CPCPracticeSpotlight17

Comprehensive Primary Care is an initiative of the Center for Medicare & Medicaid Innovation

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This strategy addresses CPC Milestones 2, 4 and 5.

For more information about the CPC initiative, visit http://innovation.cms.gov/initiatives/Comprehensive-Primary-Care-Initiative/.

Patient-Centered Care Management Resonates with Patients with Diabetes, Hypertension and Obesity

Clopton Clinic, Jonesboro, Arkansas

Multi-specialty; 9 physicians, 4 APRNs; 9,732 patients

Situation: Patients who struggle with self-management of chronic conditions such as diabetes need additional support and education from their clinical care teams. Uncontrolled A1c values and poor medication acceptance among patients with diabetes demonstrated an opportunity to improve provider-patient communication through intensive staff training and patient-centered care management.

Strategy: Clopton's care management staff crafted a patient-centered approach, using the EHR to identify a group of patients with the greatest need for improvement related to diabetes management, hypertension and obesity. To support self-management in diabetes care, the staff improved their capability by completing 26 hours of online health coaching classes through Clinical Health Coach. The curriculum emphasizes inspiring patient accountability through coaching and effective communications that improves health literacy. The staff also trained with a Certified Diabetes Educator for four hours to better understand the diabetes disease process and how to be more effective in addressing patients' concerns and needs.

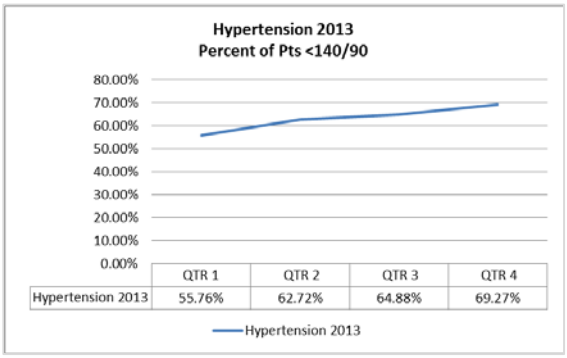

Table 1. Improved control of hypertension (<140/90)

The team identified these potential barriers to successful implementation and sustainability: ability reach patients in a timely manner to communicate health care recommendations, inaccurate or incomplete contact and medical information from patients and their caregivers, and patients' lack of knowledge of self-care. Robust teamwork, coordination and communication among the care teams have addressed most barriers.

As care management staff met one-on-one with patients and their caregivers, they developed personalized care plans for each patient and called them monthly to evaluate progress and address any emerging concerns or barriers. Preventive care and routine screenings are monitored through the EHR, and phone call reminders are made as care is needed or past due. Other practices seeking to implement this approach should also consider how to access available community resources to supplement in-clinic education and how to incorporate ongoing follow-up into regular workflows.

Patients report they appreciate the extra time care management staff takes with them to ensure they are receiving appropriate care. They acknowledge the clinic is investing in them, and in turn, they are more engaged, accountable and accepting of treatment recommendations that meet their values. Data are beginning to show improved hypertension control, improved A1c values and increased patient acceptance of medication recommendations.

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