CONTACT PATIENTS NOT AT GOAL AND WITH THERAPY CHANGE WITHIN 30 DAYS

All patients not at goal and with either a new prescription or a change in therapy receive proactive clinical contact within 30 days to assess progress. An appropriate member of the care team initiates clinical interaction(s) in the form of an office or home visit, medication therapeutic management, telephone outreach, contact via the patient portal, virtual visit, or e-messaging. Treatment is intensified as appropriate.

Most adults with diabetes have at least one comorbid chronic disease and as many as 40% have at least three. The complexity of multiple chronic diseases can be challenging for many people with diabetes to manage. Frequent clinical contact for those not at goal or with a new prescription can create opportunities to focus:

- Treatment Intensification: Accelerating care can help patients achieve their treatment goals: those not at target range who saw their care team every 1-2 weeks achieved treatment goals sooner than those who saw their team every 3-6 months.
- Treatment Adherence: Patients who have positive reinforcement from their provider and frequent support of their care team demonstrate better adherence and less risk of poor outcomes.
- Patient Engagement in Self-Management: With frequent contact, patients and care teams can develop a strong therapeutic bond that promotes patient engagement and increases patient confidence and motivation.

TIPS TO CONTACT PATIENTS WITHIN 30 DAYS

- Incorporate contact frequency into treatment guidelines.
- Consider group visits, nurse visits, telephonic follow-up, or e-messaging. Contact may not need to be face-to-face with a physician. Nurse practitioners, pharmacists, or competency-trained and tested nurses, for instance, could use standardized treatment algorithms.
- Create a reminder system via EHR, patient portal, or a simple calendar program to track patients who need follow-up.
- Identify patients who may not be adherent to their current regimen because they are not on appropriate medications.
- Schedule follow-up appointments for patients not at goal before they leave the clinic.
- Offer options for patient home monitoring and reporting through telephone, patient portal, texting, or secure e-messaging.
- Monitor performance of 30-day follow-up for those not at goal or with new prescription and report results to the diabetes team (refer to Build an Accountable Diabetes Team plank).

TOOL: DIABETIC FOLLOW-UP SCRIPTING AND NOTE

CORNERSTONE HEALTH CARE, P.A.

CORNERSTONE
HEALTH CARE

PCA Scripting:

Good morning/afternoon, may I speak with _____? Hi, Mr./Mrs. _____. My name is _____ and I'm a Patient Care Advocate from Cornerstone Health Care calling for Dr. _____ office. Do you have a moment? We noticed that it is time for you to have your six month Diabetic follow up appointment. I would like to go ahead and schedule this for you. What day and time works best for your schedule? Is your address still _____ and would you mind sharing your email address with me? In addition to what we have already discussed, is there anything else I can help you with today? Thank you for your time and choosing Cornerstone Health Care as your Medical Home. Have a great Day!

CORNERSTONE
HEALTH CARE

PCA Note:

Sept. 17, 2015

I had the opportunity to speak with Foot Chctest about ways to improve their healthcare. In an effort to improve Diabetes, I have scheduled an appointment for her to have a Follow-up. She was able to schedule an appointment for this service. I set up an appointment with _____ on _____ at _____. The patient accepted and understood the purpose of my call.

Thank you,

Patient Care Advocate

TOOL: TARGETED PATIENT PORTAL MESSAGING

PREMIER MEDICAL ASSOCIATES, P.C.

Premier Medical Associates would like to inform you that it may be time to have your A1C checked.

One part of managing your diabetes is having your A1C level checked every 3-4 months.

Please reach out to your Premier Medical Associates provider today to see if you are due for an appointment to have this important blood work drawn.

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Your Premier Medical Associates Providers would like to inform you that it may be time for your yearly diabetic eye exam.

Diabetes can damage your eyes and is the leading cause of blindness among adults. An eye exam can be a very useful tool in the reduction of vision issues.

Please reach out to your Ophthalmologist today to schedule your yearly diabetic eye exam.

If you have any vision disturbance such as blurry vision, seeing double, spots or floaters, you should see your eye provider before your yearly diabetic eye exam.

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Your Premier Medical Associates Provider would like to remind you that it is very important to take care of your feet if you have been diagnosed with diabetes. Preventive measures could deter possible loss of a toe, foot or leg in severe cases.

Your provider would like to inform you of steps to protect your toes/feet/ lower leg:

Keep your feet clean. Be sure to wash and dry between your toes. Protect your feet from injury, DO NOT GO BAREFOOT! Inspect the skin on your feet every day. Keep your skin soft and smooth. Have your Premier Medical Associates Podiatry Provider trim any corns, calluses or nails. Avoid having your feet really hot or really cold.

Be sure to remove your shoes and socks and show off your feet to your Premier Medical Associates provider at each visit.

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TOOL: DIABETES MEDICATION REFILL AND VISIT FREQUENCY GUIDELINES

MERITER-UNITYPOINT HEALTH

MERITER Medical Group

Diabetes Update – 2015

MMG Diabetes Medication Refill and Visit Frequency Guidelines

Care Team actions: During most patient contacts and for chart prep, review the following

- ✓ Review most recent A1c
- ✓ Verify that meds are filled and check medication response/tolerance
- ✓ Check standing/future lab orders and create standing orders as needed (A1c, LDL, serum creatinine, urine micro-albumin) if needed
- ✓ Reinforce home glucose monitoring if patient is monitoring
- ✓ Assure next visit is scheduled

Last A1c	Refills	Visit frequency	Additional Care Team Actions
1. New medication regardless of A1c	60 days max	Office visit within 30 days	• Contact every 2 weeks via phone or MyChart
2. Last A1c >6 months ago	30 day refill	Office visit within 30 days	
3. A1c typically less than 7 (A1c Control Goal)	6 month refill	Every 6 months	• Screen for hypoglycemia
4. A1c 7.0 to 7.9	3 month refill	Every 3 months	
5. A1c 8 - 9	3 month refill	Every 3 months	• If A1c ≥ 8 for 6 months pend order to DCT and/or pharmacists
6. A1c >9	1-3 month refill based on compliance, comorbidities, home blood glucose monitoring	Visits every 6 weeks	• Contact every 2 weeks via phone or MyChart • Monitor blood glucose checks via MyChart or phone outreach • Pend order to DCT

List of useful DM related smart phrases (type "Diabetes" to view full list)

• *Lastdiabetes3ref* (last 3 diabetes lab results) • *Medrfdm* (last office visit DM labs/refill info)	• *Diabeticteach* (review DM teaching book/ glucometer) • *DM foot exam*