CPCPracticeSpotlight21

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

Data-Driven Improvement Using Medication Management and Shared Decision Making with High-Risk Patients with Diabetes

Cherokee Nation Health Services Wilma P. Mankiller Health Center, Stilwell, Oklahoma System; 3 physicians, 3 NPs; 2,500 patients

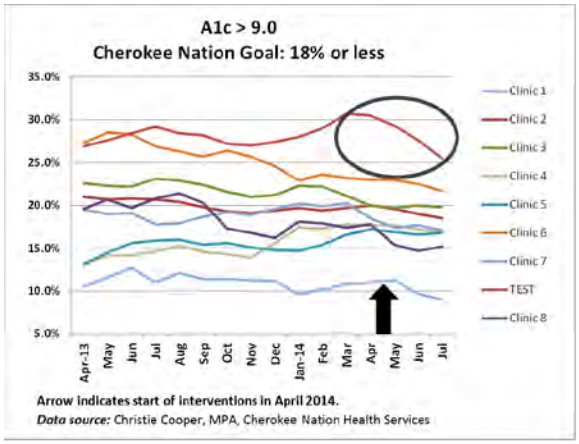
Sept. 12, 2014

This strategy addresses CPC Milestones 2, 5 and 7.

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

Situation: Data from March 2014 showed more than 30% of Mankiller Health Center's patients with diabetes demonstrated poor glucose control with an HgbA1c >9. **Cherokee Nation Health Services** (CNHS) set a population management goal of 18% or less for HgbA1c >9. Among all CNHS clinics, Mankiller clinic was furthest out of range for meeting this goal.

Strategy: The target population for intervention was divided into for two groups of patients: first, those whose HgbA1c values were close to goal range and likely to improve with a lighter intervention, and second, those patients whose HgbA1c values were far out of goal range and would need intensive interventions to help them reach goal range. Starting in April 2014, Care Manager **Jill Eubanks, BSN, RN**, reached out to the first group of patients to assess their needs and schedule clinic visits for clinical management.



Concurrently, the care teams began working with CNHS CPC Nurse Consultant LCDR **Tara Ritter, DNP, MSN, RN, CDE,** to launch the system's intensive diabetes management education program at Mankiller for those patients at highest risk for adverse events related to very poor glucose control. They opted to deepen the existing curriculum by adding a full-time pharmacist for medication management and 1:1 patient education. By providing high-risk patients with individualized medication counseling, they believed this would encourage patient engagement with treatment and result in improved HgbA1c values.

During the ramp-up period **Travis Fleming, PharmD**, shadowed clinic operations and trained on the diabetes education curriculum. While clinic data pinpointed a pilot group of patients for this intervention, physicians also weighed in with their clinical knowledge of the patients' particular situation and condition that may affect their success with the intervention.

By late May, Fleming and Eubanks began scheduling 1:1 meetings with 10 patients. During these initial one-hour appointments, the pharmacist reviewed the patient's current medications and offered a paper-based shared decision aid on diabetes medication choices. The goal was to help the patient make an informed selection of a regimen that best suited the patient's tolerance for side effects, fit well with the patient's lifestyle and in general would make it easiest for the patient to follow the suggested protocols. CNHS developed the decision aid, which aligns with the system's formulary, to ensure patients have timely access to affordable medications through the system's pharmacy. Fleming continued to meet 1:1 with patients as medications were adjusted and to support continued self-management with the medication regimen.

The pilot group expanded to about 20 patients once the care team had a better grasp of the process and workflows to make the medication management element work efficiently.

Within weeks of operationalizing both interventions, the data began to show improvement. The July 2014 data shows a decrease from 30% to 25% of patients with HgbA1c >9.

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