tool. An example is provided in the appendices and available for your use.

Documentation for Workload Credit. The note may be a group-type of format, or a note where everyone on the team can put in their own section. The format may depend on what is available as well as preferences and billing issues. Many VAs have the ability to give workload credit based solely on a provider signing a note and not necessarily filling out an individual encounter form. All providers are included on the chart note, and workload credit occurs when each provider signs the chart note.

In addition, keep in mind that a group note also provides another opportunity to interact, cross-train, and consolidate as a team (another avenue for documenting patient care).

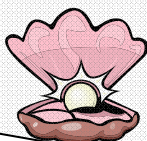
Documentation for Billing. Billing is another issue and it can be confusing at first. In the VA, Patients get billed a co-pay for a primary care visit if they qualify for co-pay. If a nurse practitioner or a physician is staffing the group you can bill at level 3 or higher for each patient.



Pearl of Wisdom: Using **Templated Notes** helps make documentation more efficient, including completion of diabetes-related clinical reminders (performance measures).

E. Guidelines and Decision Support

VA/DoD guidelines (http://www.oqp.med.va.gov/cpg/DM/DM_base.htm) provide an important source for decision support (one component of the Chronic Care Model). It is worth noting that guidelines will always be updated at some point, and therefore it is important to be linked to local experts in the area to stay up-to-date. Our notes are templated for the shared medical appointment with the VA/DoD diabetes practice guidelines embedded into the template for consistency and educational purposes. As mentioned above, it may be useful to think about whether a group and/or individual note approach is most helpful.



Pearl of Wisdom: Use the Guidelines to identify targeted patient populations. Existing registries can be used with guidelines to determine appropriate patients for group participation.

F. Challenges, Solutions, Trade-offs.

Administrative Hurdles. From an administrative standpoint, pressure to serve patients in a traditional clinic setting may present barriers to changing formats and to allowing staff the initial time needed for developing and adjusting to changes. Emphasis on the long term gains and benefits (increase in patient numbers over time, cost savings when intermediate outcome measures improve, and high patient satisfaction) must be recognized by administrators in order to persevere through the initial adjustment period. Your physician champion is often critical for getting and maintaining administrative support.



Growing Pains. At the same time, it is important for you as a team to recognize there is an investment in developing the process for each local setting, with a return, but this must happen over a period of time with those intimately committed and involved helping to refine the process. In our local setting, we met and continue to meet after each shared medical appointment for 10 to 20 minutes to collaborate on patients as well as refine the process and flow (**debriefing**). Collaboration may mean various health professionals help in ways that are not specific to his/her disciplines. For example, our health psychologist will enter no show notes at the end of the session and our nutritionist will help download glucometers when needed. Flexibility and persistence are necessary and pay off in the end.

Roles and Cross-Training. The interdisciplinary nature of SMAs may be uncomfortable until enough cross-training has occurred. The cross-training is critical because it enables more flexible roles to emerge. Being flexible and cross-training help guarantee sustainability, otherwise if you lose one person, the structure of the SMA is lost.

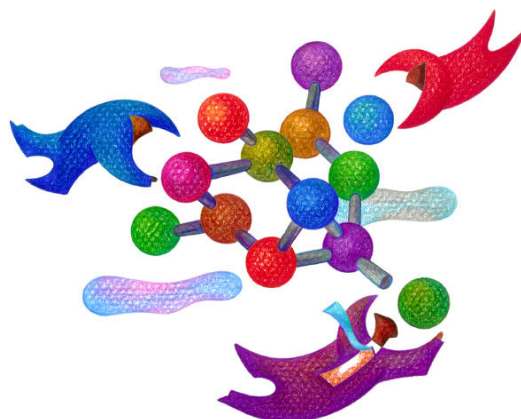
If the number of medication changers is limited, other means for facilitating order entry can be considered.

For settings where you are inviting other providers' patients, you may feel hesitant to make recommendations or changes. Our experience is that most non-participating providers appreciate the help and the documentation provided in the individual and collaborative notes. Again, the focus is on diabetes, not the gamut of the patient's other issues.

Clinic capacity. Clinic capacity depends upon space and available staff. Initially, it is often reasonable to invite fewer patients. This permits the team time to assess acuity, establish flow and adjust the process of care delivery. Patients failing to keep this type of appointment can range from 20 to 50 %. At our local site, efforts to reduce the no-show rate have included: reminder phone calls, calling patients who no-show, and clear reminder or scheduling letters. Adequate patients in clinic can be achieved additionally, by overbooking the clinic by no more than 40% of the total number of patients desired.

The group discussion usually occurs in a large group room with individual medication changes occurring in smaller exam rooms. Patients have difficulty seeing the relevance to themselves of medication changes when this is done as part of a larger group. Some clinical sites may be limited by exam rooms and by the number of providers that can change medications. Generally, the number of patients per medication changer should be about 6 to 1. Two to four small exam rooms are needed to keep the overall clinic time at 90 to 100 minutes. However, it is important to remember that 'traditional' exam rooms are not usually necessary. It is possible to work quite comfortably if you have access to only one traditional exam room and several private or semi-private spaces. Recall that the focus in the individual patient (one-on-one) session is to focus on medication changes and diabetes-relevant issues; the goal is not to conduct a complete exam.

5. Aligning Resources



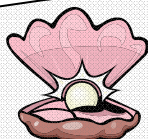
A. Key Elements for Success

We have identified six key ingredients or elements that are associated with successful implementation of SMAs, including improvement of quality of care as evidenced by significant improvement in patient clinical outcomes, high SMA patient and provider satisfaction, and decreased wait times for patients with diabetes. The core keys to success are: **1) multi-disciplinary team development (including continuity of team), 2) motivational interviewing 3) nurturing peer support, 4) teaching and encouraging self-management, 5) a registry for identifying and tracking patients 6) continuous QI/evaluation.** The keys to success are discussed below and it is important to recognize that they function together to ensure success. Thus, for example, having a highly dynamic group with peer support but without motivational interviewing strategies used by the moderators will not guarantee improvements in clinical outcomes in a timely fashion.

1) Multi-Disciplinary Team Development (including Continuity of Team)

The more consistent the team members, the more quickly a team can adapt the implementation strategies to their local environment. Deference to expertise not rank is an important consideration in fostering teamness, that is the sense of mutual interdependence and supportiveness. An example of this may be to defer to a RN case manager about how quickly to titrate insulin since he/she may know how to use different insulin regimens. We additionally focus on our successes, which allows for high provider satisfaction.

Continuity of team need not mean that only the same three people do the session each and every time. What it does mean is that there is continuity in that all team members who rotate or take turns are seen as part of the team and involved with training, updates, debriefing and continuous quality improvement. You may find it helpful to send summaries of the debriefing session to the team member(s) who aren't scheduled for that session, or decide to have a monthly Team Continuity Meeting with all team members to reinforce the common goals and objectives.



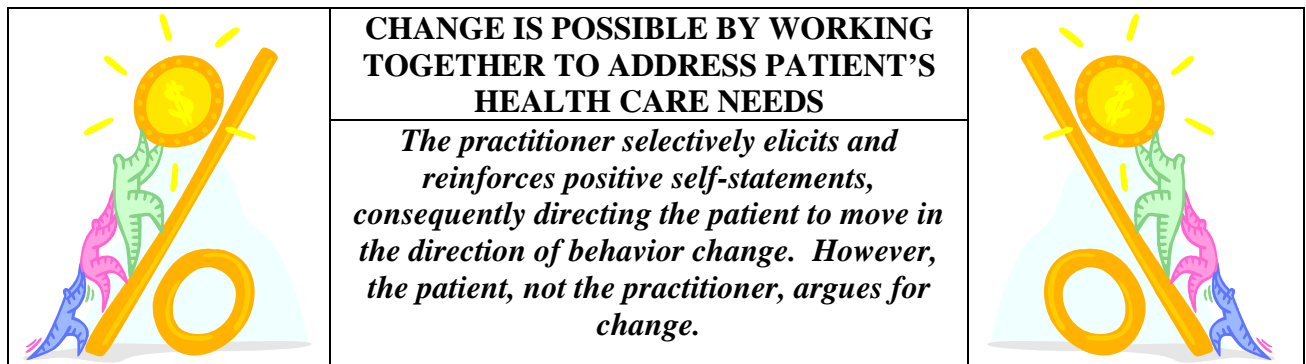
Pearl of Wisdom: Foster a sense of camaraderie and effectiveness by emphasizing that all members are equal and have important expertise.

2) Motivational Interviewing: Setting the Tone for Patient-Centered Group Encounters

Healthcare providers and group moderators help promote behavior change in individuals with chronic illness through use of innovative approaches to communication such as *motivational interviewing (MI)*. This approach is particularly useful when patient motivation and adherence are necessary in order for treatment to be effective, such as in diabetes. Given that motivation is often a significant obstacle to behavior change, MI has been used to address many health problems related to lifestyle as well as in the prevention and treatment of many chronic illnesses (Miller, 2004). Although there are many strategies that can be used in the application of this method, MI is not a technique so much as a style for provider-patient communication. MI has been described as a patient-centered counseling style used for eliciting behavior change by helping patients to explore and resolve ambivalence (Miller & Rollnick, 1991; Rollnick & Miller, 1995). Miller (2004) further described it as “a way of being with people, that is also directive in seeking to move the person toward change by selectively evoking and strengthening the patient’s own reasons for change” (p. 4). The tenets of Motivational Interviewing acknowledge (Harris, Aldea, & Kirkley, 2006):

- (a) most people move through a series of steps prior to changing behavior,
- (b) effective change is self-directed,
- (c) confrontation and negative messages are ineffective,
- (d) knowledge alone is insufficient for behavior change, and
- (e) patient ambivalence about change must be addressed before successful behavior change can be accomplished.

To use this method, the practitioner and the patient work together to address the patient’s health care needs, emphasizing a collaborative approach (Miller, 2004, p.4). In MI, the practitioner selectively elicits and reinforces positive self-statements, consequently directing the patient to move in the direction of behavior change. However, the patient, not the practitioner, argues for change.



MI is based on three fundamental components: collaboration, evocation, and autonomy. MI is a collaborative approach and therefore the provider does not assume an authoritarian or expert role in the relationship. Instead, the patient’s perspective and autonomy is respected. The second fundamental element of MI is evocation. MI’s evocative nature assumes that practitioners can elicit from patient’s their perspective and values rather than imparting their own. The provider understands that it is up to the patient to decide whether or not to change, and how best to go about that change. The provider respects the patient’s choices and decisions regarding self-direction, even if they are divergent from those that the provider considers best for the patient.



