Advances in Diabetes

Optimizing the Use of EMR to Improve Performance

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Southeast Texas Medical Associates, LLP

Harvard/Joslin Diabetes Update
November 10, 2011

Disclosures

- Dr. Holly owns stock in the parent company of the EHR SETMA uses. The identity of that EHR is not revealed in this presentation.
- Dr. Holly makes uncompensated presentations for that EHR Company.
- Dr. Holly has no other disclosures.

SETMA Achievements

- July 2010 - NCQA PC-MH Tier Three
- July 2010 – Joslin Diabetes Center Affiliate
- August 2010 - NCQA Diabetes Recognition Program
- August 2010 - AAAHC Medical Home
- August 2010 - AAAHC Ambulatory Care

SETMA Achievements

- 2011 - Health and Human Services Recognitions
  - **Office of National Coordinator** named SETMA as one of 30 exemplary practices for clinical decision support.
  - **Agency for Healthcare Research and Quality** published SETMA's LESS Initiative on its Innovation Exchange.
  - **Centers For Medicare and Medicaid** included SETMA in a quality, cost and coordination of care research project in which SETMA outperformed all others on quality and equaled the best in cost control for 2007-2010.

Articles about SETMA

At **www.jameslhollymd.com**, the following articles can be found

(number of articles is in parentheses). This material is free.

- Tutorials on all Electronic-Patient-Management tools including Diabetes, Diabetes Prevention, Hypertension Prevention and others (67)
- Diabetes (25)
- Smoking Cessation (15)
- Exercise (40)
- Weight Reduction (33)
- Cardiovascular Disease Risk Factors (22)
- LESS Initiative (66)
- Medical Home (46)
- Healthcare Reform and Public Policy (24)

The Future of Healthcare

Since SETMA adopted electronic medical records in 1998, we have come to believe the following about the future of healthcare:

The Substance	Evidenced-based medicine and comprehensive health promotion
The Method	Electronic Patient Management
The Dynamic	Patient-Centered Medical Home
The Funding	Capitation & Payment for Quality

The SETMA Model of Care

Founded on the four domains identified above, SETMA's Model of Care includes the following:

1. **Personal Performance Tracking** -- One patient at a time
2. **Auditing of Performance** -- By panel or population
3. **Analysis of Provider Performance** -- Statistical Analysis
4. **Public Reporting by Provider Name** -- At www.jameslhollymd.com
5. **Quality Assessment and Performance Improvement**

Diabetes Care Improvements

From 2000 to 2011

- HbA1C standard deviation improvement from
  1.98 to 1.33
- HbA1C mean (average) improvement from
  7.48% to 6.65%
- 95% of SETMA's patients with diabetes in 2000 had HbA1Cs below 11.44%, while in 2011 95% are below 9.31%.
- Elimination of Ethnic Disparities of Care in Diabetes

Diabetes Care Initiatives and Results

- 2000 - Design and Deployment of EHR-based Diabetes Disease Management Tool
  - **HbA1C improvement 0.3%**
- 2004 - Design and Deployment of American Diabetes Association Recognized Diabetes Self Management Education (DSME) Program
  - **HbA1C improvement 0.3%**
- 2006 - Recruitment of Endocrinologist
  - **HbA1C improvement 0.25%**

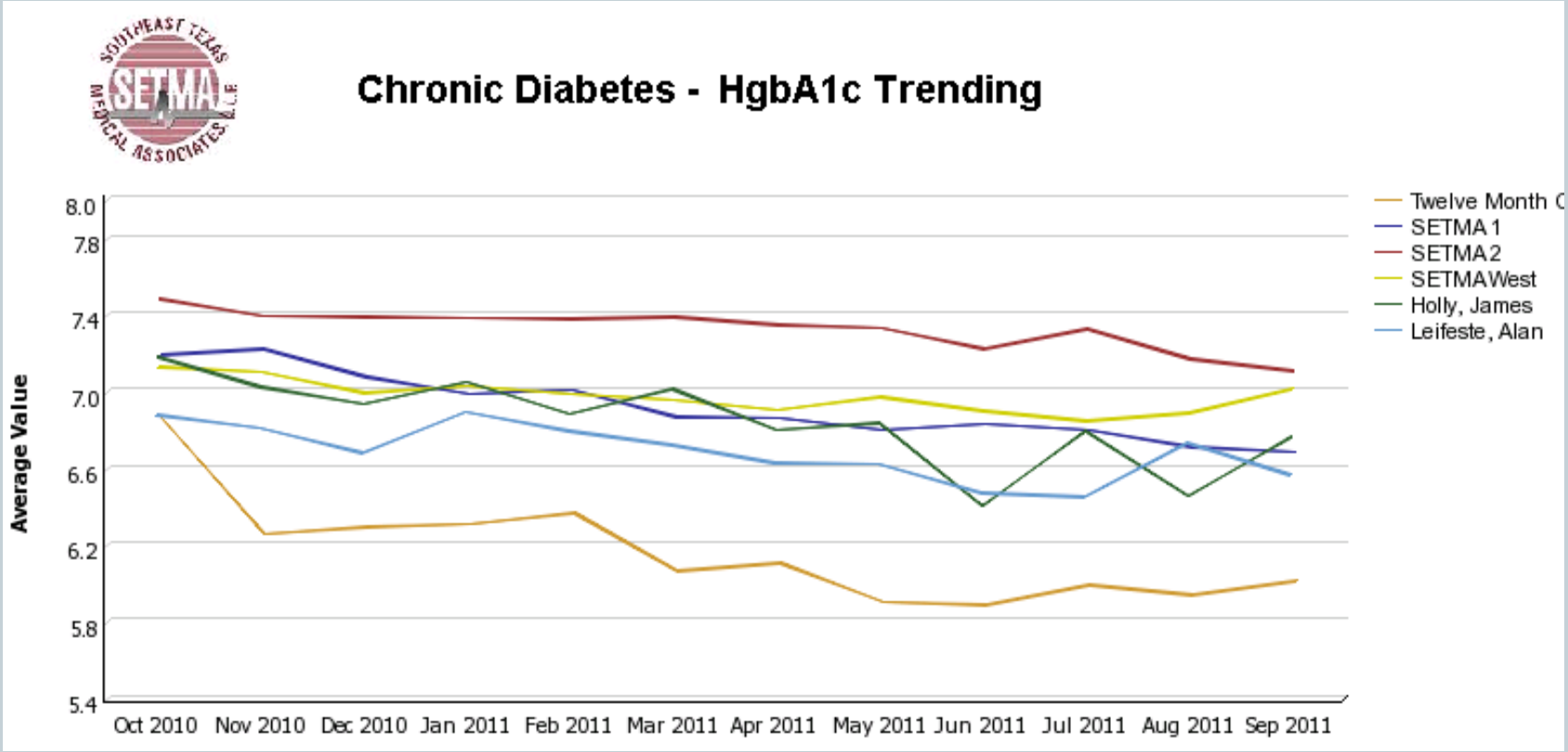
SETMA's NCQA Diabetes Metrics

NCQA Diabetes Measures

Encounter Date(s): January 1, 2011 to September 30, 2011

Location Name	Provider	Encounters	A1c >9.0 <= 15%	A1c < 8.0 >= 60%	A1c < 7.0 >= 40%	BP > 140/90 <= 35%	BP < 130/80 >= 25%	Eye Exam >= 60%	Smoking Cessation >= 80%	LDL >= 130 <= 37 %	LDL < 100 >= 36%	Nephropathy >= 80%	Foot Exam >= 80%	Total Points
SETMA 1	Aziz	769	9.9%	75.7%	59.2%	18.7%	54.2%	59.7%	96.9%	13.9%	68.8%	81.7%	74.9%	85
	Duncan	537	8.9%	81.2%	67.6%	11.9%	68.9%	59.0%	93.5%	14.2%	68.7%	83.4%	82.3%	90
	Henderson	621	10.5%	79.4%	66.2%	10.1%	69.1%	61.5%	95.1%	12.1%	67.5%	84.1%	95.3%	100
	Murphy	1,093	5.7%	86.3%	69.6%	14.0%	58.5%	46.5%	82.0%	12.3%	73.3%	87.3%	83.5%	90
	Palang	329	4.6%	47.7%	37.7%	19.5%	53.5%	23.1%	92.3%	6.7%	46.8%	31.0%	31.3%	67
	Thomas	156	9.6%	69.2%	45.5%	18.6%	55.8%	77.6%	100.0%	12.2%	60.9%	76.3%	82.7%	95
SETMA 2	Ahmed	2,078	16.3%	48.3%	32.0%	8.6%	62.6%	64.3%	72.2%	11.3%	63.5%	68.3%	99.5%	60
	Anthony	680	10.3%	78.2%	64.0%	13.4%	66.5%	65.6%	81.7%	10.4%	68.8%	92.6%	96.6%	100
	Anwar	1,013	8.5%	79.9%	65.2%	4.2%	81.2%	65.7%	96.5%	11.8%	63.6%	91.6%	75.5%	95
	Cricchio, A	829	12.1%	46.6%	30.5%	8.9%	71.7%	65.1%	79.8%	10.0%	69.5%	75.5%	99.3%	72
	Cricchio, M	632	7.8%	78.2%	64.4%	14.2%	61.2%	61.9%	66.4%	10.1%	66.6%	91.0%	85.8%	90
	Holly	219	6.4%	83.6%	71.2%	5.0%	82.6%	80.4%	71.9%	11.4%	71.2%	97.3%	95.0%	90
	Leifeste	756	7.3%	81.5%	70.8%	13.0%	65.2%	71.6%	59.6%	8.7%	69.2%	88.6%	82.7%	90
	Wheeler	486	7.6%	84.4%	73.9%	22.6%	56.6%	58.6%	81.4%	13.0%	61.9%	89.3%	88.7%	90
SETMA West	Curry	303	10.2%	77.9%	59.1%	15.8%	60.7%	70.3%	86.5%	13.2%	65.7%	87.1%	92.4%	100
	Deiparine	557	9.2%	72.2%	56.6%	25.3%	49.7%	51.3%	95.8%	13.8%	58.9%	70.7%	85.6%	85
	Halbert	911	10.9%	75.7%	62.5%	20.6%	55.5%	39.2%	98.0%	14.7%	60.9%	57.8%	84.5%	85
	Horn	563	5.2%	79.8%	65.9%	1.4%	70.5%	49.9%	90.6%	16.2%	55.1%	81.2%	95.2%	90
	Qureshi	309	19.4%	63.1%	52.1%	7.8%	71.2%	52.4%	98.7%	17.2%	59.2%	66.3%	95.8%	73
	Satterwhite	323	16.4%	60.1%	47.7%	22.6%	55.1%	53.6%	94.3%	19.2%	50.8%	76.8%	83.3%	73
	Vardiman	416	10.1%	74.0%	59.9%	19.5%	48.6%	61.1%	98.4%	13.5%	60.3%	66.1%	87.0%	95

Business Intelligence (BI)
Diabetes Audit - Trending

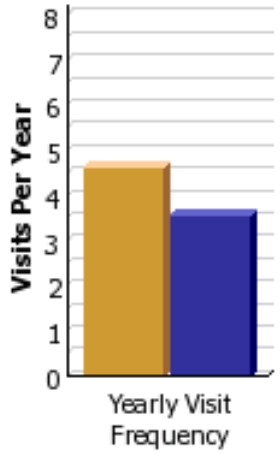


Value of Trending Audit

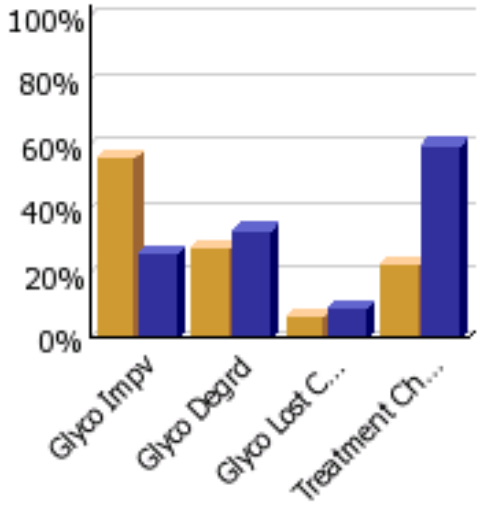
- In 2009, trending revealed that from October-December many patients were losing HbA1C control. Further analysis showed that these patients were being seen and tested less often in this period than those who maintained control.

- A 2010 Quality Improvement Initiative included writing all patients with diabetes encouraging them to make appointments and get tested in the last quarter of the year. A contract was made, which encouraged celebration of holidays while maintaining dietary discretion, exercise and testing. In 2011, analysis showed that the holiday-induced loss of control had been eliminated.

Business Intelligence Diabetes Audit



	Visit Frequency
Controlled	4.6
Selected	3.5



	Glyco Impv	Glyco Degrd	Glyco Lost Ctr	Treatment Changed
Controlled	56.0%	27.8%	6.6%	22.8%
Selected	26.6%	33.7%	9.5%	60.1%

Leverage Points Sought

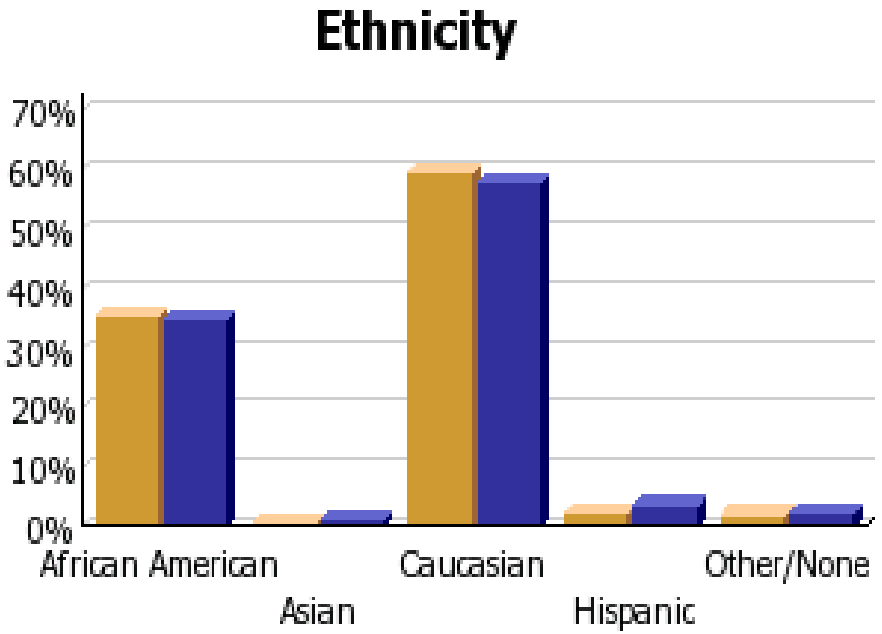
- Comparisons were made between patients whose diabetes was controlled (gold) and those whose diabetes was not controlled (purple). We discovered a statistically significant difference between the frequency of visits between patients who are controlled (4.6 visits/year) and those who are not controlled (3.5 visits/year).

