



NorthPoint Health & Wellness Center

Actively partnering to create a healthier community.



Services for Patients with Diabetes

- NCQA for Diabetes Provider Recognition 10/2006.
- ADA Diabetes Self Management Program Education Certification 3/2006.
- Endocrinologist/Diabetes Nurse and Dietician, Interpreters, Optometry, Podiatry, Dentistry and CHW/CCN.
- Mental Health within the Medical Department, and on site.
- Onsite GDM/OB
- Pharmacy/with Pharm D (medication reviews).
- Lab with Point of care A1c.
- EPIC 7/25/2008.
- Several Cultural specific Diabetes support groups and Group classes (Spanish, Hmong, Somali).



International Diabetes Center

- Relationship with IDC since 2004 (MHP/Lyons).
- Staged Diabetes Management Curriculum entire Medical Clinic 2004.
- New Medical Providers/SS are encouraged to attend courses at IDC.
- Assisted in ADA-SMEP and NCQA Recognition.
- Review Treatment Pathways when updated and adapt to our population.

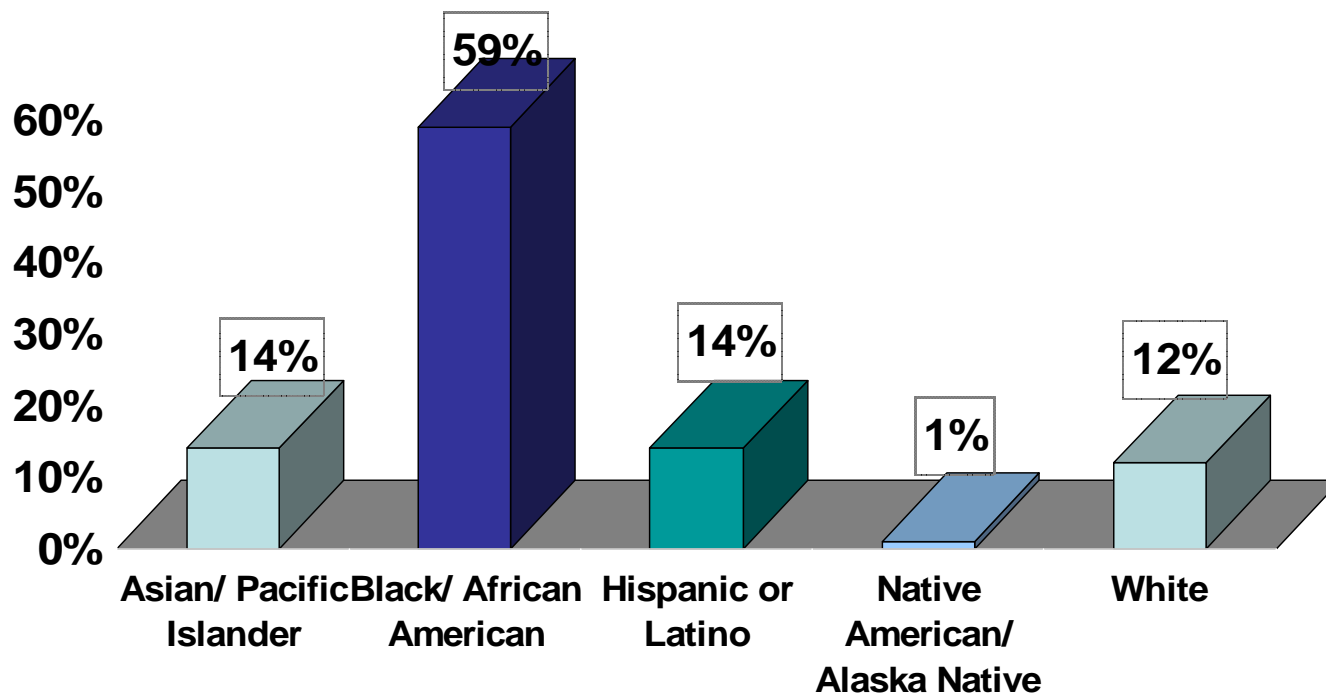


NP Visits

- 13 Medical Providers /1 Optometrist
- 2006 Statistics
 - 56,710 Medical, Mental Health and Dental visits. Projected 2008 - 72,222.
 - 85,913 Pharmacy Prescriptions. Projected 2008 - 98,000.
 - 35,848 NP Human Services Delivered. Projected 2008- 42,000.

