Enhancing Care Coordination
Between Endocrinology and Primary Care for Type 2 Diabetes
Through a Statewide Quality Improvement Collaborative

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Introduction

The Michigan Collaborative for Type 2 Diabetes (MCT2D) is a statewide quality improvement (QI) initiative aimed at enhancing type 2 diabetes (T2D) care via increased continuous glucose monitoring (CGM) usage, guideline-directed medical therapy, and low-carbohydrate diets, while promoting coordination and collaboration among primary care, endocrinology, and nephrology members.

The statewide collaborative is made up of over 1,400 physician members, representing 350 primary care practices (PCP), 24 endocrinology practices, and 14 nephrology practices from 24 of Michigan's 30 physician organizations (PO) (see figure 1).

One of MCT2D's key goals is to strengthen collaboration and communication between its member practices. **With both primary care and endocrinology practices participating within the same POs, MCT2D is uniquely positioned to assess existing referral and care coordination practices and to leverage these relationships to drive improvements in care for patients with type 2 diabetes.**

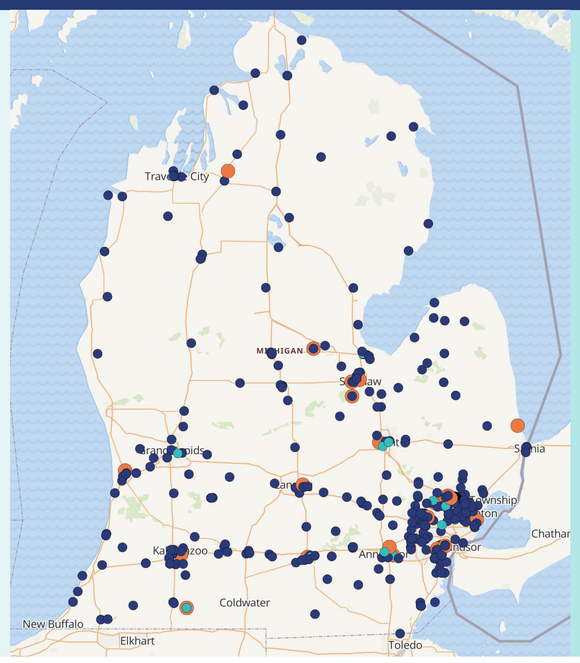

Figure 1. MCT2D's 388 participating practices including primary care (blue ●), nephrology (teal ●), and endocrinology (orange ●) across the state.

Objectives

- For endocrinology practices who joined the collaborative between 2021 and 2023 (Cohort 1), the aim was for each practice to select a quality improvement initiative in conjunction with a partnering MCT2D primary care practice in their PO, that targets a specific problem related to T2D care coordination. Practices were asked to conduct at least one PDCA (Plan-Do-Check-Act) cycle to assess outcomes and refine strategies for improvement.
- For endocrinology practices who newly joined MCT2D in 2024 (Cohort 2), the goal was to complete a baseline assessment to evaluate current care coordination practices, including referral patterns and communication methods, and to identify common barriers to effective collaboration between primary care and endocrinology teams.

Methodology and Timeline

April 1, 2024
All endocrinology practices were required to identify a partnering primary care practice ahead of the annual spring regional meetings, allowing clinical champions from both practices to meet in person. Clinical champions were encouraged to collaborate with their partnering primary care teams and PO administrative leads to identify potential areas for improvement and define the roles and responsibilities of each practice within the partnership.

June 15, 2024
Project plans were submitted to MCT2D by the partnering endocrinology and primary care practices. Each plan outlined the project focus, the specific roles of the endocrinology and primary care practice, project goals, and anticipated challenges. Project implementation began immediately after submission, with a target of completing at least one PDCA cycle by the fall Endocrinology Clinical Champions meeting.

November 21, 2024
During the Endocrinology Clinical Champions meeting, three endocrinologists were selected to present on their work and share progress made in improving care coordination.

April 8 – May 8, 2025
Each endocrinology practice developed a poster summarizing the results of their collaboration, which was presented at one of seven regional meetings across the state. These sessions provided an opportunity for peer learning, highlighting both successes and lessons learned from the projects.

