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MULTIDISCIPLINARY TEAM APPROACH

Women with pre-existing and gestational diabetes mellitus (GDM) have special needs throughout the perinatal period. The objective of the Sweet Success program is to assess these needs and provide health and nutrition education and psychosocial consultation consistent with the assessment.

This objective is best accomplished using a multidisciplinary team approach to provide care for a pregnant woman (1, 2, 3, 4). The team can be comprised of various health care professionals, depending on the health care setting, and can include physicians, nurse educators, nurse practitioners, certified nurse midwives, health educators, physician assistants, behavioral medicine specialists (social workers, marriage/family therapists, clinical psychologists), registered dietitians, and medical assistants. The roles of these team members may overlap in some cases, but all team members work closely with the woman throughout the pregnancy. Team members need to have established dynamic relationships to facilitate ongoing communication about a woman's needs and any changes in risk factors. With evolving and current communication in place, their common goal of addressing a woman's needs and facilitating an optimum outcome is more likely to be met.

The California Diabetes and Pregnancy Program (CDAPP) recommends that all affiliates strive to meet the National Standards for Diabetes Self-Management Education (DSME) (5). The Standards are:

1. The DSME entity will have documentation of its organizational structure, mission statement, and goals and will recognize and support quality DSME as an integral component of diabetes care.
2. The DSME entity shall appoint an advisory group to promote quality. This group shall include representatives from the health professions, people with diabetes, the community, and other stakeholders.
3. The DSME entity determine the diabetes educational needs of the target population(s) and identify resources necessary to meet these needs.
4. A coordinator will be designated to oversee the planning, implementation, and evaluation of diabetes self management education. The coordinator will have academic and/or experiential preparation in chronic disease care and education and in program management.

5. DSME will be provided by one or more instructors. The instructors will have recent educational and experiential preparation in education and diabetes management or will be a certified diabetes educator. The instructor(s) will obtain regular continuing education in the field of diabetes management and education. At least one of the instructors will be a registered nurse, dietician, or pharmacist. A mechanism must be in place to ensure that the participant's needs are met if those needs are outside the instructor's scope of practice and expertise.
6. A written curriculum reflecting current evidence and practice guidelines, with criteria for evaluation outcomes, will serve as the framework for the DSME entity. Assessed needs of the individual with pre-diabetes and diabetes will determine which of the content areas listed below are to be provided.
 - ❖ Describing the diabetes disease process and treatment options
 - ❖ Incorporating nutritional management into lifestyle
 - ❖ Incorporating physical activity into lifestyle
 - ❖ Using medication(s) safely and for maximum therapeutic effectiveness
 - ❖ Monitoring blood glucose and other parameters and interpreting and using the results for self-management decision making
 - ❖ Preventing, detecting, and treating acute complications.
 - ❖ Preventing, detecting, and treating chronic complications.
 - ❖ Developing personal strategies to address psychosocial issues and concerns
 - ❖ Developing personal strategies to promote health and behavior change.
8. An individual assessment and educational plan will be developed collaboratively by the participant and instructor(s) to direct the selection of appropriate educational interventions and self-management support strategies. This assessment and education plan will be documented in the education record.
9. A personalized follow-up plan for ongoing self-management support will be developed collaboratively by the participant and instructor(s). The patient's outcomes and goals and the plan for ongoing self-management support will be communicated to the referring provider.
10. The DSME entity will measure attainment of patient-defined goals and patient outcomes at regular intervals using appropriate measurement techniques to evaluate the effectiveness of the educational intervention.

11. The DSME entity will measure the effectiveness of the educational process and determine opportunities for improvement using a written continuous quality improvement plan that describes and documents a systematic review of the entities' process and outcome data.

These standards represent goals to which all affiliates should aspire. Most affiliates already meet many of these standards. Adherence to these standards will help assure a high quality diabetes self-management education program. Each team member contributes to the overall management of the woman with pre-existing diabetes or GDM during preconception, pregnancy, postpartum, and interconception. Table 1 summarizes various team members' roles and their contribution to diabetes and pregnancy care.

All clinical team members must have attended formal Sweet Success diabetes and pregnancy affiliate training sessions. They need a thorough understanding of the physiology and management of pregnancies complicated by diabetes as well as experience in educating women about diabetes related issues.

The team coordinates care and education for the woman with pre-existing diabetes or GDM during preconception, pregnancy, postpartum and interconception. Throughout the perinatal period, the woman with diabetes meets with various team members for medical care and/or diabetes self-management education. Each team member reinforces and evaluates the woman's application of the self-management instructions she has received. These instructions are the basis for skills/competencies a woman uses to successfully manage her own care.

The multidisciplinary team works together to provide integrated care within these nine areas (3):

- ❖ Preconception Counseling
- ❖ Medical Management/Nursing intervention
- ❖ Nutrition
- ❖ Psychosocial Adjustment
- ❖ Exercise
- ❖ Newborn Care
- ❖ Postpartum Care
- ❖ Breastfeeding
- ❖ Contraception

Specific instructions for each specialty area are described in the following chapters of these Guidelines for Care.

Table 1. ROLE OF TEAM MEMBERS	
Woman	The woman has an active role as a member of the management team. She is ultimately responsible for ongoing nutritional management, and self-monitoring of her blood glucose as well as keeping herself physically and mentally fit through exercise and stress management.
Physician	Physicians monitor maternal and fetal progress during the perinatal period. They direct the referral to multidisciplinary team members and additional specialists as needed.
Nurse Educator	Nurse Educators, who specialize in diabetes and perinatal care, assess, plan, instruct, evaluate, and coordinate a woman's progress toward optimal self-management and perinatal outcomes.
Registered Dietitian	Registered Dietitians (RD), with specialized training in perinatal nutrition and diabetes, assess, evaluate, and provide ongoing individualized Medical Nutrition Therapy (MNT) to promote adequate nutritional intake and normoglycemia for a woman who is preconception, postpartum, or is pregnant and has diabetes.
Behavioral Medicine Specialist	Behavioral Medicine Specialists (Social Worker, Marriage/Family Therapist, Clinical Psychologist) assess the woman's strengths, abilities, assets, psychosocial needs and identify any psychosocial risks, problems or barriers that may impede an emotionally and physically healthy pregnancy.
Health Educator	Health educators provide health education and case coordination to a pregnant woman with diabetes including an overview of diabetes and pregnancy, instruction on how to implement the required medical management and how to improve blood glucose control.
Advanced Practice Nurse	Advanced Practice Nurses (Clinical Nurse Specialists, Nurse Practitioners, Certified Nurse Midwives) are involved with planning, managing, and assisting with the obstetric care of a low risk woman with diabetes throughout the maternity cycle.
Physician Assistant	Physician assistants work under the supervision of a physician perform other special services required during a pregnancy complicated by diabetes.
Medical Assistant	Medical assistants work under the supervision of a physician and perform basic technical, education, administrative and clerical support services related to diabetes and pregnancy.
Specialists	If a complication arises, a woman may be referred to an endocrinologist and/or perinatologist, cardiologist, ophthalmologist, nephrologist, and/or other related specialist.

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