- It appeared that seeing patients an additional time each year might improve their control. We are still examining that hypothesis.

Business Intelligence Diabetes Audit

- SETMA's Model of Care was designed to help overcome "clinical inertia" through public reporting, by provider name, of quality metric results.
- To further examine "clinical inertia," the BI Audit includes a determination of patients who are improving, or losing control, and if, when a patient is seen, whose diabetes is not controlled, whether a change in treatment was made.
- Thus far, in 2011, when patients were seen whose HbA1C was not controlled, a change in treatment was made 60% of the time. In 2010, a change was made 68% of the time.

BI Diabetes Audit – Ethnicity



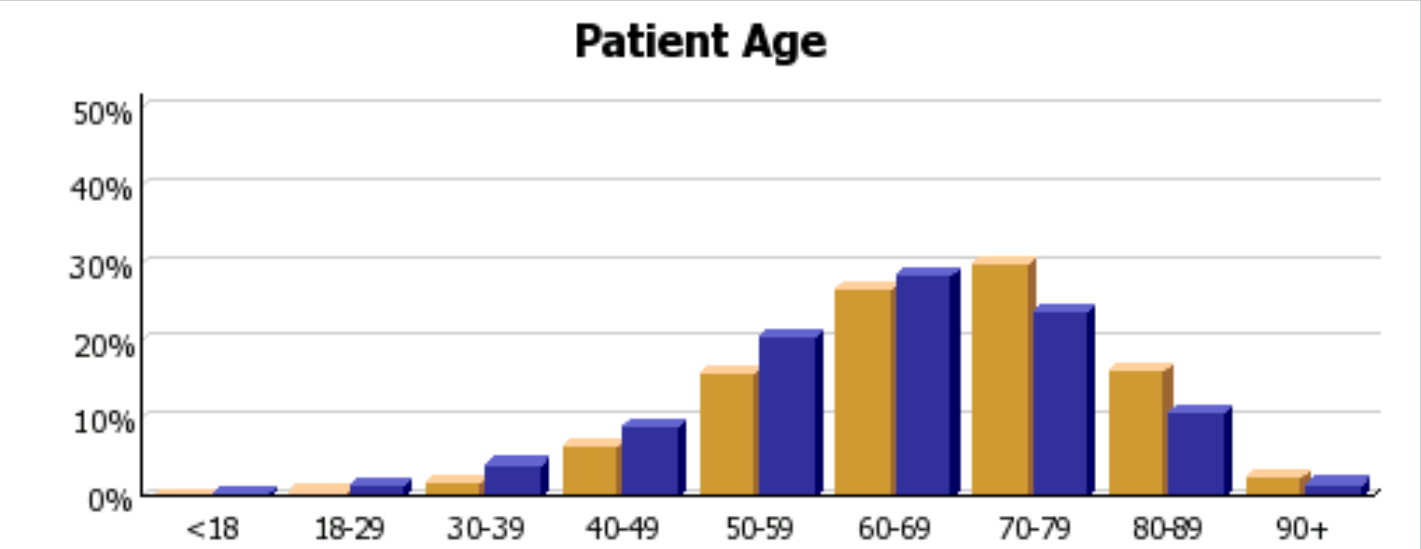
	African American	Ethnicity Asian	Caucasian	Hispanic	Other/None
Controlled	35.4%	0.5%	59.5%	2.5%	2.1%
Selected	34.8%	1.1%	58.1%	3.8%	2.3%

BI Diabetes Audit – Ethnicity

- It is important to SETMA that all people receive equal care in access, process and outcomes. As a result, we examine our treatment by ethnicity, as well as by many other categories.

- Approximately, one-third of the patients we treat with diabetes are African-American and two-thirds are Caucasian. As the control (gold) and uncontrolled (purple) groups demonstrate, there is no distinction between the treatment of patients by ethnicity.

BI Diabetes Audit – Patient Age

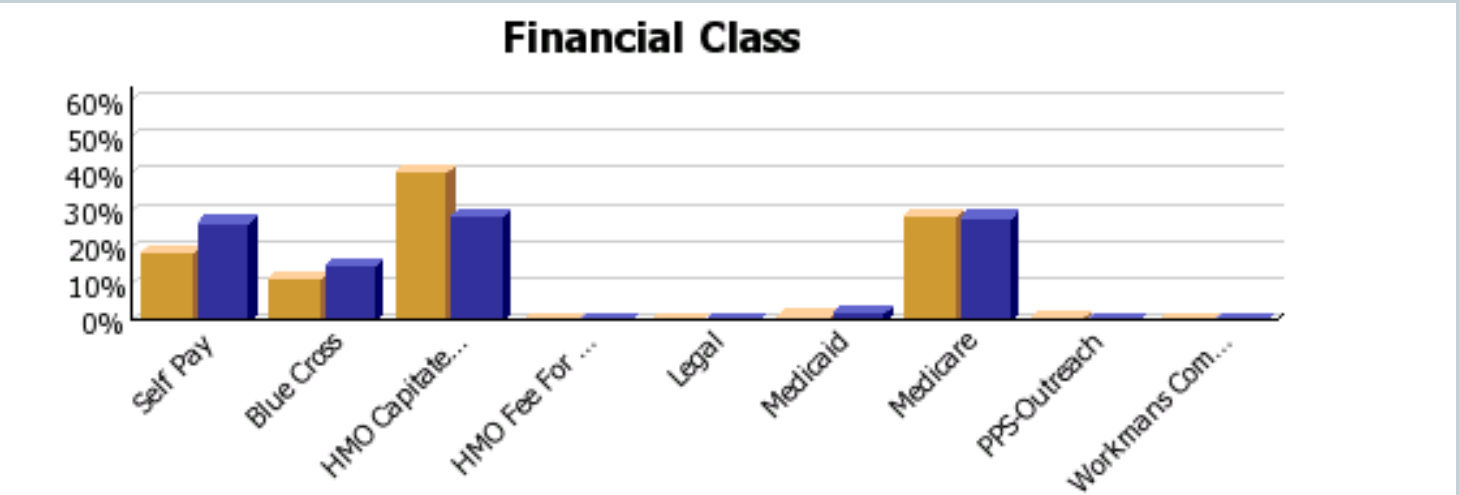


	<18	18-29	30-39	40-49	50-59	60-69	70-79	80-89	90+
Controlled	0.0%	0.4%	1.8%	6.5%	15.9%	26.6%	30.0%	16.2%	2.5%
Selected	0.2%	1.4%	4.1%	8.9%	20.6%	28.5%	23.9%	10.8%	1.6%

BI Diabetes Audit – Patient Age

As can be seen from these bar graphs, SETMA's patients between 70-90 are receiving excellent care of their diabetes. This raised the question, in that this is a vulnerable population, could the HbA1C results be caused by nutritional deficiencies? By history, longitudinal weight measurements and by laboratory tests (pre-albumin), we found that this population was not malnourished and that the results represented excellent care of diabetes in the elderly.

BI Diabetes Audit – Financial Class



	Self Pay	Blue Cross	HMO Capitated	HMO Fee For Service	Legal	Medicaid	Medicare	PPS-Outreach	Workmans Comp
Controlled	18.4%	11.5%	40.3%	0.0%	0.0%	1.0%	28.3%	0.5%	0.0%
Selected	26.7%	14.9%	28.4%	0.0%	0.0%	1.9%	28.0%	0.1%	0.0%

BI Diabetes Audit – Financial Class

- Financial barriers to care are a significant problem in the United States. Six years ago, SETMA initiated a zero co-pay for capitated HMO patients in order to totally eliminate economic barriers to care.

- Comparing FFS Medicare patients, capitated HMO and uninsured patients, it can be inferred from this data that the elimination of economic barriers results in improved care.

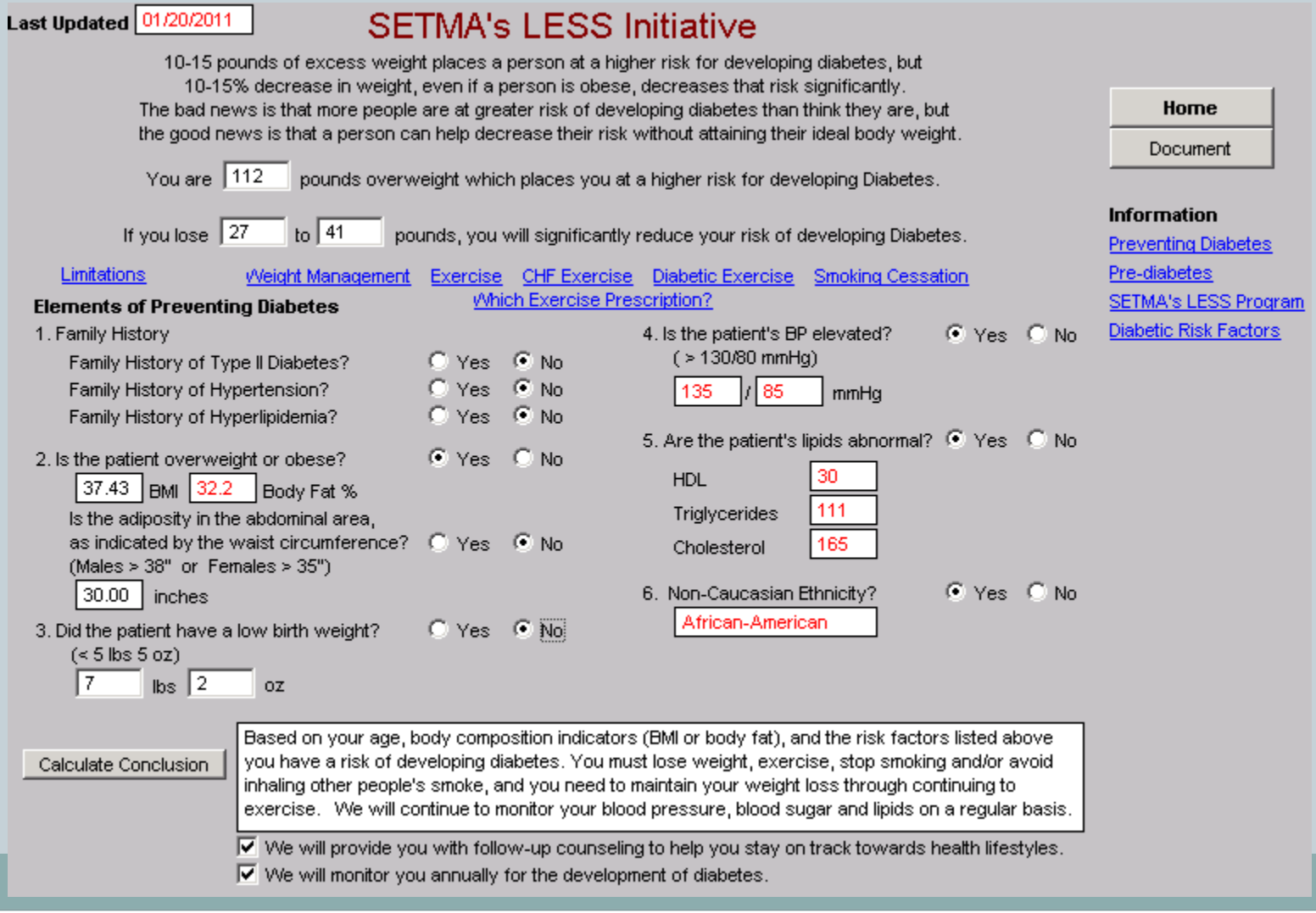
- Through SETMA's Foundation, we are making further attempts to compensate for economic barriers to care.

Diabetes Disease Management Begins with a Diabetes Prevention Program

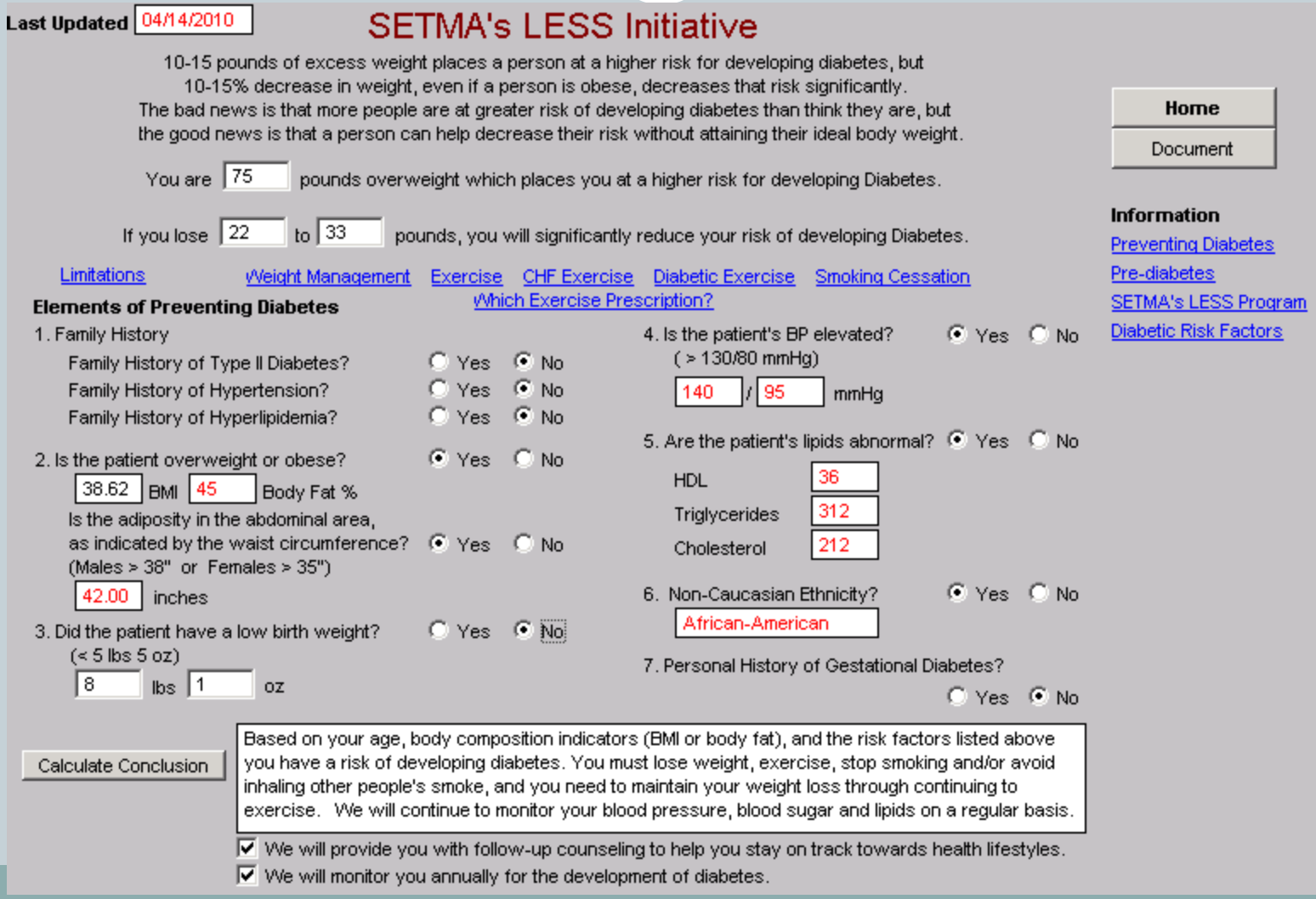
SETMA's Diabetes Prevention Program Includes

- The **LESS Initiative** in which the risk of diabetes is accessed for ALL patients seen at SETMA, along with a weight management assessment, a personalized exercise prescription and smoking cessation.
- Diabetes Screening Program for those at high risk
- Patient Education on "Progression to Diabetes"
- Explanation of Five Stages of the Progression of Diabetes

SETMA's LESS Initiative - Male



SETMA's LESS Initiative - Female



Preventing Diabetes

Preventing Diabetes

Patient [redacted]

Screening Recommendations | Predicting Diabetes | Screening Insulin Resistance | IFG and IGT | Current Strategies
Could You Have Diabetes and Not Even Know It? | Reducing Your Risk | LOW Risk of Developing Diabetes

Return
Document

Prediabetics have an atherogenic pattern of CV risk factors which are predominantly observed in prediabetics with increased HOMA IR and fasting insulin, i.e, insulin resistance.

