

# Identification of Clinic Team Roles for Effective Diabetes Management

## Purpose:

An office encounter for a patient with diabetes requires the support of the entire clinic team to assure the patient's complex care needs are addressed. By identifying roles and actively engaging all team members in practicing at the maximum scope of practice, patients can be efficiently moved through the clinic process in a coordinated manner, while having their diabetes management needs met.

The attached worksheet and reference documents will assist the clinic team to identify general responsibilities and shared accountability in optimal diabetes management.

## Instructions:

1. Assemble team members involved in diabetes management, i.e. front desk staff, care coordinator, diabetes educator, registered dietician, medical assistant, nursing, pharmacy, physician and advance practice provider.
2. Inventory current clinic work flows, protocols, standing orders, referral tools, resources for self-management and behavior change used in diabetic office encounters. What is working well? What could be improved or updated?
3. Referencing the Work Sheet: Team Roles for Effective Diabetes Management and sample provided, determine which individual team members could best support and share responsibilities of diabetes care to complement the activities of the primary care provider.  
Consider the following:
  - Clinic staffing model
  - Available supplemental support, i.e. Pharmacy services, Diabetic Educators, Dietician
  - Individual licensure, competency and expertise
4. Assure each team member is aware of their role(s) and responsibilities.
5. Consider use of the completed Clinic Team Roles: Diabetes Management form as a reminder list for staff about assigned tasks in preparing for diabetes encounters.

## Best Practice Tips:

- Conduct a team huddle at the start of each morning to review the day's schedule and communicate any issues or updates that need to be addressed. Copies of a patient summary sheet should be provided to each member of the team allowing them to quickly discuss relevant health history, diabetes management plans and progress on self-management goals. Team decisions are then made regarding who, besides the physician, will see each patient and what needs to be accomplished during the visit.
- To help identify patients with diabetes, use color-coded or identifying stickers or stamps on the charts or rooms of patients with diabetes. Practices may want to have one sticker for patients generally at goal and another for those at higher risk. This can help staff be better prepared for the patient's needs.

# Diabetes Management Team Action Items for Consideration

	<h2 style="text-align: center;">What</h2> <p style="text-align: center;"><i>Action Items for Consideration</i></p>
<p style="text-align: center;"><b>Outreach &amp; Pre-Visit Planning</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Run/pull pursuit list of Diabetic patients on a _____ basis</li> <li><input type="checkbox"/> Verify date last seen; contact patients seen &gt; _____ months to schedule appt.</li> <li><input type="checkbox"/> Verify if retinal eye exam completed within past year               <ul style="list-style-type: none"> <li><input type="radio"/> If not, take following action: _____</li> </ul> </li> <li><input type="checkbox"/> Review most recent A1c lab result, confirm done within last 3 mos. if &gt;7; every 6 mos. if &lt; 7               <ul style="list-style-type: none"> <li><input type="radio"/> If not, take following action: _____</li> </ul> </li> <li><input type="checkbox"/> Verify micro albumin done within past 12 months               <ul style="list-style-type: none"> <li><input type="radio"/> If not, take following action: _____</li> </ul> </li> <li><input type="checkbox"/> Other: _____</li> </ul>
<p style="text-align: center;"><b>Rooming</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Patient preparation               <ul style="list-style-type: none"> <li><input type="radio"/> Have patient remove shoes and socks in prep for foot exam</li> <li><input type="radio"/> Perform visual foot inspection</li> <li><input type="radio"/> If abnormalities exist or comprehensive foot exam not documented take following action: _____</li> </ul> </li> <li><input type="checkbox"/> Order &amp; testing verification               <ul style="list-style-type: none"> <li><input type="radio"/> Review care gaps and most recent A1c test</li> <li><input type="radio"/> If gaps present or A1c test needed, take following action: _____</li> </ul> </li> <li><input type="checkbox"/> Other: _____</li> </ul>
<p style="text-align: center;"><b>Patient Visit</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Confirm diabetes documented in problem list</li> <li><input type="checkbox"/> Review identified care gaps and enter/sign proposed orders as needed</li> <li><input type="checkbox"/> Perform comprehensive foot exam, record results</li> <li><input type="checkbox"/> Review A1c, other test results, manage diabetes based on <a href="#">evidence-based guidelines</a></li> <li><input type="checkbox"/> Evaluate patient progress with self- management goals &amp; life style modifications; refer to health coach/care manager, diabetes educator as indicated</li> <li><input type="checkbox"/> Follow up planning               <ul style="list-style-type: none"> <li><input type="radio"/> Pre-order labs</li> <li><input type="radio"/> Medication refill protocol</li> <li><input type="radio"/> Time-frame for follow up</li> </ul> </li> <li><input type="checkbox"/> Other: _____</li> </ul>
<p style="text-align: center;"><b>Patient Engagement</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Review self-management goals with patient; if none established take following actions: _____</li> <li><input type="checkbox"/> Provide the following resources to reinforce adherence to lifestyle modifications and goals: _____</li> <li><input type="checkbox"/> Provide and the following tools to connect patient with community resources to support success: _____</li> <li><input type="checkbox"/> Generate referral for diabetes support services:               <ul style="list-style-type: none"> <li><input type="radio"/> Diabetic education</li> <li><input type="radio"/> Behavioral health services</li> <li><input type="radio"/> Medication management</li> <li><input type="radio"/> Nutrition counseling</li> </ul> </li> <li><input type="checkbox"/> Other: _____</li> </ul>
<p style="text-align: center;"><b>Follow Up Scheduling</b></p>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Schedule follow-up visit prior to patient departure               <ul style="list-style-type: none"> <li><input type="radio"/> Frequency of follow up determined by: _____</li> <li><input type="radio"/> Include "DM follow-up" as reason for visit</li> </ul> </li> <li><input type="checkbox"/> Other: _____</li> </ul>

