Care Coordination at UNC Health Care

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UNC Practice Quality and Innovation

Enhanced Care Disease Management in UNC's Internal Medicine Clinic

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UNC HEALTH CARE

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

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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

www.med.unc.edu/im/files/enhanced-care-files/DiabetesProgramBackground.pdf

UNC HEALTH CARE

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

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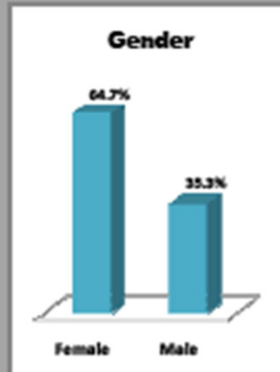
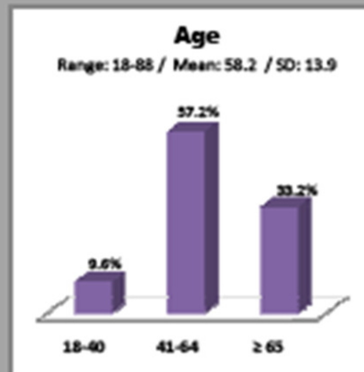
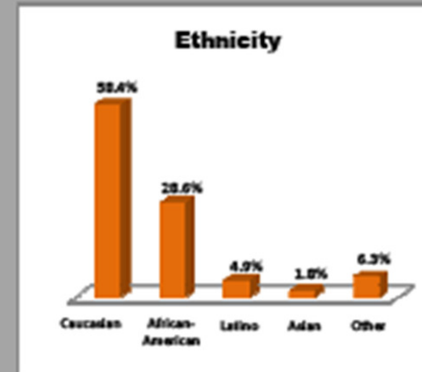
Our patients: Top 10 diagnoses

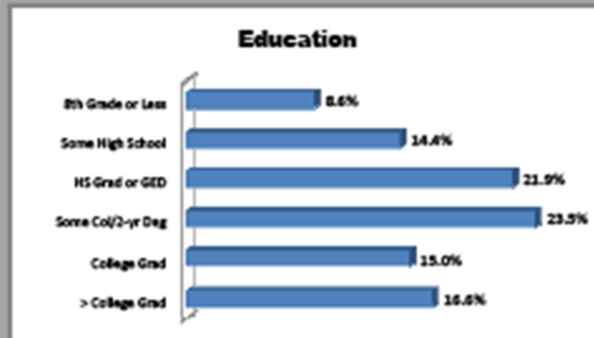
Q1 FY09

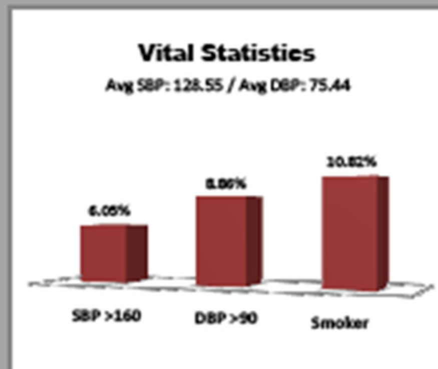
Our patients: Key characteristics

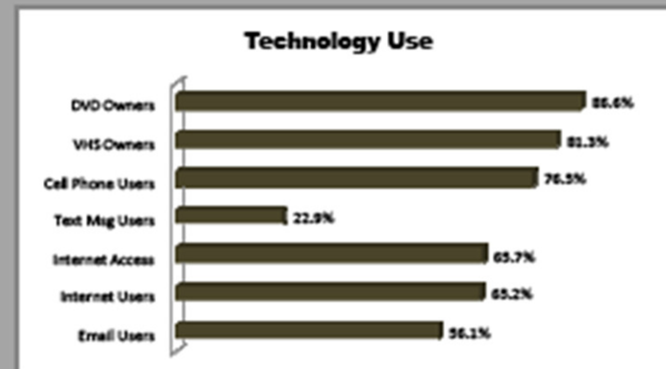












Q1 FY09

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Our patients: Where they come from

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UNC Internal Medicine Clinic: Patients 2001-2002

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

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

Sources: UNC Billing Data 2001-2002 ; Claritas Inc., 2000.
Produced by: Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

UNC
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CENTER FOR EXCELLENCE
IN CHRONIC ILLNESS CARE

Our current 'Enhanced Care' programs

Active management	Surveillance and prompting
Diabetes	Heart disease
Anticoagulation	Colon cancer
Chronic pain	Cervical cancer
Depression	?Transitions
Decision support	

All programs grounded in quality improvement efforts

Link to more information: 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

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Lessons learned

- A registry with decision support for proactive care

Advanced, integrated registry

Schematic of CIPHER Data Compilation, Dissemination, and Collection

UNC ISD and P&A Sources

Carolina's Data Warehouse for Health (CDW-H)

WebCIS, Vitals

Lab Information System

GE Billing

GE Scheduling

CIPHER®

Disease Management Registries

(Diabetes, Anticoagulation, Pain, Colon Cancer Screening, Health Maintenance, CHF, HTN)

