Care Coordination at UNC Health Care
Jennifer Lord, Medical Home Project Manager
UNC Practice Quality and Innovation

Enhanced Care Disease Management
in UNC’s Internal Medicine Clinic

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Brief history of our practice

Late 1990’s: traditional practice, added mid-level providers

Early 2000’s: developed population care capability and evidence-based algorithms, proof of concept, rigorous evaluation

Mid-2000’s: solidified care assistant role, began to integrate throughout the practice

Late 2000’s: focus on the model for improvement, efficiency and spread, added decision support, additional extenders
Care philosophy today

Key elements

- Patient engagement
- ‘Universal precautions’ for low literacy
- Multidisciplinary teams
- Population-level data
- Evidence-based care algorithms
- Continuous improvement, guided by data
- Decision support
- Proactive care coordination

Accreditations

- NCQA Level 3 PCMH
- NCQA Diabetes Recognition
- ADA-Approved Diabetes Self-Management Class

Results

Today: Large academic practice with a multi-disciplinary team

### Practice staff

- 125 - Physicians (part-time)
  - 25 - Attendings
  - 100 - Residents
- 12 - Nurses
  - 1 - RN/Manager
  - 8 - LPNs
  - 3 - CNAs
  - 1 - MOA
- 18 Administrative staff
  - 9 - front-desk/registration staff
  - 3 - dedicated schedulers
  - 2 - referral coordinators
    (1 specialty, 1 ancillary)

### Program staff

- 3 - pharmacist practitioners
- 2 - physician assistants
- 1 - nurse practitioner
- 1 - registered dietitian
- 1 - social worker
- 3 - care assistants
- 1 - QI manager
- 1 - programmer
- 2 - administrative assistants

2/23/2011
Our patients: Top 10 diagnoses

1. Hypertension (2517)
2. Diabetes (1358)
3. Hypercholesterolemia (913)
4. Back Pain (508)
5. Depression (446)
6. Limb Soft Tissue Pain (423)
7. Coronary Artery Disease (327)
8. Abdominal Pain (286)
9. Hypothyroidism (282)
10. Esophageal Reflux (248)

Q1 FY09
Our patients: Key characteristics

**Gender**
- Female: 64.7%
- Male: 35.3%

**Age**
- Range: 18-88 / Mean: 58.2 / SD: 13.9
- 18-40: 9.6%
- 41-64: 33.2%
- 65+: 57.2%

**Ethnicity**
- Caucasian: 58.4%
- African-American: 29.6%
- Latino: 4.8%
- Asian: 1.0%
- Other: 6.3%

**Education**
- 8th Grade or Less: 6.4%
- Some High School: 14.4%
- HS Grad or GED: 21.9%
- Some College or Deg: 23.3%
- College Grad: 15.0%
- > College Grad: 18.8%

**Income**
- < $15K: 37%
- $15-25K: 29%
- $25-35K: 11%
- > $35K: 21%
- N/A: 2%

**Vital Statistics**
- Avg SBP: 128.55 / Avg DBP: 75.44
- SBP > 160: 6.05%
- DBP > 90: 9.06%
- Smoker: 10.82%

**Technology Use**
- DVD Owners: 86.6%
- VHS Owners: 81.3%
- Cell Phone Users: 76.5%
- Text Msg Users: 22.8%
- Internet Access: 69.7%
- Internet Users: 65.7%
- Email Users: 56.1%

Q1 FY09
Our patients: Where they come from

UNC Internal Medicine Clinic: Patients 2001-2002

Patients from North Carolina ZIP Codes
(93 Out of State Patients)

- 500 to 1,800 (5)
- 100 to 500 (12)
- 25 to 100 (42)
- 10 to 25 (65)
- 0 to 10 (260)

Produced by: Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.
Our current ‘Enhanced Care’ programs

<table>
<thead>
<tr>
<th>Active management</th>
<th>Surveillance and prompting</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>Heart disease</td>
</tr>
<tr>
<td>Anticoagulation</td>
<td>Colon cancer</td>
</tr>
<tr>
<td>Chronic pain</td>
<td>Cervical cancer</td>
</tr>
<tr>
<td>Depression</td>
<td>?Transitions</td>
</tr>
<tr>
<td>Decision support</td>
<td></td>
</tr>
</tbody>
</table>