Three Fundamental Elements of Motivational Interviewing

1 – COLLABORATION:

Provider does not take on role as authority or expert

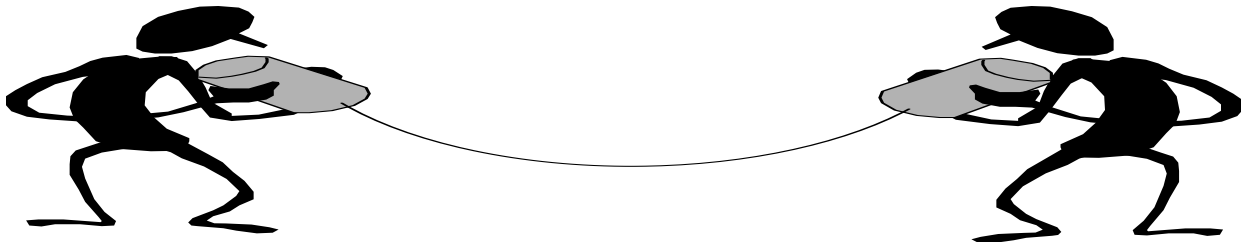
2 – EVOCATION:

Providers can elicit from patients their own perspectives and values

3 – AUTONOMY:

Provider respects patient’s choices, even if they are divergent from what the provider feels is best

To promote positive behavior change, providers must learn to utilize several principles in communicating with patients and these include roll with resistance, express empathy, avoid arguing, develop discrepancy and support self-efficacy (READS). Ambivalence regarding change is considered part of the process. Thus, the central goal in MI is to recognize the discrepancy between the patient’s stated goals and their present behavior. Eliciting reasons for change from the patient is more powerful than giving the patient prescribed reasons why change is necessary (Miller & Rollnick, 1991, 2002).



PRINCIPLES IN COMMUNICATING WITH PATIENT TO PROMOTE POSITIVE BEHAVIOR CHANGE

R	Roll with Resistance	Rolling with resistance is critical in relationship building and requires the provider to avoid arguing with a patient who is resistant to change.
E	Express Empathy	Expressing empathy requires actively listening to the patient and conveying an understanding of his/her perspective.
A	Avoid Arguing	It is important to understand that patient’s often become further entrenched in negative behavior and more resistant to change when the communication becomes argumentative.
D	Develop Discrepancy	Once recognized, providers must be skillful in drawing attention to the discrepancies presented by the patient without exerting pressure on him/her to make changes.
S	Support Self-Efficacy	Providers must express confidence in the patient’s ability to change and acknowledge previous statements and efforts toward positive change.

A primary goal in MI is to shape the language that patients use to describe their dilemmas. “**Change talk**” occurs when patients provide their own reasons and arguments for a behavior change (Miller & Rollnick, 1991, 2002) and generally falls into one of four categories: **desire, ability, reasons, and need (DARN)**. Key words that indicate a desire for change include want, wish, and prefer. Change talk that reflects a patient’s ability to change often includes statements of self-confidence, such as “I could...,” “I might be able to...,” or “I can...” Reasons for change often reflect the costs and benefits of change. Statements that reflect the need to change are “I ought to...,” “I have to...,” or “I really should...” The four change talk categories predict patient commitment to change, which in turn predicts behavior

change by the patient (Amrhein, Miller, Yahne, Palmer, & Fulcher, 2003). When a patient offers a practitioner change talk, the provider then has an opportunity to reiterate the patient's own arguments for change. These statements allow the patient to hear his or her change talk, which further reinforces what the patient has said (Miller, 2004).

Skills used in MI to elicit change talk from patients are often referred to by the acronym OARS and include the following:

- (1) asking **O**pen questions,
- (2) **A**ffirming,
- (3) listening **R**eflectively, and
- (4) **S**ummarizing.

What is *NOT* Listening

- **Ordering, directing, commanding**
- **Warning or threatening**
- **Giving advice, suggestions, solutions**
- **Persuading or lecturing**
- **Moralizing, preaching (fixing, healing, and converting)**
- **Disagreeing, judging, criticizing, or blaming**
- **Agreeing, approving, or praising**
- **Shaming, ridiculing, or labeling**
- **Reassuring, sympathizing, or consoling**
- **Questioning or probing**

Clinical Example of Using DARN and OARS:

Scenario: A patient with DM comes to the Diabetes Shared Medical Appointment (DM SMA). The nurse diabetic educator tells the team members the patient (Mr. X) has had high blood sugars for some time despite taking his oral diabetes medications and needs to start insulin. The provider, nurse and health psychologist enter the exam room with Mr. X.

Provider: Mr. X, we noticed your blood sugars have been running very high despite your taking oral medications. We need to get you started on insulin.

Mr. X: (Shaking his head no). No, I can't do that. I just can't do that.

Provider: (Interrupting)...but if you don't start insulin your sugars will continue to stay high and that won't be good for you.

Health Psychologist (HP): Excuse me, may I ask Mr. X a question. Mr. X, you seemed to have a strong reaction to starting insulin. May I ask why?

Mr. X: (Breaking off eye contact and continuing to shake his head no). The lady down the street has diabetes. She started insulin and not so long after had her legs cut off.

HP: And you're afraid that the same thing could happen to you. (*Reflection*)

Mr. X.: Yes.

HP: OK, Mr. X., let's talk about some of your concerns. We know you are concerned about amputation. Can you tell us if there are any concerns you have about having high blood sugars? (*Reasons*)

Mr. X.: Well, I know it's not good for my heart, my kidneys, and blood flow. And my eyes are pretty bad too.

HP: So, having high blood sugars could lead to a heart attack, kidney disease, and poor circulation which could lead to amputation and has already affected your eyes (*Reflection*). I'm imagining that you want to prevent those things from happening and preventing your eye sight from worsening. What do you think needs to happen to prevent these things from occurring? (*Desire*)

Mr. X.: Well, I need to get my sugars down.

HP: What do you think could be done to get your sugars down? (*Ability*)

Mr. X.: I can continue to take my oral medications and maybe eat better. But I'm still afraid of the insulin.

HP: So, continuing the oral meds and eating better. But it sounds like you still have concerns about the insulin. Other than your neighbor having her legs amputated after starting insulin, do you have any other concerns about insulin? (*Reasons*)

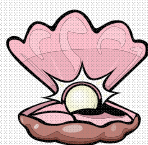
Mr. X.: Yes, I don't see well and I'm afraid I'd overdose myself because I can't see the line on the syringe.

HP: It sounds like if you were certain that the correct amount of insulin could be drawn-up in the syringe you might consider taking insulin. Tell us if you have some ideas how that might happen. (*Ability*)

Mr. X.: My cousin comes over every morning to check my blood sugars on the meter because I can't see the meter either. Maybe he can draw up the insulin then.

HP: That sounds like a pretty good idea. What do you think about our nurse diabetic educator getting together with you and your cousin to do some training?

Mr. X.: I like that idea. (*Commitment*)



Pearl of Wisdom: MOTIVATIONAL INTERVIEWING is not a technique so much as a style for provider-patient communication ~ a patient-centered counseling style used for eliciting behavior change by helping patients to explore and resolve ambivalence.

3) Nurturing Peer Support

Peer support is considered an essential component of SMAs. The success of peer support appears to be in part due to the sharing of similar life experiences and challenges, offering support and patient activation. Among patients dealing with the same chronic illness, sharing experiences with others adjusting to similar medical and/or behavioral regimens has been found to be an effective means of gaining mastery over self-management skills and improving disease outcomes (Heisler & Piette, 2005). Assimilating new knowledge and appraisals through mutual exchange of experiences may occur more effectively when presented by peers with whom the patient identifies and shares common experiences. Group interaction appears to provide emotional support while lessening feelings of isolation and stigmatism that are associated with chronic illness (Weinger, 2003). Peer support also provides an additional social support network that many individuals lack when trying to meet the demands of their illness. Patients are actively involved in decision-making and problem solving in relation to issues raised by others within the group. Moreover, the act of assisting another person can promote a real sense of contribution and certainly increase group cohesiveness (Olsson, 2005). Research has shown that patients found meaning and positive reinforcement for their own behavioral goals in seeking also to support other patient's efforts in managing their behavioral goals (Heisler & Piette, 2005).

Promoting peer support in shared medical appointments requires the group moderator to attend to both the content of what is being said and the process of the group (e.g., who is talking, for how long, which patients are disengaged, etc.). Often new moderators interact with patients by either lecturing or engaging in a question/answer session. This interaction sets the norms for the group and will inhibit patients from engaging in discussion with one another. Promoting peer support begins with the initial interaction and can be fostered by the moderator.

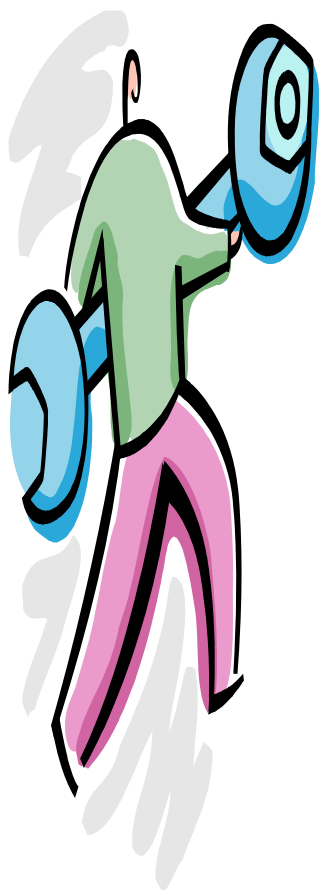


General Points to Keep In Mind to Encourage Peer Discussion and Peer Support



<i>Sit at the table as an equal</i>	Moderator should sit at the table with the patients, this communicates a more equal relationship and does not give the impression that the moderator is there to "teach."
<i>Validate patients as experts and valuable contributors</i>	Moderator can provide an introduction such as: "Welcome to the Diabetes Shared Medical Appointment. You will notice that you are here with many other individuals who also have diabetes. These appointments are a new approach to care. We have discovered that what patients do at home is even more important than what we do for you here in clinic. You take care of yourself 360 days per year but only see us in clinic 5-7 times per year. You guys are 'experts' so you may have suggestions that would be helpful for someone else with diabetes or you may find that someone else is able to offer suggestions for you that could help improve your health. The group is meant to be a discussion. I am not here to lecture but will certainly assist in answering any questions."
<i>Invite brief background stories</i>	Moderator asks patients to introduce themselves, indicate how long they have had diabetes, and whether they take oral medication, insulin, or both.
<i>Jump in as needed with open-ended questions</i>	The moderator should be prepared to start the discussion with a specific open-ended question in case patients start out more passively, but the moderator should also be flexible so that if the group decides to go in a direction that is different, the moderator is able to adjust. These tools are also useful to keep the discussion going (see next box of suggested tools for peer support tool kit).
<i>Don't rush the pauses</i>	<i>**Remember silence can be an indication of thought / reflection / change.**</i>

Suggested Tools for Fostering Peer Discussion and Support



<i>Tool:</i>	<i>Example:</i>
Use an Exercise	Have everyone write down what they ate for dinner last night and pass it to the person on their left who will individually assess the meal for carbohydrates and fats, etc. Then ask if someone has an example of a really well-balanced meal.
Use a “Quiz” Format	Ask each group member to guess how many others in the room follow an exercise program, have well controlled blood sugars, or take medications regularly. Once each participant has offered a response, the moderator asks group members who are "following an exercise program" to raise their hands.
Open with an Engaging Question	What's the most difficult challenge to managing diabetes?
Integrate Lay Resources	Start group with a popular press item (e.g. increasing incidence of diabetes in children, dangers of hypoglycemia, incidence of depression among people with diabetes, diabetes role in erectile dysfunction). Ask group to offer opinions regarding these issues.
Share a Story	Moderator relays a story about a previous patient who was afraid to start insulin and then asks the group members whether any of them have felt similarly?