Patient Entered/Prompted Data

Email

Internet

Kiosk

Paper Survey

Data Dissemination & User Access

Network Printer

Network PC Access

Provider & Staff Internet Forms

Provider & Staff Email

Reports, Collection, & Decision Support

Reports

Documents

Entry Forms

Data Entry

Data Entry by Scanner

Data entry by Staff

Lessons learned

- Consensus backed by evidence-based algorithms

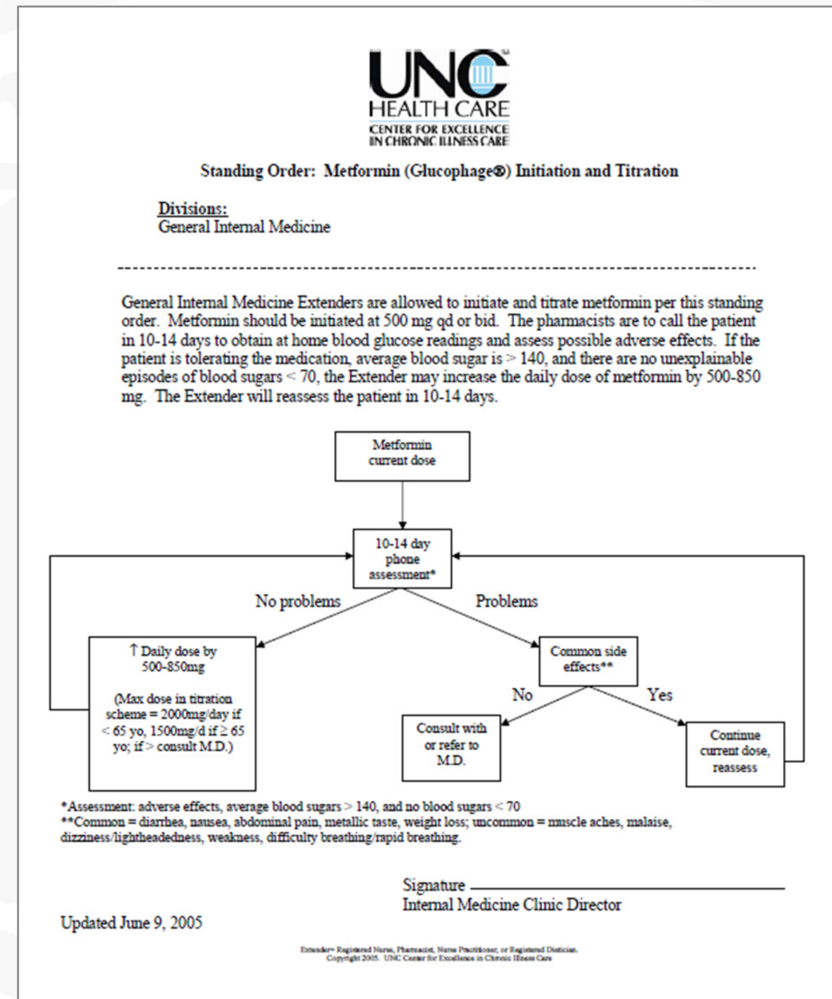
Evidence-based algorithms

Our algorithms are:

- Evidence based
- Consensus driven

Algorithms

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



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CENTER FOR EXCELLENCE IN CHRONIC ILLNESS CARE

Standing Order: Metformin (Glucophage®) Initiation and Titration

Divisions:
General Internal Medicine

General Internal Medicine Extenders are allowed to initiate and titrate metformin per this standing order. Metformin should be initiated at 500 mg qd or bid. The pharmacists are to call the patient in 10-14 days to obtain at home blood glucose readings and assess possible adverse effects. If the patient is tolerating the medication, average blood sugar is > 140, and there are no unexplainable episodes of blood sugars < 70, the Extender may increase the daily dose of metformin by 500-850 mg. The Extender will reassess the patient in 10-14 days.

*Assessment: adverse effects, average blood sugars > 140, and no blood sugars < 70
**Common = diarrhea, nausea, abdominal pain, metallic taste, weight loss; uncommon = muscle aches, malaise, dizziness/lightheadedness, weakness, difficulty breathing/rapid breathing.

Signature ______________________
Internal Medicine Clinic Director

Updated June 9, 2005

Extender= Registered Nurse, Pharmacist, Nurse Practitioner, or Registered Dietician.
Copyright 2005. UNC Center for Excellence in Chronic Illness Care

For more information:

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

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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

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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

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Lessons learned

- Proactive care
- Evolution, change is necessary

Our own evolution- pre-visit, out of clinic

Interest in Hypothetical Online Patient Portal			
Interested in doing online:	**Internet Users n = 122**	**Non-Users n = 65**	**All n = 187**
Receiving health information from the clinic	87%	40%	71%
Asking PCP questions between visits	87%	37%	70%
Receiving messages from the clinic	88%	40%	71%
Providing information about medical problems before a visit	88%	40%	71%
Discussing medical problems with other patients	55%	26%	45%

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

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UNC HEALTH CARE
GENERAL INTERNAL MEDICINE

Patient Health Survey

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.

