DHS Diabetes Day

How to co-manage diabetes patients between endocrinology and the medical home - eConsult and beyond

David Campa, Eli Ipp, Andy Lee and Paul Giboney

Disclosures

• Paul Giboney and Andy Lee have no relevant financial relationships to disclose
• Eli Ipp reports the following financial relationship:
  – Research grants from Bristol Myers Squibb and Novo-Nordisk (medications unrelated to this presentation)
• David Campa reports the following relationship:
  – co-investigator on Pfizer Foundation-funded project “Technology-Enhanced Immunization Outreach in the Los Angeles Safety Net” coordinated by the Olive View-UCLA Education and Research Institute (no payment received)

A Vision for Coordinated Diabetes Care

A healthcare system that meets the needs of our diabetic patients in a way that combines:
• a highly capable medical home,
• effective and appropriately utilized specialty expertise and ancillary services
• using tools that promote provider to provider communication, bi-directional sharing of medical information [labs, notes, etc.] and efficient transitions of care when necessary.

Goals for this session:

1. Hear from you –
   1. What sort of interaction are you looking for in a co-management relationship?
   2. What works, what doesn’t?
2. Share our experience in co-management using eConsult, specialty clinics and other approaches.
3. Discussion

NOVEL PRIMARY CARE – SPECIALTY INTERACTIONS IN DIABETES MANAGEMENT

ELI IPP M.D.
Head, Section of Diabetes & Metabolism
HARBOR-UCLA MEDICAL CENTER

LAC DHS Diabetes Day, 2014

Standard Model of referral to Specialty Care in LAC DHS

• PCP identifies issues in diabetes care that require specialty assistance (usually inadequate glycemic control)
• Consult results in Referral to Diabetes Clinic to be seen by a consulting physician
Alternative Models of Co-Management

- **One Visit Referral**: (e.g., discussion to initiate insulin)
- **Short-Term Case Management**: (e.g., initiate or switch insulin regimen in an adherent patient)
- **Long-Term Case Management**: the difficult cases

Three models allow for different degrees of PCP involvement, with a varying extent of co-management:

- **Single-Visit or Short-Term Case Management**: implies continuing PCP involvement
- **Long-Term Case Management**: is also a choice for the PCP, with the understanding that (unless urgent intervention is required), diabetes management is not shared, but is driven by the specialist team
- **All models are based on Team Intervention**: The PCP becomes part of the team approach to DM management

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**eConsult Diabetes Co-Management**

Andy Lee, DO
Medical Director, Outpatient Specialty Care
LAC+USC Medical Center

LAC DHS Diabetes Day, 2014

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**eConsult DM Co-Management**

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**PCMH Foundation**

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welee@dhs.lacounty.gov 12/3/2014
Co-Management of Diabetes from the PCMH PCP Perspective

David Campa, MD, MPH
Director, Primary Care – Ambulatory Care Network
Interim Medical Director – Hubert H. Humphrey Comprehensive Health Center
LAC DHS Diabetes Day 2014

Diabetes Care and Patient-Centered Medical Homes (PCMHs)

- PCMHs are built upon three main pillars:
  - Team-based care with delegation of patient care tasks to all members of the team based on scope of practice
  - Empannelment of patients to the provider/team (panel)
  - Use of registry to support panel management
- Care Manager (RN3) assists with management of high-risk patients (e.g., A1c > 12 x 6-12 months)
- Other team members assist with lower risk pts.
- Need: Increase DM care capacity of our PCMHs
  - eConsult/DMP co-management, sharing of Tx tools, etc

Diabetes Care and Patient-Centered Medical Homes (PCMHS)

- RNs in the PCMH will soon have standardized, evidence-based treatment protocols to assist PCPs in management of diabetic patients:
  - Starting Bedtime Insulin/Daytime Oral Agents (BIDO)
  - Oral Antidiabetic Medication Initiation & Adjustments
  - Others to be adapted to PCMH (eg, HTN, lipid mgmt)
- PCPs can initiate or intensify DM treatment and hand off to PCMH RN to optimize dosing.
- Other team members can order simple tests (eg, A1C) or interventions (eg, vaccines) to close care gaps.
- Co-management with DM specialist occurs as needed based on guidelines or PCP judgment.

“PCMH Nirvana” and DM Care

- High functioning PCMH teams do the following:
  - Clearly identify entire panel of patients -> diabetics
  - Stratify diabetic patients by risk level -> drives type of care patients receive; role of all team members clearly defined
  - Patients activated/educated, self-manage, participate more in care
  - Use evidence-based guidelines, standardized procedures
  - Use registry to pro-actively manage panel of diabetics
  - Offer convenient, patient-centered access to PCMH team
  - Co-manage care of highest-risk patients with DM specialist through e-Consult or DMP, use same tools
  - Specialists, DMP, and community resources are part of the “patient-centered medical neighborhood.”
  - Use local QI process to continuously improve care