PATIENTS BY RACE/ ETHNICITY/ LANGUAGE

2006 UDS Version with Hispanic/Latino



NorthPoint Clients with Diabetes

- NIH/BPHC Diabetes Care Collaborative since 1999.
- 649 patients with Diabetes
 - 63%F/36%M.
 - 51% AA
 - 16% Asian
 - 10%Caucasian
 - 9% Latino
 - 3% AI
- Insurance
 - 46% Medicaid
 - 28% Medicare
 - 34% Uninsured
 - 3% Private Insurance



Diabetic Care Collaborative

- Average A1c is 7.8% (649)
 - 40% <7, 25% 7-7.9, 16% 8-8.9, 7% 9-9.9, 12.6% >10.
 - Community Care Network (CCN) Project. Grant funded by UCARE and the Neighborhood Health Care Network.
 - IDC Basics curriculum
 - BASICS ADA diabetes education program with addition of a CHW- Lifestyle overview and Care manager. Collaboration with West Side CHS.
 - **Presentation by West Side CHS**



CCN Care Coordination Overview

- Invitation – A1c > 8.5%
- Medical assessment
- Psycho-social risk overview (LSO)
- Care plan/patient goal development
- CHW works with the patient in the clinic, by phone and/or at home
- Gifts for goal progress and attainment
- Documentation
- Care Team reviews progress and adjusts care plan
- A1c goal achievement
- 117 patients at NPHWC
- A1c decreased by 2% in 9 months

Community Care Network

Care Team Members:

- Provider
- Care Coordinator
- Dietitian
- Social Workers
- Community Health Worker - regularly meets with or calls the patient to provide:

Reinforcement of disease-related education given by the provider, care coordinator, diabetes educator and/or the dietitian

Information & resources to meet psycho-social and/or medical needs

Coaching the patient regarding self-management goals and activities to achieve them

