Clinical and Economic Impact of an Integrated Care Team Model on Targeted, High-Risk Medicare Patients With Type 2 Diabetes

Cory A. Nelson, Chris K. Park, Ryan J. Gates, Melisa E. Arreguin, Tracy M. Salsa, Heather B. Miller, and Monica M. Manga.

DOI: https://doi.org/10.2337/cd17-0071 Published 28 March 2018

Supplementary Data

- Supplementary Appendix
- Supplementary Figures

Kaweah Delta
Chronic Disease Management Center
A division of Kaweah Delta Health Care District

Date: [XX/XX/XXXX]

Dear: [PCP NAME]

Re: [PATIENT NAME] DOB: [XX/XX/XXXX]

Thank you for your referral to the Chronic Disease Management Center for type 2 diabetes care. We are very excited to continue our relationship with you and [PATIENT NAME]. Our goal is to help our patients better manage their diabetes through collaborative efforts from our multidisciplinary team. We aim to provide comprehensive care, improve treatment adherence and reduce long term complications. At our last visit on [XX/XX/XXXX] we identified possible gaps in care. If any of the following have already been addressed, please disregard.

[IF NEEDED, INCLUDE ANY JUSTIFICATION FOR RECOMMENDATIONS]

These are the following recommendations:
1.
2.
3.

If you would prefer, we can perform the following services at the patient's next visit:

☐ CDMC to provide service

☐ Please schedule patient a visit with PCP to address

Please fax this form back to: XXX-XXX-XXXX.

Sincerely,

Kaweah Delta Chronic Disease Management Center

Chronic Disease Management Center
Street Address
City, State
Telephone: XXX.XXX.XXXX **Fax:** XXX.XXX.XXXX

Figure 1. Overview of healthcare delivery model

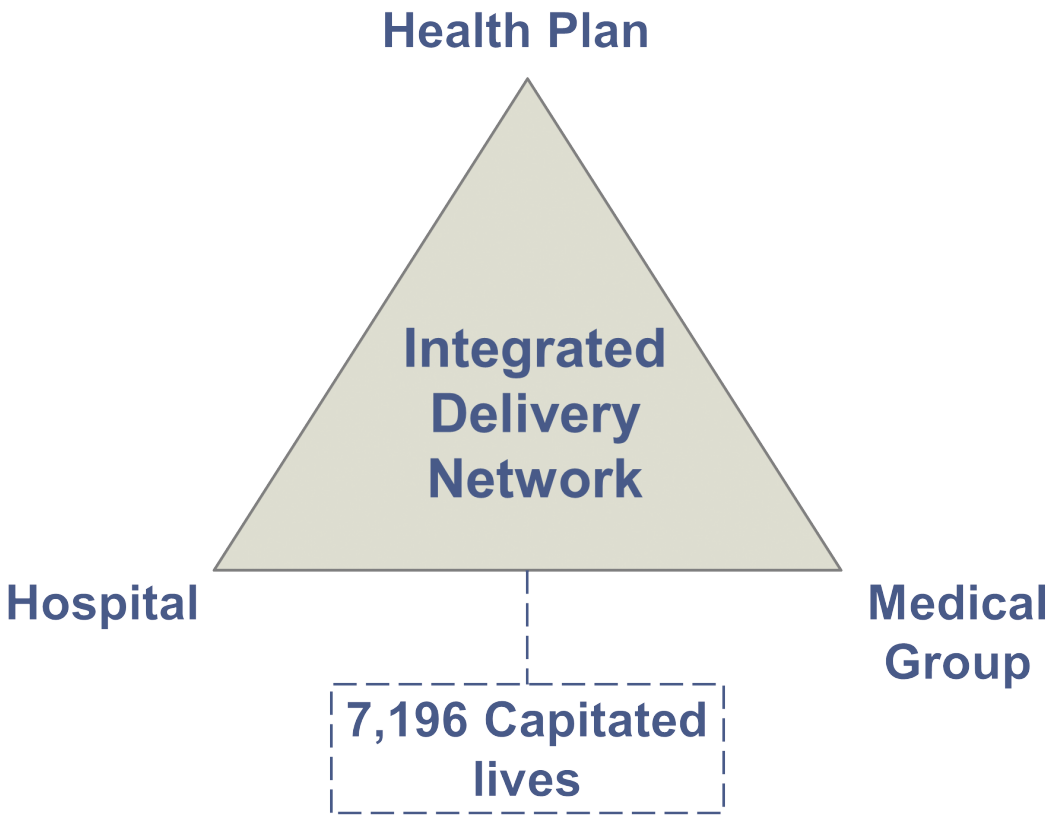

Figure 2. IDN population by diabetes mellitus (DM) status

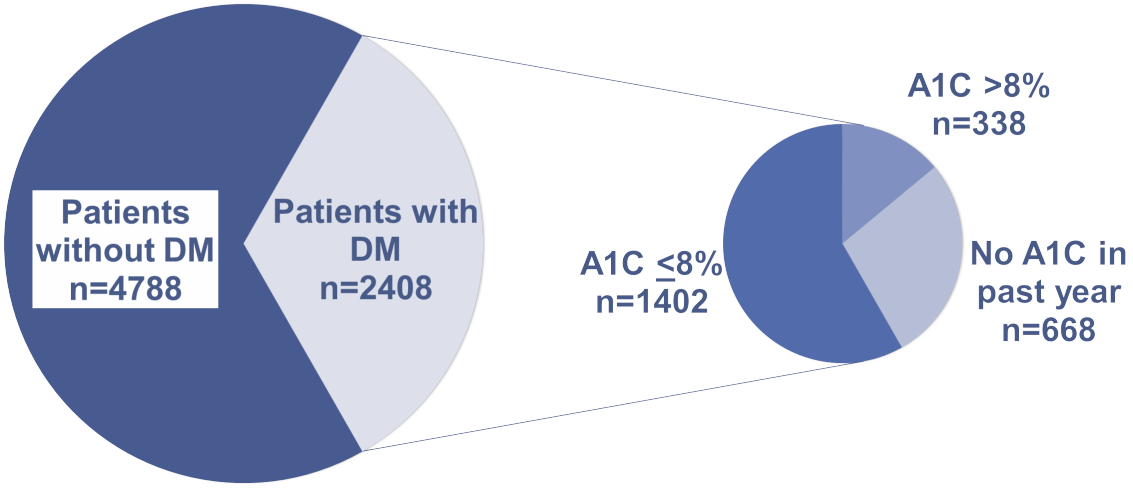

Figure 3. Program overview