INNOVATIONS IN PRIMARY CARE
Enhanced Care Team Nurse Process to Improve Diabetes Care

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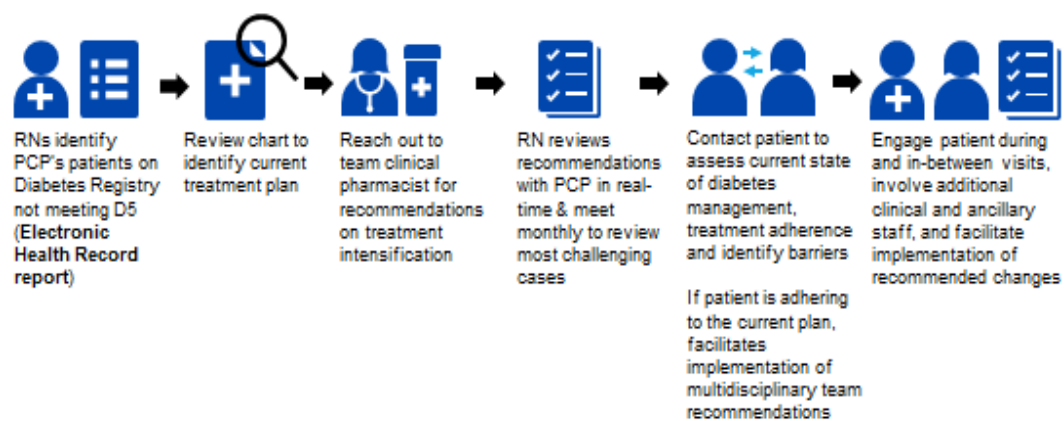**Supplemental Appendix**

Content of Initial RN Assessment

1. Medication review with adherence and adverse effect assessment

2. Social history and lifestyle factors

    a. Eating pattern and weight history

    b. Sleep behaviors

    c. Physical activity

    d. Tobacco, alcohol, substance use

    e. Social supports

3. Barriers to effective diabetes management

4. Patient goals

Review of MN Community Measurement D5

MN Community Measurement (MNCM) is a collaborative organization including physicians, hospitals and health systems, state government, consumers, employers and health plans. MNCM develops, collects, analyzes and publically reports health care quality, cost and patient experience information in an effort to empower the community. One measure reported by MNCM is the D5 for diabetes. This is an all or none composite measure for patients aged 18-75 and includes the following five components;

- HbA1c < 8% within the last 12 months

- In-office blood pressure < 140/90 within the past 12 months

- For patients with a co-morbidity of Ischemic Vascular/Cardiovascular Disease patient has documented aspirin/antiplatelet on medication list or contraindication/allergy

- Tobacco-free status documented within the last year

- LDL done in the last five years

    o Age 18-20 – no LDL requirement

    o Age 21-39 – LDL < 190 or on statin medication or a contraindication to a statin medication or attempt to use a statin medication in the last 5 years

    o Age 40-75 – LDL < 70 with the same other criteria as age 21-39

    o If Diabetic with Vascular Disease – LDL < 40 with the same other criteria as age 21-39

Supplemental Figure.

RNs identify PCP's patients on Diabetes Registry not meeting D5 (**Electronic Health Record** report)

Review chart to identify current treatment plan

Reach out to team clinical pharmacist for recommendations on treatment intensification

RN reviews recommendations with PCP in real-time & meet monthly to review most challenging cases

Contact patient to assess current state of diabetes management, treatment adherence and identify barriers

If patient is adhering to the current plan, facilitates implementation of multidisciplinary team recommendations

Engage patient during and in-between visits, involve additional clinical and ancillary staff, and facilitate implementation of recommended changes

Supplemental Table. Electronic Health Record Report Variables

Patient Information	Optimal Care Measures Status (Met/not met)	Patient Assessment Tools	
Name	HbA1c	Last HbA1c value and date	Next diabetes outreach date
Medical record number	Blood pressure	Last blood pressure value and date	Next primary care provider appointment date
Primary care provider	Cholesterol	Last LDL value and date	Next appointment date in any department
Care team name	Aspirin/antiplatelet	Last tobacco use date	Aspirin/antiplatelet name and strength
Communication preference	Tobacco-free status	Last tobacco assessment review date	Statin name and strength
	Composite	Care coordination enrollment status	