Emotional support

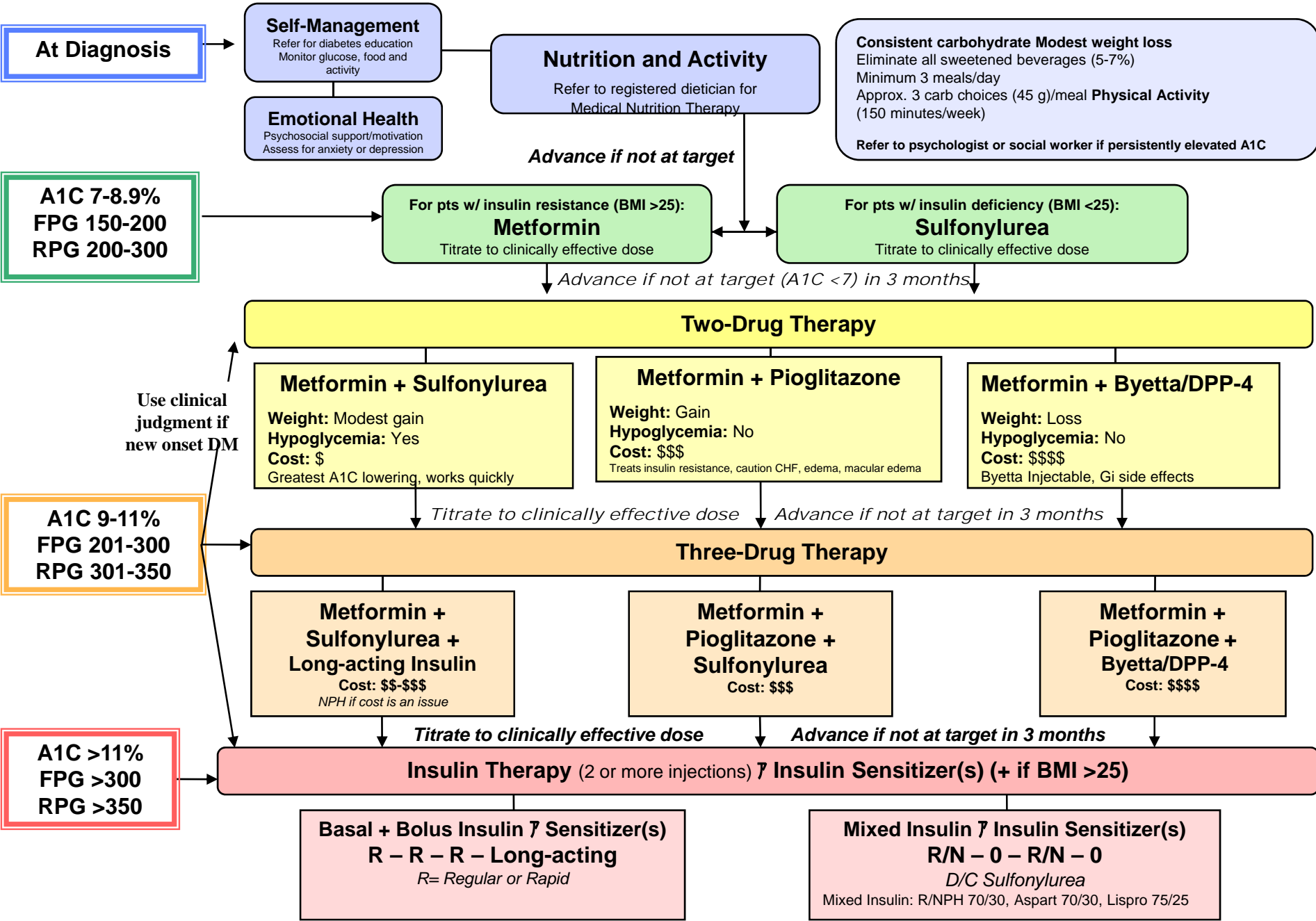
Referral to and/or scheduling of additional services (dental, eye, food shelf)

Documentation of activities

Community Integration:

- Multi-cultural, bi-lingual staff
- Community-based health care services
- Knowledge of community resources

TYPE 2 DIABETES: MASTER DECISION PATH



At Diagnosis

Self-Management
Refer for diabetes education
Monitor glucose, food and activity

Emotional Health
Psychosocial support/motivation
Assess for anxiety or depression

Nutrition and Activity
Refer to registered dietician for
Medical Nutrition Therapy

Consistent carbohydrate Modest weight loss
Eliminate all sweetened beverages (5-7%)
Minimum 3 meals/day
Approx. 3 carb choices (45 g)/meal
Physical Activity
(150 minutes/week)
Refer to psychologist or social worker if persistently elevated A1C

A1C 7-8.9%
FPG 150-200
RPG 200-300

For pts w/ insulin resistance (BMI >25):
Metformin
Titrates to clinically effective dose

For pts w/ insulin deficiency (BMI <25):
Sulfonylurea
Titrates to clinically effective dose

Two-Drug Therapy

Metformin + Sulfonylurea
Weight: Modest gain
Hypoglycemia: Yes
Cost: \$
Greatest A1C lowering, works quickly

Metformin + Pioglitazone
Weight: Gain
Hypoglycemia: No
Cost: \$\$\$
Treats insulin resistance, caution CHF, edema, macular edema

Metformin + Byetta/DPP-4
Weight: Loss
Hypoglycemia: No
Cost: \$\$\$\$
Byetta Injectable, Gi side effects

A1C 9-11%
FPG 201-300
RPG 301-350

Three-Drug Therapy

Metformin + Sulfonylurea + Long-acting Insulin
Cost: \$\$-\$\$\$\$
NPH if cost is an issue