Example Using Tools and Strategies to Nurture Peer Support:

Moderator: *(Knowing that several patients in the group need to start insulin, the moderator shares a story about a previous patient who was afraid of needles)* Have any of you felt afraid to start insulin?

Patient 1: That was my biggest fear about diabetes. I know I'm a big, tough marine but I just really hate needles.

Patient 2: I know what you mean, they keep trying to get me to start insulin and I just don't think I can do it.

Moderator: *(directed to Patient 1)* How did you overcome that barrier?

Patient 1: Well, the clinic nurse was really great and she showed me how to do the injections and let me practice.

Moderator: Did that alleviate your fear?

Patient 1: No, I was still really nervous the first few times I gave the injection but I realized it didn't hurt nearly as much as testing my blood sugar.

Patient 2: Really, you think testing your blood sugar hurts more than giving an insulin injection?

Patient 1: Absolutely.

Patient 3: I agree, but at first I couldn't stick myself with the needle so my sister did it for me.

Patient 2: I don't know – I think it would be easier if I did it myself rather than let someone else do that to me.

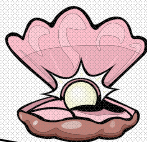
Patient 4: Have you heard about those pens that they use to give the injections – I've used one and you can't really screw up.

Moderator: *(directed to Patient 4) Would you show Patient 2 your insulin pen? (It is better to allow another patient to do the demonstrations. This is also true for BP machines, glucometers, insulin injections, label reading, etc.)*

Patient 4: I haven't been able to get the pen from the VA but I can show you how I set up my insulin. *(Patient takes out case with needles for Patient 2 to see)*

Patient 2: O.K. I'm willing to talk to the nurse and see.

In general, the moderator's job is to find ways to keep the patients talking with one another. Questions/interaction should be aimed at facilitating/promoting peer interaction. Sometimes you have to work harder to get patients interacting, but avoid falling into a lecturing style: ask questions, ask for stories, engage patients you know, rephrase question with another example, and don't feel like you have to fill the silence with information.

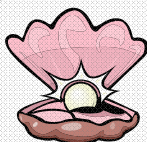


Pearl of Wisdom: Help patients to share by having an open, accepting atmosphere. Recognize that patients bring expertise to the table also.

4) Teaching and Encouraging Self-management

The focus of self-management education within the Diabetes Shared Medical Appointment includes an emphasis on **self-efficacy** and the ABC's (A1c value, BP goal, Cholesterol goals, Diet, Eye exam, Foot exam) of Diabetes (included in supplemental materials section), review of individual lab values and information about Hypoglycemia. This is not meant to take the place of Diabetes self-management education but to address those necessary and pertinent topics for safety, and attainment of **problem-solving skills** in chronic disease care. Patients are encouraged to set a goal to help attain one of the above mentioned values or other health care measures (such as smoking cessation or weight loss).

[Resource JAMA Patient Self-management of Chronic Disease in Primary Care. Thomas Bodenheimer, MD; Kate Lorig, RN, DrPH; Halsted Holman, MD; Kevin Grumbach, MD JAMA. 2002;288:2469-2475.]

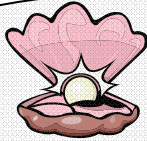


Pearl of Wisdom: Foster self-efficacy by encouraging patients to set goals related to ABC's of self-management.

5) Registry for Identifying and Tracking Patients

The registry is any form of record that identifies actively managed patients with diabetes. Furthermore, the registry can be used to identify patients with A1c, BP or cholesterol parameters that fall outside the acceptable guideline measure. This list should also provide those in need of an eye or foot exam.

If there is no current diabetes registry then a computer generated list of diabetes clinical reminders can act as a reasonable proxy for the registry (this will only populate patients seen in the clinic within the last 12-18 months and perhaps miss those not seen greater than 12-18 months). We have included a copy of a screen image of the registry in the appendices.



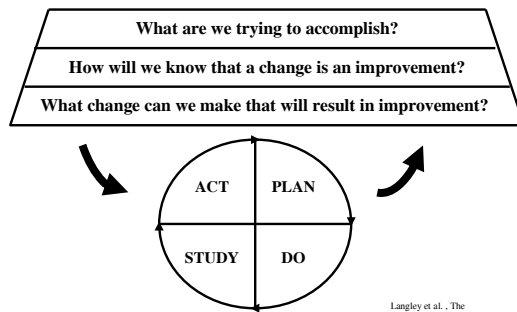
Pearl of Wisdom: Take advantage of resources to help identify patients you want to target. The VA provides electronic resources that shouldn't be overlooked.

6) Continuous Quality Improvement: Sustaining Progress and Staying Alert to Unintended Consequences

No matter how careful the planning, fine-tuning of operations is virtually always necessary. There will be expected as well as unexpected challenges. Responding effectively requires a high degree of reflective practice of all team participants. One useful method to capture perceptions and make changes rapidly is a routine debriefing after the SMA has been conducted. Thus, the debriefing sessions at the end of each SMA allow an opportunity to not only discuss patient issues, but process issues to improve the clinic flow for the next SMA session. The team reviews how the SMA went: what went well and what could be improved. As an example, we tried multiple ways of checking patients in before we decided to do vitals signs quietly in the group room. As another example, we found that patients wanted the expertise that a nutritionist could provide. Therefore, a nutritionist was added to the team. We also tested a variety of other process changes prospectively.

A model for improvement using the PDSA (Plan-Do-Study-Act) Cycle is shown below. The approach to improvement can be accomplished with varying degrees of formality. This can be done with qualitative data or quantitative data or both. The debriefing approach we used primarily depended upon qualitative data. Quantitative data for SMA operations could include length of the session, number of patients seen, etc. Two examples are shown below. Further information can be obtained from the Clinical Microsystems Guide.

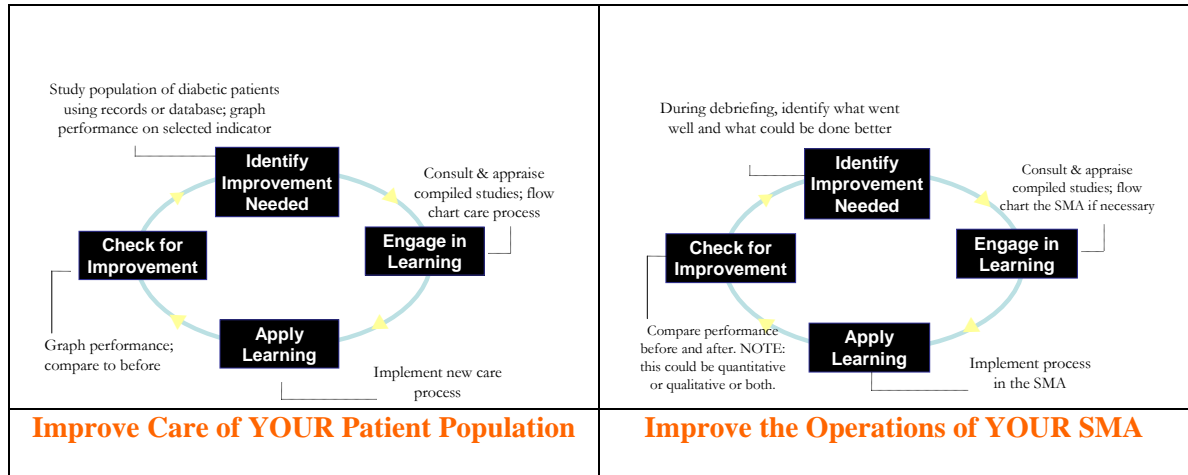
A Model for Improvement



Langley et al., The Improvement Guide, 1996

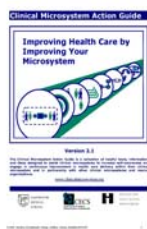
In our experience, changes are still made two plus years after the initiation of SMAs. This process is both retrospective and prospective. This experimentation tests the implementation of new ideas. Rigor

can be brought to this continuing cycle of process evaluation by employing the techniques of continuous quality improvement. Specifically, this involves addressing three questions: What are we trying to improve? How do we want to improve it? And how will we know that a change is an improvement? Therefore, the outcomes of interest must be specified. These may include patient-centered outcomes such as intermediate outcome measures (A1c, ldl-cholesterol, and systolic blood pressure), patient self-efficacy, self-management skills, and others.



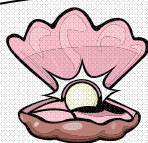
Debriefing and continuous quality improvement will also help alert the team to unintended consequences. As is true of most things in life, we can't anticipate all the consequences – some of which will further facilitate care management, and some of which may hinder it. Monitoring of the process and the outcomes helps develop a watchful eye for the unexpected so that you can quickly address issues that threaten success and progress. Sustainability is not possible without integrating continuous quality improvement into the routine operation of Shared Medical Appointments.

Action Guides



The Clinical Microsystem Action Guide is a collection of helpful tools, information, and ideas designed to assist clinical microsystems to increase self-awareness and engage in continuous improvement in health care delivery within their clinical microsystem and in partnership with supporting departments and other clinical microsystems.

