Diabetes and Hypertension Project ECHO* Clinic

*ECHO: Extension of Community Healthcare Outcomes

January 14, 2020

If you have already created your VCU Health CE account, scan this QR code to claim CE:

Or text

19144-18817

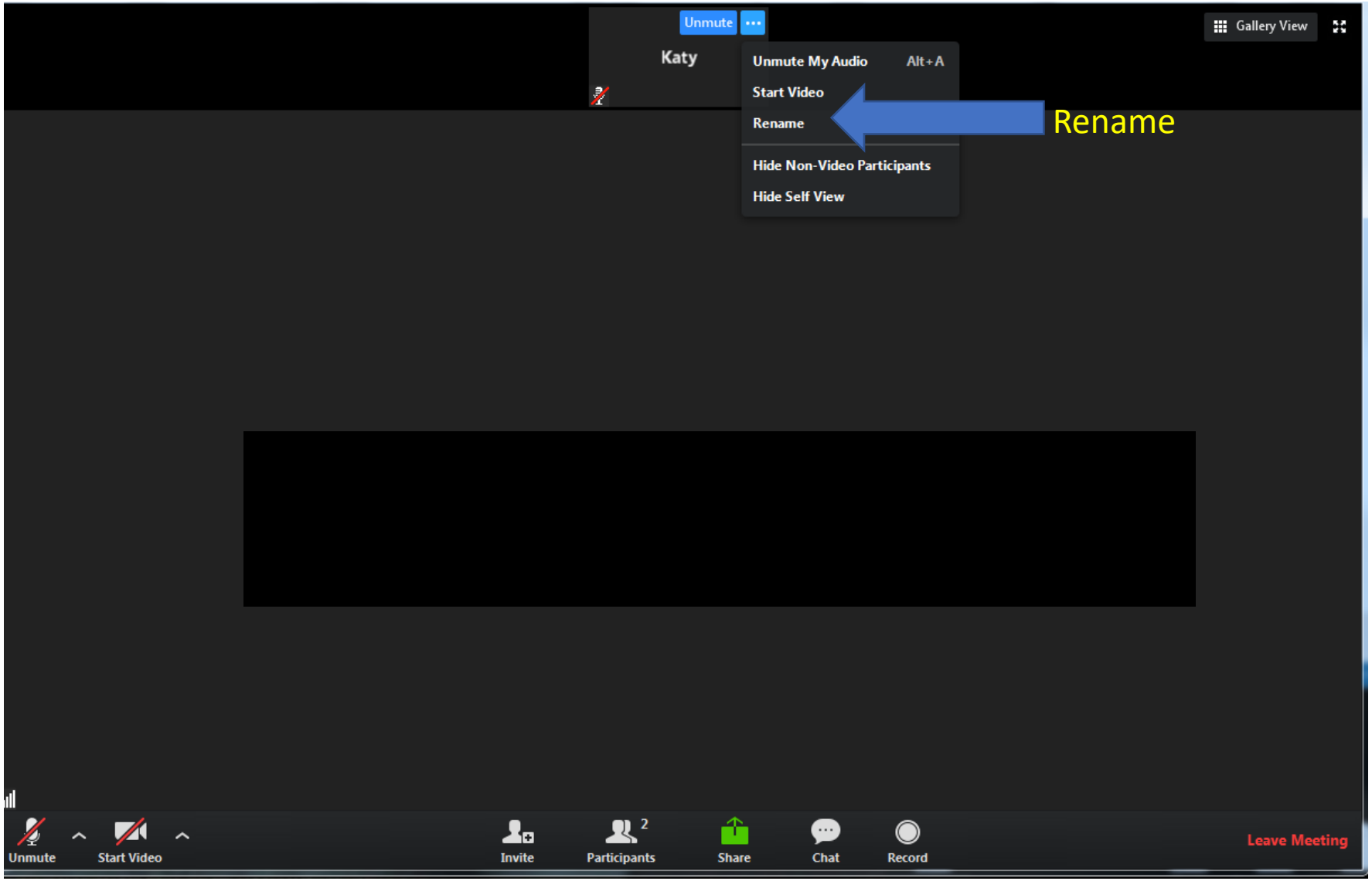
to

804-625-4041

https://VCU.cloud-cme.com/WebService/SelfAttendScan.aspx?EventID=19144

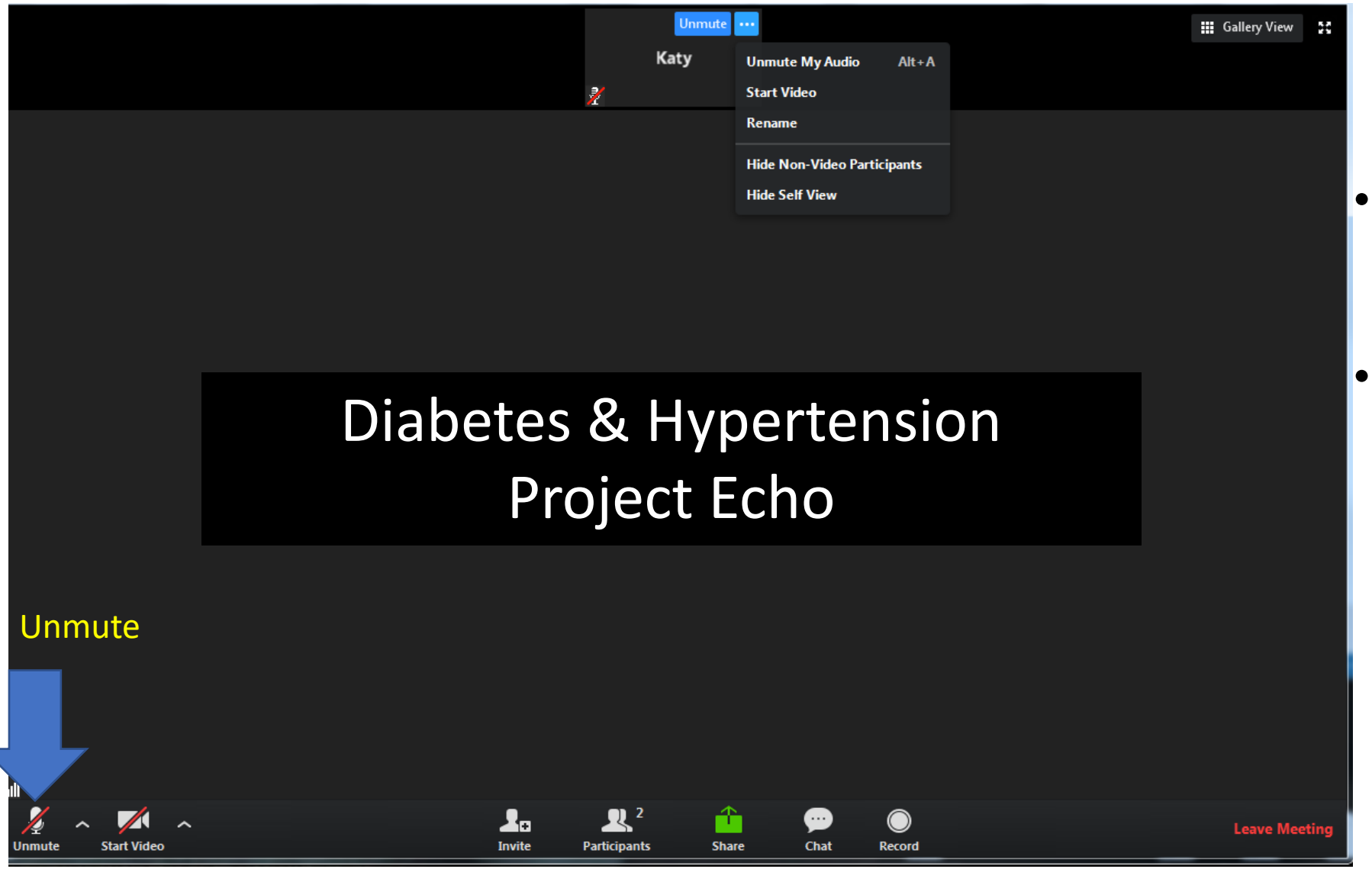
Be thinking of a favorite moment from your holiday to share during introductions!