All programs grounded in quality improvement efforts

Link to more information: [http://www.med.unc.edu/im/staff/clinic/programs](http://www.med.unc.edu/im/staff/clinic/programs)
Practice patient breakdown:
Every patient receives ‘enhanced care’

FY10 Annual Visit Volume: 41,404
(3215 New / 38,189 Return)

10,056 unique, active patients

2458 Diabetes
692 Coag or Pain
6906 Surveillance
What we learned from the early years

A successful program must include:

- Consensus backed by evidence-based algorithms
- A multidisciplinary team
- Care coordination and management
- A registry with decision support for proactive care
- Reporting, reporting, reporting

Persistence and leadership are key

 Appropriately designed interventions or systems can overcome patient vulnerability

Continual evolution, change is necessary, an opportunity

- Embrace rapid cycle change and the MFI
What we learned from the early years

A successful program must include:

- Consensus backed by evidence-based algorithms
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Persistence and leadership are key

 Appropriately designed interventions or systems can overcome patient vulnerability

Continual evolution, change is necessary, an opportunity

- Embrace rapid cycle change and the MFI
Lessons learned

- A registry with decision support for proactive care
Advanced, integrated registry
Lessons learned

- Consensus backed by evidence-based algorithms
Evidence-based algorithms

Our algorithms are:
- Evidence based
- Consensus driven

Algorithms
- Standardize care
- Set expectations
- Facilitate reporting/improvement
- Enable optimization of the care team

For more information:

www.med.unc.edu/im/staff/clinic/programs/diabetes/protocols
Lessons learned

- A multidisciplinary team
- Care coordination and management
Care Assistant (CA) position

Our multidisciplinary programs are anchored by ‘care assistants’

- Graduates considering application to medical school, social work, and/or physician assistant programs
- Full-time employees who participate in direct patient care, program support, and quality improvement work
  - Diabetes Program Care Assistant
  - Chronic Pain Program Care Assistant
    - Depression
  - Transitions care

Link to more information
www.med.unc.edu/im/staff/enhanced-care-programs/CA
The CA role: Diabetes example

Implement Enhanced Care evidence-based algorithms to direct care:

- regular phone calls to patients for reinforcement and intervention
- education, instruction (i.e., glucometer, injections)
- assessment of adherence and progress
- symptom assessment
- patient oriented problem solving
- Patient liaison between clinicians and staff
- medication management (with extender support)
- depression screening follow-up
- smoking cessation counseling
Lessons learned

- Proactive care
- Evolution, change is necessary
## Our own evolution- pre-visit, out of clinic

<table>
<thead>
<tr>
<th>Interest in doing online:</th>
<th>Internet Users n = 122</th>
<th>Non-Users n = 65</th>
<th>All n = 187</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receiving health information from the clinic</td>
<td>87%</td>
<td>40%</td>
<td>71%</td>
</tr>
<tr>
<td>Asking PCP questions between visits</td>
<td>87%</td>
<td>37%</td>
<td>70%</td>
</tr>
<tr>
<td>Receiving messages from the clinic</td>
<td>88%</td>
<td>40%</td>
<td>71%</td>
</tr>
<tr>
<td>Providing information about medical problems before a visit</td>
<td>88%</td>
<td>40%</td>
<td>71%</td>
</tr>
<tr>
<td>Discussing medical problems with other patients</td>
<td>55%</td>
<td>26%</td>
<td>45%</td>
</tr>
</tbody>
</table>
Surveys and education driven by IT and decision support

Algorithms drive survey delivery

- Patient identification through diagnosis codes
- Demographics
- Branching logic within surveys
- Eligibility

Data from patients to drive the system

- Patient specific decision aid delivery
- Drives care at point of service
Welcome
This is the Internal Medicine Clinic's Patient Health Summary. There are some questions we'd like you to answer.

The information that you give us here will:

- Help your doctor know how you feel right now and what has been going on since the last time you spoke
- Help you get the most out of the time with your doctor by providing you with health information on things that are important to you.