Diagnosis	Fasting Test	Casual Test
Diabetes	> 126 mg/dL	> 200 mg/dL
Pre-Diabetes	100 - 125 mg/dL	140 - 199 mg/dL
None	< 100 mg/dL	< 140 mg/dL

Vital Signs

Height	64.00	Waist	42.00
Weight	225.0	Hips	35.00
BMI	38.62	Ratio	0.00
Body Fat	45	Blood Pressure	140 / 95
BMR	1700		
Protein Req	122		

Fasting Lab Results

Check for New Labs

FPG	129	12/02/2009	Cholesterol	212	12/02/2009
			HDL	36	12/02/2009
2-Hr OGTT	144	01/07/2010	LDL	145	12/02/2009
			Triglycerides	312	12/02/2009
DM Prediction Rule			Magnesium	1.8	12/02/2009

4 > 4 doubles the risk of DM

Treatment

Insulin Resistance	Homocysteine
Impaired Fasting Glucose	hsCRP
Hypertriglyceridemia	Endothelial Dysfunction

Diabetic Education Referral (Double-Click)

Priority	Referring First	Referring Last	Referral
Routine	Dia	Abochamah	asdf

Links

Insulin Resistance | Hypertension Mgmt | Weight Mgmt | Exercise | Lipids Mgmt | Metabolic Syndrome | Smoking Cessation

Patient Information

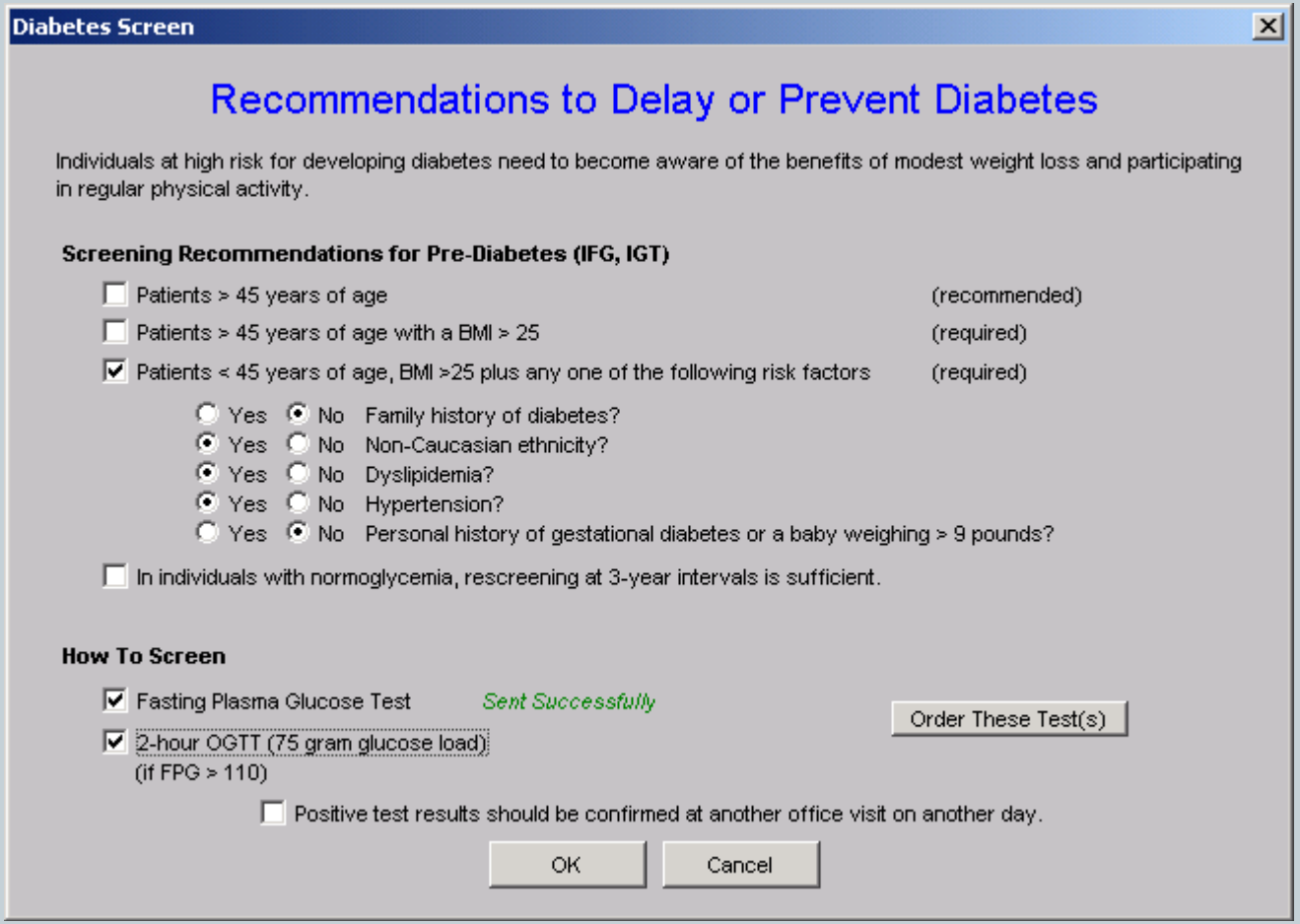
What is Pre-Diabetes?
Carb Confusion
What To Do About It
Taking Steps To Prevent
You Have The Power
More Than 50 Ways To Prevent
Importance of Glycemic Index
Applying the Glycemic Index
Glycemic Load
Insulin - Friend or Foe
Hyperinsulinemia
Hunger, Insulin, and Meals
Hunger, Fat, and Fav Foods

Print All

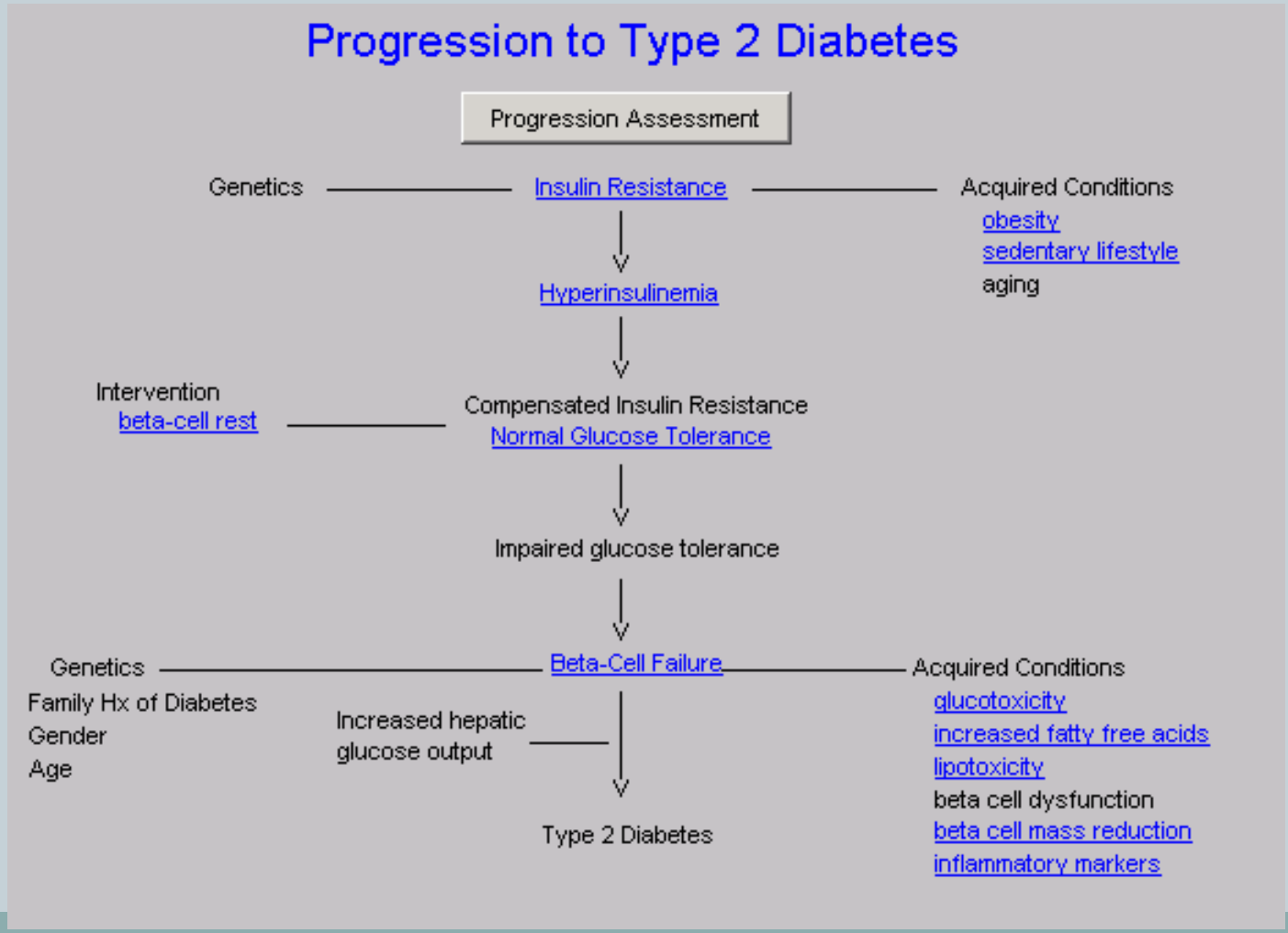
Provider Information

Glycemic Index and Prevention
Weight Loss
Physical Activity
Behavior Modifications
Summary of Studies
Lifestyle and Diabetes
Visceral Fat
Insulin Resistance Summary
Questions and Answers