EXIT

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GENERAL INTERNAL MEDICINE

Patient Health Survey

In general, would you say your health is:

- Excellent
- Very Good
- Good
- Fair
- Poor

PREVIOUS QUESTION

NEXT QUESTION

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QUIT

UNC
HEALTH CARE
GENERAL INTERNAL MEDICINE

Patient Health Survey

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

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new! VERSION 2.14.10

New Patient

Patient Record

CPOE eChart

ICU Flowsheet

Schedules

Activity List

0 7

Patient Lists

Inpatient Census

Logoff

Reference

Administration

Help
(919-966-5647)

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

.---------------------------------.
:::::::::::     :     : DECISION :
::::::::::: YES : NO  : SUPPORT  :
:::::::::::     :     : ELIGIBLE*:
+=================================+
: Hip Pain:  X  :     :          :
+---------------------------------+
:Knee Pain:     :  X  :          :
+---------------------------------+
: Diabetes:     :  X  :          :
+---------------------------------+

PATIENT REPORTED SCREENING:
Patient DENIES personal history of COLON CANCER

.------------------------------------------------------.
:            :  NEVER   :OUT OF DATE: UP  TO :DECISION:
:            : SCREENED : SCREENING :  DATE  :SUPPORT :
:            :          :           :        :ELIGIBLE:
+======================================================+
:COLON CANCER:    X     :           :        :        :
.-------------------------------------------------------.
------------------------------------------------------------------------------
* 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
```

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Lessons learned

- A multidisciplinary team
- Care coordination and management
- A registry with decision support for proactive care

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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

Visit Planner (version 5.0)

Return this form to front desk. Feedback provided will be incorporated into the patients registry profile.

Instructions: Check box or write letter/number.

Example: Yes No / Letter / Score

MRN: 1 *Patient Name: TEST, PATIENT T* DOB: 1/1/1986

3/4/2010 08:00:00 AM Provider: MALONE 3/17/2471

Front Desk Staff Responsibilities

Late Arrival: 1=15-20 mins, 2=30+mins

Order POC A1c

Order Total Cholesterol/HDL/TG/dLDL

Visit Barrier: Multiple No Shows

Patient Needs: Interpreter

REASON POC LABS NOT ORDERED (Letter)