Helpful Reminders



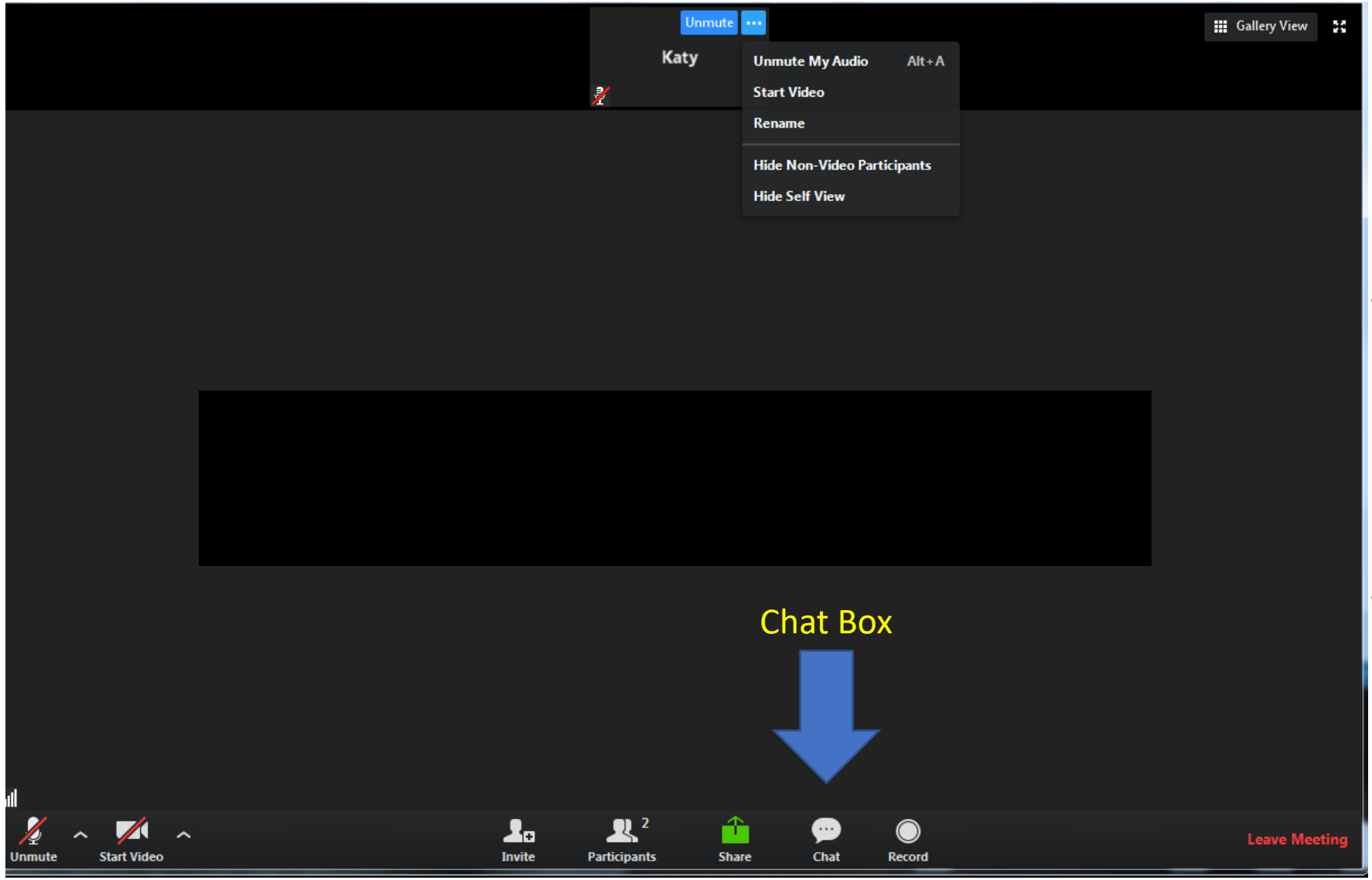
*Rename your Zoom screen with your name and organization

Helpful Reminders



- You are all on mute. Please unmute to talk
- If joining by telephone audio only, press *6 to mute and unmute

Helpful Reminders



- Please type your full name and organization in the chat box
- Use the chat function to speak with our team or ask questions

VCU Health Diabetes & Hypertension ECHO Clinics

- Bimonthly, 1.5-hour tele-ECHO clinics on 2nd and 4th Thursdays
- Every tele-ECHO clinic includes a 30-minute didactic presentation followed by case discussions
- Didactic presentations are developed and delivered by interprofessional experts
- Website: www.vcuhealth.org/echodmhtn
  - Directions for creating an account and claiming CE can be found here also
  - You have up to six days after our session to claim CE by texting **19144-18817** to **804-625-4041**

Hub and Participant Introductions

VCU Team	
Principal Investigator	Dave Dixon, PharmD
Administrative Medical Director ECHO Hub	Vimal Mishra, MD, MMCi
Clinical Experts	Niraj Kothari, MD Trang Le, MD
Project Coordinator/IT Support	Madeleine Wagner, BA
Program Manager	Bhakti Dave, MPH

- Use chat function for introduction
  - Name
  - Organization

Reminder: Mute and unmute screen to talk or press *6 for phone audio

Share your name, organization, and a favorite moment from your holiday!

Housekeeping items

- Please feel free to eat your lunch or step away briefly if needed
- We are recording and can share sessions upon request
  - Each session's slides are available on www.vcuhealth.org/echodmhtn
  - We encourage you to keep your camera on, but if you are uncomfortable being recorded, feel free to turn it off
- Please **do not share any protected health information** in your discussion or the chat
- Project ECHO operates on the "All Teach, All Learn" model
  - Feel free to ask questions in the chat or unmute to ask questions at designated times
  - We're all here to learn from each other and value each person's input and expertise!