Metformin + Pioglitazone + Sulfonylurea
Cost: \$\$\$

Metformin + Pioglitazone + Byetta/DPP-4
Cost: \$\$\$\$

A1C >11%
FPG >300
RPG >350

Insulin Therapy (2 or more injections) 7 Insulin Sensitizer(s) (+ if BMI >25)

Basal + Bolus Insulin 7 Sensitizer(s)
R - R - R - Long-acting
R= Regular or Rapid

Mixed Insulin 7 Insulin Sensitizer(s)
R/N - 0 - R/N - 0
D/C Sulfonylurea
Mixed Insulin: R/NPH 70/30, Aspart 70/30, Lispro 75/25

Use clinical judgment if new onset DM

Advance if not at target

Advance if not at target (A1C <7) in 3 months

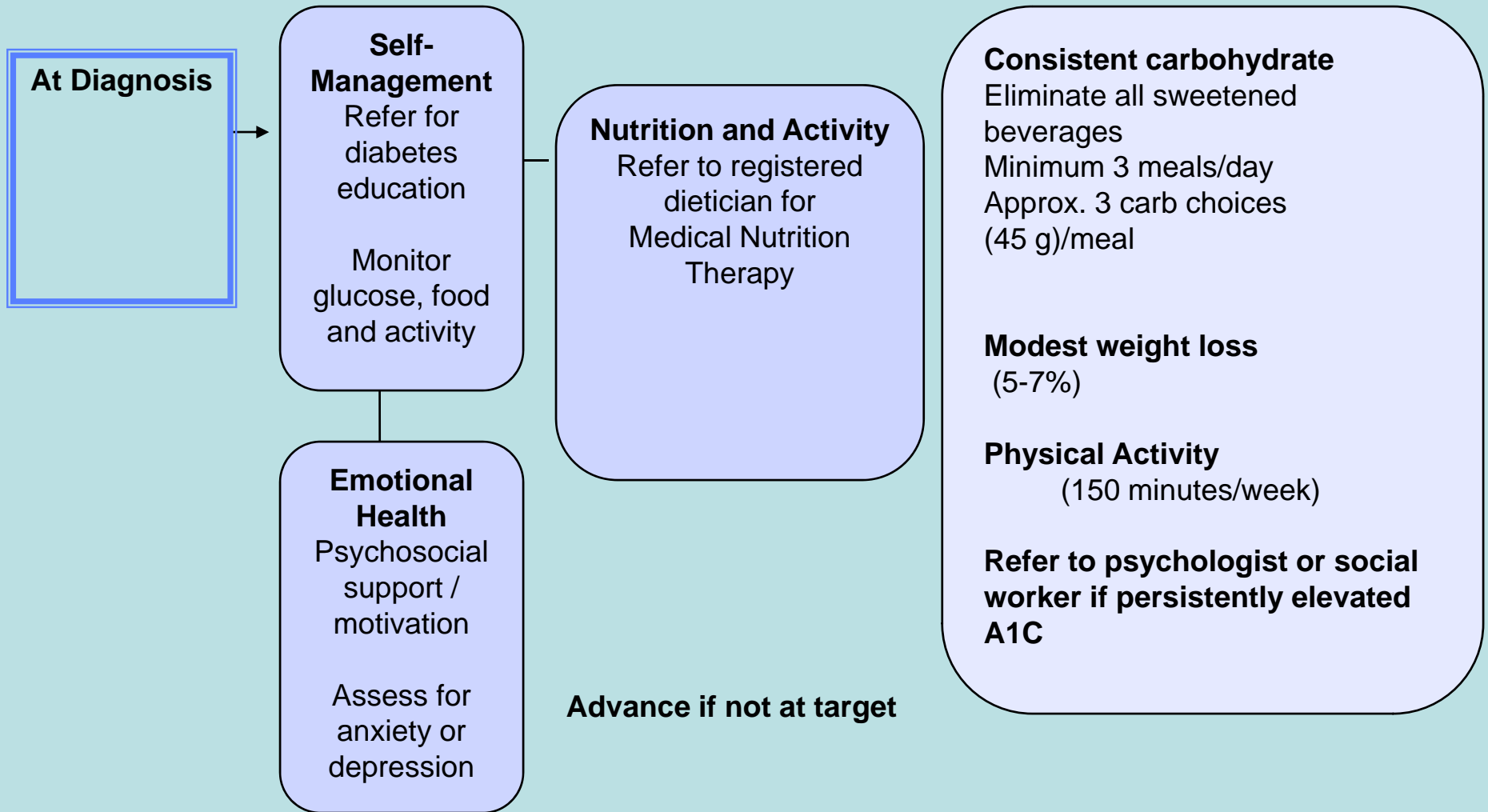
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Advance if not at target in 3 months