* R=patient refused, L=patient was late, B=lab backup *

Staff Intials:

Nursing Staff Responsibilities

PHQ2 Depression Assessment (Yes No Score)

Over the past 2 weeks, how often have you lost enjoyment or taken little interest in your usual activities?

Over the past 2 weeks, how often have you felt down, depressed, or hopeless?

* Choices: 0=Not at all 1=Several days 2=More than 1/2 the days 3=Nearly every day *

Add score of 2 questions and enter total.

If score equals 3 or more, flip this page over and have patient fill out PHQ9. Was PHQ9 given to patient?

Diabetes Retinal Exam (Yes No)

Has patient had an eye exam within past 12 months?

* If out-of-date or unknown, we recommend retinal photos today. If has had exam within past 12 months stop here.*

Does patient want retinal camera visit today? (If yes, contact CA and send to Rm 3105 after visit)

If no camera today, does patient want retinal camera at next visit?

If patient refuses camera, referral to UNC for dilated retinal exam?

Foot History (Yes No)

Have you had an amputation of toes, a foot or a limb?

Have you had ulcers, sores or infections of your feet?

Have you been told that you have peripheral vascular disease or blockages in the blood flow to your feet?

Have you seen a foot doctor within the last year? If so, date seen __/__/____

Do you wear diabetic shoes?

REASON PROMPTS NOT COMPLETED (Letter)

* R=patient refused, I=interrupted by provider, T=technical issue, H=higher priorities *

Nurse Intials:

Provider Responsibilities

TChol: HDL: LDL: TG: A1c: Micral:

Vital Date: SBP: DBP: WT:

Disease state(s) driving prompts: Diabetes,

Other issues not prompted today:

Comments:

Depression Screening, Review PHQ Results (Yes No)

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

Is PHQ2 score >= 3? (see above)

If yes, did you score PHQ9 and complete prompts on back?

Antithrombotic Indicated (Yes No Letter)

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

Did you add to CIS Meds today?

If not, R=refused, C=contraindicated, D=delay, N=not indicated

Age > 40 yrs, Aspirin Indicated (Yes No Letter)

* Aspirin or aggrenox not in CIS med list. *

Did you add to CIS Meds today?

If not, R=refused, C=contraindicated, D=delay, N=not indicated

Return ALL forms to the front desk

Front Desk

Nurses

Provider

www.med.unc.edu/im/staff/clinic/programs/diabetes/Tools

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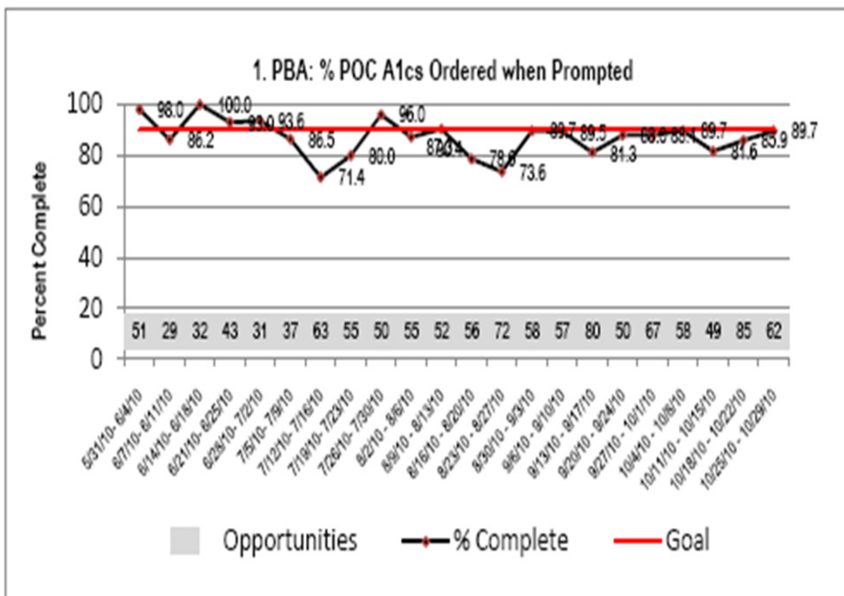
Front Desk Staff Prompts

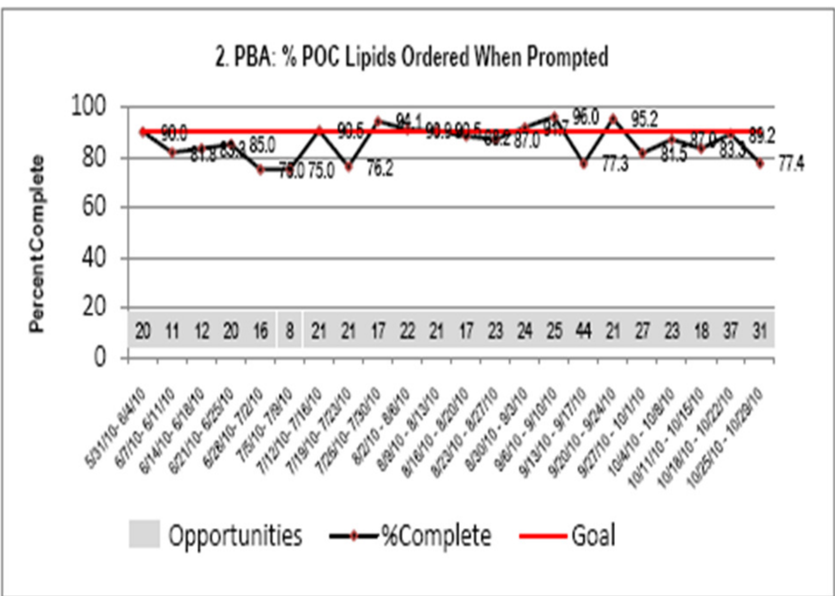