What to Expect

I. Didactic Presentations
    I. Teaching Patients Diabetes Self-Management Skills
II. Case presentations
    I. Case 1
        I. Case summary
        II. Clarifying questions
        III. Recommendations
    II. Case 2
        I. Case summary
        II. Clarifying questions
        III. Recommendations
III. Closing and questions

Let's get started!

Didactic Presentation

Disclosures

Trang Le, MD has no financial conflicts of interest to disclose.

Niraj Kothari, MD has no financial conflicts of interest to disclose.

There is no commercial or in-kind support for this activity.

Learning Objectives

- Apply current best practices for comprehensive diabetes and hypertension care to patient case scenarios.
- Recognize best practices for implementing team-based diabetes and hypertension care.
- Demonstrate awareness of opportunities to improve care provided to patients with diabetes and hypertension.

Teaching Patients Diabetes Self-Management Skills

Learning Objectives

- List components of optimal diabetes self-management education and support (DSMES) services
- Define patient centered care
- Develop tools to facilitate shared decision making
- Discuss basic principles of motivational interviewing

5. Facilitating Behavior Change and Well-being to Improve Health Outcomes: *Standards of Medical Care in Diabetes—2021*

Diabetes Care 2021;44(Suppl. 1):S53–S72 | https://doi.org/10.2337/dc21-S005

American Diabetes Association

- DSMES services
- Medical nutrition therapy
- Physical activity
- Smoking cessation
- Psychosocial Care

DSMES services

- facilitate the knowledge, decision-making, and skills mastery necessary for optimal diabetes self-care
- incorporate the needs, goals, and life experiences of the person with diabetes

CDE→CDCES

- The American Association of Diabetes Educators (AADE) is now the Association of Diabetes Care & Education Specialists (ADCES).
- The National Certification Board of Diabetes Care and Education updated its name at the same time, meaning that a certified diabetes educator (CDE) is now called a certified diabetes care and education specialist (CDCES).
- This change aims to increase awareness about the many roles that diabetes care and education specialists (formerly called CDEs) play in providing services to people with diabetes and prediabetes, including direct care, education, prevention, and ongoing support.

DSMES services

- considers the burden of treatment and the patient's level of confidence/self-efficacy for management behaviors as well as the level of social and family support → *patient centered care*

What are the components of patient-centered care?

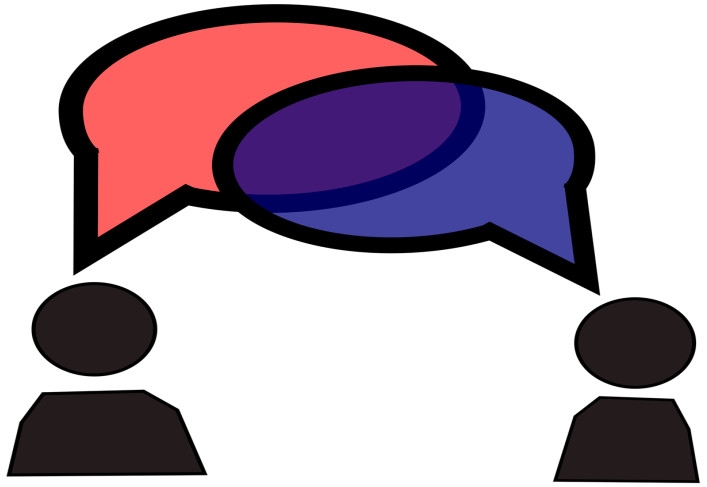
- Respect for patients and their values, preferences, and expressed needs
- Coordinated and integrated care
- Clear, high-quality information and education for the patient and family

→ Facilitates *shared decision making*

From: Gerteis M, Edgman-Levitan S, Daley J, Delbanco T. Through the patient's eyes. San Francisco: Jossey-Bass, 1993.

Shared Decision-Making

- Enables patients to feel empowered to set goals and contribute to developing a treatment plan
- Returns an element of control back to patients that they lost when they were diagnosed with disease
- Increases the chances of successful implementation of the care plan



Words Matter

- "…in response to the growing literature that associates potentially judgmental words with increased feelings of shame and guilt, providers are encouraged to consider the impact that language has on building therapeutic relationships and to choose positive, strength-based words and phrases that put people first"

Diabetes Care 2021;44(Suppl. 1):S53–S72 | https://doi.org/10.2337/dc21-S005

Specifics of applying patient centered care in T2DM:

Challenges for patients with diabetes

- Financial constraints:
  - Insurance coverage and copays
    - Supplies + medications
- Transportation (ability to get to clinic, pharmacy…)

- Environment (safe neighborhoods? food deserts?)
- Health literacy
- Support: how much do patients receive (family, friends, community, work) and how much do patients provide for others who depend on them

Challenges for patients with diabetes

- Cultural background / expectations / attitudes:
  - What foods appeal to the patient? why?