<http://www.clinicalmicrosystem.org/>



Pearl of Wisdom: Success means the process of checking and tweaking, as needed, is ongoing.



6. Challenges and Suggested Solutions for Conducting Group Sessions

A. Leading the Group. At the beginning it is best to identify a moderator to help lead the group. This helps avoid conflict at the outset when the process is new. As time unfolds and cross-training happens, this becomes less of an issue. A health psychologist is a good choice, if one is available. Many other options exist if there is no psychologist or behaviorist available – the important consideration is to have someone with people skills and comfortable with doing motivational interviewing and enabling peer support, which may take some practice.

It is also important for the moderator to know that they don't have to walk into the group with all the knowledge in the world about diabetes. It's okay to say, "That's a really good question. Let's ask the physician or nurse practitioner when they come back in the room." The moderator's role is to help with the flow and to use other resources in the room, including the other team members: that's why the team is interdisciplinary.

B. Roles and Group Processes versus Individual Needs. The interdisciplinary team is critical for the group discussion. However, it is not feasible for all the team to observe and participate in the entire group discussion or individual patient (one-on-one) sessions and medication changes may end up rushed or running over the allotted time. We recommend medication changers/adjusters start pulling individual patients out after 30 minutes of group discussion. Also, others besides medication changers may find a need to see patients individually. For example, if it is clear one patient is having particular and serious problems with carbohydrate counting, the nutritionist should feel free to meet with the patient after the group discussion.

C. Common Challenges and Solutions. As is true of most group dynamics, some issues will arise that can potentially undermine the keys to success. In this section we offer some examples to common challenges found in group discussions along with solutions that are consistent with motivational interviewing, nurturing peer support, and encouraging self-management skills.

The Talkative Patient:

It is important not to "shut-down" the talkative patient. If they seem to be monopolizing the discussion, find a point or two that are pertinent to the discussion, make a statement such as "you raised a good

point about..." or "that's an interesting idea you had about..." and redirect the statement to the group by saying something like "what do the rest of you think about...". This method stops the talkative patient from monopolizing, allows them to save face, and brings the discussion back to the group.

The Talkative Provider:

Sometimes clinical providers who are not familiar with group process or dynamics tend to start lecturing in an attempt to educate the patients. As this happens you can see the patients turn off. They may start fidgeting, talking among themselves, yawning, etc. The facilitator may, again, find a specific point the talkative provider was trying to make, make a statement about the point, and redirect the statement (in the form of an open-ended question) to the group. For example, "Dr. Smith mentioned that it's important to carry glucose tablets with you at all times. How do you remember to keep the tablets with you, or if you forget, what else can you do?"

The Silent Patient:

Silent patients sometimes are uncomfortable speaking in groups for various reasons (e.g., anxiety, can't hear well). Sometimes they are angry or even paranoid about being in a group. Some get up and leave. For those who leave, a fellow team member (not the facilitator) may follow the patient into the hallway, and make a statement that might reflect the emotion the patient is feeling. For example, "Mr. Smith, you seem upset about being in the group today. Would you like to talk about it?" Allow the patient to vent. You can use some of the Customer Service training you've had to defuse the situation. For those patients who remain in the group but are silent, the facilitator can paraphrase what some of the other group members have said about a particular topic and then make a statement such as "I wonder what the rest of you think about...?" Some people will remain silent. It probably is best not to single the individual out. Rather, as patients are being seen individually in the exam room, the clinician may comment "Mr. Smith, you seemed pretty quiet today in the group." You can wait for the patient to respond to the comment.

The Silent or Absent Provider

Occasionally, team members are preoccupied, tired, bored, or if new to the notion of group work, may feel anxious themselves about their role or how to integrate themselves into the mix. As the discussion progresses there may be an issue that comes up where the silent provider may be prompted by the facilitator to participate. For example, "Mr. Jones raised an important question about... Dr. Smith is a bit of an expert in that area and may be willing to say a few words about it."

Managing Misinformation, Old Wives-Tales and Urban Legends:

Occasionally patients will want to discuss home remedies for diabetes as if the remedy is scientifically based. This can almost have an infectious effect among group members. They often want to know more about the "cures". Patients have talked about (among other examples) fasting then using honey and vinegar to control blood sugar; sometimes with disastrous outcomes. One way to defuse this type of misinformation is to gently interrupt the discussion, recognize that there are many home remedies that people have tried over centuries, that science is investigating some of these complementary and alternative treatments, but for our discussions we have to stay with what science recommends now, but also realize that other treatment modalities (some based on home remedies) may be included in our treatment options in the future after they have been verified by sound science.

Comparisons (What private Docs and VA PCPs prescribe):

Some patients see primary care physicians outside the VA in addition to having primary care providers here at the VA. This scenario can lead to conflicting information and confusion among patients. Patients seen in shared medical appointments often raise the conflicting information as discussion points. It is important that facilitators and other SMA team members not fall into the trap of defending the VA providers while negating the private physician's treatment plan. Remember, the patient has

established rapport with both providers. It is best if the team describes why both modes of treatment are effective, the differences between them (e.g., the VA may have a comparable but different drug on formulary), cost savings for the patient (VA pharmacy co-payment will be the least expensive option for the patient), and the safest treatment for the patient (e.g., take only one of the prescribed medications; not both the private physician's and VA PCP's prescriptions).



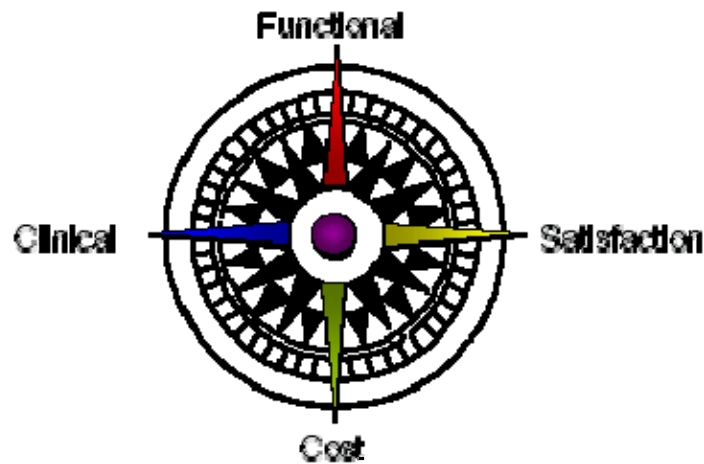
Pearl of Wisdom: SMAs are an effective way to share information and correct misinformation. The challenges associated with group dynamics can be handled best by remembering one of the core tenets of motivational interviewing: Respecting all group members



7. Assessing Progress: Measuring Outcomes

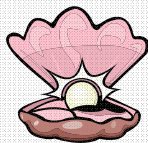
It is important to assess progress and measure the intended consequences. The Clinical Value Compass as seen in Figure 3 helps to identify the possible measures to evaluate. The domains include: functional, satisfaction, cost and clinical. The Functional status (including risk status and well-being) may include quality of life measures or self-management skills. The Satisfaction measure can include general satisfaction with the visit, change in barriers to diabetes self-care, degree of self-efficacy, P-ACIC (patient chronic disease activation measure). Measures of cost can include waiting times for clinic prior to and after SMAs, number of visits to Emergency Rooms for hypo or hyperglycemia, hospital admissions for hypo or hyperglycemia and amount of provider time to improve performance measures. Clinical outcome measures can be identified through the clinical reminders or VA performance measures for patients with diabetes and include measurement of: A1c, ldl-c, systolic blood pressure, aspirin use, HCTZ for patients with hypertension, annual foot examination, annual eye examination, and microalbumin/creatinine ratio.

Figure 3: The Clinical Value Compass



We have found the clinical value compass helpful for guiding our assessments of SMAs and hope you find it useful for guiding your decisions. We have chosen to measure the following clinical outcomes- A1c, ldl-c, systolic blood pressure, aspirin use, foot exams, eye exams, medication adherence, and self-management goal setting. We assess general patient satisfaction with the SMA session and with quality of care. Attendance rates are constantly monitored and used as another measure of patient satisfaction for those who are invited to return for another session.

As mentioned earlier, a key component of success is continuous quality improvement, it is impossible to evaluate progress and make adjustments without measuring aspects of the care provided. We are fortunate to be working in the VA healthcare system because of the ready access to information that helps us monitor patient health routinely.



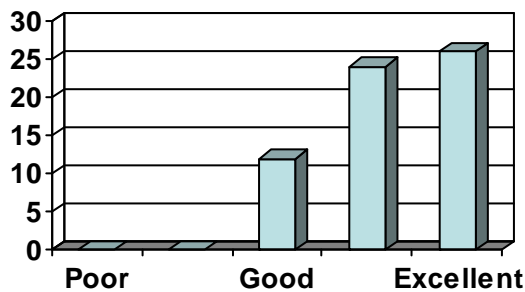
Pearl of Wisdom: The value compass provides a way to approach measuring the impact of SMAs.



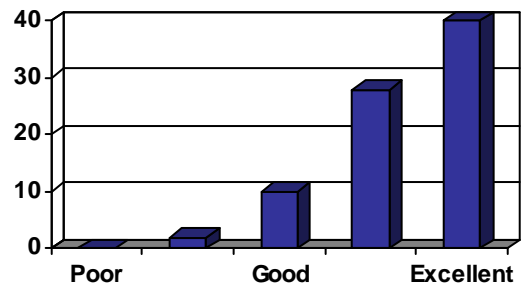
8. Conclusions

As mentioned at the beginning of this manual, overall patients are very satisfied with the SMA experience and give high overall ratings regarding satisfaction with the group visit and quality of the visit, as seen below in data from the Dayton VAMC and the Cleveland VAMC for patients participating in their groups. In addition, most of the patients attending diabetes SMAs at the Dayton VAMC found them useful and most of the patients at the Cleveland VAMC strongly agreed that all their medical needs were addressed and that they would recommend SMAs to others.