To Do Now

Please click on the clipboard to complete your patient health survey.
This survey will ask you a few quick questions about how you are feeling right now and about what has been going on since the last time you talked to your doctor.

Other Information You Might Find Interesting

Living Better with Chronic Pain
This program presents information for patients living with chronic pain.
In general, would you say your health is:

- Excellent
- Very Good
- Good
- Fair
- Poor

PREVIOUS QUESTION NEXT QUESTION QUIT
Our records show that you have not seen this video yet. Please press play to start it.

0:43 / 44:14

Rewind  Play  Pause  Stop  Fast

Finished Movie

©2008 UNC Internal Medicine and the UNC Center for Decision Quality
FINAL REPORT

PREVIOUS SCREENING AND PATIENT REPORTED SYMPTOMS
~Patient Reported Information - collected on: 03/29/2010~

PATIENT REPORTED GENERAL HEALTH STATUS: Excellent
Health Summary Completed by: PATIENT

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Decision</th>
<th>Support</th>
<th>Eligible*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hip Pain</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knee Pain</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>X</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

PATIENT REPORTED SCREENING:
Patient DENIES personal history of COLON CANCER

<table>
<thead>
<tr>
<th>Screening</th>
<th>Date Support</th>
<th>Eligible*</th>
</tr>
</thead>
<tbody>
<tr>
<td>COLON CANCER</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Patient accepted decision support material for this topic
VIEWING REPORT: Once the patient has completed the decision support material, a report will be sent

Electronically signed on 03/29/2010 by CRISTIN COLFORD
Lessons learned

- A multidisciplinary team
- Care coordination and management
- A registry with decision support for proactive care
The Visit Planner 5.0

- Introduced in 2008
- Pivotal to planned care approach
- Specific prompts to assess needs
- Coordinate/identify team roles throughout the visit
- Spread interventions among a larger team
- Improve patient care
- Help patients access clinic services

www.med.unc.edu/im/staff/clinic/programs/diabetes/Tools
Front Desk Staff Prompts

<table>
<thead>
<tr>
<th>Late Arrival:</th>
<th>1=15-29 mins, 2=30+ mins</th>
</tr>
</thead>
<tbody>
<tr>
<td>Order POC A1c</td>
<td></td>
</tr>
<tr>
<td>Order Total Cholesterol/HDL/TG/dLDL</td>
<td></td>
</tr>
</tbody>
</table>

**REASON POC LABS NOT ORDERED**

- R=patient refused
- L=patient was late
- B=lab backup

<table>
<thead>
<tr>
<th>Staff Initials:</th>
</tr>
</thead>
</table>

**1. PBA: % POC A1csOrdered when Prompted**

<table>
<thead>
<tr>
<th>Percent Complete</th>
<th>Opportunities</th>
<th>% Complete</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**2. PBA: % POC Lipids Ordered When Prompted**

<table>
<thead>
<tr>
<th>Percent Complete</th>
<th>Opportunities</th>
<th>% Complete</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Nursing Prompts

--- No prompts indicated today ---

## Nursing Staff Responsibilities

<table>
<thead>
<tr>
<th>Prompt</th>
<th>Response Options</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pneumovax Indicated</strong></td>
<td>Yes/No</td>
</tr>
<tr>
<td>Patient had previous pneumovax? Yes/No</td>
<td></td>
</tr>
<tr>
<td>If no, given today?</td>
<td></td>
</tr>
<tr>
<td>If not given today, was pneumovax refused?</td>
<td></td>
</tr>
<tr>
<td>If not given today, was pneumovax delayed until next visit?</td>
<td></td>
</tr>
<tr>
<td>If not given today, was it contraindicated?</td>
<td></td>
</tr>
<tr>
<td><strong>Patient Education Indicated</strong></td>
<td>Yes/No</td>
</tr>
<tr>
<td>* Nurse, ON COMPUTER please open IMC PATIENT EDUCATION link in Internet Explorer FAVORITES MENU. *</td>
<td></td>
</tr>
<tr>
<td>* Call Chris or Leslie on the walkie or at 6-0106 with problems. *</td>
<td></td>
</tr>
<tr>
<td>Did you open the website?</td>
<td></td>
</tr>
<tr>
<td>R=patient refused, I=interrupted by provider, T=technical issue, H=higher priorities</td>
<td></td>
</tr>
<tr>
<td><strong>DV Screen Indicated</strong></td>
<td>Yes/No</td>
</tr>
<tr>
<td>Do you feel unsafe in your current relationship?</td>
<td></td>
</tr>
<tr>
<td>In the past year, has your partner hit, kicked or otherwise hurt or threatened you?</td>
<td></td>
</tr>
<tr>
<td>If any answer is 'Yes', contact Beacon Program. Beacon Program contacted?</td>
<td></td>
</tr>
<tr>
<td>If any answer is 'Yes', notify provider. Provider notified?</td>
<td></td>
</tr>
<tr>
<td>Unable to screen * R=pt refuse, N=not in relationship, S=setting inappropriate *</td>
<td></td>
</tr>
</tbody>
</table>

