TITLE: **PROTOCOL FOR CLOSING THE LOOP: DIABETES**

PURPOSE: Protocol for Patient Health Coach (PHC) to perform point-of-care diabetes education, medication reconciliation, action planning with diabetics post-visit with their PCP.

PROTOCOL:

- The Patient Health Coach is a medical assistant who has received training on chronic disease management, motivational interviewing, medication reconciliation counseling techniques, and developing action plans with patients.
- The Patient Health Coach will identify diabetic patients for Closing the Loop through a list generated by the report server.
- Reasons for referral by PCP for diabetes counseling include the following:
    - Patients who are confused about their medications
    - Patients whose medications were recently changed
    - Newly diagnosed patients with diabetes
    - Patients who can use additional education on diabetes diet, exercise, smoking cessation and weight management
- Counseling by the health coach will take place in small 10-15 minute increments over several visits depending on the patient's knowledge about their chronic disease ("stepped counseling"). In order to avoid overwhelming patients, it is up to the health coach's discretion to determine how much information should be provided to the patient at each visit.
- Counseling by the health coach can take place before or after the visit with the PCP.

PROCEDURES:

1. The Patient Health Coach will greet the patient and explain his/her role on the health care team.
2. Using the "Ask" method, the health coach will review the patient's diabetes medications, doses, and timing of doses with patient to assess patient understanding, assess patient response to medications, and assess potential barriers. Where needed, the health coach will provide medication adherence techniques and counseling.
3. The health coach will review with the patient what his/her "ABC" goals are (**A**1C, **B**P, **C**holesterol/LDL) and how that compares to their most recent results. The health coach will utilize the "ABCs of Diabetes" and "A1c thermometer" handouts to facilitate teaching.
4. The health coach will review diabetes diet and exercise recommendations. Where needed, the patient will provide handouts to help patients improve diet and exercise. Where relevant, the health coach will incorporate counseling on the maintenance of a healthy body weight.
5. The health coach will help the patient create an Action Plan to self manage their diabetes. The Action Plan will be documented in the "NEMS Edu Goal" template, and the patient will retain a hard copy of the Action Plan to encourage their successful adoption of healthier behaviors outlined in the Action Plan.
6. If the patient is a current smoker, the health coach will discuss the health risks of smoking, and if the patient is interested in quitting smoking or cutting down their smoking habit, the coach will provide educational materials and assist with goal-setting, as appropriate.

7. The health coach will also check that the patient has had a recent retinopathy screen. If the patient has not had a retinopathy screen in the past year, the health coach will help schedule a digital retinopathy and order the digital retinopathy via standing order.
8. As needed, the health coach will educate the patient about foot complications and routine foot self-care methods.
9. As needed, the health coach will teach the patient how to use a glucometer, how to engage in glucometer self-monitoring, and provide patients with self-management tools for self-monitoring.
10. The health coach will ensure that the patient knows the next time he/she should follow-up with their PCP and when their next lab tests should be completed.
11. After the patient has left, the health coach will complete proper documentation for Closing the Loop in the "NEMS Edu Goal" template and fill out the appropriate Health Education reimbursement forms for "Y" patients.
12. If the health coach notices that diabetes labs are not up-to-date, they may remind the PCP that labs are due or order per standing orders.