TYPE 2 DIABETES: MASTER DECISION PATH



Pre-diabetes /Newly diagnosed Diabetes or new to our clinic

- Diabetic Education early
- Emphasis on treating Pre-diabetes, BMI obtained on all patients.
- High incidence of Obesity, PCOS, IR/MS and (GDM).
- Nutrition Assessment and Therapy ? Carbs / Fat diet
- Ethnic foods/American/POP vs. H2O.
- Homeopathic herbs, seeds, prickly pear cactus?
- Can they afford greens and fruit?
- Ca/Vit. D intake.
- Physical Activity, Weight loss drugs (not covered by Insurance in most cases).
- Can they be active, is the neighborhood safe? Can they afford the YMCA?



- ? Living, Homeless, Shelter, need a food shelf?
- County resident? New immigrant, temporary visit-returning home? What F/U and medications are available in home country? 3 month of medications.
- PHQ 2 and or PHQ 9, what is their Mental health?
- 30% Uninsured. Many come to our clinic thinking we are a Free Clinic having lost insurance and off their medication for some time.
- Finances; will they be able to get insurance, are they eligible for our Sliding Scale Program?
- Can they afford their Co-pay?
- How many prescriptions? Multiple chronic illness plus Mental Health Concerns.

If we prescribe will they Comply?

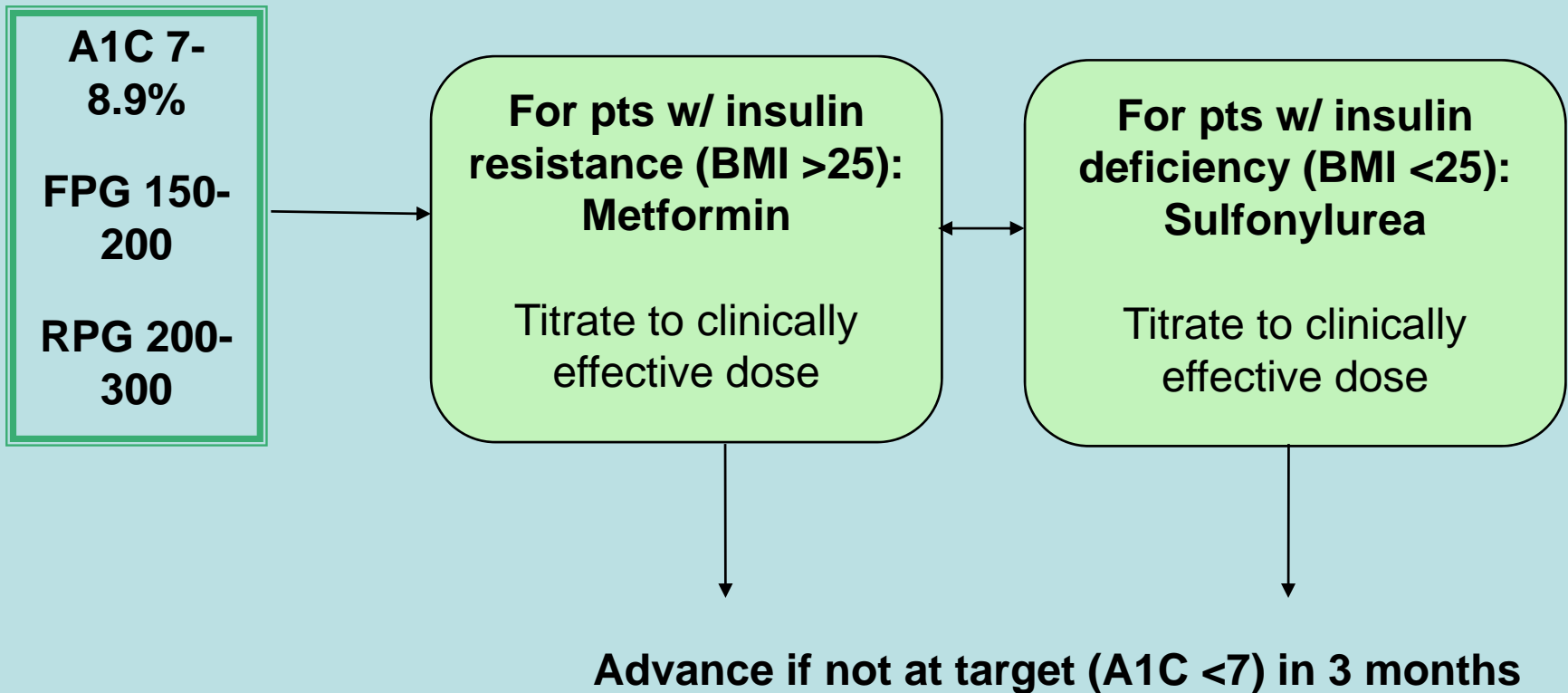
- Language and Literacy Barrier, we have interpreters but often patients cannot read in primary language. No Hmong word for Pancreas!
- Preconceived ideas about medication,
 - Stop taking when bottle runs out, despite refills.
 - Pill size, mg size, or number “Too strong” so even if not causing side effects don’t always take recommended amounts.
 - Pill counts are a necessity.
 - Bartering and Bargaining are not unheard of!
 - 24 hour recall of diet/medications.