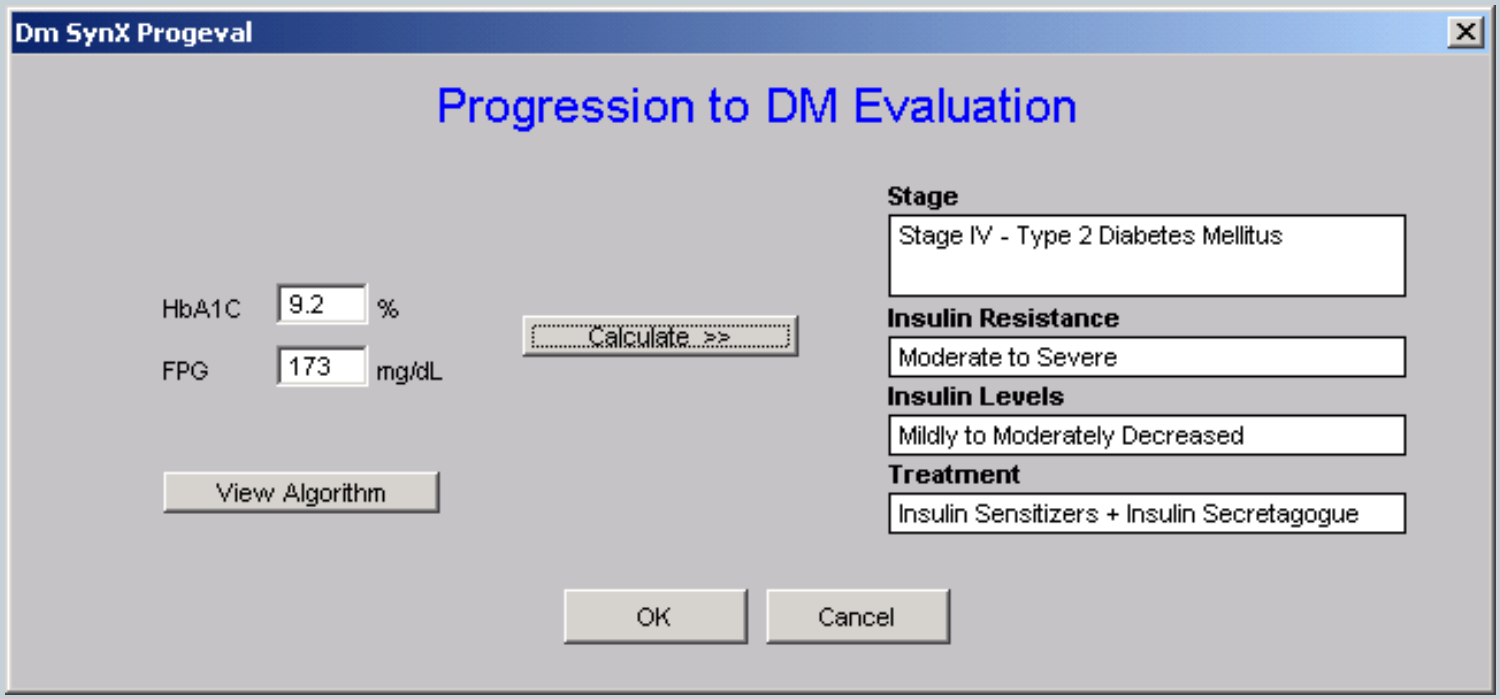
Preventing Diabetes Testing



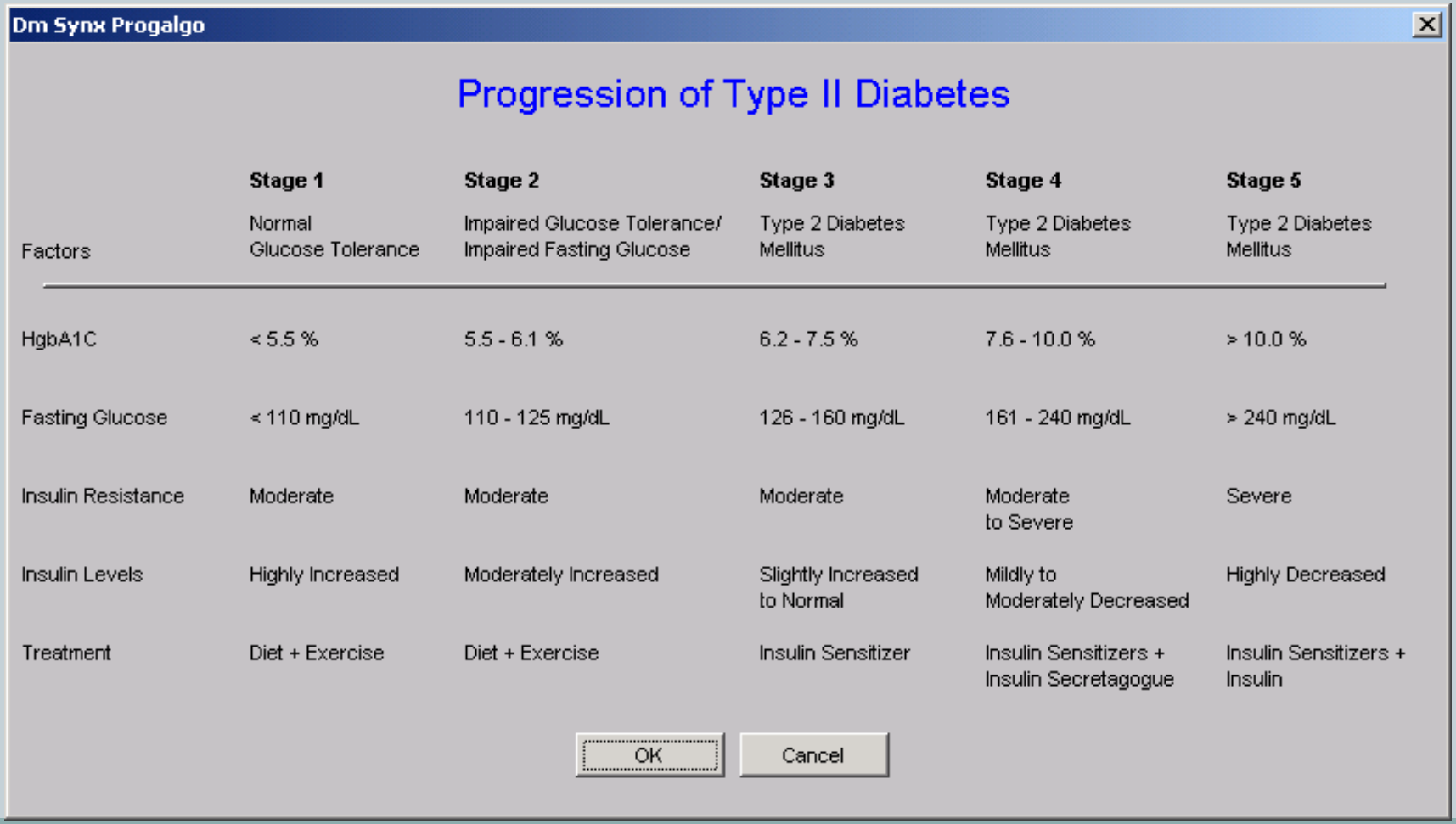
Progression to Diabetes



Progression to Diabetes Assessment



Algorithm for Progression to Diabetes Assessment



Cardiovascular Risk in Diabetes

Diabetes is an independent risk factor for cardiovascular disease. Two additional ways, in which cardiovascular risk should be evaluated are:

- **Framingham Cardiovascular Risk Scores**

  The only Framingham Score which includes HbA1C as opposed to simply the presence or absence of diabetes is the Global Cardiovascular Risk Score. At the suggested of Joslin, SETMA developed the "What IF" Scenarios.

- **Cardiometabolic Risk Score**

Framingham Risk Scores

Framingham Heart Study Risk Calculators

Last Updated/Reviewed: 09/21/2011

General Cardiovascular Disease, 10-Year Risk

	Total Points	Total Risk	Relative Heart Age
	19	>30 %	>80 years

Real Heart Age: 46 years

WHAT IF?

All Elements To Goal	10	9.4	54
Overall 20% Improvement	12	13.2	60
Blood Pressure To Goal	18	>30	>80
Lipids To Goal	15	21.6	72
Smoking Cessation (if applicable)	0	N/A	N/A

Global Cardiovascular Risk Score

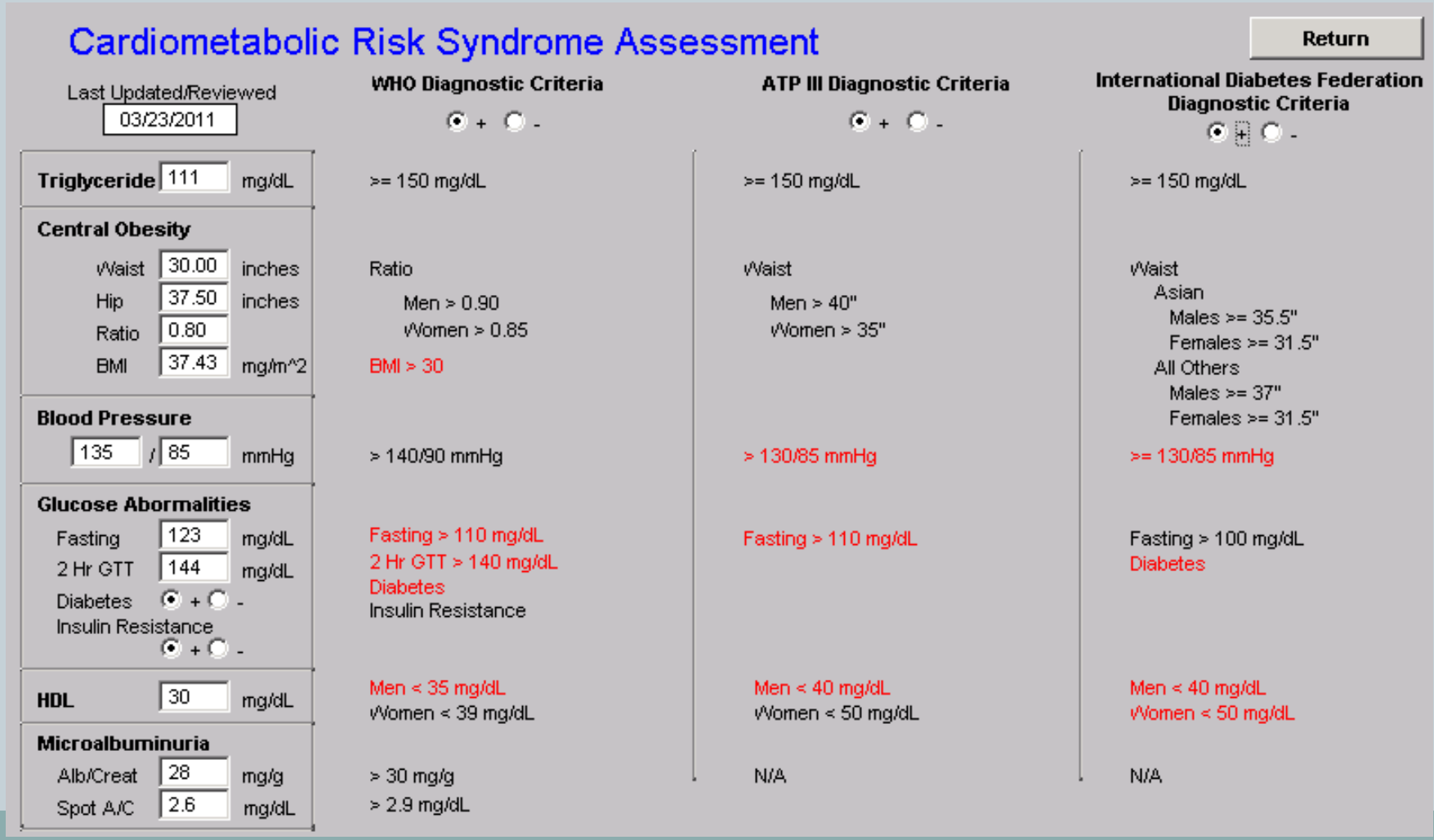
Total Points: 10.0

A score above 4 indicates increased risk of a cardiovascular event.

WHAT IF?

All Elements To Goal	0.5
Overall 20% Improvement	3.8
Blood Pressure To Goal	8.5
Lipids To Goal	6.5
HgbA1c To Goal	7.3
Smoking Cessation (if applicable)	0.0