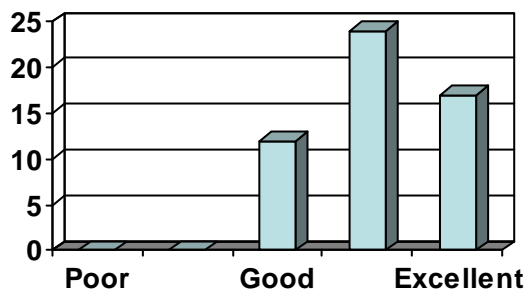
Counts of Ratings for Overall Satisfaction with Group Visit (n=62) Dayton



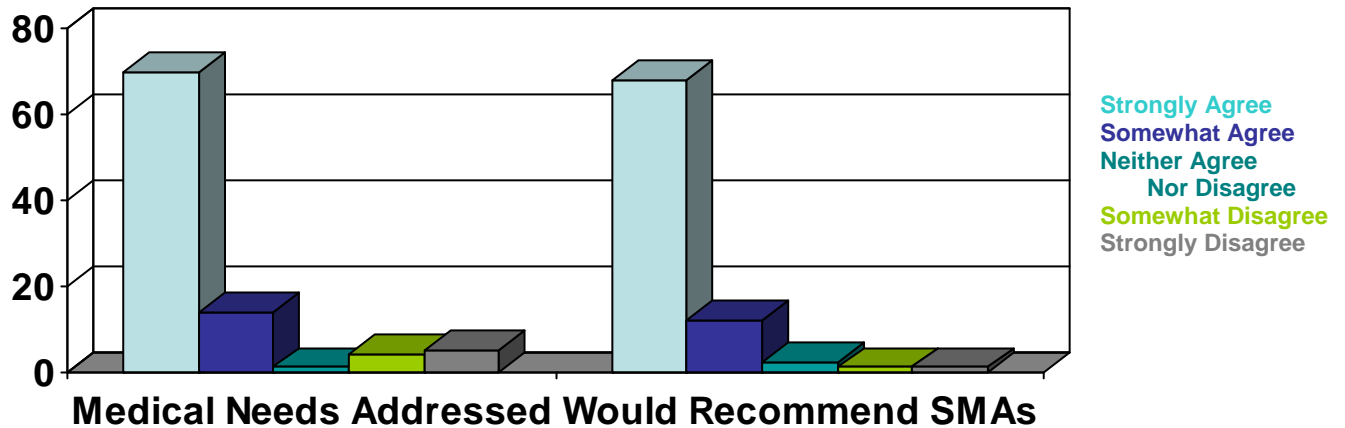
Counts of Ratings for Quality of SMA Visit (n=80) Cleveland



Counts of Ratings for Usefulness of Group (n=53) Dayton

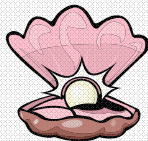


**Counts of Ratings for "All My Medical Needs were Addressed" (n=85)
and "I Would Recommend a Shared Medical Appointment to Others"
(n=84) Cleveland VAMC**



The patient-centered care in an SMA reinforces the concept that each patient is an individual, with unique life experiences, values, religious and cultural influences and psychological strengths and weaknesses that are taken into account in treatment and discharge planning. Informed and activated patients understand the vital role they play in managing their condition. SMAs provide an opportunity for providers to see and learn things that don't happen during a one-on-one session, providing more insights for helping patients manage their diabetes 365 days a year.

While implementing a new shared medical appointment, it is prudent to recognize that there will undoubtedly be challenges, but if you are persistent and adhere to the essential phases, core ingredients, and key elements for success, it will be worth the effort for you and your patients.



Pearl of Wisdom: Management of diabetes can not be successful until patients are made part of the team – and this can not happen without providers partnering with patients. Shared medical appointments provide a mechanism to make that happen and create comprehensive patient-centered care.

9. Supplemental Materials

Tools, References and Web-based Resources

ENROLLMENT LETTERS



James R Sweet
1111 Candy Rd
Cleveland, OH 44106

May 4, 2006

Dear Mr. Sweet,

I have tried to contact you by the phone number listed in your chart-it is disconnected. The computer has detected that your blood sugars and/or cholesterol (lipids) were previously elevated. I would like to invite you to come to the Louis Stokes Cleveland VA on _____ at _____ for a group diabetes shared medical appointment in the Firm B medical clinic where we can help you control your blood sugar values and address other concerns.

The appointment costs the same as any clinic visit with your primary care provider but you will have access to more than one provider.

We encourage you to bring a family member or friend.

Please feel free to call 216.791.3800 x 3263 if you have any questions. I hope to see you soon.

Sharon A. Watts
Nurse Practitioner Diabetes
Wade Park VA
10701 East Blvd.
Cleveland, OH 44106

James R Sweet
 1111 Candy Rd
 Cleveland, OH 44106



May 6, 2006

Mr. Sweet,

Happy Birthday!

Dr. X, your primary care clinician, is pleased to provide you with your Diabetes Birthday Report Card. It shows how you are doing on five important tests for diabetes as of **March 31, 2006**. **It shows you the tests you will need before next year.** Regular testing lowers the chance that diabetes will harm your eyes, heart and kidneys.

Levels listed are for the average patient. You and Dr. Mohiuddin should find the goal that is right for you.










	Your Test	What it Means	Next Test	
Blood Pressure (this is an average of your last 3 blood pressures)	133 / 77	Your top number is a little too high . The target is between 110 and 130 The bottom number is good . The target is between 50 and 80	By June 2006	
A1c	8.7%	Your blood sugar runs too high , on average. Ideally, your A1c target is between 7% and 8%.	By January 2007	
LDL-cholesterol	152	Your LDL-cholesterol is too high . High LDL increases your risk for heart attack, stroke, or loss of a foot or leg.	By January 2007	
Foot Exam	Overdue more than 1 year	Yearly exams help to spot trouble before permanent damage occurs	Now	
Eye Exam	Done Feb 9, 2006	Yearly exams help to spot diabetic eye disease before permanent damage occurs	By Feb 2007	

I would like to invite you to come to the Louis Stokes Cleveland VA on _____ at _____ for a group diabetes shared medical appointment in the Firm B medical clinic where we can help you control your blood sugar values and address other concerns.

The appointment costs the same as any clinic visit with your primary care provider but you will have access to more than one provider.

Please call Ms. Lenore Wright RN, diabetes case manager, to confirm.
(440) 244-3833 Ext 2247

Diabetes care: The ABCs to better health

		How often	Goal	My level
	A1c test to measure your average blood sugar control over the past 3 months... (Blood Sugar 90-130 before meals)	Every 3-6 months	7-7.9%	_____
	Blood pressure control	Every visit	<140/80	_____
	Cholesterol levels.....	Yearly	LDL 100 -130	_____
	Diabetes kidney screening urine microalbumin test.....	Yearly		_____
	Eye exam: if last eye exam was normal..... if last eye exam was abnormal...	Every 2 years As directed		_____
	Foot exam (pulse, sensation, appearance)..	Yearly		_____
	Goals for self-management.....	Every visit		_____
	Heart protection with statins (cholesterol medication) and aspirin (if your doctor orders it).....	Every day if needed		_____
	I am convinced I need to set a self-management goal AND I am confident I can reach my self-management goal			_____

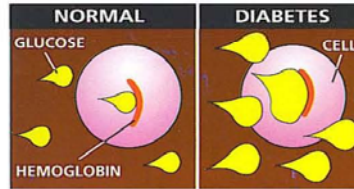
Remembering Your ABC's!!



Heart disease and stroke are the leading causes of early death in people with diabetes. But you can fight back!! Adherence to the ABC's of diabetes care may help reduce your risk as well as other adverse outcomes of diabetes including blindness, kidney disease and limb amputation. Take control of your ABC's of diabetes today and live a long and healthy life.

A is for A1c. Your 3-month blood sugar.

Target: Less than 7% (average blood sugar less than 170)



A

A is for Aspirin.

Aspirin everyday helps to thin the blood, which can help prevent heart attacks and stroke.



Check with your doctor before starting daily aspirin.

B is for Blood Pressure

Target: Less than 130/80

High blood pressure makes your heart work too hard and can cause damage to your kidneys and eyes.



B

Things you can do to help lower blood pressure:

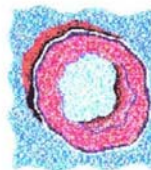
- ♥ Take medications as ordered
- ♥ Lose weight/maintain desirable body weight
- ♥ Add or increase exercise
- ♥ Decrease salt/sodium in your diet
- ♥ Find ways to manage your stress
- ♥ Stop smoking
- ♥ Limit/avoid drinking alcohol
- ♥ Add more fruits and vegetables to your diet

C is for Cholesterol.

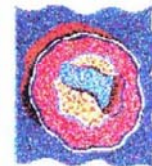
The lousy cholesterol (LDL) builds up and clogs your arteries, which increases your risk of a heart attack or stroke.

Things you can do to help lower your bad cholesterol and increase your good cholesterol:

- ♥ Decrease your intake of animal fats
- ♥ Add or increase your exercise
- ♥ Use monounsaturated fats (olive & canola oil, nuts) instead of saturated fats (butter, lard, vegetable oil)



Normal



Build up of cholesterol

Targets: *LDL (lousy) Cholesterol*
HDL (healthy) Cholesterol
Triglycerides

Less than 100
More than 40 (men)
More than 50 (women)
Less than 150

LSCVAMC 0187-12/21/04

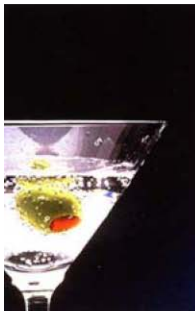
Reasons and Treatments for Hypoglycemia

Reason

20 minutes activity
(Can lower blood sugar by 50 points- may happen up to 8 hours later)



Drink of alcohol



Skipping a meal

Counting up carbohydrates incorrectly at a meal

Taking too much diabetes medicine by mistake

Weight loss



Treatment

Cover with carbohydrate (3 glucose tablets) or lower diabetes medicines (Check with provider first)

Eat carbohydrates (bread, fruit) with alcohol & drink moderately (No more than 1 serving women/day, 2 servings men/day)



Carry emergency food such as crackers/cheese, juice boxes

Schedule appointment with a Registered Dietitian

Eat carbohydrate foods, call if unable to bring sugars up

Call primary provider to adjust diabetes medicines



VA TELE-NURSE

1-888-838-6446 OR 1-888-350-3100

VA Hospital Hypoglycemia 15-15 RULE

Blood sugar of less than 70 is considered low blood sugar. Some symptoms you can expect are:

Mild

Shakiness
Sweating
Fast heart beat
Dizziness
Hunger
Blurred vision
Difficulty concentrating
Palpitations
Hunger
Anxious
Headache
Tired

Moderate

Difficulty moving
Confusion
Unusual behavior

Severe

Seizure
Coma
Combative

Causes of Low Blood Sugar

- Taking too much insulin or medication
- Missing a meal or snack or eating less than usual
- More activity or exercise than usual
- Drinking alcohol on an empty stomach

How to Treat a Low Blood Sugar Below 70

15 Grams of Carbohydrate. **Examples:**

- 1 Tube of glucose gel
- 3 glucose tablets
- 6 pieces of hard candy
- 8 oz. of milk, skim
- 4 oz. of juice, no tomato / V-8
- 1 tablespoon of jam/preserves, jelly, honey, sugar

How to Treat a Low Blood Sugar Below 50

30 Grams of Carbohydrate. **Examples:**

- 2 Tubes of glucose gel
- 6 glucose tablets
- 8 oz. of juice
- 2 tablespoons of jam/preserves, jelly, honey, sugar

Check your blood sugar results in 15 minutes, if no improvement repeat treatment with 15 GM of Carbohydrate. Follow with your next meal, if it is time, or have a snack of 1/2 sandwich and a glass of milk if it is 1-2 hours or longer away.