------------------------- **Front Desk Staff Responsibilities** -------------------------

Late Arrival: 1=15-29 mins, 2=30+ mins	☐
Order POC A1c	○
Order Total Cholesterol/HDL/TG/dLDL	○

REASON POC LABS NOT ORDERED Letter

* R=patient refused, L=patient was late, B=lab backup * ☐ **Staff Intials:** ☐☐





www.med.unc.edu/im/staff/QI/reports/

UNC HEALTH CARE

Nursing Prompts

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

------------------------ Nursing Staff Responsibilities ------------------------

--No prompts indicated today--

REASON PROMPTS NOT COMPLETED

* R=patient refused, I=interupted by provider, T=techr

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

------------------------ Nursing Staff Responsibilities ------------------------

Pneumovax Indicated	Yes No
Patient had previous pneumovax? ___/___/______ at UNC or Outside Facility	○ ○
If no, given today?	○ ○
If not given today, was pneumovax refused?	○ ○
If not given today, was pneumovax delayed until next visit?	○ ○
If not given today, was it contraindicated?	○ ○

Patient Education Indicated	Yes No
* Nurse, ON COMPUTER please open IMC PATIENT EDUCATION link in Internet Explorer FAVORITES MENU. *	
* Call Chris or Leslie on the walkie or at 6-0106 with problems. *	
Did you open the website?	○ ○
* R=patient refused, I=interrupted by provider, T=technical issue, H=higher priorities *	☐

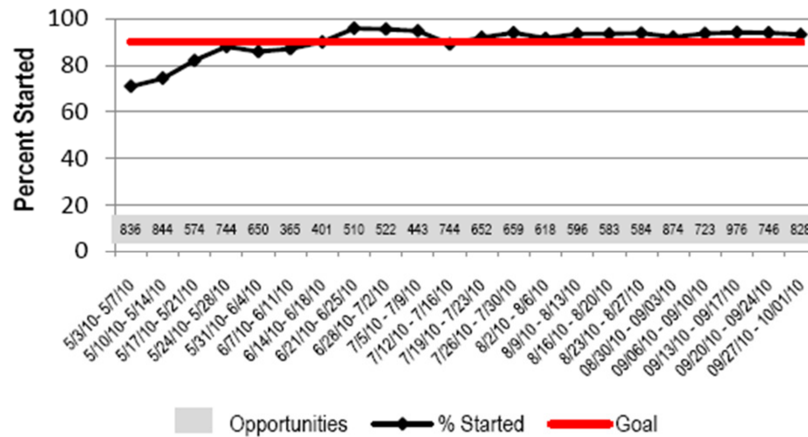
DV Screen Indicated	Yes No
Do you feel unsafe in your current relationship?	○ ○
In the past year, has your partner hit, kicked or otherwise hurt or threatened you?	○ ○
If any answer is 'Yes', contact Beacon Program. Beacon Program contacted?	○ ○
If any answer is 'Yes', notify provider. Provider notified?	○ ○
Unable to screen * R=pt refuse, N=not in relationship, S=setting inappropriate *	☐

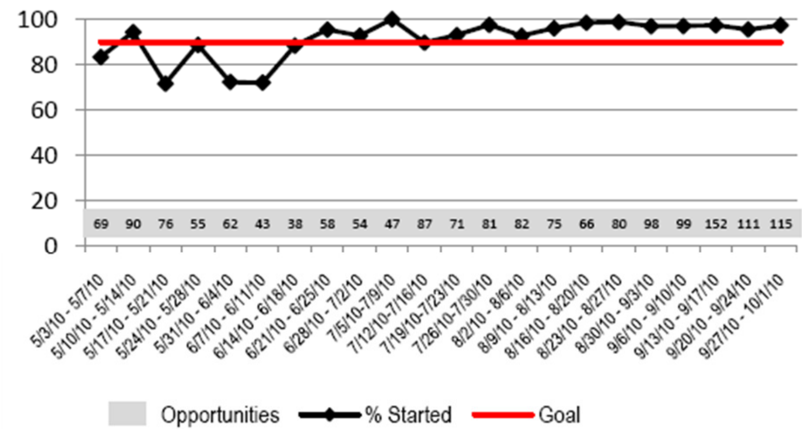
REASON PROMPTS NOT COMPLETED Letter

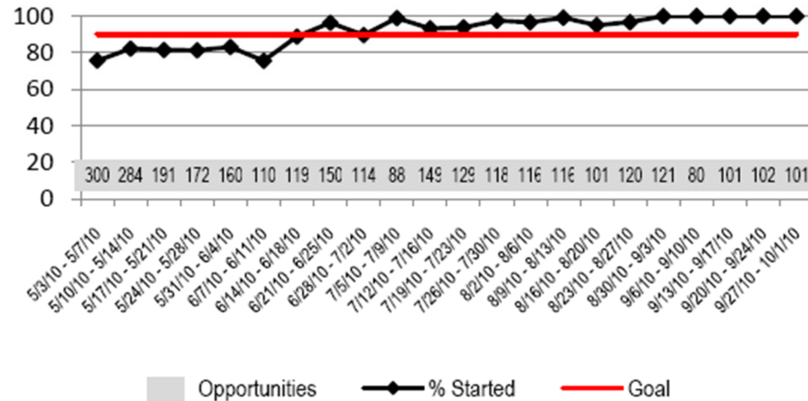
* R=patient refused, I=interupted by provider, T=technical issue, H=higher priorities *

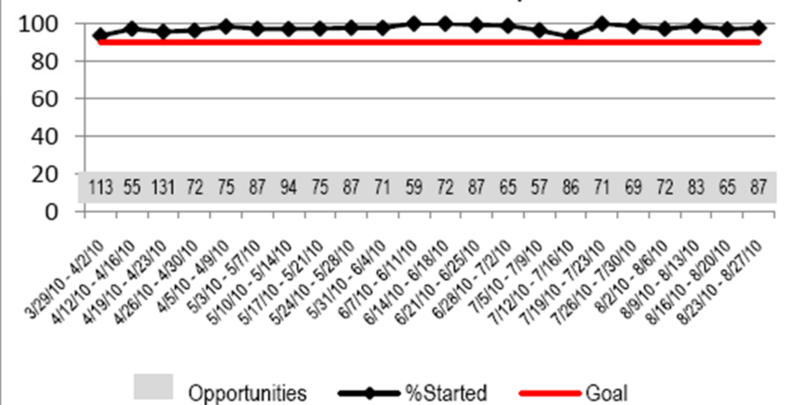
Nurse Intials:

VP prompt response - nurse









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Provider Prompts

------------------------ Provider Responsibilities ------------------------

TChol:	263	2/1/2010	**Vital Date:**	5/10/2010	
HDL:	74	2/1/2010	**SBP:**	103	
LDL:	164	2/1/2010	**DBP:**	68	
TG:	124	2/1/2010	**WT:**	62.01	
A1c:			**PHQ Date:**		
Micral:			**PHQ:**		

--No prompts indicated today--

Disease state(s) driving prompts:

Other issues not prompted today:

Comments:

------------------------ Provider Responsibilities ------------------------

TChol:	151	8/26/2009	**Vital Date:**	7/12/2010
HDL:	41	8/26/2009	**SBP:**	120
LDL:			**DBP:**	85
TG:			**WT:**	73.4
A1c:	5.4	10/10/2009	**PHQ Date:**	
Micral:			**PHQ:**	

Disease state(s) driving prompts:
Heart Disease

Other issues not prompted today:

Comments:

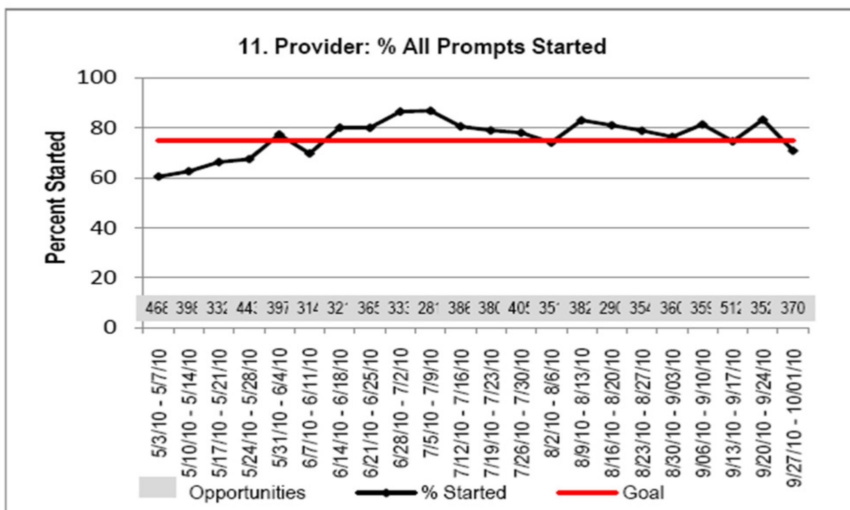
Depression Screening, Review PHQ Results	Yes	No
* If PHQ2 >=3 patient may be depressed, PHQ9 needed. *		
Is PHQ2 score >= 3? (see above)	○	○
If yes, did you score PHQ9 and complete prompts on back?	○	○

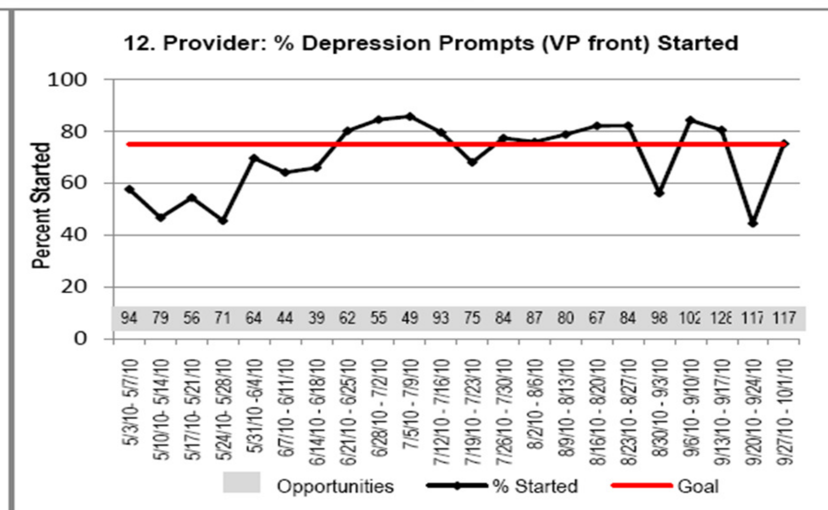
Antithrombotic Indicated	Yes	No	Letter
* Aspirin, aggrenox, plavix or Coumadin not in med list. *			
Did you add to CIS Meds today?	○	○	
If not, R=refused, C=contraindicated, D=delay, N=not indicated			☐

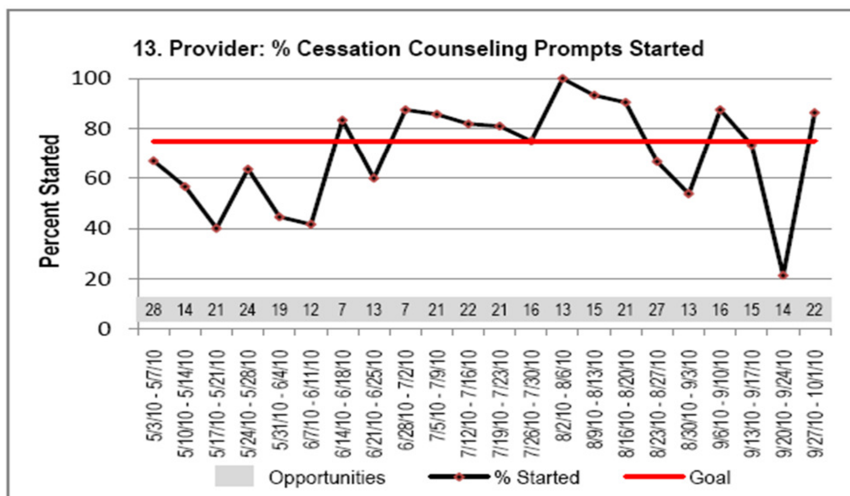
---------------------- Return ALL forms to the front desk ----------------------

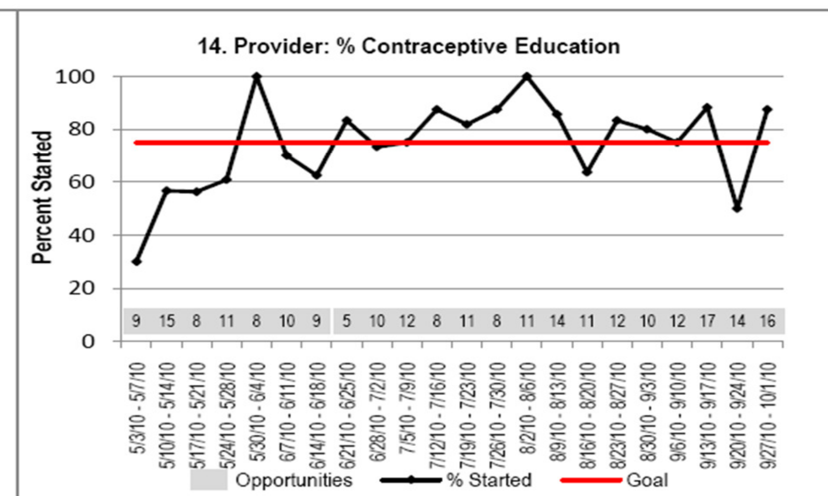
UNC HEALTH CARE

VP prompt response- provider









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Examples of other quality reporting

UNC HEALTH CARE
CENTER FOR EXCELLENCE IN CHRONIC ILLNESS CARE

General Internal Medicine
Enhanced Care Diabetes Program
October 2010 – Run Charts

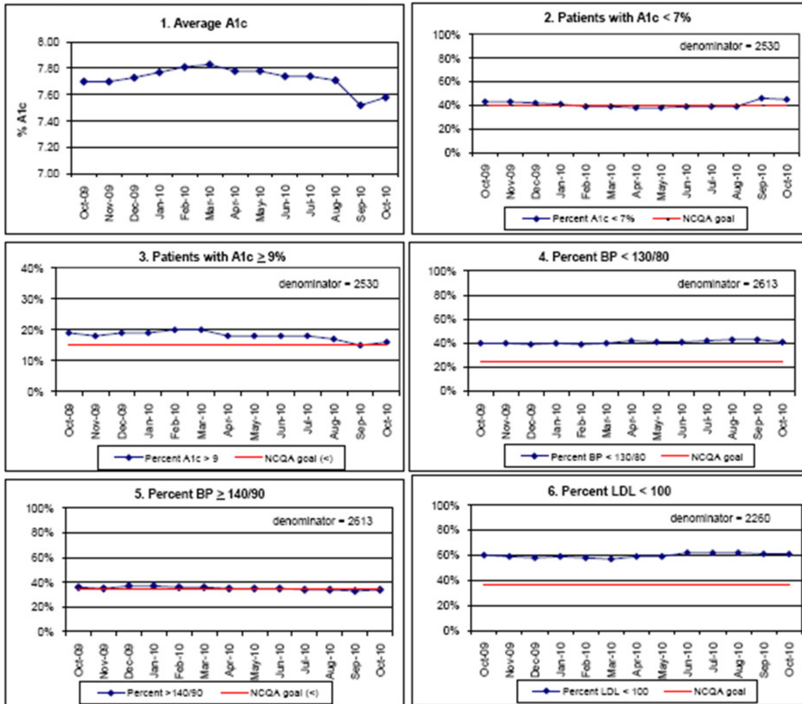
Aim: We aim to improve the care we provide by continually assessing key measures of diabetes care, care processes and the impact of comorbid conditions on glycemic control, cardiovascular risk and complications from diabetes. As a team we will utilize this data to identify areas to improve upon, focus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

---Key Work/Findings---

Revision of Runchart Data: This month Average 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, pneumovax, 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 calls has increased as has the number of skipped in clinic visits. The skipped 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, RD 0.25, LCSW 0.5, Program Coordinator .25, Database Programmer 0.5, Admin Asst 0.5, Care Assistants 2.5, QI Coordinator 0.25

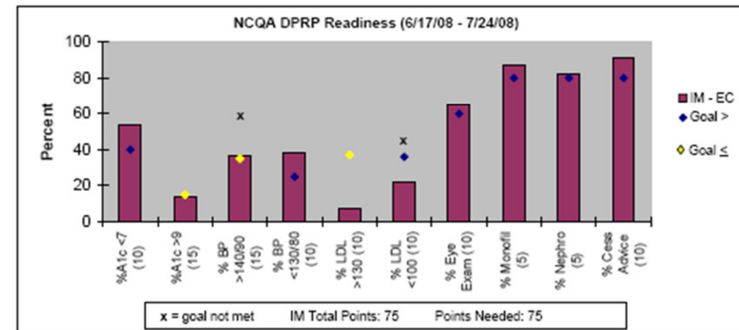


General Internal Medicine Enhanced Care Diabetes Program
July 2008 – Quality Improvement Work

See http://www.med.unc.edu/medicine/generalm/quality.html#projects for more details of quality improvement work.

TOPIC	INTERVENTION/CHANGE	STATUS	NOTES