--- Reason Prompts Not Completed ---

* Patient refused. I=interrupted by provider. T=technical issue. H=higher priorities *

**Nurse Initials:**
VP prompt response - nurse
**Provider Prompts**

<table>
<thead>
<tr>
<th>Provider Responsibilities</th>
<th>Provider Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TChol:</strong> 263 2/1/2010</td>
<td><strong>Vital Date:</strong> 5/10/2010</td>
</tr>
<tr>
<td><strong>HDL:</strong> 74 2/1/2010</td>
<td><strong>SBP:</strong> 103</td>
</tr>
<tr>
<td><strong>LDL:</strong> 164 2/1/2010</td>
<td><strong>DBP:</strong> 68</td>
</tr>
<tr>
<td><strong>TG:</strong> 124 2/1/2010</td>
<td><strong>WT:</strong> 62.01</td>
</tr>
<tr>
<td><strong>A1c:</strong> 5.4 10/10/2009</td>
<td><strong>PHQ Date:</strong></td>
</tr>
<tr>
<td><strong>Micral:</strong></td>
<td><strong>PHQ:</strong></td>
</tr>
</tbody>
</table>

---

**Disease state(s) driving prompts:**

Heart Disease

**Other issues not prompted today:**

---

**Comments:**

---

**Provider Responsibilities**

**Depression Screening, Review PHQ Results**

* If PHQ2 >=3 patient may be depressed, PHQ9 needed. *

**Antithrombotic Indicated**

* Aspirin, aggrenox, plavix or Coumadin not in med list. *

---

Return ALL forms to the front desk
VP prompt response - provider

11. Provider: % All Prompts Started

12. Provider: % Depression Prompts (VP front) Started

13. Provider: % Cessation Counseling Prompts Started

14. Provider: % Contraceptive Education
Examples of other quality reporting

Aim: The aim of this project is to improve the care we provide by continually assessing key measures of diabetes care, care processes, and the impact of comorbid conditions on glycemic control, cardiovascular risk, and complications from diabetes. As a team, we will utilize this data to identify areas to improve upon, focus on barriers to optimal care, and evaluate the level of care we are providing.

---Key Work/Findings---

Revision of Runchart Data: This month, A1c was a bit higher, however other measures for A1c, BP, and LDL/HDL are fairly consistent. As expected, the Enhanced Care measures (depression screening, pulmonary, foot exams) moved in positive directions due to previously unknown, well-controlled diabetes patients being added to the diabetes registry who are now being provided with additional disease state monitoring.

Patient Follow-up: Care Assistants report that continuity of care has improved. As expected, visit data shows that the number of patient visits has increased as has the number of skipped clinic visits. The skip visit increase is due mostly to the increase in well-controlled patients added last month. CA-Provider visits for red zone patients and new diagnoses are still plentiful as these patients benefit most from the face-to-face case management services. In coming months, we should be able to report data on patient interactions by Care Assistant panel.

