CPCPracticeSpotlight16

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

Lower A1c Among Patients with Diabetes Through Standardized Team Approach

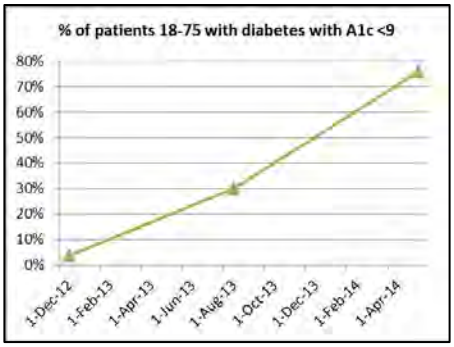
Warren Clinic – Bishops offices 220 and 420, Tulsa, Oklahoma System; 37 physicians; 46,400 patients

Aug. 8, 2014

This innovation addresses CPC Milestones 2 and 5.

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

Situation: Warren Clinic physicians **Dina Azadi, DO,** and **Christy Mayfield, MD,** chose to address lowering A1c values among their patients with diabetes as one of the clinic's clinical quality measures. Baseline data collected on Dec. 31, 2012, showed only 3.8% of patients with diabetes in their combined two practices had an A1c <9.



Baseline data in Dec. 2012 was 3.8%; A1c <9 rates in Aug. 2013 had improved to 30%. Most current data as of May 2014 is 76% for both practices.

Innovation: When **Tim Ingram, BSN, RN,** care guidance nurse, was hired in August 2013, he worked with the physicians to identify patients to whom this quality measure is applicable and to create a standardized approach called INCOGNITO. The strengths of this approach are that it leverages data to identify patients, uses the consistency of a team approach to reach out to patients, adapts to address each patient's needs and provides a follow-up mechanism for patients who remain at high risk. Both practices' care teams followed the steps below to help patients with diabetes:

I – Identify: Use risk stratification methodology to identify patients with diabetes.

N – Numbers: Most recent A1c values were evaluated as overdue, controlled and uncontrolled.

C – Call Beforehand: Patients overdue for diabetes care were contacted for appointments.

O – Organize: Staff called patients with diabetes the week before their scheduled appointments to ensure lab work was completed prior to the upcoming appointment.

G – Goal Setting: During appointments, the care guidance nurse discussed personal goal setting with each patient.

N – Needs: The care guidance nurse evaluated each patient for potential financial or social needs that prevented acceptance of medication recommendations and addressed those needs.

I – Initiation: Based on assessment, the physician and care guidance nurse provide more in-depth and personalized diabetes education. The care guidance nurse sees all patients with an A1c >7.

T –Telephone Afterward: Staff flagged patients with a history of poor acceptance of medication recommendations and planned follow-up contact within two weeks to evaluate current control and regimen effectiveness.

O – Open Door Policy: Patients are invited to call the care guidance nurse any time with questions or concerns.

Most recent data show the practices' combined rate has improved to 76% of patients with diabetes having an A1c <9.

TMF Health Quality Institute

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