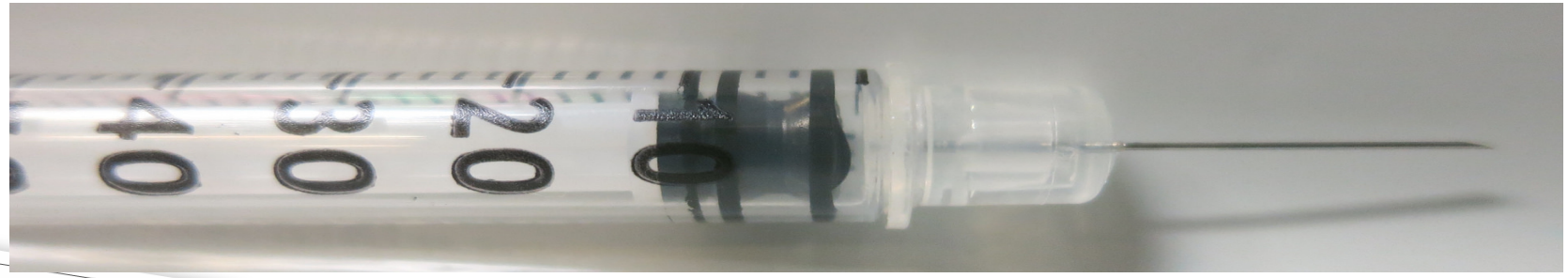
    → *emotional connections between food and the sense of identity are fundamental*
  - How did they grow up?
  - What are the attitudes about injections?
    - "My dad went on insulin, and next thing I knew he was on dialysis."
- Fatalism: "Everybody else in my whole family / my whole community has this and I will end up like them"

Some helpful tips

- During the clinical encounter, the patient's preferred level of involvement should be gauged and therapeutic choices explored
- Ask permission to discuss topics that may be uncomfortable
- Place the burden not just on the patient's level of understanding, but also on how well we as providers did at explaining and educating.

Some helpful phrases

- “We talk about A1c a lot in diabetes. What does that mean to you?”
- “Do you know anybody else who’s been on insulin, and what was that like for them?”
- “Tell me what you understood from everything we discussed today, so that I can see if I did a good job explaining things to you.”

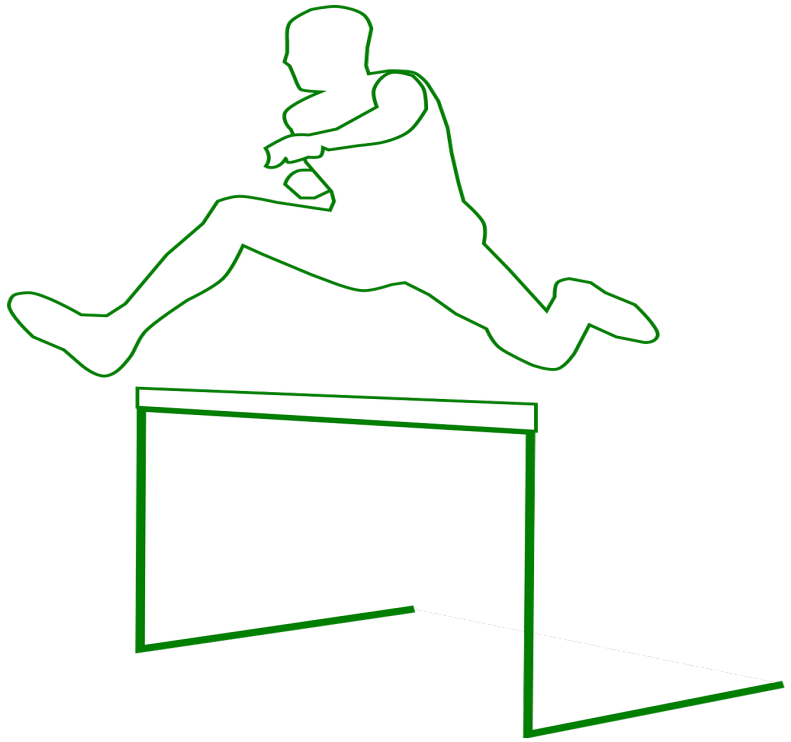


Why are some of these phrases better than others?

- A. Your diabetes is poorly controlled.
- B. Your diabetes is uncontrolled.
- C. Your diabetes is not at your goal.

Why are some of these phrases better than others?

- What is the greatest challenge you face as a diabetic?
- What is the greatest challenge you face as a person who has diabetes?



Why are some of these phrases better than others?