Results

- Endocrinology practices in Cohort 1 (*N*=19), along with their partnering primary care practices, developed QI projects focused on care coordination.
- Most common project themes are shown in Figure 2.
- 18 out of 19 practices successfully implemented change and achieved documented improvements in care coordination.
- Only 1 practice reported being unable to complete a full PDCA cycle, citing lack of engagement from their primary care partner.
- A selection of these project posters are show in Figures 4-7.
- 11 endocrinologists representing 5 distinct practices in Cohort 2 completed care coordination assessments.
- Key results from these assessments are shown in Figure 3.

Figure 2.

Improving referral processes (*n*=8)

Patient co-management (*n*=5)

Increasing CGM utilization (*n*=4)

Discharging stable patients back to primary care (*n*=2)

Figure 3.

91%
Deemed the majority of T2D referrals appropriate for specialty care

27%
Felt the majority of patients with T2D should have been referred sooner

73%
Reported effective care coordination in fewer than half of co-managed patients

91%
Used the EMR to coordinate with primary care about co-managed patients, far more than any other communication method

Conclusions & Next Steps:

- MCT2D successfully launched joint QI projects between endocrinology and primary care practices, demonstrating how collaboration between specialties can drive meaningful change for patients.
- Each participating site received tailored feedback on their poster presentation, aimed at enhancing their quality improvement capabilities and ensuring the sustainability and broader adoption of best practices.
- Ongoing challenges reported among the newly joined practices emphasize the need for continued collaborative efforts to drive sustained improvements in the care of patients with type 2 diabetes, and reinforces the importance of partnerships across specialties.

EXAMPLE PROJECT POSTERS

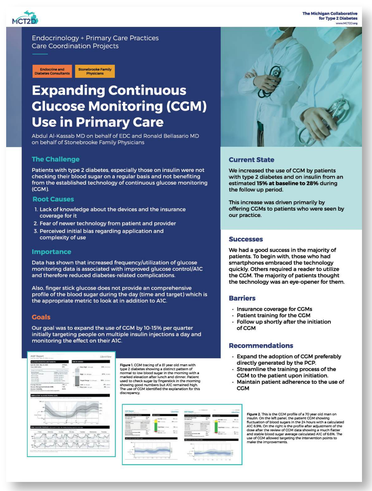

Figure 4. Example Project 1 - Expanding Continuous Glucose Monitoring Use in Primary Care

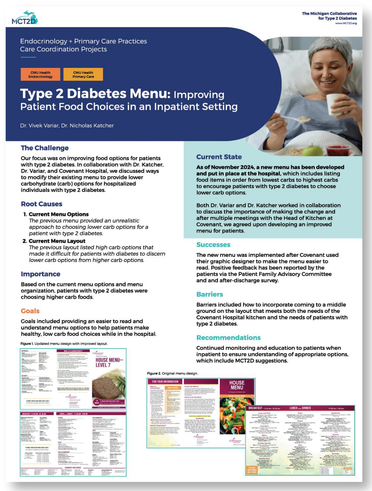

Figure 5. Example Project 2 - Type 2 Diabetes Menu: Improving Patient Food Choices in an Inpatient Setting

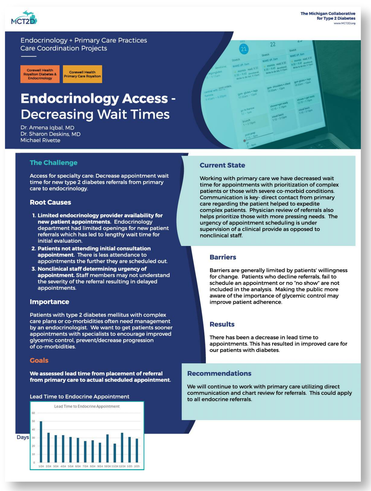

Figure 6. Example Project 3 - Endocrinology Access: Decreasing Wait Times

Figure 7. Example Project 4 - Supporting Patients Together: Increasing Utilization of Continuous Glucose Monitoring in Primary Care

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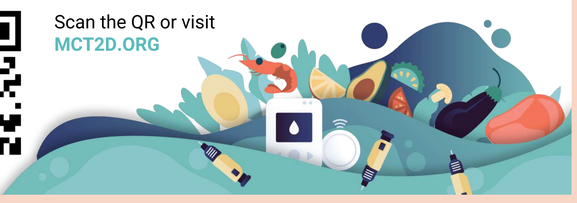

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