A1c <7%

- Refer for Diabetic Education and Nutrition and LSM.
- Treatment of Co-morbid conditions,
 - (BP,LIPIDS, SMOKING, DEPRESSION).
- Pre-diabetes and failed LSM.
 - Low threshold to start Metformin.
 - Safe, effective, no hypoglycemia and cheap.

TYPE 2 DIABETES: MASTER DECISION PATH



A1c 7-8.9%

- Diabetes: Has the patient had Diabetes for awhile?
- Stable
 - BMI >25 Metformin,
 - BMI <25 Sulfonylurea.
 - Intolerant of Metformin, Pioglitazone (Price break on Pioglitazone, FQHC). DPP-4. \$\$\$\$
- Effective, Easy, Safe, BMI, Cheapest.
- Most drugs available if not at our pharmacy elsewhere and covered by MA.
- All Oral Agents are about equal in lowering A1c.



- If insurance not an issue? Compliance? Side effects?
- What are the patients' habits? Kidney function and Liver function? Hepatitis C? Do they have CHF or macular edema?
- NP pharmacy preferred - can track medication history and compliance better, FQHC status allows some more expensive medications to be cheaper for the patients paying cash. (Pioglitizone).



TYPE 2 DIABETES: MASTER DECISION PATH

Two-Drug Therapy

Metformin + Sulfonylurea
Weight: Modest gain
Hypoglycemia: Yes
Cost: \$
 Greatest A1C lowering, works quickly

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Metformin + Pioglitazone + Byetta/DPP-4
Cost: \$\$\$\$

Titrate to clinically effective dose

Advance if not at target in 3 months

Insulin Therapy (2 or more injections) ± Insulin Sensitizer(s) (+ if BMI >25)

Treatment A1c 9-11

- Not at goal in 3 months, advance to
 - Combination therapy, 2 drugs.
- How sick are they?
- Do they need to be hospitalized
- Is weight loss an Issue?
- Can we avoid hypoglycemia and weight gain?
- Combination drugs less pills.
- What are providers comfortable with?
- Cost/Do they have Insurance?
- Emerging safety issues (Byetta-
?pancreatitis). Injection BID.
- CHF/macular edema- Glitizones.