Cardiometabolic Risk Syndrome Assessment

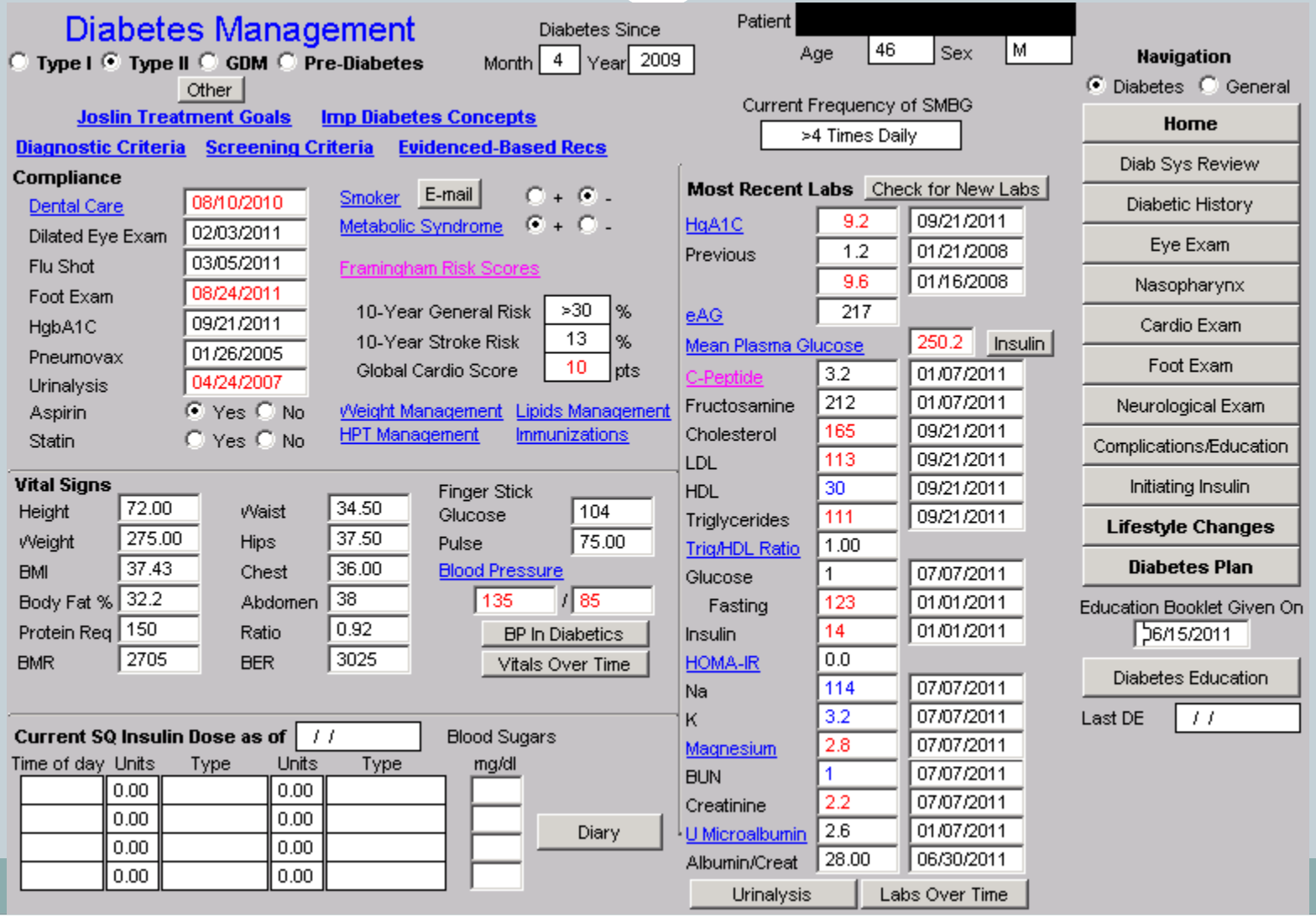


Diabetes Disease Management Tools

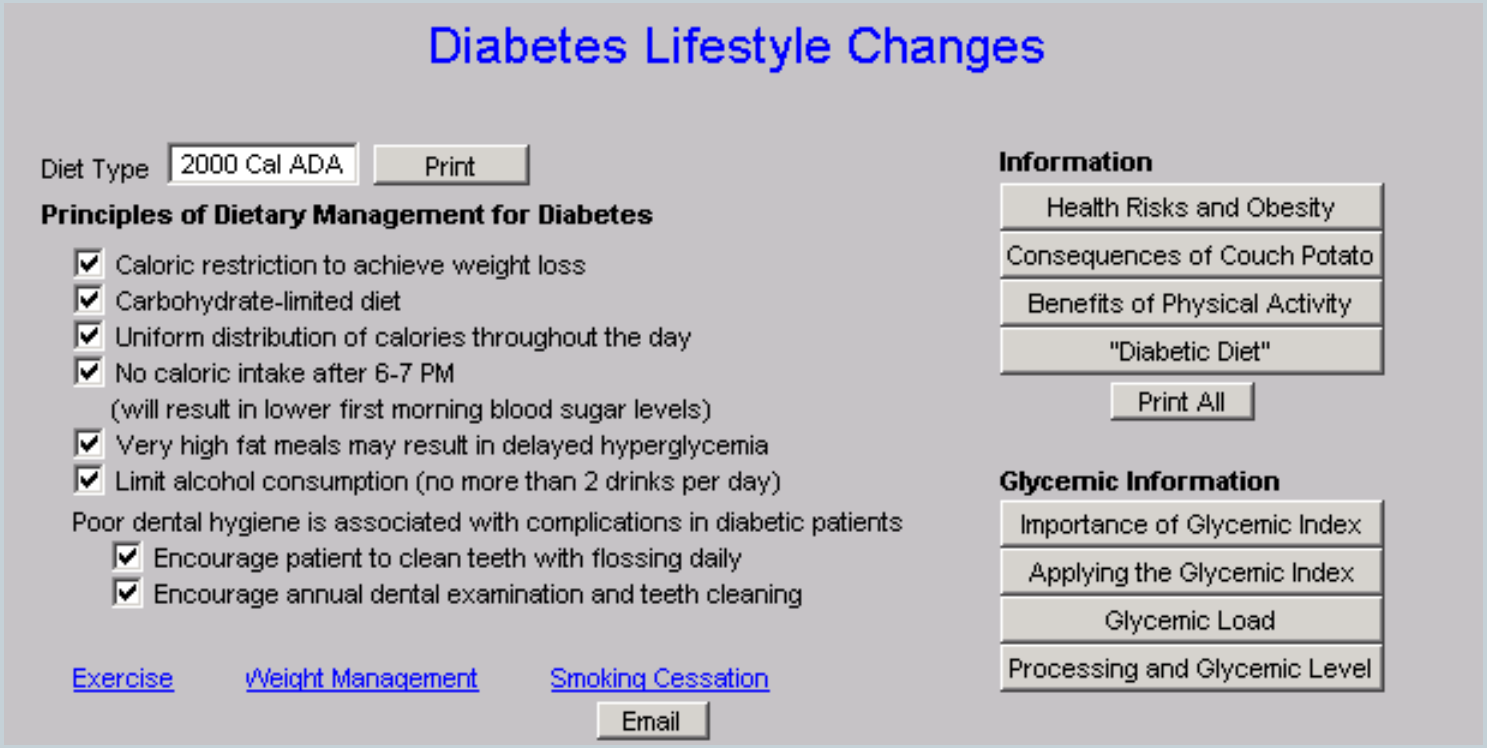
The first major improvement in SETMA's care of patients with diabetes resulted from the deployment of our disease management tool in 2000. This includes:

- Display of essential data including labs
- Clinical Decision Supports
- Assessment of fulfillment of quality metrics
- Adherence Assessment
- Life Style Changes including dietary, weight, exercise and smoking cessation
- Dilated Eye examination
- Foot care
- Dental Care
- Treatment Plan and Plan of Care
- Diabetes Self Management Assessment Education
- Medical Nutrition Therapy
- Diabetes Care Team
- The Passing of the Baton