- “Sodas and other sugary drinks are terrible for diabetics”
- “Tell me what you know about how sodas and juice can affect your blood sugars”

Critical time points for evaluating DSMES

- At initial diagnosis
- Annually, and when not meeting treatment targets
- When complications develop that can influence self management
  - mental / physical health conditions
  - social / economic factors
- When life transitions occur

How can I help a patient make meaningful, sustainable changes to self care?

What is Motivational Interviewing (MI) ?

Myth: There is something wrong with the patient who seems unmotivated to change or doesn't follow a provider's recommendations.

Truth: No person is completely unmotivated

What is Motivational Interviewing (MI) ?

MI is NOT:

- tricking people into doing what they don't want to do
- "directive, struggling, telling"

MI IS:

- a style of drawing out a patient's motivations for making changes to improve health
- "collaborative, evocative, honoring of patient autonomy"

The Four Guiding Principles of MI

- Resist the "Righting Reflex"
- Understand Your Patient's Motivations
- Listen to Your Patient
  - Receive as much information as you give
- Empower Your patient
  - Patients who take an active role in determining the care plan are more likely to feel invested and then follow through

From: Rollnick S, Miller W., Butler C.. Motivational Interviewing in Health Care. Guilford Press, 2008.

The Four Guiding Principles of MI:
Resist the Righting Reflex

- We spend years in higher education to help our patients
- The impulse: share all of your hard-earned knowledge and correct "problem behaviors"
  - "You're not checking your blood sugars enough."
  - "Not taking your medications causes diabetes-related complications. "
  - "Starchy foods will worsen your blood sugars."
- Remember: the feeling of being "corrected" can engender resistance

From: Rollnick S, Miller W., Butler C.. Motivational Interviewing in Health Care. Guilford Press, 2008.

The Four Guiding Principles of MI:
Understand Your Patient's Motivations

- Learn about and be genuinely interested in your patient's hopes, fears, and values
- This will help you identify your patient's motivations
- The patient's motivations for change (not the provider's) are the most likely to result in change

From: Rollnick S, Miller W., Butler C.. Motivational Interviewing in Health Care. Guilford Press, 2008.

The Four Guiding Principles of MI:
Listen to your patient

- Receive as much information as you provide
- Take <u>time</u> to listen: think of this an investment – patients perceive that you've spent more time with them than you actually have if they feel that you've put effort into listening to them
- Ask open-ended questions
- Remember: "asking" and "listening" are not the same thing
- *<u>Avoid asking more then 1 question at a time</u>*

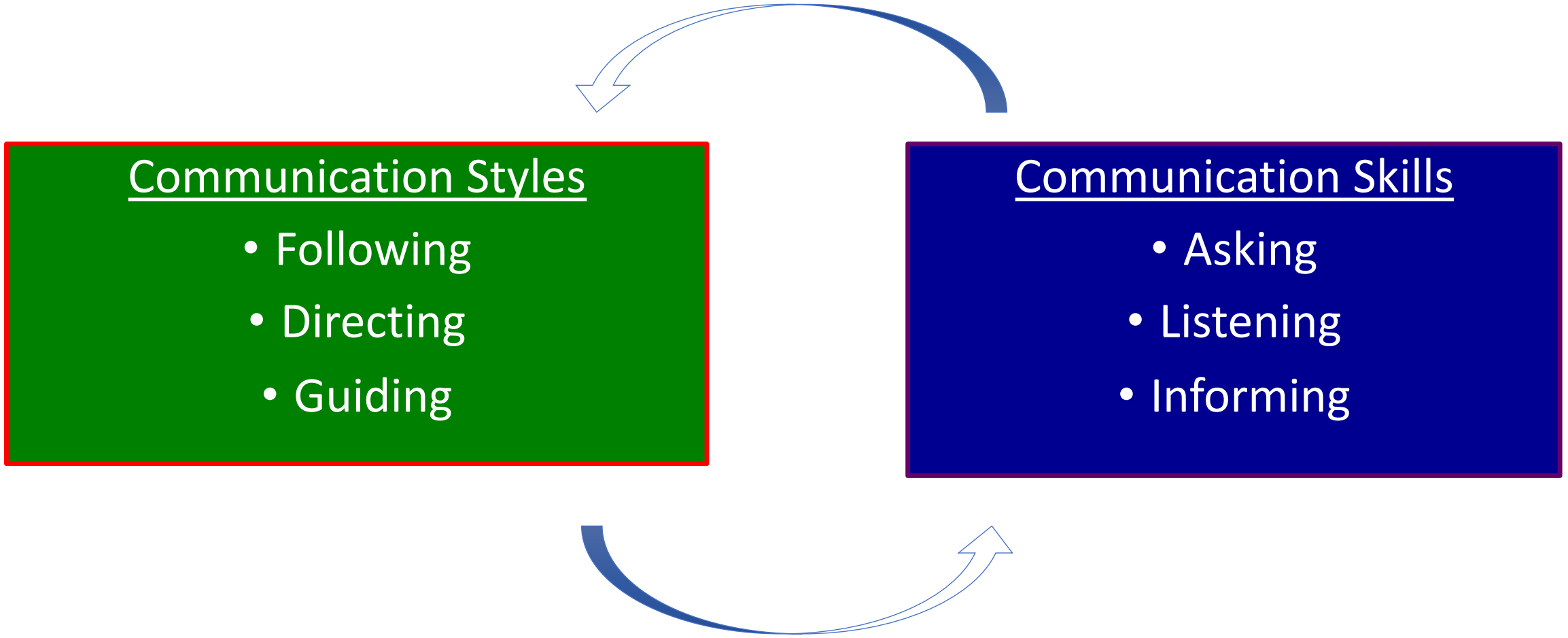
From: Rollnick S, Miller W., Butler C.. Motivational Interviewing in Health Care. Guilford Press, 2008.