Aspirin Utilization	Project complete. Cleared for publication by IRB.	Final data: 88% patients were contacted for follow up after receiving ASA letter, 46% started ASA due to letter.	Will run query every 6 months to find patients not on ASA and complete letter campaign. Will work on publication.
Statin Utilization/ Email alerts	Will resume email alerts in August.	On hold.	Resume after statin/lipids division meeting 7/31/08.
POC Testing	Have front desk staff identify patients for testing from patient yellow sheet stapled to encounter form instead of POC list.	Before intervention (2.5 wks data): 81% A1c, 66% chol testing. After intervention (3 days data): 83% A1c, 71% chol	Majority of missed tests due to missed ordering at front desk. Staff reported that new method was easier than POC list.
Statin Medication Utilization/Decision Making	Launched survey to get provider opinions about initiating statins.	Presented current data on patients not taking statins as well as survey results to get division consensus.	Robb to discuss cases w attendings. Resume alert emails. Address non-fasting LDL testing possibilities.
Nurse Diabetes Tasks (Monofilament & Smoking Advice)	Continue to track rates of completion based on opportunities.	Monfilament completion rates ranged from 63% to 88% with an average of 79%. Smoking advice was 74%.	Monofilament completion was similar to June. Smoking advice decreased compared to June (80%).
Nurse - Diabetes CA follow up (PHQ & cessation counseling)	Continue tracking completion rates for CA follow up when indicated.	PHQ f/u decreased to 53% (9 of 17) and cessation f/u decreased to 53% (9 of 17).	CA follow up rates decreased this month. PHQ f/u dropped from 83% to 53%. Cessation f/u from 100% to 53%.

NCQA Diabetes Physician^ Recognition Program Application Readiness



^ Attending physicians only

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Next step: alternative care delivery models http://news.unchealthcare.org/news/2011/January/bcbsnc

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

— filed under: Announcement, Roper

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 would 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.ipressroom.com
UNC Health Care Contact: Jennifer James • 919-966-7622
UNC Health Care Online Newsroom: http://news.unchealthcare.org/

click to enlarge
Brad Wilson (left), CEO of Blue Cross Blue Shield of North Carolina and Dr. William William L. Roper, CEO of UNC Health Care (right) shake hands after signing the agreement to team up for a model practice that focuses on patients.

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.