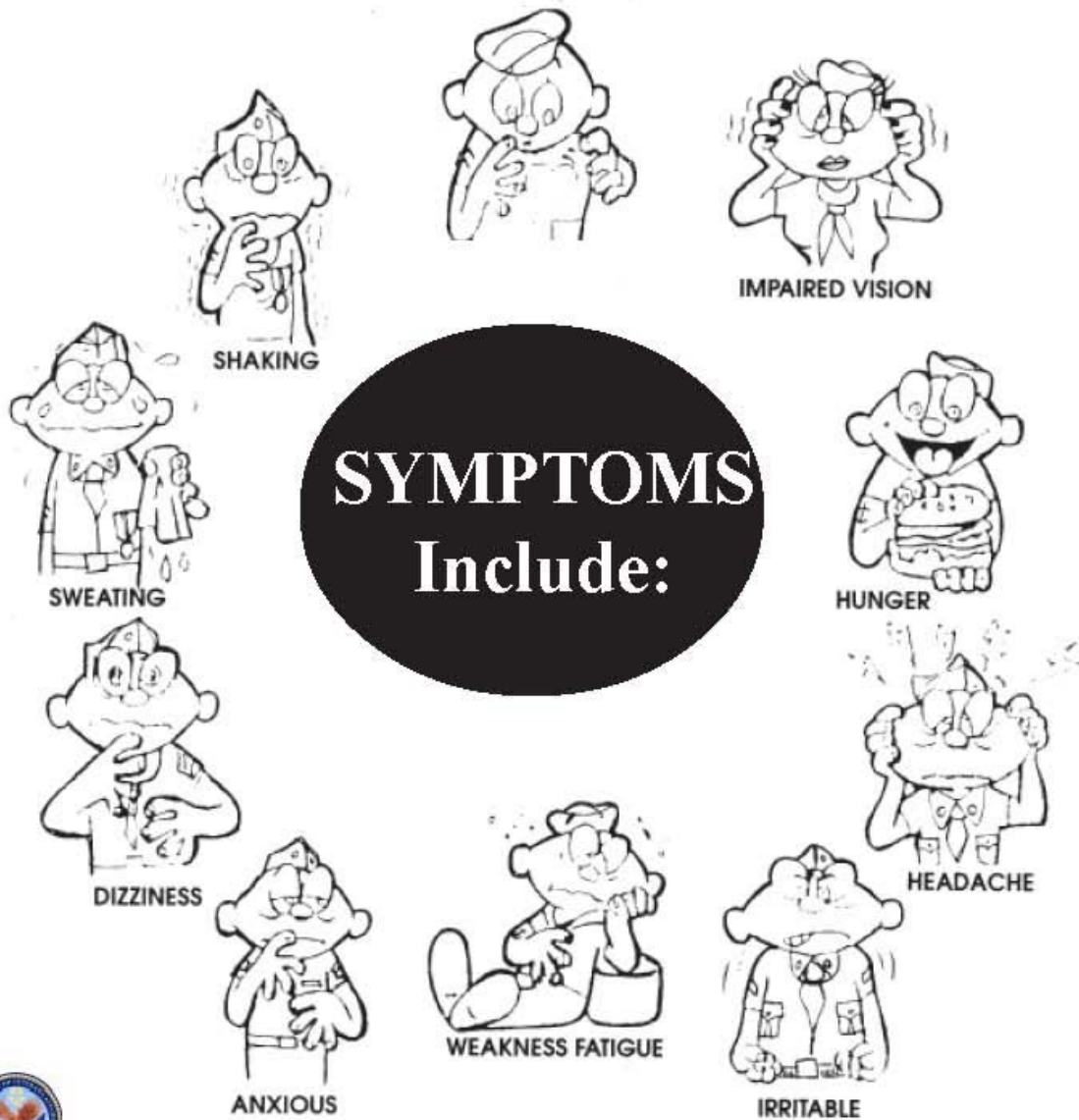
Remember

- Wear an identification bracelet or necklace (ask your diabetes educator)
- Always carry a quick source of sugar with you
- Check your blood sugar before driving and never drive when it is low
- Call your doctor or Telephone Advice Nurse if you have repeated low blood sugars.
- If not responsive or unable to swallow, please call 911.

VA Telephone Advice Nurse (216) 231-3260 or 1-888-350-3100

Causes of low Blood Glucose are:

- Taking too much insulin or medication
- Missing a meal or snack
- More exercise than usual
- Drinking alcohol on an empty stomach






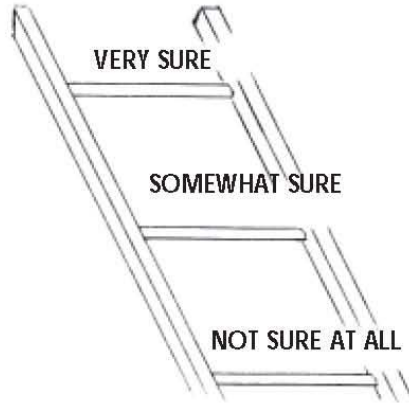



Louis Stokes
Cleveland VA Medical Center

LSCVAMC 8/15/06

MY DIABETES ACTION PLAN

I _____ Last 4 _____ have agreed with my health care provider that to improve my health I will:

<p>1. Choose <u>ONE</u> of the activities below:</p> <p> _____ Take my medications</p> <p>_____ Work on something that's bothering me:</p> <p> _____ Stay more physically active!</p> <p>_____ Attend diabetes class</p> <p> _____ Cut down on smoking</p> <p> _____ Improve my food choices</p> <p>_____ Reduce my stress</p> <p> _____ Check my blood sugar</p>	<p>2. Choose your confidence level:</p> <p>This is how sure I am that I will be able to do my action plan:</p>  <p>3. Complete below for the chosen activity:</p> <p>What: _____</p> <p>_____</p> <p>How Much: _____</p> <p>_____</p> <p>When: _____</p> <p>_____</p> <p>How Often: _____</p> <p>_____</p> <p>_____</p> 
---	--

BLOOD SUGAR TARGETS

BEFORE MEALS

90 - 130

TWO HOURS AFTER MEALS

100 - 180

BED TIME

110 - 150

**BEFORE DRIVING or EXERCISE
ABOVE 100**

PATTERN MANAGEMENT FOR BLOOD SUGARS

Good blood sugar control depends on a number of factors. Pattern Management can help by taking into account a person's:

1. Blood sugar levels
2. Food intake.
3. Diabetes medications
4. Level of activity
5. Stress levels/sickness



Pattern Management involves 5 steps:

1. Know your blood sugar targets. Check with your primary care provider. ADA Goals are:
 - Before Meals - 90-130 mg/dl
 - 2 hours after eating - less than 180mg/dl
 - Bedtime - 110-150mg/dl
2. Record blood sugar levels/activity levels/stress/diet changes.
3. Look for patterns of highs or lows for a few days.
4. Try to correct the highs and lows.
5. Report patterns of highs and lows to medical provider if you cannot change them.



LSCVAMC0229 - 10/2005

TEMPLATED GROUP NOTE (IMAGES OF SCREEN)

resident/Attending Note

Verbal consent to participate in this group visit was obtained prior to scheduling.

Pt presented to Firm Diabetes Group. Topics discussed included:

- HbA1c goal <7% and the importance of glycemic control
- LDL goal <100 mg/dL and BP goal <130/80mmHg
- Complications of DM such as retinopathy, nephropathy, neuropathy, & ED
- Mood changes, obesity, exercise, and smoking cessation

Education Topics:

- Pt educated on signs/symptoms of hypoglycemia.
- Pt educated on proper medication use and possible adverse effects.
- Heart Healthy Diabetes Meal Planning reviewed by dietitian in relation to clinical goals for diabetes mellitus, hypertension, hyperlipidemia.
- Importance of goal setting in chronic care management was discussed and self-management goal was established.

Patient is a 44 year old here for follow up of Diabetes:

Number of years patient has had diabetes:

CHIEF COMPLAINT:

Active Inpatient and Outpatient Medications (including Supplies):

No Medications Found

ALLERGIES:

No Allergy Assessment

Templates	
Reminders	
Encounter	<No encounter information entered>
New Note	

Sheet Problems Meds Orders Notes Consults Surgery D/C Summ Labs Reports

HYPERTENSION

- At goal with Blood Pressure < 130 mmHg/80mmHg. Continue current regimen.
- Fair Blood Pressure control, however unable to safely adjust medications due to
- Not at goal. Consider ACE-I / ARB for renoprotective effects. Consider diuretic since Diabetes patients retain sodium.

DIABETES

- At goal with A1C < 7%. Continue current regimen.
- Fair A1C control (7-7.9%), however unable to safely adjust medications due to
- Not at goal. Consider referral to Diabetes self-management classes for a "refresher" for patient/caregivers. Consider referral to Nutrition for individual instruction on carbohydrate counting.
(Links to the CONSULTS are located below in the Consult Section)

DYSLIPIDEMIA

- At goal with LDL < 100mg/dl. Continue current regimen.
- Fair LDL control, however unable to adjust medications due to
- Not at goal.

CONSULTS:

- Diabetes Self Management Education (WP).
- Nutrition (WP).
- Optometry (WP). (Last Optometry Visit ^^)
- Pharm D (BP, Lipids or Med Adherence).
- RN Case Management (Meters, Insulin Instruction) WP.
- Behavioral Medicine (WP)

Labs

Patient Self Management Goal : walk 30 minutes 3 times a week

FOLLOW UP

: 4 weeks

Click web link to give patient Diabetes Action Plan.