The Four Guiding Principles of MI:
Empower your patient

- Patients who are active in determining their care plans are more likely to feel invested and then follow through
- Your patient should get to pick which battles are worth fighting
- They will appreciate that you trusted them to choose what's most manageable for them
- Giving patients back some control will help them feel that they can do better

From: Rollnick S, Miller W., Butler C.. Motivational Interviewing in Health Care. Guilford Press, 2008.

MI is built on a foundation of:

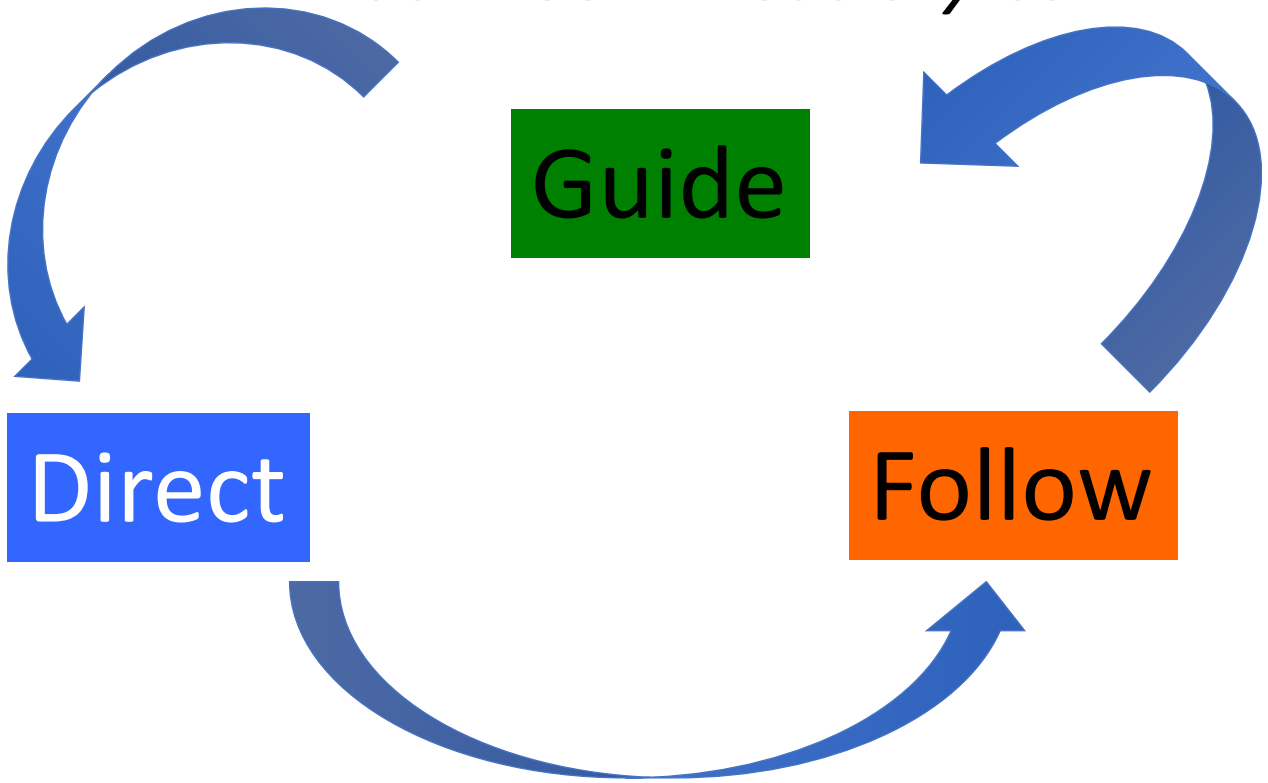


Communication Styles: Following / Directing / Guiding

- Following = listening; a good way to open up an interview
- Directing = provider takes charge in providing information /decision making
  - *Be wary of overuse of directing
- Guiding = helping the patient figure out how to reach the patient's goals

Communication Styles:
Following / Directing / Guiding

Good communication involves the ability to fluidly shift between these styles



Reflection question:

What do you think <u>your</u>
primary communication style is?