Current Staffing/FTE: Mid-level providers 0.7, RN 0.25, LCSW 0.5, Program Coordinator 0.25, Database Programmer 0.5, Admin Asst 0.5, Care Assistants 2.5, QI Coordinator 0.25

<table>
<thead>
<tr>
<th>Topic</th>
<th>Intervention/Change</th>
<th>Status</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspirin Utilization</td>
<td>Project complete. Cleared for publication by IRB.</td>
<td>Final data: 80% patients were contacted for follow up after receiving ASA letter. 40% started ASA due to letter.</td>
<td>Will run query every 6 months to find patients not on ASA and complete letter campaign. Will work on publication.</td>
</tr>
<tr>
<td>Statin Utilization/Email alerts</td>
<td>Will resume email alerts in August.</td>
<td>On hold.</td>
<td>Resume after transplant division meeting 7/15/08.</td>
</tr>
<tr>
<td>POC Testing</td>
<td>Have front desk staff identify patients for testing from patient yellow sheet stopped to encounter form instead of POC list.</td>
<td>Before intervention: 56% A1c, 66% cholesterol. After intervention: 56.4% A1c, 71% cholesterol</td>
<td>Majority of missed tests due to missed ordering at front desk. Staff reported that new method was easier than POC list.</td>
</tr>
<tr>
<td>Statin Medication Utilization/Decision Making</td>
<td>Launched survey to get provider opinions about initiating statins.</td>
<td>Presented current data on patients not taking statins as well as survey results to get division consensus.</td>
<td>Rob to discuss cases at attendings. Resume alert emails. Address non-tasting LDL testing possibilities.</td>
</tr>
<tr>
<td>Nurse Diabetes Tasks (Monofilament &amp; Smoking Advice)</td>
<td>Continue to track rates of completion based on opportunities.</td>
<td>Monofilament completion rates ranged from 53% to 89% with an average of 78%. Smoking advice was 74%.</td>
<td>Monofilament compliance was similar to June. Smoking advice decreased compared to June (33%).</td>
</tr>
<tr>
<td>Nurse - Diabetes CA Follow up (PHQ &amp; cessation counseling)</td>
<td>Continue tracking completion rates for CA follow up when indicated.</td>
<td>PHQ2 fx decreased to 53% (of 17) and cessation fx decreased to 53% (of 17).</td>
<td>CA follow up rates decreased this month. PHQ fx dropped from 83% to 53%. Cessation fx from 100% to 53%.</td>
</tr>
</tbody>
</table>

NCQA Diabetes Physician® Recognition Program Application Readiness

NCQA DPRP Readiness (6/17/08 - 7/24/08)

x = goal not met
IM Total Points: 76
Points Needed: 75

x Attending physicians only
Next step: alternative care delivery models


BCBSNC, UNC Health Care Announce Partnership to Launch Novel Patient-Centered Practice

The first-of-its-kind medical practice in North Carolina aims to improve health, increase satisfaction, and reduce health care costs for patients. This venture will be the first product of what Blue Cross and Blue Shield and UNC Health Care expect will be an ongoing collaboration in which they work together to enhance health care quality, improve efficiency and effectiveness, and reduce health care costs.

BCBSNC Contact: Michelle Douglas • 919-765-3005
BCBSNC Online Newsroom: http://bcbsncmediacenter.pressroom.com
UNC Health Care Contact: Jennifer James • 919-966-7622
UNC Health Care Online Newsroom: http://news.unchealthcare.org/

Tuesday, Jan. 11, 2011

Chapel Hill, N.C. — The state’s leading health insurer and the state’s health care system will collaborate to develop a completely new type of medical practice in which patients — not just their symptoms — are the focus of care. This advanced medical practice will extend beyond what is currently called the ‘medical home’ and will enable teams of health care providers to work collaboratively with patients and families in delivering high quality, coordinated care. Blue Cross and Blue Shield of North Carolina (BCBSNC) and UNC Health Care expect the new practice, which will likely be located in Orange or Durham county, to open in the fourth quarter of 2011.

This venture would be the first product of what BCBSNC and UNC Health Care expect will be an ongoing collaboration in which they work together to enhance health care quality, improve efficiency and effectiveness, and reduce health care costs.

“The team approach to care emphasizes patient involvement and allows more time for clinical interaction and patient education and support,” said BCBSNC President and CEO Brad Wilson. “We believe this approach will result in improved health and fewer complications — both of which will help control rising health care costs.”

