Standardizing Roles in a Diabetes Care Management Model

Summary

The diabetic population at West Ann Arbor General Medicine utilizes more services across the care continuum. Despite frequent encounters with care managers, readmission rates remain higher for the diabetic population than the average primary care population. Developing a Primary Care Diabetes Care Management model creates the opportunity to improve patient care.

West Ann Arbor General Medicine
Ann Arbor, MI

Practice type:
University-owned

Track: 2

EHR: Epic

CPC Classic participant: No

Number of practitioners: 8

Number of patients: 7,245

Type of patient population:
Urban

Insurance breakdown:
29% Medicare, 4% Medicaid,
67% private insurance,
0% uninsured/self-pay

Population characteristics:
We have an older patient population, including many patients with hypertension.

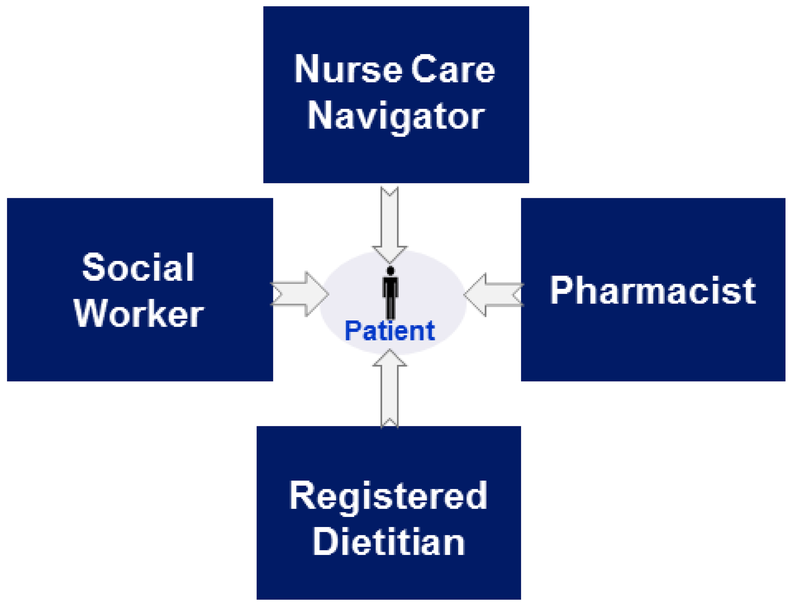
Change concept:
1.2.B Provide longitudinal care management to patients at high risk for adverse health outcome or harm

Strategy for Change

The Primary Care Diabetes Care Management model stratifies patients with elevated HbA1c and other complexities and assigns a lead care manager to coordinate patients' care.

- Care teams meet weekly to discuss care plans for patients with an elevated HbA1c.
- Care team members work together to support patients and their families in achieving their goals and accessing care/support needed.
- All care is linked to a Primary Care Diabetes Management episode in our electronic health record to facilitate communication across care team members.
- Patients alternate diabetes visits with a Nurse Care Navigator and their practitioner.

> *"Patients share that this proactive care team approach has helped them get back on the wagon."*
>
> *– Patient*



Results

Of the total diabetic population attributed to West Ann Arbor General Medicine, 10% were identified as out of control through the care model from July 2018 to September 2018. Providers are recognizing that the value of care team members and a proactive approach help manage this chronic disease. Two patients who have had return visits with their practitioner have already seen decreases in their A1c.

Next Steps

- Track and monitor inpatient and outpatient utilization (both inappropriate and appropriate) over the next three months.
- Identify and target other chronic conditions (e.g., asthma, COPD, hypertension).
- Create standard care team roles and responsibilities at primary care clinics across Michigan Medicine.