Your patient's visit

- How do you usually ask patients about their home blood sugar monitoring?

Your patient's visit:

- A. "How many times a day are you checking your blood sugars?"
- B. "What has your experience been with blood sugar checks?"
- C. "What do you think checking your blood sugars will help you accomplish?"

Categorize these Asking questions as guiding, directing, or following:

- "How many times a day are you checking your blood sugars?" Directing
- "What has your experience been with blood sugar checks?" Following
- "What do you think checking your blood sugars will help you accomplish?" Guiding

Summary

- Optimal diabetes self-management education and support (DSMES) services requires as much effort on support as on education
- Patient centered care enables shared decision making
- Motivational interviewing can be a powerful tool for development of mutually satisfactory plans for meaningful changes in self-care skills

Case presentation #1

- 67 year old gentleman with T2DM x 20 years, with neuropathy and retinopathy, hyperlipidemia, HTN, prior h/o gastric bypass surgery 13 years prior to today's visits
- On insulin prior to gastric bypass surgery, discontinued shortly after surgery, and has been on metformin and glipizide for the last ~ 10 years
- A1c 6.5%→7.4%→8.3% over three visits. Started on Januvia for ~ 6 months and then discontinued due to cost and does not want to resume
- Checks blood glucose 3-4x per week
- Wishes to focus on lifestyle modifications before changing the medication regimen

Case presentation #1

- Returns for follow up 9 months later, A1c 9.6%, able to restart Januvia, → A1c 9.4% → 10.6%→11.3%
- Patient is frustrated as he feels that he has maximized his ability to reasonable restrict carbohydrate intake and increase physical activity
- He does not want to resume insulin
- The Challenge: how to devise a care plan that is acceptable to the patient?

Any clarifying questions?

Any recommendations?

Case presentation #1

- How would you present those recommendations to the patient?

- Summary

Case presentation #2

- 29yo gentleman with T1DM diagnosed at age 11 years, previously followed in pediatric endocrinology until age 16 years and then no specific endocrinology follow up
- Comorbidities: ESRD on dialysis, retinopathy, neuropathy, gastroparesis
- Recently seen in ER for 3rd episode DKA in 6 months
- Diabetes medications: NPH 12 units BID.
- Frequency of glucose monitoring: 1-2x per week, reports hypoglycemia symptoms 3-4x per week

Case presentation #2

Any clarifying questions?

Any recommendations?

- How would you present these recommendations to the patient?

Summary

Case Studies

- Anyone can submit cases: www.vcuhealth.org/echodmhtn
- Receive feedback from participants and content experts
- Earn **$150** for submitting and presenting

Provide Feedback

www.vcuhealth.org/echodmhtn

- Feedback
  - Overall feedback related to session content and flow?
  - Ideas for guest speakers?

Access Your Evaluation

vcuhealth.org/services/telehealth/for-providers/education/diabetes-and-hypertension-project-echo

For Providers

- Education
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  - VCU Health Palliative Care ECHO
  - Virginia Opioid Addiction ECHO
  - Virginia Sickle Cell Disease ECHO

Diabetes and Hypertension Project ECHO

Welcome to the Diabetes and Hypertension Extension for Community Health Outcomes or ECHO, a virtual network of multidisciplinary diabetes and hypertension experts. An ECHO model connects professionals with each other in real-time collaborative virtual sessions on Zoom. Participants present de-identified cases to one another, share resources, connect to each other, and grow in their expertise. This ECHO will address practice level issues and solutions related to managing complex patients with difficult to control diabetes and hypertension. Register now for an ECHO Session!

Network, Participate and Present

- Engage in a collaborative community with your peers.
- Listen, learn and discuss informational and case presentations in real-time.
- Take the opportunity to submit your de-identified case study for feedback from a team of specialists for diabetes and hypertension.
- Provide valuable feedback.
- Claim CE credit by texting in attendance.

Benefits

VCU Diabetes & Hypertension Project ECHO Clinics

2nd and 4th Thursdays — 12-1:30 p.m.

Mark Your Calendars — Upcoming Sessions

Jan. 28: Chronic Kidney Disease

Feb. 11: Selection of Basal Insulin Regimens

Feb. 25: Secondary Hypertension

Please register at www.vcuhealth.org/echodmhtn

THANK YOU!

Or text **19144-18817** to **804-625-4041**

Reminder: Mute and Unmute to talk
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Use chat function for questions