The Michigan Collaborative for Type 2 Diabetes
www.MCT2D.org

Endocrinology + Primary Care Practices
Care Coordination Projects

Bloomfield Endocrinology

CoreMed Plus

Care Coordination – Working Together – Achieving More

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The Challenge

The problems identified by our Endocrinologist and PCP were two- fold:

1. **Determining the need for early specialist intervention**, specifically, poor DM control as defined by an A1C > 8% for 6 months or more.
2. **Poor care coordination and communication regarding plans of care.** The challenges involve not only the referral process but continued communication regarding the plan of care. For example: Historically, when the PCP would refer to a specialist, there had not been any follow up process defined on the PCP side. The patient would be responsible for making the appointment and following up with the specialist. In turn, it was difficult to obtain notes from the specialist regarding the visit and plan. Many times, due to a variety of factors, specialist appointments were not timely.

Root Causes

1. **Inadequate patient identification and follow up**
   a. This leads to disease advancement and the development of potential complications among the general as well as high risk patient population. In addition, it can also lead to more costly care.
2. **Inefficient office processes**
   a. This leads to poor communication between the Specialist and PCP in terms of plans of care. This also could lead to redundancy in work and testing.

Importance

We believe effective care coordination and communication are central to quality patient care and outcomes. Early identification and employing early interventions before referring to a specialist can result in more efficient, effective and lower cost care.

Goals

1. Improved A1C, BMI
2. Reduced gaps in care i.e. timely retinal eye exam screens and follow-up diabetes management visits
3. Return to PCP once condition is improved, with a communicated and documented plan of care. The targets for returning a patient back to the PCP were if the patient had maintained an A1C under 7% for 6 months or greater.

Workflow

PCP Responsibilities:

- PCP Identification of high- risk patients:
  - High risk patients were defined as a patient that does not gain satisfactory DM control as defined by an A1C over 8% for 6 months despite PCP interventions.
- Review MCT2D Patient list data
- Care manager huddle with PCP regarding potential patients to refer to Specialist
- PCP consults with Specialist
- CM shares plan of care with patient and coordinates specialist referral/visit
- PCP CM coordinates warm hand-off with Specialist CM and monitors progress

Specialist Responsibilities:

- Schedules a timely visit with patient
- Sends plan of care notes to PCP in a timely manner
- Specialist CM coordinates follow up discussions and patient progress with PCP CM.
- Specialist communicates with PCP when patient will be returned to PCP and communicates ongoing plan of care.

This workflow has been defined, however, it is frequently reviewed and issues/improvements to the process are explored by the PCP/Specialist/CM's.

Current State

We decided the **specialist would be available for a discussion/consult with the PCP and the care manager** would then assist the patient with scheduling the visit and with follow up, defined as the scheduled specialist appointment and reviewing specialist plan of care. The expectation is that the specialist would send notes. We did have care managers embedded in both PCP and specialist offices which improved the process and coordination.

The PCP role and expectations have been defined, specifically pertaining to early identification and deployment of interventions. This includes comprehensive DM education, ensuring appropriate blood sugar monitoring and follow up, and RN Care Management.

The Specialist role and expectations defined include timely availability for consults and patient scheduling as well as communication regarding the plan of care. Also, communication and a plan of care for when the patient can return to the PCP for ongoing management.

Barriers

Barriers include:

- Lack of office staff.
- Lack of defined processes to enhance communication.
- Lack of consistent care management presence in the offices.

Results

We have improved communication among PCP and Specialists in terms of consult, discussions and availability of specialist appointments.

We have also increased patient compliance due to improved team based care, with the patient knowing that their PCP/Specialist and care manager are communicating on a regular basis.

Recommendations

- Continued work on more efficient office processes.
- Continued conversations between the PCP/ Specialist regarding processes.
- Continued data sharing regarding patient outcomes.