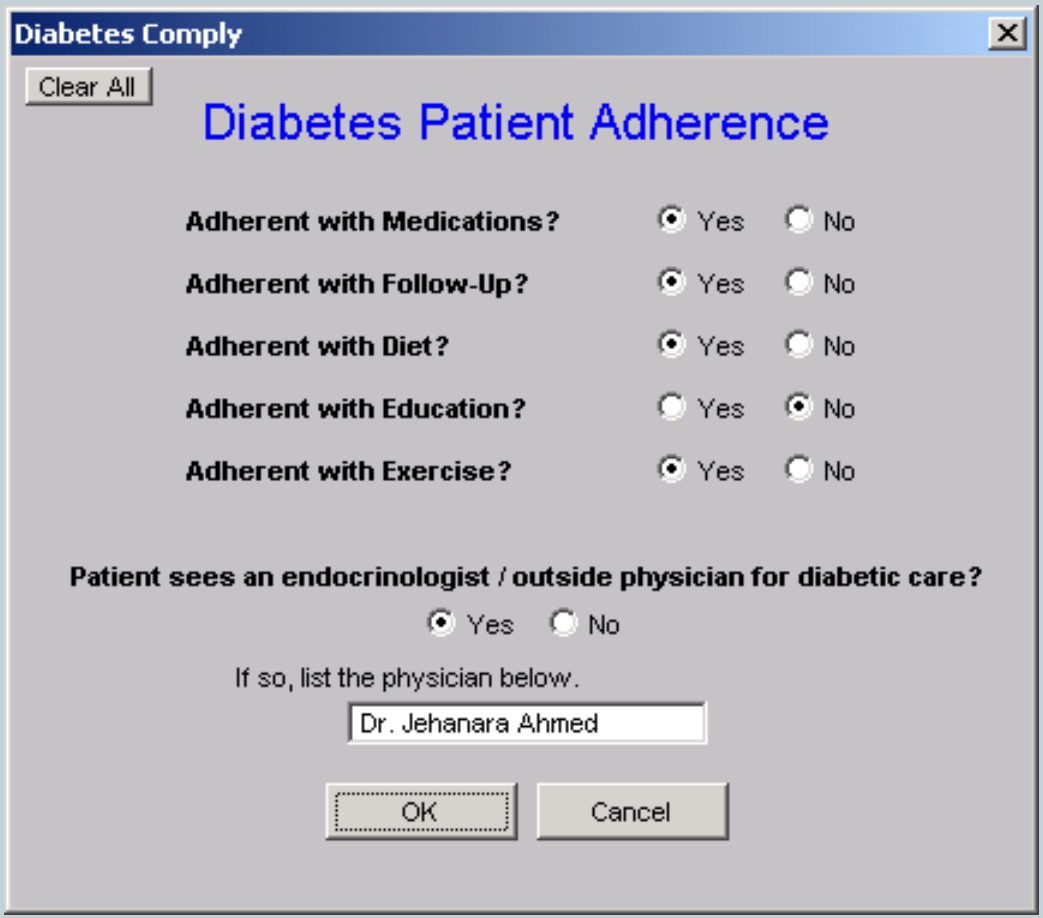
SETMA's Diabetes Disease Management



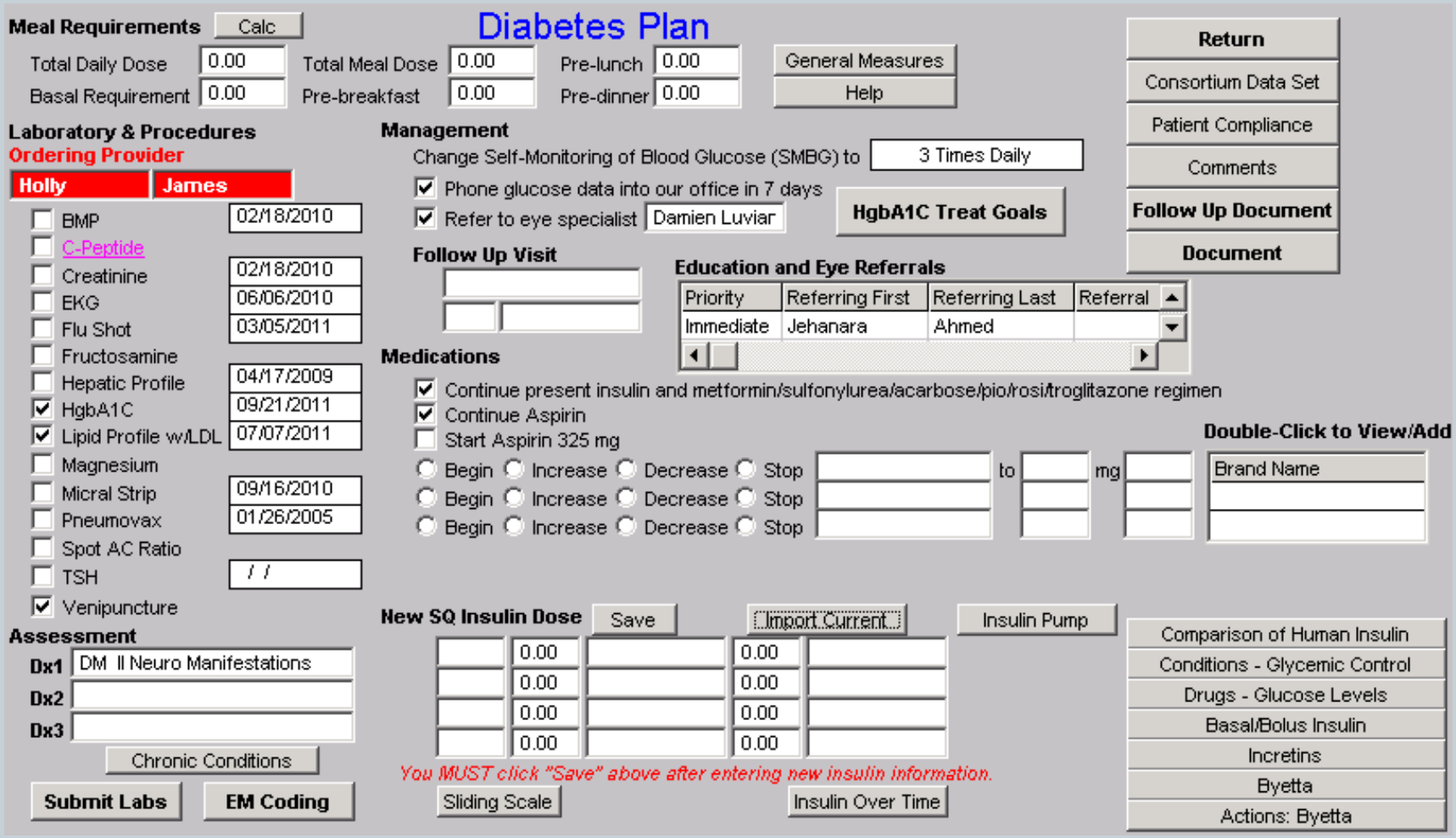
Lifestyle Changes



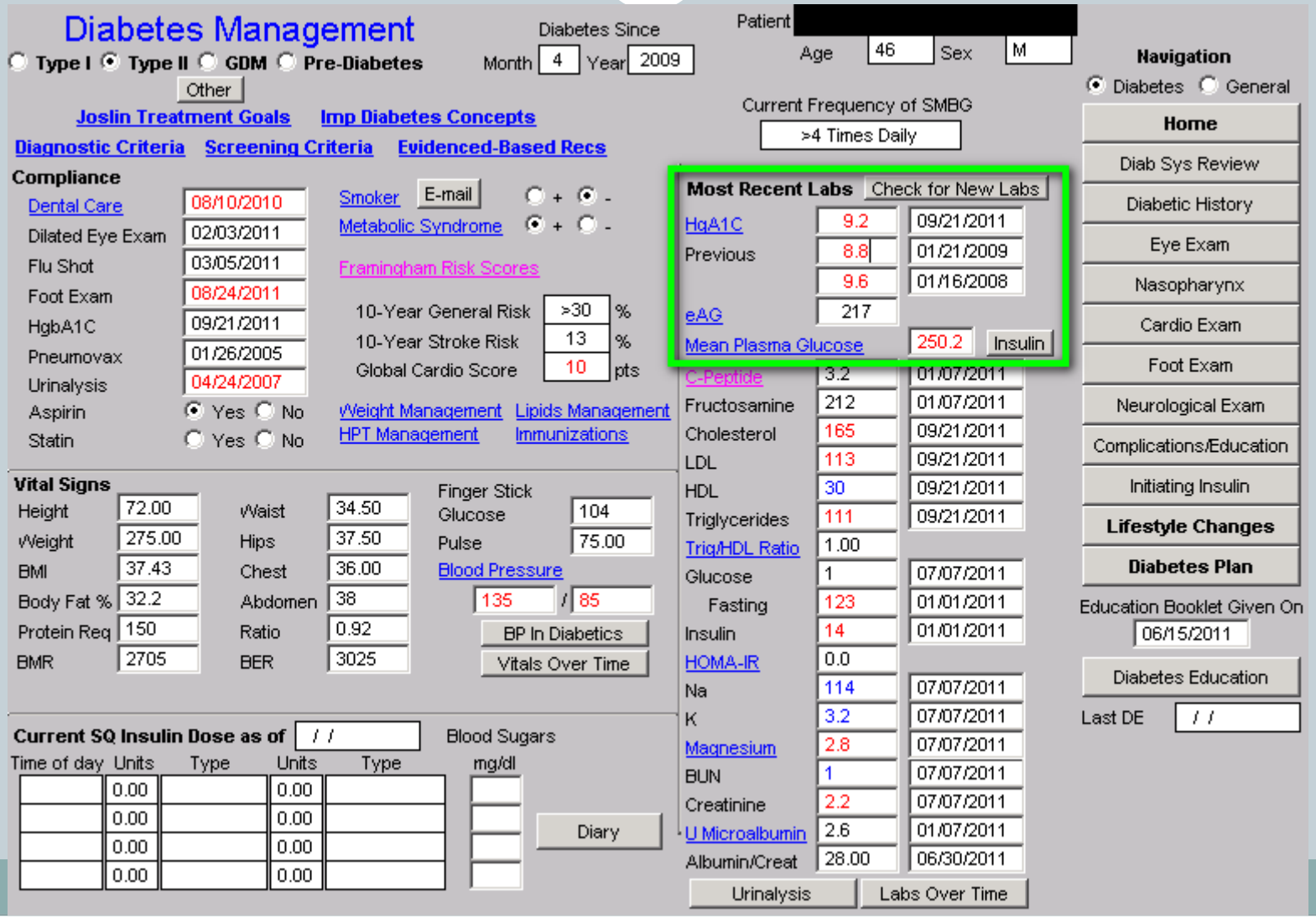
Patient Adherence



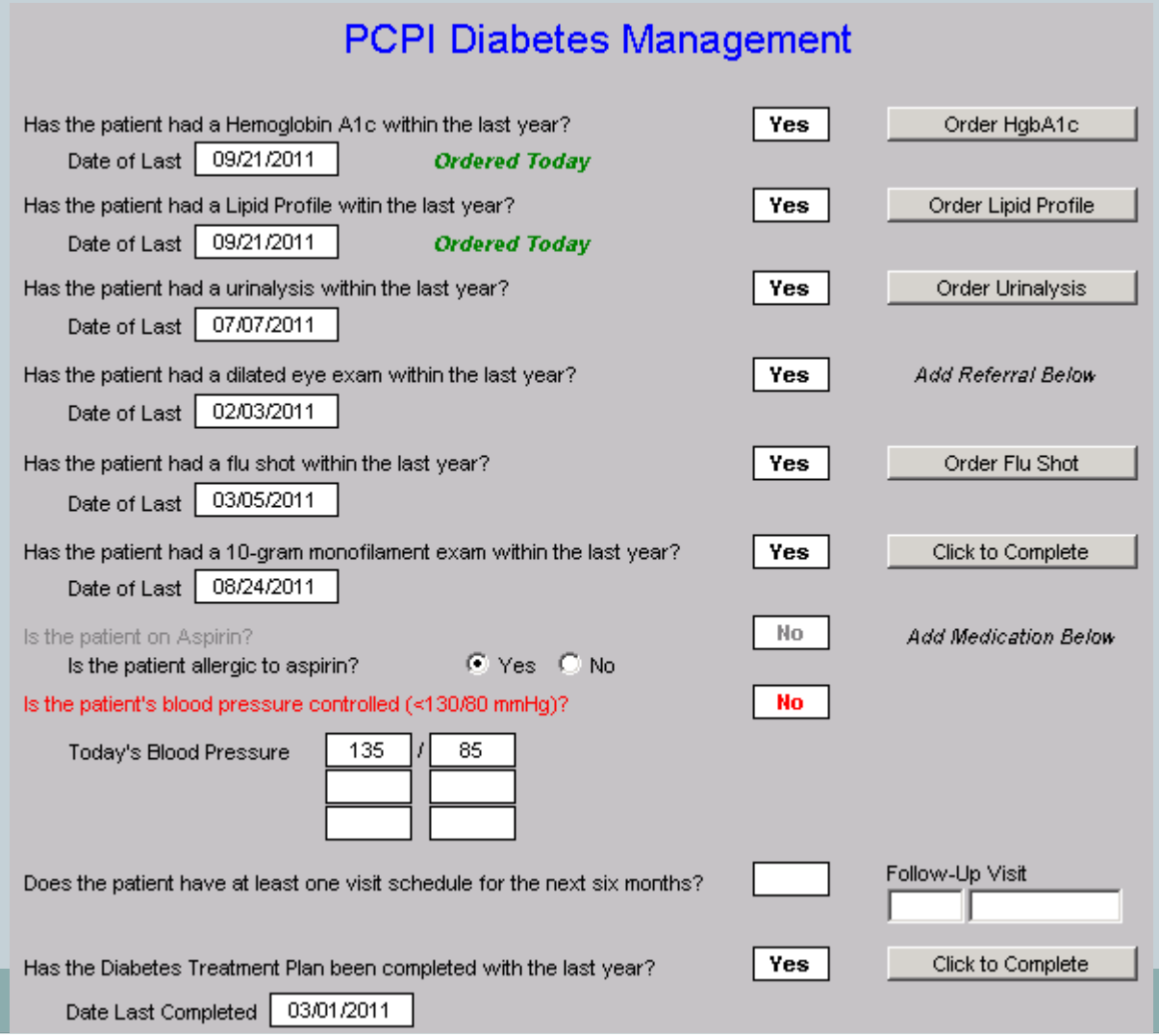
Diabetes Plan of Care



HbA1c and eAG



PCPI Audit


PCPI Diabetes Management
Has the patient had a Hemoglobin A1c within the last year?
Yes
Order HgbA1c
Date of Last 09/21/2011
Ordered Today
Has the patient had a Lipid Profile witin the last year?
Yes
Order Lipid Profile
Date of Last 09/21/2011
Ordered Today
Has the patient had a urinalysis within the last year?
Yes
Order Urinalysis
Date of Last 07/07/2011
Has the patient had a dilated eye exam within the last year?
Yes
Add Referral Below
Date of Last 02/03/2011
Has the patient had a flu shot within the last year?
Yes
Order Flu Shot
Date of Last 03/05/2011
Has the patient had a 10-gram monofilament exam within the last year?
Yes
Click to Complete
Date of Last 08/24/2011
Is the patient on Aspirin?
No
Add Medication Below
Is the patient allergic to aspirin?
Yes
No
Is the patient's blood pressure controlled (<130/80 mmHg)?
No
Today's Blood Pressure
135
/
85
Does the patient have at least one visit schedule for the next six months?
Follow-Up Visit
Has the Diabetes Treatment Plan been completed with the last year?
Yes
Click to Complete
Date Last Completed
03/01/2011

Plan of Care and Treatment Plan

SETMA I - 2929 Calder, Suite 100
SETMA II - 3570 College, Suite 200
SETMA West - 2010 Dowlen
(409) 833-7797
www.setma.com

Diabetes Follow-Up Note
Treatment Plan and Plan of Care

Treatment Goals

HgbA1c	Less than 7.0 %
Blood Pressure	Less than 130/80 mmHg
Cholesterol (LDL)	Less than 100 mg/dL
	Less than 70 mg/dL (if you have cardiovascular disease)
Microalbumin	Less than 30 mcg/mg of creatinine

Patient [redacted]
Date of Birth
Age 74 years
Ethnicity
Sex M

Encounter Date 09/20/11

The Secret to Diabetes: Learning

Remember, Dr. Joslin, one of the founders of modern care of diabetes said, "He who knows the most about diabetes will live the longest." If you have not been to diabetes self-management education classes in the past two years, ask your provider to give you a referral.

Plan of Care and Treatment Plan

Compliance/Adherence

As a patient with diabetes, it is crucial that you have the following care according to the following schedule:

	Compliance Standard	Your Adherence
Annual Dilated Eye Examination by an Ophthalmologist	annual	Yes, you are adherent.
Hemoglobin A1C	three months or each visit	Yes, you are adherent.
Monofilament Examination of Your Feet	annual	Yes, you are adherent.
Controlled Blood Pressure	each visit	Yes, you are adherent.
Urine for Protein for Kidney Damage	annual	Yes, you are adherent.
Flu Immunization	annual	Yes, you are adherent.
Taking an 81 mg Aspirin	each visit	Yes, you are adherent.
Dental Care with Cleaning of Teeth	every six monthss	Yes, you are adherent.
Cholesterol Check (LDL)	annual	Yes, you are adherent.
Pneumovax	every ten years	Yes, you are adherent.
DSME (Diabetes Self Management Education)	every two years	Yes, you are adherent.
Medical Nutrition Therapy	once in first year diagnosis	You are not adherent.
Screening for PVD with Pedal Pulses, ABI or Arterial Doppler	routinely after age 50	

Plan of Care Adherence

Our plan of care for the treatment of your diabetes is based on the evaluation of your compliance with your care.

Are you adherent with your medications? *Yes, you are adherent.*
Are you adherent with your follow-up? *Yes, you are adherent.*
Are you adherent with your diet? *Yes, you are adherent.*
Are you adherent with your education? *You are not adherent.*
Are you adherent with your exercise? *Yes, you are adherent.*

You must take your medications, keep your appointments, and learn all you can about diabetes.

Our records show that you have not attended a Diabetes Self Management Education class. Please arrange with your provider to attend a class.

HbA1c

We will monitor your blood values regularly. Remember the Hemoglobin A1C (HgbA1C) estimates the average blood sugar which you have had for the past three months. If your HgbA1C is above 6.0, your eyes, your kidneys, you heart, your nerves and your blood vessels are subject to being damaged. It is important for you personally to know your HgbA1C and that you keep track of it.

In order to prevent duplications in laboratory testing, please have all of your labs done at SETMA. In that way, the results will be in our computer and we will send the results to your endocrinologist if he/she is not a part of SETMA.

Your current HgbA1c is 10.4 %. Your diabetes is totally out of control and without immediate improvement your health is at serious risk of permenant, long-term damage.

In that your HgbA1c is above 6.5 %, you need to have your eyes examined every six months. Your last eye examination was 1 0/12/2010. Ask for a referral to your ophthalmologist to schedule your next eye exam.

Your Urine Microalbumin is Negative.

You have had diabetes since 5 1993.

HbA1c and eAG

The following are Joslin Diabetes Center's goals for monitoring your blood sugar:

Fasting	70 - 130 mg/dL
2 Hours After Meals	Less than 180 mg/dL

The relationship between the HgbA1C and the values you get from your glucometer (referred to as "eAG") is explained below.

Relationship between HgbA1c and eAG

HgbA1c (%)	eAG (mg/dL) (95% CI)
12	298 (240-347)
11	269 (217-214)
10	240 (193-282)
9	212 (170-249)
8	183 (147-217)
7	154 (123-185)
6	126 (100-152)
5	97 (76-120)
4	68 (51-86)

Remember, the most important value for the prediction of complications of diabetes is HgbA1C. Our goal - yours and mine - will be to work together to achieve consistent, excellent blood sugar and blood pressure control with a HgbA1C below 7% and a blood pressure below 130/80 mmHg. If you are concerned about a particular result, look at the "average blood glucose" value on your glucometer. That value is the most important other than your HgbA1C.

Plan of Care and Treatment Plan

Lifestyle Changes for Improving Your Health

There are three lifestyle changes which will improve your health, help control your diabetes, decrease your cardiovascular disease risk and help minimize the complications of diabetes. They are:

* Lose weight
* Exercise
* Stop Smoking (if you do)

With your diabetes plan of care and treatment plan, you have received a copy of your SETMA LESS Initiative. Follow it. Get active, lose weight and treat tobacco smoke as a plague.

How You Can Take Charge of Your Own Treatment

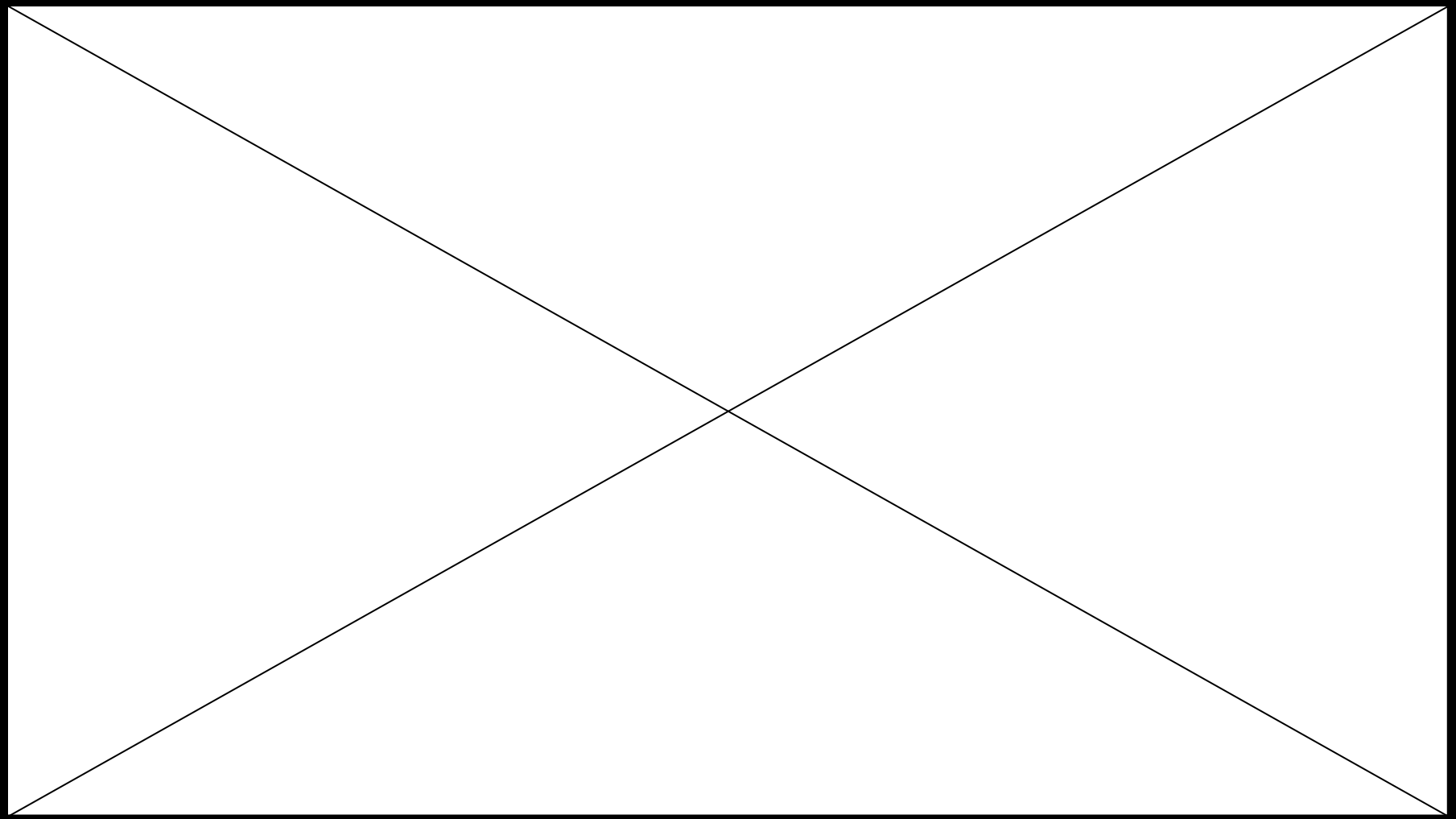
1. Bring your self-monitoring results with you to every clinic visit. I very much appreciate you doing that and thank you for it.

2. Know and understand your HgbA1C.
   Your most recent HgbA1C was 10.4 % on 08/03/2011.
   Your previous values were:
   10.1 % on 02/16/2010
   8.5 % on 08/11/2009

3. Make sure that you note any time your blood sugar drops to 70 mg/dL or below. Note on your log what you were doing at the time.

4. Make sure that you are satisfied with your numbers. Remember, if your HgbA1C is below 7%, you greatly reduce the complications to your health from diabetes.


Firmly in the provider's hand,
the baton – the care and treatment plan –
must be confidently and securely grasped by the patient,
if change is to make a difference,
8,760 hours a year.