Treatment

- After 3 months not at goal A1c <7%
- On 2 drugs add a third oral drug, OR Insulin qhs OR Byetta/DPP-4.
- Same issues
 - Cost
 - Number of pills, q day preferred.
 - Getting confusing, side effects. BMI.
 - How much do we need to lower the A1c? Is it a newly diagnosed patient or a patient who is on 2 drugs with an A1c still at 10.5%
 - All Insulins are covered and available at NPHWC.
 - Newer analog Insulin/PENS etc 2X the cost.
 - What's the problem with Insulin? Overcome patient and provider inertia.



TYPE 2 DIABETES: MASTER DECISION PATH

A1C >11%

FPG >300

RPG >350

**Insulin Therapy (2 or more injections)
± Insulin Sensitizer(s) (+ if BMI >25)**

**Basal + Bolus Insulin ±
Sensitizer(s)**
R – R – R – Long-acting

R= Regular or Rapid

**Mixed Insulin ± Insulin
Sensitizer(s)**

R/N – 0 – R/N – 0
D/C Sulfonylurea

Mixed Insulin: R/NPH 70/30,
Aspart 70/30, Lispro 75/25

Insulin Inertia

A1c >11

- Insulin Start Orders.
- All Pharmacists are trained on Insulin Starts.
- Pharm D on site to review complex medication regimen.
- In the end even with Basal/Bolus therapy fewer medications than multiple drugs.





PATIENT LABEL

NorthPoint Insulin Start Orders

Date: _____ A1c: _____ Weight: _____ kg (lb/2.2)

BASAL INSULIN THERAPY

Basal Insulin only, combination with oral agent therapy

- A1c < 9 start NPH or Glargine or Detemir 0.1 unit/kg at bedtime
- A1c > 9 start NPH or Glargine or Detemir 0.2 units/kg at bedtime

NPH _____ units at bedtime

Glargine _____ units at bedtime or anytime

Glargine Pen

Detemir _____ units at bedtime AM and PM

Detemir Pen

BASAL AND BOLUS THERAPY

Twice daily insulin regimens

- A1c > 9 on combination oral agents or A1c > 11
- Start mixed insulin therapy (Novolin 70/30 or NovoLOG mix 70/30) 0.3 to 0.4 units/kg/24 hours

Novolin 70/30 _____ units SQ AM and _____ units SQ PM (30 minutes before meals)

Novolin 70/30 Pen

Novo LOG Mix 70/30 _____ units SQ AM and _____ units SQ PM (with meals or right after)

Novo LOG Mix 70/30 Pen

BOLUS THERAPY

Short and Rapid acting insulin, can be used in combination with basal regimens above

Regular _____ units _____

Novo LOG _____ units _____

Humalog _____ units _____

Novolog or Humalog Pen

DISPENSE: One vial/box One month supply Other _____ Refills _____

Stop Secretagogue (Glyburide, Glipizide, Glimepiride, Prandin (repaglinide))

Continue Sensitizer (Metformin, Pioglitazone, Rosiglitazone)

Stop _____

MONITORING AND SUPPLIES

Blood Glucose Monitor

One Touch Ultra

Lancets

Bayer Contour

Pen Needles

Strips

Alcohol Pads

Insulin Syringes

Refill _____ (no refills on monitor)

TEST _____ TIMES PER DAY; before meals, 2 hours after meals, bedtime, _____

FOLLOW-UP

Appointment with Diabetes Nurse NOW _____ 1 week _____

Appointment with Provider in _____ week(s)

Call Diabetes Nurse with any questions and with follow-up blood glucose levels: **612-302-4676**

