Impacting Diabetes Outcomes Through Lifestyle Medicine, Standardized Documentation, and Interdisciplinary Care

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Background

- Type 2 diabetes mellitus (T2DM) prevalence continues to rise in the United States and poses significant challenges for quality of life[1].
- Effective management requires a comprehensive approach that includes standardized care documentation and multidisciplinary team collaboration.[1]
- Multidisciplinary team-based care models demonstrate positive diabetes outcomes in FQHCs (Federally Qualified Health Centers).[2]
- This study evaluates the impact of implementing a standardized diabetic care protocol, incorporating the six pillars of lifestyle medicine and motivational interviewing (MI) delivered with interdisciplinary teams in a Federally Qualified Health Center (FQHC).

Smart Aim

- Create a standardized diabetic dot phrase for comprehensive, team-based care for patients with uncontrolled T2DM by addressing the six pillars of Lifestyle Medicine via motivational interviewing and referrals to resources with Behavioral Health Consultants in one year.

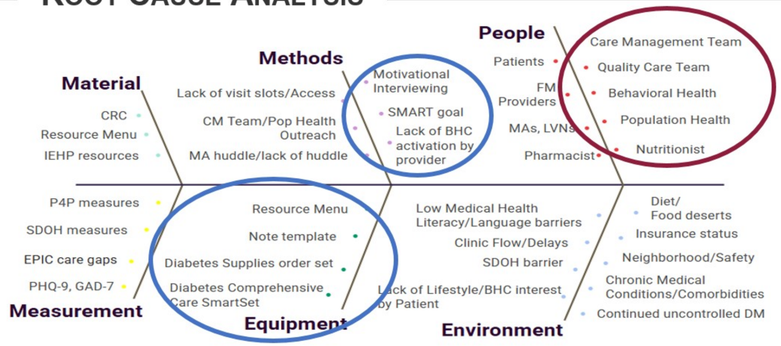
Methods

Two team-based quality improvement projects within Plan-Do-Study-Act (PDSA) cycles were conducted at urban an FQHC in a high-demand, high-need area of southern California.

1. PDSA Cycle 1 July – December 2024. Utilize a standardized note template to capture comprehensive diabetic histories and provide shared decision making with a Diabetes Care Menu encompassing services aligned with the six pillars of lifestyle medicine.

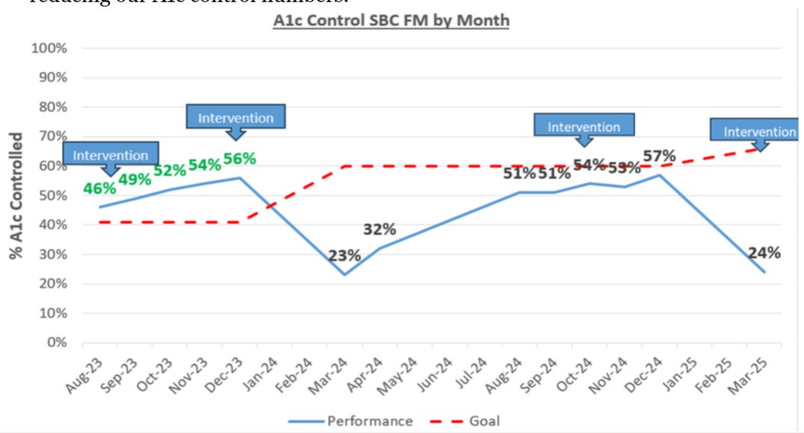
2. PDSA Cycle 2 December 2024 – April 2025. Implement a team-based care model with Integrated Behavioral Health Consultants to help patients choose options on the Diabetes Care Menu via warm handoffs to take control of their health.

Root Cause Analysis



Results

- Residents agreed a diabetes note template of key history and management improved efficiency of a diabetes visit. Residents strongly agreed that a consolidation of resources for diabetes would improve patients' self-management.
- Following PDSA Cycle 1, there was an increase in A1c control (A1c <8) from 32% to 54%
- Following Cycle 2, the diabetes care menu distribution and utilization increased, and there was an increase in warm handoffs of patients with diabetes to BHCs. However, the IEHP measure changed by removing all patients on a GLP-1 for weight loss reducing our A1c control numbers.



Interventions

Comprehensive Diabetes Visit Note

Last A1c: ***
Home Blood Sugars: ***
Denies increased thirst, increased urination, increased hunger, or unintentional weight loss***.
Denies headache, lightheadedness, confusion, palpitations, sweating, hunger, weakness, tingling or numbness***.

HTN/CKD/HF: ***
DM Meds: ***
Adherence to DM Meds: {Yes/No:20467}***
Statin: {Yes/No:20467}***

Last Urine microalbumin: ***
Last Diabetic Eye Exam: ***
Last Foot Exam/Concerns with Feet: ***

{TIP- HAVE BHC SEE PATIENT TO COMPLETE BELOW :29942}
SDOH reviewed:
Diet:
Exercise:
Substance Use:
Mood/Stress:
Sleep:
Social connection:
Stage of Change:
SMART goal:

Diabetes Care Menu

Medication/Stress Management
☐ Pharmacist*
☐ Behavioral Health Team*
☐ IEHP Community Wellness Center
☐ Virtual Diabetes Education Class*

Substance Use
☐ Behavioral Health Team*
☐ MAT/Addiction Clinic *
☐ Celebrate Recovery
☐ IEHP Community Wellness Center

Physical Activity
☐ IEHP Community Wellness Center
☐ Lifestyle Medicine Clinic*

*Place order in Epic.
For other resources, use FMDMAWSM

Nutrition
☐ Week on Wic Recipes
☐ Community Food Distribution @ SBC, Norton
☐ Fresh Produce Distribution @ Norton
☐ Dietician/Nutritionist*
☐ IEHP Community Wellness Center
☐ Lifestyle Medicine Clinic*

Sleep
☐ Lifestyle Medicine Clinic*
☐ Behavioral Health Team*

Social Connections
☐ Behavioral Health Team*
☐ IEHP Community Wellness Center

Conclusions

- Standardized documentation and team-based care models can significantly improve management and outcomes.
- Enhancing diabetes education and leveraging an interdisciplinary approach can lead to sustainable improvements in diabetes care and self-management.
- Future initiatives will focus on expanding resources and access to care.

References

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2. Saiyed M, Woodard LD, Williams B, Holmes HM. Impact of a multi-disciplinary team-based care model for patients with diabetes in a safety-net healthcare setting. *BMC Health Serv Res*. 2024; 24:11062. doi:10.1186/s12913-024-11062-4.
3. Funnell MM, Anderson RM. Empowerment and self-management of diabetes. *Diabetes Educ*. 2021;47(2):127-143. doi:10.1177/0145721720930959.

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