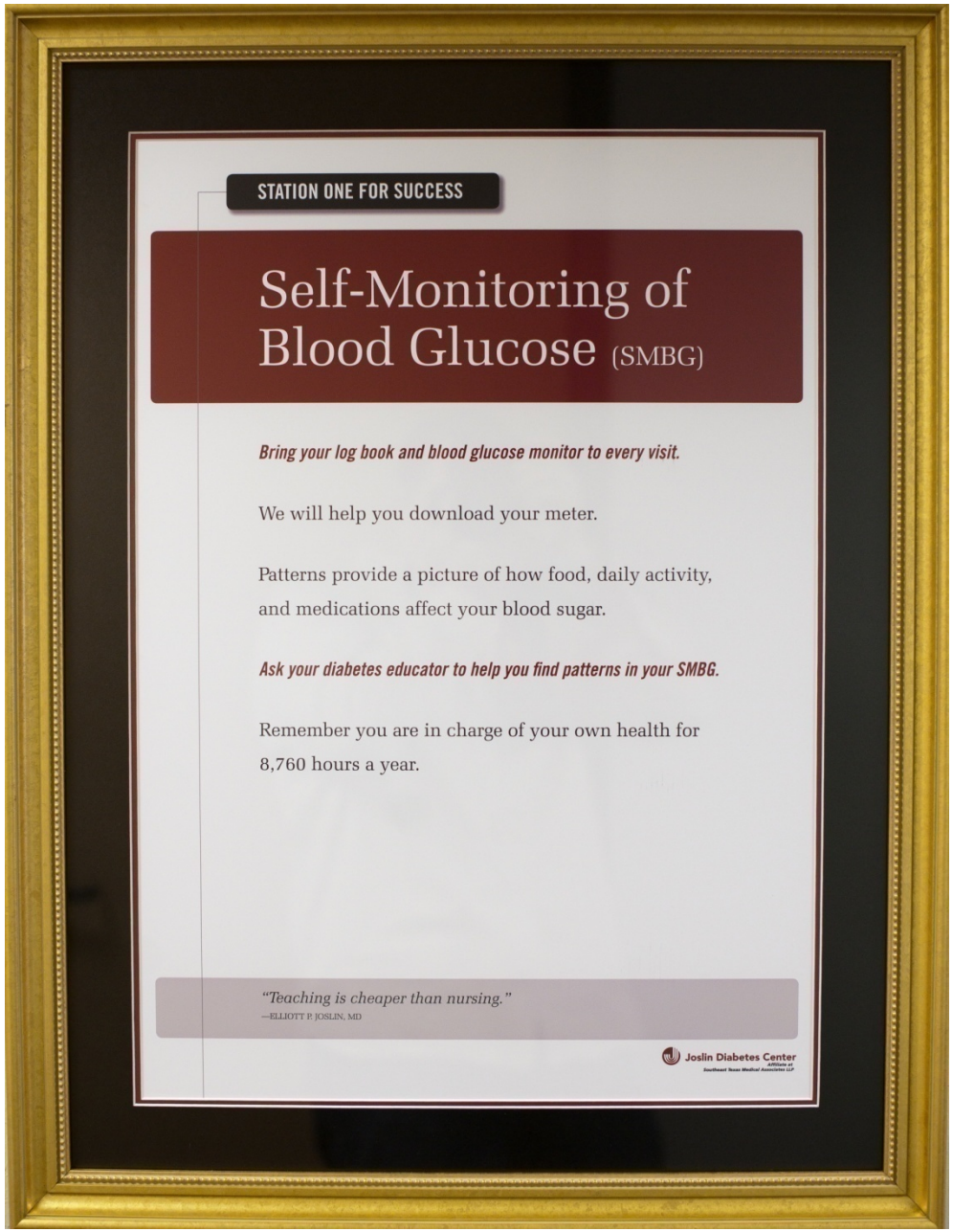
The Baton

Firmly in the provider's hand, the baton – the care and treatment plan – must be confidently and securely grasped by the patient if change is to make a difference, 8,760 hours a year.

Addendum - The Seven Stations of Success

SETMA Designed the Seven Stations of Success as visual reminders of the leverage points for improving the care of patients with diabetes by providers and by the patients themselves.

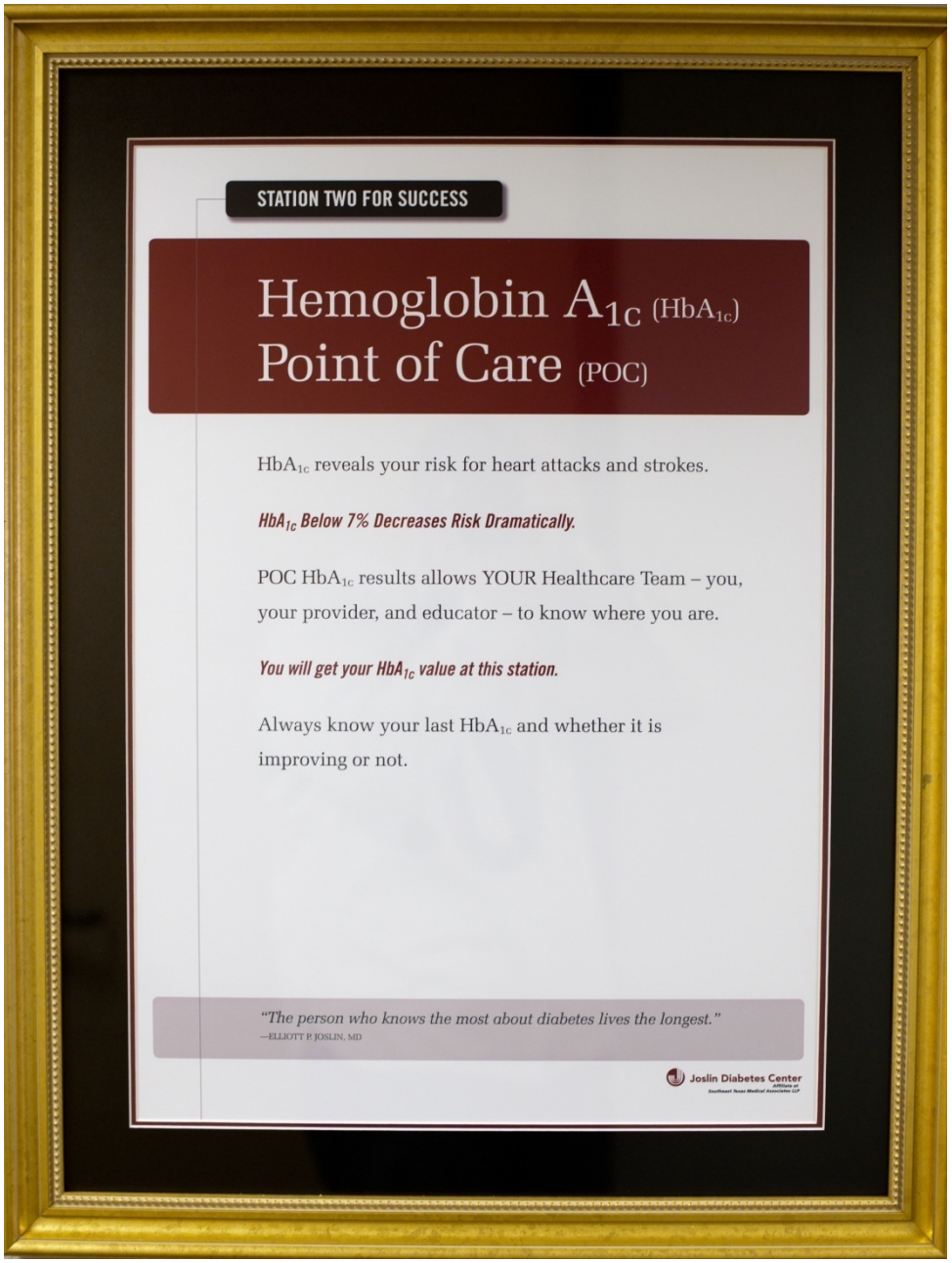
1. A set of the stations are displayed in the hallway leading to the Joslin Affiliate Clinic.
2. A framed copy of each station is displayed at the point of care for each activity within the clinic.
3. Station Seven -- “SETMA is Your Health Home” is on the door through which the patient exits the Joslin Clinic.


STATION ONE FOR SUCCESS
Self-Monitoring of Blood Glucose (SMBG)
Bring your log book and blood glucose monitor to every visit.
We will help you download your meter.
Patterns provide a picture of how food, daily activity, and medications affect your blood sugar.
Ask your diabetes educator to help you find patterns in your SMBG.
Remember you are in charge of your own health for 8,760 hours a year.
"Teaching is cheaper than nursing."
—ELLIOTT P. JOSLIN, MD
Joslin Diabetes Center

Station 1
Self-Monitoring of Blood Glucose

- Bring your log book and blood glucose monitor to every visit.
- We will help you download your meter.
- Patterns provide a picture of how food, daily activity and medications affect your blood sugar.
- Ask your diabetes educator to help you find patterns in your SMBG.
- Remember you are in charge of your own health for 8,760 hours a year.

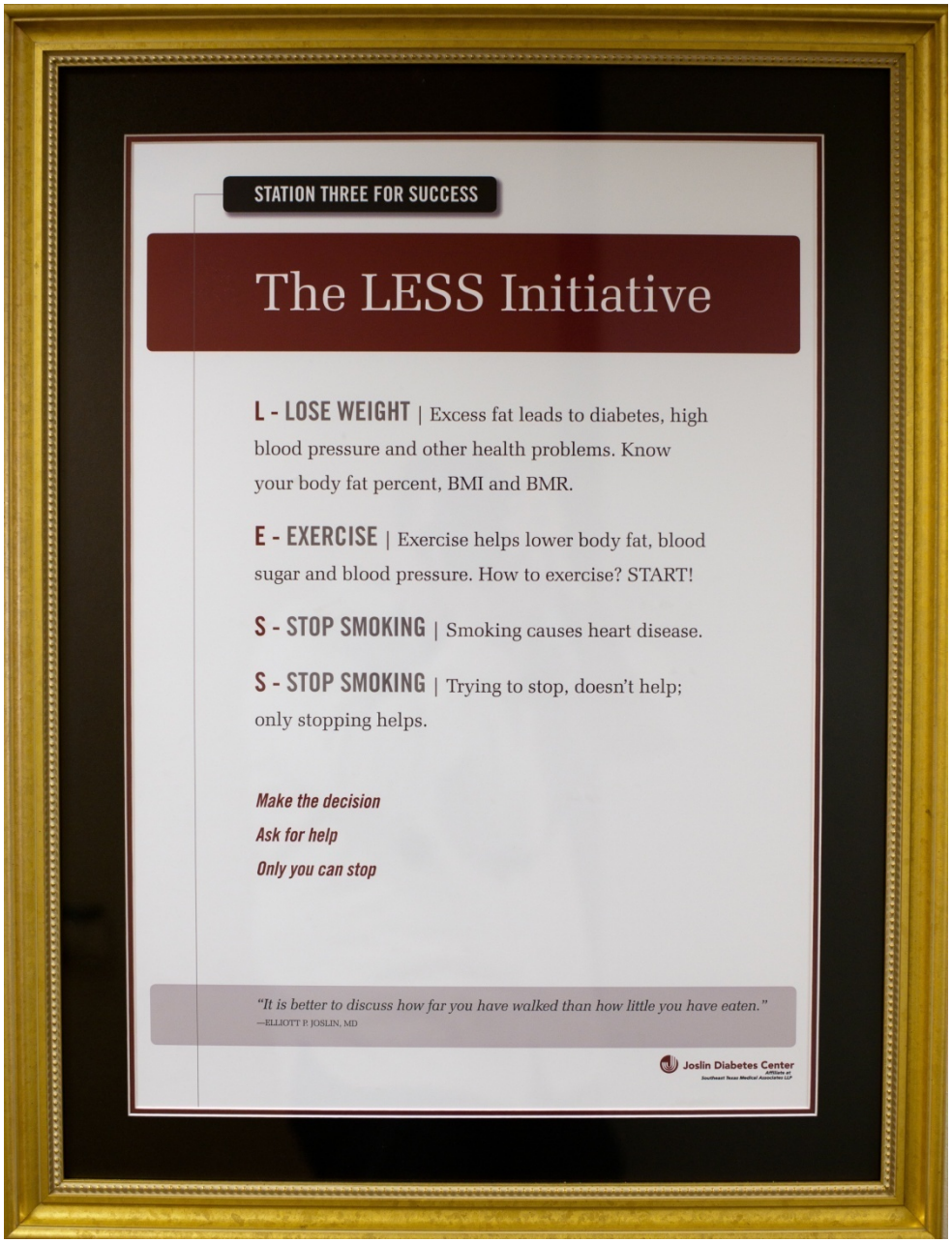
"Teaching is cheaper than nursing."
-Elliot P. Joslin, MD


STATION TWO FOR SUCCESS
Hemoglobin A1c (HbA1c)
Point of Care (POC)
HbA1c reveals your risk for heart attacks and strokes.
HbA1c Below 7% Decreases Risk Dramatically.
POC HbA1c results allows YOUR Healthcare Team – you, your provider, and educator – to know where you are.
You will get your HbA1c value at this station.
Always know your last HbA1c and whether it is improving or not.
"The person who knows the most about diabetes lives the longest."
—ELLIOTT P. JOSLIN, MD
Joslin Diabetes Center

Station 2
HbA1c Point of Care

- **HbA1c reveals your risk for heart attacks and stroke.**
- **HbA1c below 7% decreases risk dramatically.**
- **POC HbA1c results allows your healthcare team – you, your provider and educator – to know where you are.**
- **You will get your HbA1c value at this station.**
- **Always know your last HbA1c and whether it is improving or not.**

"The person who knows the most about diabetes lives the longest."
-Elliot P. Joslin, MD