<http://vaww.cleveland.med.va.gov/patientedu/documents/diabetes/DiabetesActionPlan.pdf>

LEVEL OF SUPERVISION

Cleveland VA Medical Center
Diabetes Group Medical Visit: Patient Satisfaction Survey

How many years have you had diabetes? _____

In general, how would you rate your overall health today? Excellent Good Fair Poor

Including today, how many diabetes group appointments have you attended? 1 2 3 4 5+

Would you want to attend another diabetes group appointment? Yes No

Outside of this group medical appointment, do you discuss your diabetes? Yes No

If yes, with whom? (select all that apply)

- Spouse Partner Other family Friends
 Medical Staff Religious Members Other: _____

How strongly do you agree or disagree with the following statements?

	strongly agree	somewhat agree	neutral	somewhat disagree	strongly disagree
I have the ability to control my blood sugar.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have the ability to control my blood pressure.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have the ability to control my diet.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise is important in controlling my blood sugar.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I know how to minimize further problems associated with my health condition.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other group members have the same types of problems that I have.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I learned new ideas for diabetes control from other members in the group.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My problems are different from other members in the group.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Group discussion was useful to me.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am very worried about what diabetes will do to my health in the near future.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

In today's group medical appointment...

I shared a problem that I have been having.	Yes	No
I asked a question which I have been wondering.	Yes	No
I learned something new about my diabetes.	Yes	No

How would you rate the overall quality of today's appointment? Excellent Good Fair Poor

Thank you for your participation in this survey. We appreciate the service you gave to your country, and we appreciate the opportunity to serve you.

RESOURCE FOR PROVIDERS: STEPS FOR ANALYZING BLOOD GLUCOSE PATTERNS

Guideline	Pattern	Example	Caution
Look for lows first	2 or more 1 very low BS needs to be explained- too much activity, skipped meal?	Every morning, Every afternoon after exercise	Nightmares & night sweats may signify night-time lows
Look for consistent highs	Several at same time of day	Always at HS? Consider adding dinner R or analog, or too much snacking	May be related to snacking, inactivity or skipping medicines
Correct AM fasting	Majority > 90-130 mg/dl	Correcting AM fasting will allow rest of day to follow lower	R/O Somogyi or rebound high after 3 am low-can set pt. alarm to R/O (rare in Type 2)
Make one change at a time	This allows pattern changes to be monitored	Change only insulin or meds 1 at a time	Too many changes may cause hypoglycemia
Change insulin at 10-20% increments only at a time	Change can be titrated q 3-4 d	HS insulin titration to achieve fasting of 90-130 mg/dl	Change one insulin dose at a time
Correct 2-hr post-prandial	≤ 140 mg/dl is norm w/o DM	Check before and 2 hours after largest meal	Cardiovascular risk may be linked with elevated PP levels
Keep HS BS above 110 mg/dL		If too low-may be too much dinner R or rapid analog	HS snack is necessary only if BS < 110 mg/dL

WEB-BASED RESOURCES FOR PROVIDERS

Chronic Care: www.improvingchroniccare.org

VA Clinical Practice Guidelines - Diabetes:

Intranet: <http://vaww.oqp.med.va.gov/CPGintra/cpg/cpg.htm>

Internet: <http://www.oqp.med.va.gov/cpg/cpg.htm>

http://www.oqp.med.va.gov/cpg/DM/DM_base.htm

WEB-BASED RESOURCES FOR PROVIDERS AND PATIENTS

VA Patient Education Materials:

<https://vhav10share.v10.med.va.gov/sites/cleveland/ptedu/default.aspx>

10. References

References for Executive Summary Section, *Some Findings from Various Studies:*

Kirsh, S, Watts, Sharon, Pascuzzi, K, O'Day, ME, Davidson, D, Strauss, G, Kern, E, Aron, DC. Shared medical appointments based on the chronic care model: a quality improvement project to address the challenges of patients with diabetes with high cardiovascular risk. Quality & Safety in Health Care, 16(5):349-353, October 2007.

Kirsh SR, Lawrence RH, and Aron DC. Tailoring an intervention to the context and system redesign related to the intervention: Case study of implementing shared medical appointments for diabetes. *Implementation Science*, 3:34-48, 2008.

Dawn E. Clancy, Peng Huang, Eni Okonofua, Derik Yeager, and Kathryn Marley Magruder. Group Visits: Promoting Adherence to Diabetes Guidelines. J Gen Intern Med., 22(5): 620–624, May, 2007.

M. Trento, P. Passera, M. Bajardi, M. Tomalino, G. Grassi, E. Borgo, C. Donnola, F. Cavallo, P. Bondonio, M. Porta. Lifestyle intervention by group care prevents deterioration of Type II diabetes: a 4-year randomized controlled clinical trial. Diabetologia, 45(9): 1231-1239, September 2002.

Wagner EH, Grothaus LC, Sandhu N, et al. Chronic care clinics for diabetes in primary care. Diabetes Care, 25:695-700, 2001.

References for Section 1: An Overview of Shared Medical Appointments for Veterans with Diabetes: Why do group visits in the VA?

Kirsh, S, Watts, Sharon, Pascuzzi, K, O'Day, ME, Davidson, D, Strauss, G, Kern, E, Aron, DC. Shared medical appointments based on the chronic care model: a quality improvement project to address the challenges of patients with diabetes with high cardiovascular risk. Quality & Safety in Health Care, 16(5):349-353, October 2007.

Masley S, Sokoloff J, and Hawes, C. Planning Group Visits for High-Risk Patients. Family Practice Management, 7(6): 33-37, 2000.

Noffsinger, E. & Scott, J. Understanding Today's Group Visit Models. Group Practice Journal, 49(2): 46-58, February, 2000.

Select References for CCM, Section 2: Group Visit and Patient Activation Model: Chronic Care Model as an Implementation Tool

Bodenheimer, T., Wagner, E., and Grumbach, K. Improving primary care for patients with chronic illness: the chronic care model. JAMA, 288: 1775-1779, 2002(a).

Bodenheimer, T., Wagner, E., and Grumbach, K. Improving Primary Care for Patients with Chronic Illness The Chronic Care Model, Part 2. JAMA, 288: 1909-1914, 2002(b).

Bonomi AE, Wagner EH, Glasgow RE, and VonKorff M. Assessment of Chronic Illness Care (ACIC): A practical tool to measure quality improvement. Health Services Research, 37(3): 791-820, June 2000.

Wagner EH. Chronic disease management: What will it take to improve care for chronic illness? Effective Clinical Practice, 1998;1(1):2-4.

Wagner EH, Glasgow RE, Davis C, Bonomi AE, Provost L, McCulloch D, Carver P, and Sixta C. Quality improvement in chronic illness care: A collaborative approach. Journal of Quality Improvement, 27(2): 63-80, February 2001.

References for Section 5: Aligning Resources - A) Key Elements for Success

2) Motivational Interviewing: Setting the Tone for Patient-Centered Group Encounters

Amrhein, P. C., Miller, W. R., Yahne, C. E., Palmer, M., and Fulcher, L. Client commitment language during motivational interviewing predicts drug use outcomes. Journal of Consulting and Clinical Psychology, 71: 862-878, 2003.

Harris, R. S., Jr., Aldea, M. A., and Kirkley, D. E. A motivational interviewing and common factors approach to change in working with alcohol use and abuse in college students. Professional Psychology: Research and Practice, 37(6): 614-621, 2006.

Miller, W. R. Motivational interviewing in the service of health promotion. Art of Health Promotion in American Journal of Health Promotion, 18(3), 1-10, 2004.

Miller, W. R., & Rollnick, S. (1991). Motivational interviewing: Preparing people to change addictive behavior. New York: Guilford Press, 1991.

Miller, W. R., & Rollnick, S. What is Motivational Interviewing? Behavioral and Cognitive Psychotherapy, 23(4): 325-334, 1995.

Miller, W. R., & Rollnick, S. (2002). Motivational interviewing: Preparing people for change (2nd ed.). New York: Guilford Press, 2002.

3) Nurturing Peer Support

Heislern M. and J. D. Piette, JD. "I Help You, and You Help Me": Facilitated Telephone Peer Support Among Patients With Diabetes. The Diabetes Educator, 31(6): 869 – 879, November 2005.

Olsson, CA, Boyce, MF, Toumbourou, JW, and Sawyer, SM. The Role of Peer Support in Facilitating Psychosocial Adjustment to Chronic Illness in Adolescence. Clinical Child Psychology and Psychiatry, 10 (1): 78-87, 2005.

Heisler, M. and Piette, J.D. I help you and you help me. The Diabetes Educator, 31(6), 869-879, 2005.

Weinger, K. Group interventions: Emerging applications for diabetes care. Diabetes Spectrum, 16; 86-87, 2003.

4) Teaching and Encouraging Self-management

Bodenheimer, T, Lorig, K, Holman, H, Grumbach, K. Patient Self-management of Chronic Disease in Primary Care. JAMA, 288:2469-2475, 2002.

SHARED MEDICAL APPOINTMENTS:
Easy Reference Summary Sheets, Reminders and Check-List
(Please Pull-out and Post for Easy Access)

DIABETES SHARED MEDICAL APPOINTMENT SCHEDULE

TIME FRAME	TASKS	MAIN TEAM MEMBER
PREPARATIONS PRIOR TO SESSION		
1 – 2 weeks before	Send Letters of Invitation (At first schedule 10 patients)	CLERK
2 days before	Make reminder phone calls Print note (12 font) Highlight lab values (don't use green or blue) Assemble handouts	CASE MANAGER CLERK
PREPARATIONS DAY OF SMA SESSION (if starts at 9am):		
SET UP ROOM 8:30	Ensure enough chairs and placed in a Discussion-type format Put handouts around with pencils	NURSE
PATIENTS START ARRIVING 8:45	CHECK-IN Vitals Download glucose data Eye and food screening (triage and grabs) Clinical routing slip	NURSE (Screener)
GROUP SESSION BEGINS 9:00	Welcome and privacy reminder	MODERATOR
	Introductions: ask everyone to introduce self and have patients share their: -Name, -How long had diabetes, -Whether or not on insulin	Patients invited via moderator
GROUP DISCUSSION 9:10-9:30	Socratic discussion of issues Begin process by referring to printed notes and asking patients their values and target values ABCs of Diabetes discussed via questions to engage patients (no lecturing)	Moderator and Patients
START PULLING OUT PATIENTS 9:30	INDIVIDUAL SESSIONS Begin with patients who have time constraints, have hearing problems, are disengaged, are engaging in disruptive behaviors, or have been to previous sessions	Physician/Medicati on Changer (Adjuster) (Moderator helps identify patients)

*****PRIOR TO SMA Session: Team member prints FIRM DIABETES GROUP NOTE template from medical record and highlights relevant values for patient to refer to during the SMA*****

We use the following color coding:

ORANGE: Daily aspirin therapy for cardioprotection

GREEN: Medications & Vitals related to hypertension control

PINK: Medications & Labs related to glucose control

BLUE: Medications & Labs related to lipid control

YELLOW: Labs related to kidney function including Microalbumin/creatinine panel

PURPLE: Eye care and Foot care Clinical Reminders that are due for completion

Verbal consent to participate in this group visit was obtained prior to scheduling.