# SAMPLE

## Clinic Team Roles: Tips for Effective Diabetes Management



### Outreach & Pre-visit Planning

#### Who: Clinic Staff

##### What: Conduct weekly review of diabetic registry patient list

- Verify date last seen; contact patients seen  $\geq 3$  months to schedule appt.
- Verify if retinal eye exam completed within past year; assure results in record
  - If not, facilitate order for retinal eye exam and contact patient for scheduling
- Review most recent A1c lab result, confirm done within last 3 mos. if  $>7$ ; every 6 mos. if  $< 7$ 
  - If not, facilitate order and contact patient for pre-visit lab draw
- Verify micro albumin done within past 12 months
  - If not, facilitate order and contact patient for pre-visit lab draw



### Rooming

#### Who: MA, Nurse

##### What: Patient preparation, order verification and testing

- Review care gaps and propose orders as needed (see above)
- Perform A1c test as needed (every 3 mos. if  $> 7$ ; every 6 mos.  $< 7$ )
- Have patient remove shoes and socks in prep for foot exam
  - Perform visual foot inspection
  - If abnormalities exist or comprehensive foot exam not documented in past year-notify provider



### Patient Visit

#### Who: Provider

##### What: Data review, orders & tests, management and follow up

- Confirm diabetes documented in problem list (include date of onset if possible)
- Review identified care gaps and enter/sign proposed orders as needed
- Perform comprehensive foot exam, record results
- Review A1c, other test results, manage diabetes based on [evidence-based guidelines](#)
- Use medication refill protocol
  - Limit to 1 mo. for new meds & 3 mos. for A1c  $> 7$
  - Use Pharmacy referral as needed
- Evaluate patient progress with self-management goals & life style modifications; refer to health coach/care manager, diabetes educator as indicated
- Order 3 mo. follow up for patients with A1c  $> 7$  ; pre-order labs



### Patient Engagement

#### Who: All Team Members

##### What: Support patient in self-management in every visit

- Review self-management goals with patient; if none established, alert provider or health coach/care manager
- Utilize motivational interviewing techniques to empower patients in setting/achieving goals
- Provide positive reinforcement for adherence to lifestyle modifications and goals
- Encourage patient use of educational tools and connection with community resources, health coaches to support success



### Follow Up Scheduling

#### Who: Front Desk Staff

##### What: Schedule follow-up visits

- Schedule follow-up visit prior to patient departure
- Include "DM follow-up" as reason for visit

# Clinic Team Roles: Diabetes Management

## CLINIC

### Outreach & Pre-visit Planning

Action Item	Title

### Rooming

Action Item	Title

### Patient Visit

Action Item	Title

### Patient Engagement

Action Item	Title

### Follow Up Scheduling

Action Item	Title