Interprofessional Team Management: Partnering to Optimize Outcomes in Type 2 Diabetes Patients

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Background

- Healthcare delivery requires re-engineering to effectively care for chronically ill, medically-complex adults
  - Half of Medicare's cost are consumed by 5% of recipients
  - Chronic conditions, such as diabetes, account for 66% of health care expenditures
  - Diabetes affects 1 in 5 over age 65
  - Exacerbations & associated complications cause significant financial & human cost
- IOM endorses interprofessional team-based care
- NPs are well positioned to influence cost effective, value-driven care
- NP-led team huddles direct effective care coordination & management
- Healthcare systems are vulnerable due to:
  - Financial responsibility for care outcomes & patient satisfaction
  - An aging population with chronic disease
  - Managing care delivery & associated costs
  - Ongoing healthcare reform

Project Objective

Explore impact of NP-led interprofessional care management on:

- Health-related quality of life (Hr-QOL)
- Self-care behaviors (SCBs)
- Physiological outcomes: BMI, A1C, BP, lipids
- Utilization of emergent & acute services
- Costs of care

Methodology

- Pre/post test design
- Convenience sample (N=52)

Qualitative data collected pre/post team care

- Medical Outcomes Health Survey evaluated Hr-QOL
- Self-Care Inventory-Revised evaluated self-care behaviors

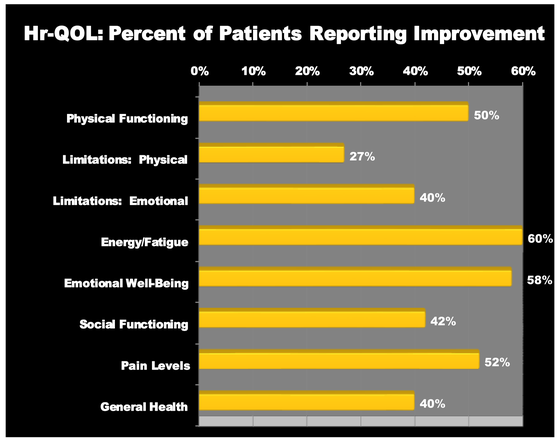
Quantitative data collected pre/post team care

- Physiological indicators: BMI, A1C, BP, LDL, Triglycerides
- Utilization
- Costs of care

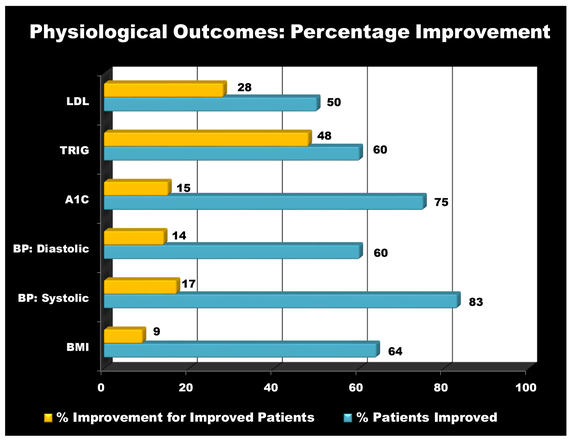
The Interprofessional Team

- Internist/Geriatrician, FNP/GNP, RN case managers, PharmD, MSWs, LCSWs, MAs, Nurse Educator, Palliative/Hospice RN
- Enables accessible, equitable, evidence based patient-centered care
- Empowers patients through shared decision making
- Assesses physical, psychosocial, fiscal & educational needs
- Counsels, coaches, & reinforces appropriate self-care

Health-related Quality of Life



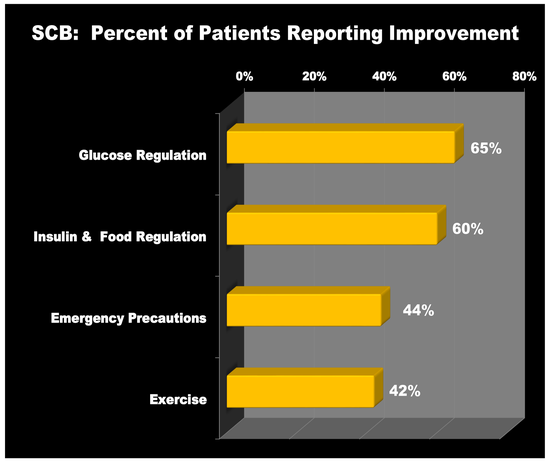
Physiological Outcomes



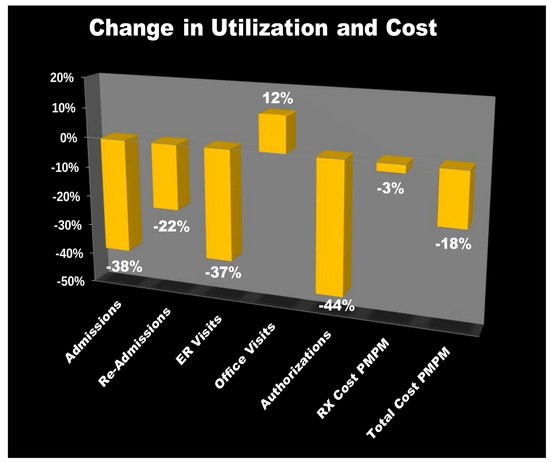
Practice Implications for NPs

- Ongoing advocacy of NP role optimization & education of stakeholders
- Continued inclusion of NPs as core members in planning/ implementation of innovative, effective care models
- Consistent validation of NP outcomes to substantiate delivery of quality, competent, cost effective chronic disease management

Self-care Behaviors



Utilization Care Costs



Conclusions

- **NPs** significantly impact care management & outcomes
- **Hr-QOL**: 90% reported improvement in 2 or more categories
- **Self-Care**: 60% reported enhanced glucose, food, & insulin regulation
- **BMI**: reduction observed in 64% of participants
- **A1C**: improvement in baseline noted in 75% of patients
- **Reductions:** admissions 38%, readmissions 22%, ED visits 37%
- **Patient satisfaction**: 4.7 out of 5.0 per Likert scale