Pt presented to Firm Diabetes Group. Topics discussed included:

- HbA1c goal < 7% and the importance of glycemic control
- LDL goal 100 mg/dL and BP goal 130/80mmHg
- Complications of DM such as retinopathy, nephropathy, neuropathy, & ED
- Mood changes, obesity, exercise, and smoking cessation

Education Topics:

- Pt educated on signs/symptoms of hypoglycemia.
- Pt educated on proper medication use and possible adverse effects.
- Heart Healthy Diabetes Meal Planning reviewed by dietitian in relation to clinical goals for diabetes mellitus, hypertension, hyperlipidemia.
- Importance of goal setting in chronic care management was discussed and self-management goal was established.

Patient is a 51 year old here for follow up of Diabetes:

Number of years patient has had diabetes: 11

CHIEF COMPLAINT:

Outpatient Medications	Status Refill	Issue Date Last Fill Expiration
1. ACETAMINOPHEN 325MG TAB Qty: 200 for 30 days Sig: TAKE TWO TABLETS BY MOUTH FOUR TIMES A DAY AS NEEDED FOR PAIN	ACTIVE Refills: 0	Issu: / /07 Last: / /07 Expr: / /08
2. ASPIRIN 81MG EC TAB Qty: 30 for 30 days Sig: TAKE ONE TABLET BY MOUTH EVERY MORNING WITH BREAKFAST	ACTIVE Refills: 0	Issu: / /07 Last: / /07 Expr: / /08
3. DIVALPROEX 500MG 24HR (ER) SA TAB Qty: 60 for 30 days Sig: TAKE TWO TABLETS BY MOUTH AT BEDTIME (WITH FOOD)	ACTIVE Refills: 3	Issu: / /07 Last: / /07 Expr: / /08
4. FOSINOPRIL NA 20MG TAB Qty: 60 for 30 days Sig: TAKE EVERY MORNING AN HOUR BEFORE BREAKFAST TWO TABLETS BY MOUTH	ACTIVE Refills: 5	Issu: / /07 Last: / /07 Expr: / /08
5. GLIPIZIDE 10MG TAB Qty: 240 for 60 days Sig: TAKE TWO TABLETS BY MOUTH TWICE A DAY (HALF AN HOUR BEFORE A MEAL)	ACTIVE Refills: 2	Issu: / /07 Last: / /08 Expr: / /08
6. HYDROCHLOROTHIAZIDE 25MG TAB Qty: 90 for 90 days Sig: TAKE ONE TABLET BY MOUTH EVERY MORNING (WITH FOOD)	ACTIVE (S) Refills: 2	Issu: / /07 Last: / /08 Expr: / /08

MEDICAL RECORD

PROGRESS NOTES

7. INSULIN NPH HUMAN 100 UNIT/ML NOVOLIN N Qty: 1 for 30 days Sig: INJECT 10 UNITS SUBCUTANEOUSLY AT BEDTIME (DISCARD VIAL 28 DAYS AFTER FIRST USE)	ACTIVE Refills: 2	Issu: / /07 Last: / /07 Expr: / /08
8. MENTHOL 10%/METHYL SALICYLATE 15% CREAM Qty: 90 for 30 days Sig: APPLY A SUFFICIENT AMOUNT TO AFFECTED AREA TWICE A DAY AS NEEDED FOR PAIN	ACTIVE Refills: 0	Issu: / /07 Last: / /07 Expr: / /08
9. METFORMIN HCL 1000MG TAB Qty: 60 for 30 days Sig: TAKE ONE TABLET BY MOUTH TWICE A DAY WITH MEALS (WITH FOOD; AVOID ALCOHOL)	ACTIVE Refills: 5	Issu: / /07 Last: / /07 Expr: / /08
10. SIMVASTATIN 80MG TAB Qty: 30 for 60 days Sig: TAKE ONE-HALF TABLET BY MOUTH AT BEDTIME	ACTIVE Refills: 0	Issu: / /07 Last: / /07 Expr: / /08
11. TRAZODONE HCL 100MG TAB Qty: 30 for 30 days Sig: TAKE ONE TABLET BY MOUTH AT BEDTIME (WITH FOOD OR SNACK)	ACTIVE Refills: 5	Issu: / /07 Last: / /07 Expr: / /08
12. VARDENAFIL HCL 20MG TAB Qty: 12 for 90days Sig: TAKE ONE TABLET BY MOUTH ONE TIME ONE HOUR BEFORE SEXUAL ACTIVITY (NO MORE THAN 1 DOSE PER 24 HOUR PERIOD) {THIS IS A 90 DAY SUPPLY}	ACTIVE(S) Refills: 0	Issu: / /07 Last: / /07 Expr: / /08

Supply Items Outpatient Medications	Status	Issue Date Last Fill Expiration
1. INSULIN SYRINGE 0.5ML LOW DOSE 29G 0.5IN Qty: 100 for 60 days Sig: USE SYRINGE AT BEDTIME Refills: 1	ACTIVE	Issu: / /07 Last: / /08 Expr: / /08
2. LANCET,TECHLITE 28G Qty: 200 for 90 days Sig: USE LANCETS AS DIRECTED FOR BLOOD SUGAR TESTING Refills: 2	ACTIVE	Issu: / /07 Last: / /08 Expr: / /08
3. PRECISION XTRA (INSULIN USER) STRIP(S) Qty: 200 for 90 days Sig: USE STRIPS TWICE A DAY BEFORE MEALS FOR BLOOD SUGAR TESTING (BREAKFAST AND DINNER) Refills: 2	ACTIVE	Issu: / /07 Last: / /08 Expr: / /08
4.) SHARPS CONTAINER (1.4 QT) Qty: 1 for 90 days Sig: USE 1 CONTAINER AS DIRECTED {WILL BE REPLACED IF HAND RETURNED TO THE PHARMACY SEALED AND FULL - NEVER MAIL BACK - AND THERE IS STILL AN ACTIVE ORDER FOR SYRINGES OR INJECTION}	ACTIVE	Issu: / /07 Last: / /07 Expr: / /08

Recently Expired Outpatient Meds	Status	Issue Date Last Fill Expiration
1.ACETAMINOPHEN 325MG TAB Qty: 200 for 30 days Sig: TAKE TWO TABLETS BY MOUTH EVERY 8 HOURS AS NEEDED FOR LEG PAIN	EXPIRED	Issu: //07 Last: //07 Expr: //07
2. CHOLINE MG TRISALICYLATE 750MG TAB Qty: for 30 days Sig: TAKE ONE TABLET BY MOUTH THREE TIMES A DAY WITH MEALS	EXPIRED	Issu: //07 Last: //07 Expr: //07
3. GABAPENTIN 400MG CAP Qty: 180 for days Sig: TAKE TWO CAPSULES BY MOUTH THREE TIMES A DAY	EXPIRED	Issu: //07 Last: //07 Expr: //07
4. HYDROXYZINE PAMOATE 50MG CAP Qty: 90 for 30 days Sig: TAKE ONE CAPSULE MOUTH EVERY 8 HOURS AS NEEDED FOR ANXIETY	EXPIRED	Issu: //07 Last: //07 Expr: //07

21 Total Medications

ALLERGIES:
Patient has answered NKA

BLOOD PRESSURE:
115/64 (//2007)
108/70 (//2007)

BMI:

LABS

Hemoglobin A1C:
HGBA1C: 9.7 (//2007) BLOOD

Renal Panel:

ALBUMIN:	3.8	//07	SERUM
ANI GAP:	14	//07	SERUM
BUN:	11	//07	SERUM
CA:	10	//07	SERUM
CL:	103	//07	SERUM
CO2:	26	//07	SERUM
CREAT:	58	//07	URINE
EGFR-C:	94	//07	SERUM
GLUCOSE:	162	//07	SERUM
K:	4.4	//07	SERUM
NA:	139	//07	SERUM

Lipid Panel:

CHOL:	192	//07	SERUM
HDL CHO:	33	//07	SERUM
LDL CHO:	114	//07	SERUM
TRIGLYC:	223	//07	SERUM

Liver Function Test:

ALBUMIN:	//07	SERUM
ALK PHO:	//07	SERUM
D BILI:	//07	SERUM
PROTEIN:	//07	SERUM
SGOT:	//07	SERUM
SGPT:	//07	SERUM
T. BIL:	//07	SERUM

MICROALBUMIN/CREATININE PANEL //07

CREATININE:	58.4
URINE MICROALBUMIN:	0.4
URINE ALB./CREAT. RATIO:	6.8

BLOOD GLUCOSE LEVELS:

A.M. Fasting glucose (prior to meals with target range 90-130):

ASSESSMENT/PLAN:

HYPERTENSION

At goal with Blood Pressure < 130 mmHg/80mmHg. Continue current regimen.

DIABETES

Not at goal.

DYSLIPIDEMIA

Fair LDL control, however unable to adjust medications due to

OPTOMETRY - DILATED FUNDUS EXAM: Past due for DFE

PODIATRY FOOT EXAM: Past due for foot exam

FOLLOW UP

Patient received handout: "My Diabetes Action Plan"

Clinical Reminders Activity

Diabetes: Eye Exam:

Patient had an outside Retinal Eye Exam previously.

The results were:

Date:

Results:

SHARED MEDICAL APPOINTMENTS TEAM CHECK-LIST

(3 months; 6 months; 12 months)

Component	Specific Actions	3 months	6 months	12 months
Participants	Populating with those identified as a priority			
	Letting them go			
Group Session	NOT Lecturing			
	Using Motivational Interviewing			
	Allowing Peer Support			
Debriefing	Reviewing difficult patients			
	Cross-training			
	Reviewing process			
	Rewarding and applauding team			

REMINDERS for CONDUCTING
SHARED MEDICAL APPOINTMENTS

TARGET PRIORITIZED PATIENTS

Don't Lecture

ENCOURAGE PATIENTS TO HELP EACH OTHER

DEBRIEF

SHARED MEDICAL APPOINTMENTS' STOP LIGHT



STOP LECTURING

*CAUTION: This is not a
primary care visit*

**GO PEER SUPPORT/
GROUP DISCUSSION**