Provider Signature _____

Date _____

Dictated Note

Registered Nurse Reviewed

ENTER INTO PECS AND FILE

ENTER INTO PECS AND TOSS

Certified Diabetic Self-Management Education Program
certified 2006

	TEST / ACTIVITY / GOAL	YOUR RESULTS	YOUR RESULTS	WHAT TO DO NEXT
A.	A1c : < 7 Average blood sugar over past 3 months.	___/___/___ A1c:	___/___/___ A1c:	<ul style="list-style-type: none"> - Check blood sugar at least 2x/day - Lower weight - Physical activity - Take medication as directed - Avoid smoking
	Aspirin : 1 Daily .	Taking Aspirin daily? Y N		<ul style="list-style-type: none"> - Discuss alternative with provider
B.	Blood Pressure : <130/80 High blood pressure makes heart work harder.	___/___/___ BP WT ___ HT ___ ACE / A R B	___/___/___ BP ACE / A R B	<ul style="list-style-type: none"> - Lower weight - Physical activity - Take medication as directed - Avoid smoking - Low salt diet
C.	Cholesterol : LDL : < 100 LDL (bad cholesterol) can build up and clog blood vessels that carry blood away from the heart.	___/___/___ LDL STAT IN		<ul style="list-style-type: none"> - Avoid fried and fatty foods - Lower weight - Physical activity - Take medication as directed - Avoid smoking
D.	Dental Care : Exam 2/yr. Gum disease (infection in your gums) can make your blood sugar results go higher.	Date of last dental exam : ___/___/___	___/___/___	<ul style="list-style-type: none"> - Get regular checkups 2 times a year (even if you wear dentures) - Brush and floss A M & P M
	Depression : Screen yearly Feeling sad or hopeless	___/___/___ PHQ -2 + / -	During the last month: felt down/depressed . Y/N Little interest or felt hopeless . Y /N	<ul style="list-style-type: none"> - Discuss with provider
E.	Eye Care : Dilated eye exam yearly. Diabetes can cause more eye disease	Date of last eye exam : ___/___/___		<ul style="list-style-type: none"> - Control BP - Control blood sugar - Yearly eye exam
	Education - Diabetes yearly,	Date of Diabetes education : ___/___/___	Date of Nutrition educ.: ___/___/___	<ul style="list-style-type: none"> - Testing Blood sugars ___ times/day
F.	Foot Care : Yearly . People with diabetes can have nerve damage in their feet resulting in less feeling of pain, heat, or cold	Date of last foot exam: ___/___/___	<ul style="list-style-type: none"> - Check feet daily for sore spots or reddened areas - Wear sturdy protective shoes 	
G.	Goal for M anaging Your Diabetes :	Goal : Fasting/ Pre meal 70-100 mg/d l. Post meal <160 mg/d l.		
H.	Health Maintenance Exam :	Smoker Y N Referal/Medication To Stop ___/___/___		<ul style="list-style-type: none"> - Yearly Exam - Avoid smoking
I.	Immunization s :	Tdap ___/___/___ Flu ___/___/___ Pneumovax ___/___/___		<ul style="list-style-type: none"> - Other : _____
K.	Kidney Care : Blood and urine test time a year.	MARU result ___ ___/___/___		<ul style="list-style-type: none"> - Control blood pressure - Control sugar level - Control salt intake

D5 Incentive Program

- Patients should be rewarded vs. providers. They do the work.
- Patients who achieve all FIVE D5 (A1c, BP <130/80, LDL <100, Aspirin use, Nonsmoker) components within the next year will get a \$50 Gift card.
- Provider notification of personal D5 quarterly.



the D5

FIVE GOALS FOR LIVING WITH DIABETES

When it comes to treating diabetes, five is the magic number. Achieving the five treatment goals that make up the D5 not only reduces your risk for serious cardiovascular problems like heart attack and stroke, it puts you on a path to better health.

Ask your doctor how you can achieve D5 success.



		GOALS
1	MAINTAIN BLOOD PRESSURE	BP less than 130/80 mmHg
2	LOWER BAD CHOLESTEROL	LDL less than 100 mg/dl
3	CONTROL BLOOD SUGAR	A1c less than 7%
4	BE TOBACCO-FREE	✓ YES
5	TAKE ASPIRIN DAILY (ages 40 & older)	✓ YES



NORTHPOINT
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We at NorthPoint want to partner with you to achieve the best control of your diabetes and your health.

If you achieve the five D5 goals by December 2008, you will receive a \$50 gift card for all your efforts.

Schedule an appointment if you haven't had one recently, to work on reaching these goals.