UNC HEALTH CARE

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

UNC
HEALTH CARE

Case management

Care Assistants assigned to group of patients:

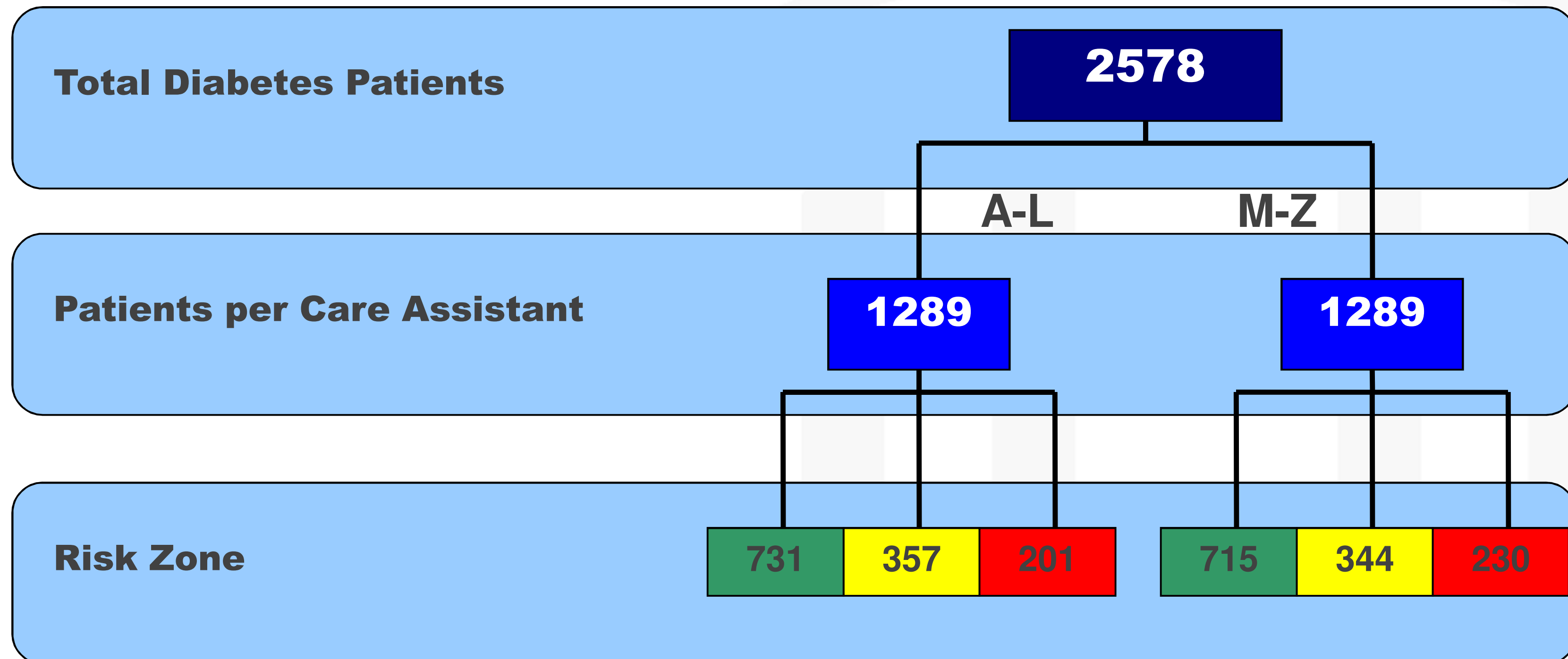
- Improved, personalized communication to create partnership
- Enhanced patient monitoring

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)

UNC
HEALTH CARE

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

Moderate Risk**
Risk Score of 3 to 5

A patient with any of the following:
A1C 7.5 to 9.0%
AND
BP > 140-160/90-95
AND
Barrier Assessment Fair

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 (High Risk)

- 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.

Patient Care Plan (Moderate Risk)

- 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.

Patient Care Plan (Low Risk)

- 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

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Pre-clinic call → In clinic visit → Post-clinic call

Case Management of High Risk Patients

Pre-clinic call

In clinic visit

Post-clinic call

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

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HEALTH CARE

Pre-clinic call

In clinic visit

Post-clinic call

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

Pre-clinic call | In clinic visit | Post-clinic call

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

UNC HEALTH CARE

Referral Coordination

UNC SCHOOL OF MEDICINE

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Clinic Support Website

General Internal Medicine
- Home
- Email Admin
- Reporting
- Users / Roles
- Provider List
- Logout

You are here: Clinic Support Website

SPECIALTY CLINIC REFERRAL FORM

Provider/Patient Information

Provider ID:(6 digits) 230631 | Provider Name: Robb Malone
Provider Email: rmalone@med.unc.edu | Pager Number: 216-5736
Submitted by: Robb Malone | Email Address: rmalone@med.unc.edu
Phone: (5 digits) | Date Submitted: 02/08/11

Patient Information:

First Name: | Last Name: | MR # (include check digit)

Request Information

Referral type:
New to referred clinic
Return to referred clinic

Referring to: select one | Doctor:

When:
Routine
Within 2 weeks

Diagnosis/Symptoms:

Reason for Referral:

I have informed the patient that he/she will need to call to schedule this appointment: Yes No

Priority tracking takes a lot of effort.
Please reserve its use for the most important referrals.
Priority referral; needs tracking - Yes: No:

See WebCIS Note Date:

- 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