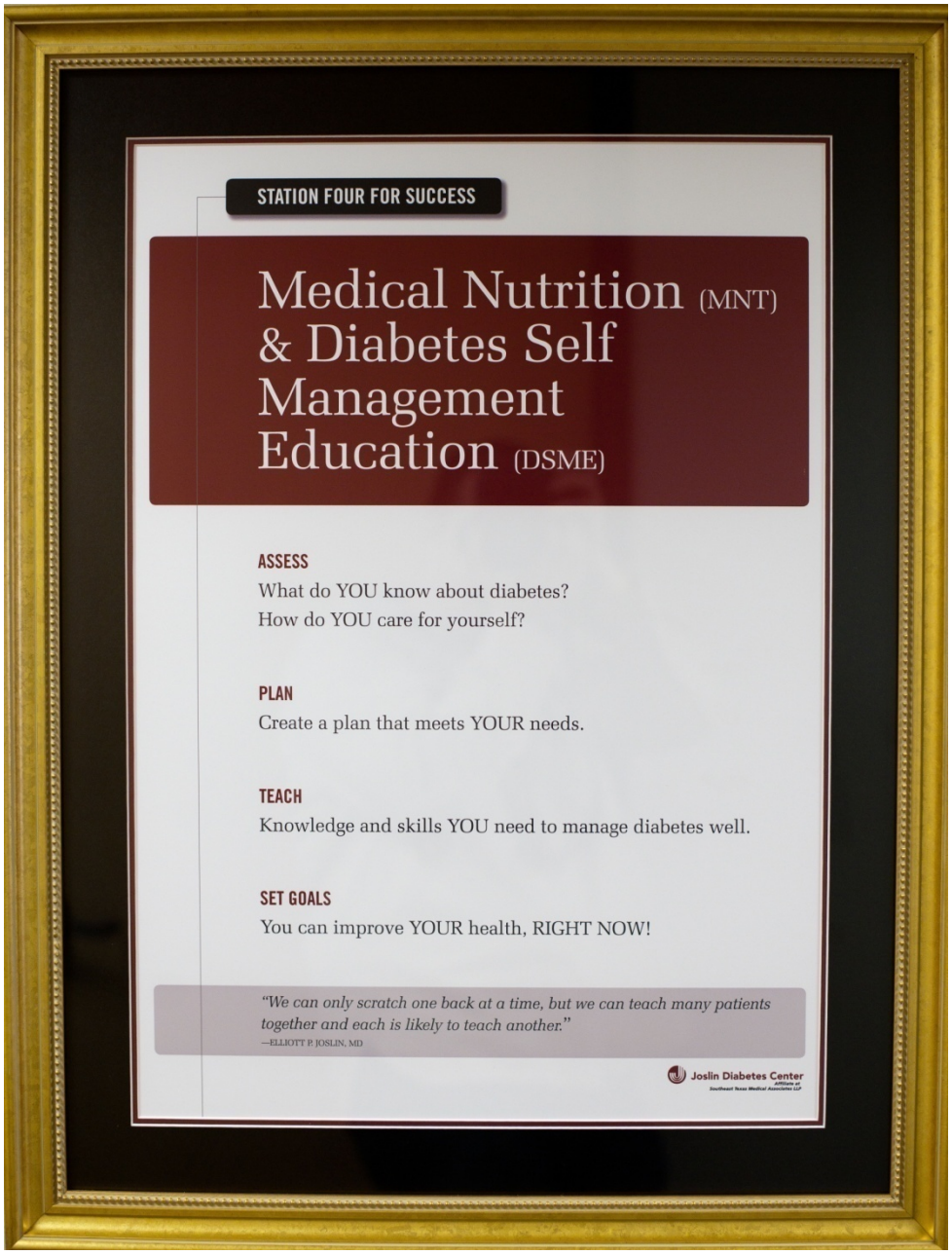

STATION THREE FOR SUCCESS
The LESS Initiative
L - LOSE WEIGHT | Excess fat leads to diabetes, high blood pressure and other health problems. Know your body fat percent, BMI and BMR.
E - EXERCISE | Exercise helps lower body fat, blood sugar and blood pressure. How to exercise? START!
S - STOP SMOKING | Smoking causes heart disease.
S - STOP SMOKING | Trying to stop, doesn't help; only stopping helps.
Make the decision
Ask for help
Only you can stop
"It is better to discuss how far you have walked than how little you have eaten."
—ELLIOTT P. JOSLIN, MD
Joslin Diabetes Center

Station 3
The LESS Initiative

- **L – Lose Weight – Excess fat leads to diabetes, high blood pressure and other health problems. Know your body fat, BMI and BMR.**
- **E – Exercise – Exercise helps lower body fat, blood sugar and blood pressure. How to exercise? START!**
- **S – Stop Smoking – Smoking causes heart disease.**
- **S – Stop Smoking – Trying to stop doesn't help; only stopping helps.**

"It is better to discuss how far you have walked than how little you have eaten."

-Elliot P. Joslin, MD


STATION FOUR FOR SUCCESS
Medical Nutrition (MNT) & Diabetes Self Management Education (DSME)
ASSESS
What do YOU know about diabetes?
How do YOU care for yourself?
PLAN
Create a plan that meets YOUR needs.
TEACH
Knowledge and skills YOU need to manage diabetes well.
SET GOALS
You can improve YOUR health, RIGHT NOW!
"We can only scratch one back at a time, but we can teach many patients together and each is likely to teach another."
—ELLIOTT P. JOSLIN, MD
Joslin Diabetes Center

Station 4
Medical Nutrition & Diabetes Self Management Education

- **Assess** – What do YOU know about diabetes? How do YOU care for yourself?
- **Plan** – Create a plan that meets YOUR needs.
- **Teach** – Knowledge and skills YOU need to manage diabetes well.
- **Set Goals** – You can improve YOUR health, RIGHT NOW!

"We can only scratch one back at a time, but we can teach many patients together and each is likely to teach another."

-Elliot P. Joslin, MD

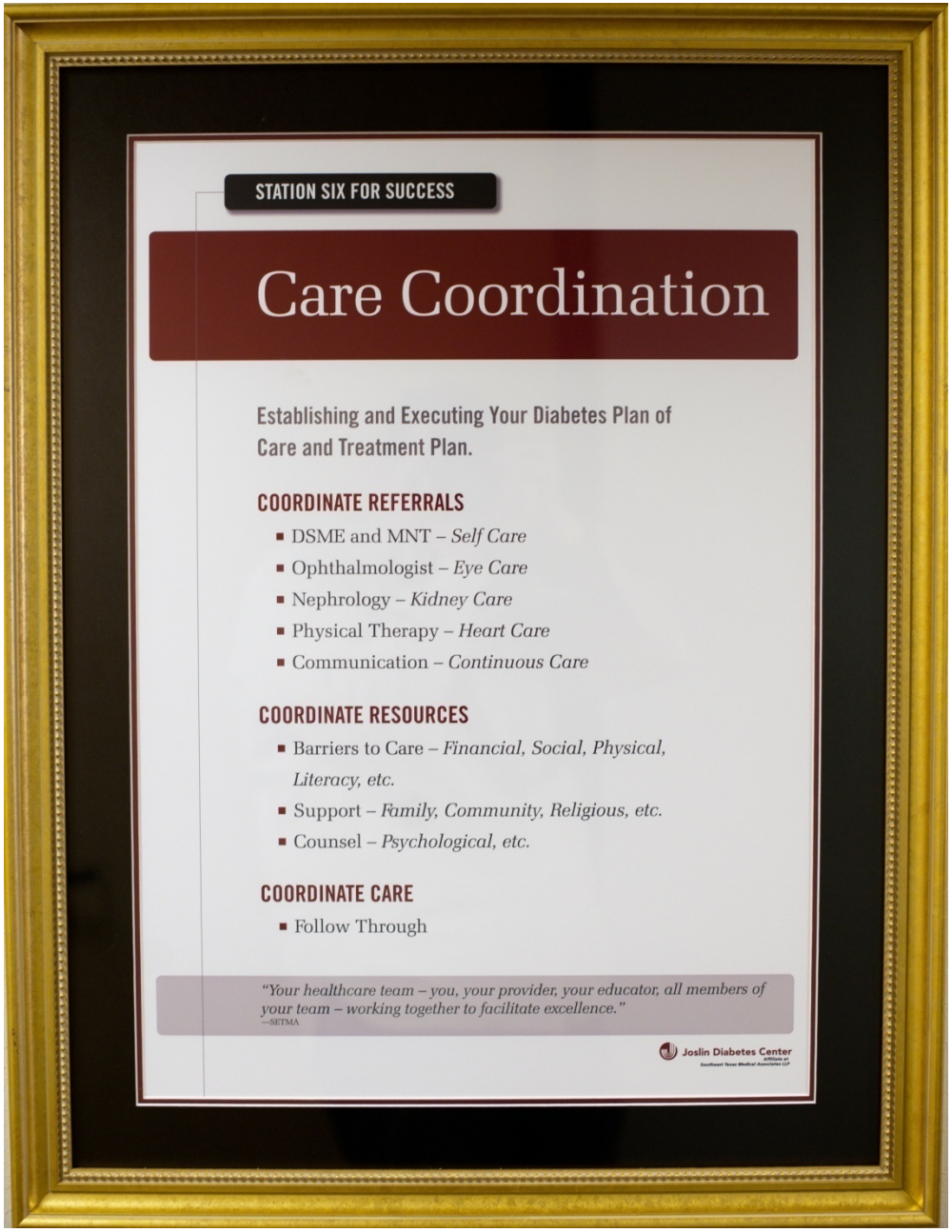

STATION FIVE FOR SUCCESS
Physician Partnership With YOU
TOGETHER, set goals of blood glucose, blood pressure and cholesterol.
TOGETHER, determine your risk of complications.
TOGETHER, plan for preventing complications.
TOGETHER, review and agree on treatment plan.
"You and your healthcare provider are 'in this together.' Be an active part of YOUR team."
—SETMA
Joslin Diabetes Center

Station 5
Physician Partnership with YOU

- **TOGETHER, set goals of blood glucose, blood pressure and cholesterol.**
- **TOGETHER, determine your risk of complications.**
- **TOGETHER, plan for preventing complications.**
- **TOGETHER, review and agree on treatment plan.**

"You and your healthcare provider are 'in this together.' Be an active part of YOUR team."

-SETMA


STATION SIX FOR SUCCESS
Care Coordination
Establishing and Executing Your Diabetes Plan of Care and Treatment Plan.
COORDINATE REFERRALS
DSME and MNT – Self Care
Ophthalmologist – Eye Care
Nephrology – Kidney Care
Physical Therapy – Heart Care
Communication – Continuous Care
COORDINATE RESOURCES
Barriers to Care – Financial, Social, Physical, Literacy, etc.
Support – Family, Community, Religious, etc.
Counsel – Psychological, etc.
COORDINATE CARE
Follow Through
"Your healthcare team – you, your provider, your educator, all members of your team – working together to facilitate excellence."
—SETMA
Joslin Diabetes Center

Station 6
Care Coordination

Establishing and Executing Your Diabetes Plan of Care and Treatment Plan

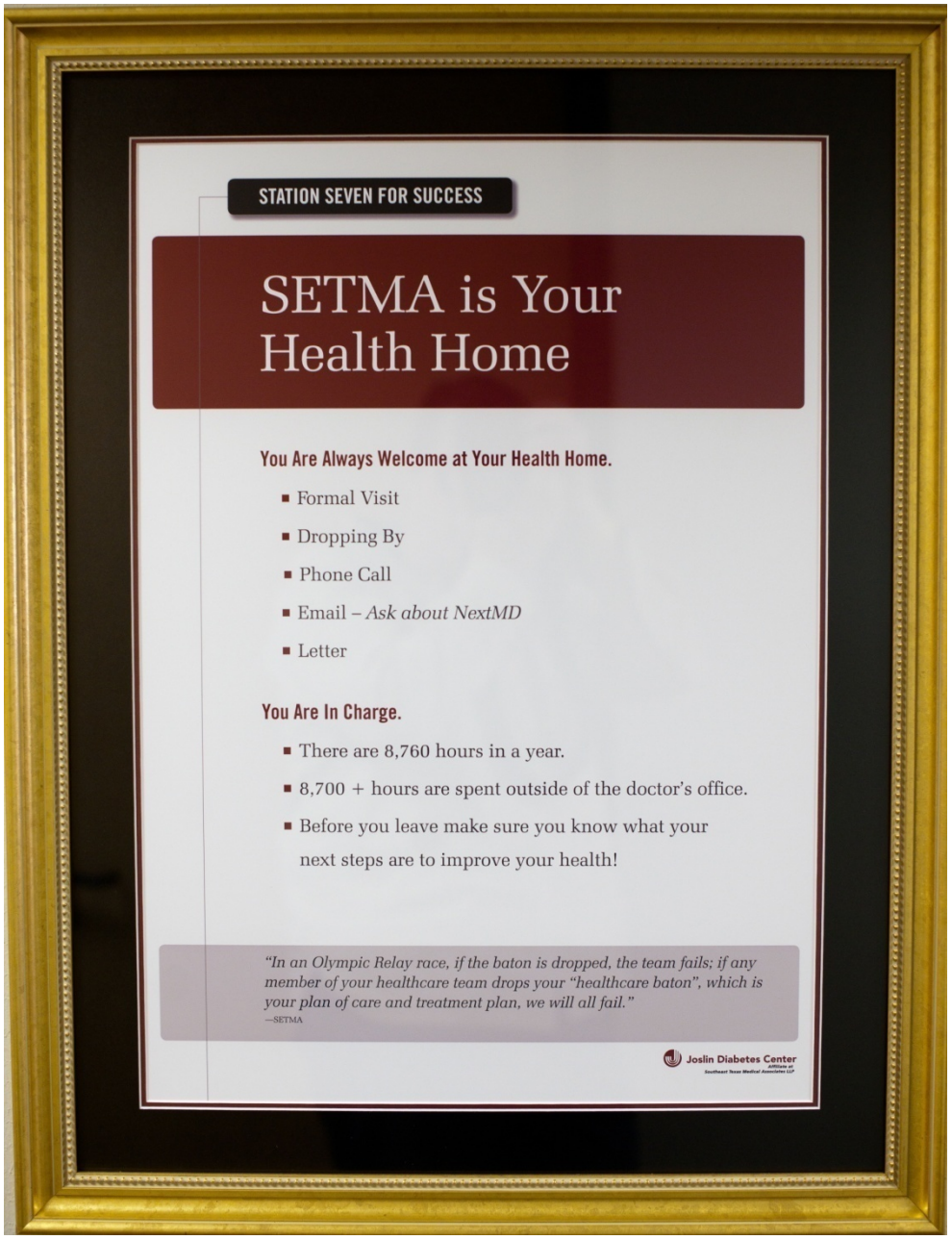
- **Coordinate Referrals**
  - **DSME and MNT – Self Care**
  - **Ophthalmology – Eye Care**
  - **Nephrology – Kidney Care**
  - **Physical Therapy – Heart Care**
  - **Communication – Continuous Care**

Station 6
Care Coordination

- **Coordinate Resources**
  - **Barriers to Care – Financial, Social, Physical, Literacy, etc.**
  - **Support – Family, Community, Religious, etc.**
  - **Counsel – Psychological, etc.**
- **Coordinate Care**
  - **Follow Through**

"Your healthcare team – you, your provider, your educator, all members of your team – working together to facilitate excellence."

-SETMA


STATION SEVEN FOR SUCCESS
SETMA is Your Health Home
You Are Always Welcome at Your Health Home.
Formal Visit
Dropping By
Phone Call
Email – Ask about NextMD
Letter
You Are In Charge.
There are 8,760 hours in a year.
8,700 + hours are spent outside of the doctor's office.
Before you leave make sure you know what your next steps are to improve your health!
"In an Olympic Relay race, if the baton is dropped, the team fails; if any member of your healthcare team drops your "healthcare baton", which is your plan of care and treatment plan, we will all fail."
—SETMA
Joslin Diabetes Center

Station 7
SETMA is Your Health Home

- **You Are Always Welcome at Your Health Home**
  - **Formal Visit**
  - **Dropping By**
  - **Phone Call**
  - **Email – *Ask about NextMD***
  - **Letter**

Station 7
SETMA is Your Health Home

- **You Are Always Welcome at Your Health Home**
  - **There are 8,760 hours in a year.**
  - **8,700 + hours are spent outside of the doctor's office.**
  - **Before you leave make sure you know what your next steps are to improve your health.**

"In an Olympic relay race, if the baton is dropped, the team fails; if any member of your healthcare team drops your 'healthcare baton,' which is your plan of care and treatment plan, we will all fail."

-SETMA