

MEASURE HbA1c EVERY 3-6 MONTHS



HbA1c is measured every three to six months for patients with Type 2 diabetes, according to American Diabetes Association (ADA) guidelines. This will occur without exception and processes are in place to monitor system adherence and conduct outreach to patients overdue for testing.

HbA1c is the most important surveillance tool to monitor glycemic control and provides an accurate reflection of how well the treatment plan is working. HbA1c levels are predictive of risk for diabetic microvascular complications. The ADA's Standards of Medical Care recommend that HbA1c testing be done for patients with Type 2 diabetes at least two times per year for those meeting treatment goals, and quarterly for those whose therapy has changed or are not at target.

Successful diabetes improvement interventions assure that patients are aware of the need for testing, create monitoring systems to assure testing is completed, perform routine outreach to those who are overdue, and embed patient education to convey the importance and meaning of the results. Equally critical is the need for care providers to respond timely to the HbA1c result by intensifying treatment for all those not at target.

STEPS TO ASSURE HbA1c TESTING IS BEING PERFORMED EFFECTIVELY FOR YOUR DIABETES POPULATION

- Incorporate HbA1c testing frequency recommendations into your guidelines (refer to Adopt Treatment Algorithm plank).
- Include specific HbA1c frequency in each individual patient's care plan.
- Make HbA1c awareness a key component in your patient education efforts. Use simple language, pictures, and patient stories that communicate the critical importance of this test.
- Add language to the after-visit summary, your patient portal, and other individualized patient materials that explains the meaning of the HbA1c test, indicates whether the patient is at target range, and displays when the patient is due for his or her next test.
- Create a list from your diabetes registry at a specified interval (e.g., monthly, quarterly) of patients overdue for HbA1c testing. Consider starting by identifying patients who have not had an HbA1c test in over a year. For more information, refer to Use a Patient Registry plank.
- Contact those overdue for testing using letters, phone calls, or automated tools such as text messaging.
- Use point-of-care alerts within the EHR that indicate if a patient is overdue. Consider implementing these prompts for all providers, not just primary care, and developing standardized processes to alert patients at the time of their visit to obtain necessary testing.
- Implement standard order sets for patients with diabetes that can be deployed by non-physicians to facilitate HbA1c testing.
- Monitor your organization's HbA1c testing performance on and report back to the Accountable Diabetes Team (refer to Build an Accountable Diabetes Team plank).
- Include data comparing A1c ordered versus completed as part of your internal reports (refer to Publish Transparent Internal Reports plank) to illustrate potential gaps in care.
- Incorporate simple, low-cost strategies, such as room signage with a clear call-to-action, to foster discussion regarding needed testing.

TOOL: DIABETES MEDICATION REFILL AND VISIT FREQUENCY GUIDELINES

MERITER-UNITYPOINT HEALTH



Diabetes Update – 2015

MMG Diabetes Medication Refill and Visit Frequency Guidelines

Care Team actions: During most patient contacts and for chart prep, review the following

- ✓ Review most recent A1c
- ✓ Verify that meds are filled and check medication response/tolerance
- ✓ Check standing/future lab orders and create standing orders as needed (A1c, LDL, serum creatinine, urine micro-albumin) if needed
- ✓ Reinforce home glucose monitoring if patient is monitoring
- ✓ Assure next visit is scheduled

Last A1c	Refills	Visit frequency	Additional Care Team Actions
1. New medication regardless of A1c	60 days max	Office visit within 30 days	<ul style="list-style-type: none"> • Contact every 2 weeks via phone or MyChart
2. Last A1c >6 months ago	30 day refill	Office visit within 30 days	
3. A1c typically less than 7	6 month refill	Every 6 months	<ul style="list-style-type: none"> • Screen for hypoglycemia
4. A1c 7.0 to 7.9	3 month refill	Every 3 months	
5. A1c 8 - 9	3 month refill	Every 3 months	<ul style="list-style-type: none"> • If A1c \geq 8 for 6 months pend order to DCT and/or pharmacists
6. A1c >9	1-3 month refill based on compliance, comorbidities, home blood glucose monitoring	Visits every 6 weeks	<ul style="list-style-type: none"> • Contact every 2 weeks via phone or MyChart • Monitor blood glucose checks via MyChart or phone outreach • Pend order to DCT

A1c Control Goal

List of useful DM related smart phrases (type "Diabetes" to view full list)

<ul style="list-style-type: none"> • <i>Lastdiabetes3ref</i> (last 3 diabetes lab results) • <i>Medrfdm</i> (last office visit DM labs/refill info) 	<ul style="list-style-type: none"> • <i>Diabeticteach</i> (review DM teaching book/glucometer) • <i>DM foot exam</i>
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