“We’re in an era of change in health care, so let’s work together to make positive change,” said Dr. William L. Roper, CEO of UNC Health Care. “This innovative approach with education, patient support and self-management is one important step toward making health care less mysterious and more effective.”

The practice will care for 5,000 BCBSNC members focusing on patients with chronic conditions, including coronary artery disease, hypertension, diabetes, obstructive lung disease, major depression, and asthma.
Extra Slides

GIM Enhanced Care
Diabetes Program Example
Diabetes services

Education

- Individual sessions and group classes
- Medication education and adjustments
  - Insulin teaching
- Glucose meter
  - Teaching, troubleshooting
  - Download in clinic

Retinal Camera

Patient Follow-up

- Visits
- Phone calls
Case management

Care Assistants assigned to group of patients:
- Improved, personalized communication to create partnership
- Enhanced patient monitoring

Patients that need extra help:
- Proactive phone follow-up (before/after visit)
- Improved visit coordination
- Improved utilization of clinic services
- Improve access to care (transportation and appointment)
GIM diabetes patients

Risk Zone calculation (includes, but not limited to):
- A1c
- Blood Pressure
- Key medication use
- Depression assessment
- Smoking assessment
Diabetes patient zones

**High Risk**
- Risk Score of 6 or more
- A patient with any of the following:
  - A1C > 9.0%
  - OR
  - BP > 160/95
  - OR
  - Barrier Assessment Poor

**Patient Care Plan**
- Automatic referral to diabetes mid-level provider.
- Case management to assess need for visit or phone call follow-up, address barriers and interventions, including non-diabetes related prompting.
- Provider prompted to assess:
  - addition of insulin, if not taking
  - addition or titration of diabetes medications
  - future follow-up with diabetes mid-level provider
  - and/or follow-up with care assistant at that visit.
- Patient can call Enhanced Care for assistance during business hours.

**Moderate Risk**
- Risk Score of 3 to 5
- A patient with any of the following:
  - A1C 7.5 to 8.0%
  - AND
  - BP > 140-160/90-95
  - AND
  - Barrier Assessment Fair

**Patient Care Plan**
- Provider prompted to assess:
  - addition or titration of diabetes medications
  - future follow-up with diabetes mid-level provider
  - and/or follow-up with care assistant at that visit.
- Patient can call Enhanced Care for assistance during business hours.

**Low Risk**
- Risk Score of < 3
- A patient with any of the following:
  - A1C < 7.5%
  - AND
  - BP < 140/90
  - AND
  - Barrier Assessment Good

**Patient Care Plan**
- Patient or provider can request assistance by CA during clinic visit.
- Patient can call Enhanced Care for assistance during business hours.

**Continuous Clinical Reassessment**
High Risk Zone

- Call 2 weeks before visit
- Care Assistant follow-up in clinic
- Call on same day if no-show
- Call within 2 weeks after visit
- Visit coordination for other clinic services
Case Management of High Risk Patients
Pre-clinic call:
- Not checking blood sugar
- Eye exam out-of-date
- No-show for last appointment

Intervention:
- Assessed appropriate use of medication
- Plan for glucose monitoring
- Confirmed upcoming clinic visit
- Scheduled retinal camera appointment at upcoming visit
- Reminded to bring meter and medicines
In clinic visit:
- Stamped provider schedule
- On arrival, meter downloaded, medication assessed and CA identified that patient had not been taking Metformin
- Communication with provider – plan to restart Metformin and begin daily walking routine
- Provided summary sheet with goal, medication changes, follow-up plan and contact information
- Patient taken to retinal camera
2 week post-clinic call:
- Medication compliance
- Blood sugar monitoring
- Goal to start daily walking routine
- Patient reported GI distress

Intervention:
- Precepted with Diabetes Practitioner
- Adjusted Metformin dose
- Phone follow-up in 1 week
Extra Slides

GIM Enhanced Care
Diabetes Program Example
Referral Coordination

- 1 member of clinic staff
- Role defined as:
  - Local expert
  - Liaison with specialty practices
  - Navigating the appointment process
  - Informing the provider of issues
  - Closing the loop