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CAPSULE

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Patient Care Registries: A Tool for Timely Follow-Up When A1C is Above Target

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Evidence suggests that a standard three-to-six-month follow-up is not soon enough for patients with A1C above target.[1] Patient care registries can help practices identify patients who have not yet reached glycemic targets and track timely follow-up visits for patients with diabetes.

As part of a comprehensive, individualized treatment plan, these more frequent visits can be led by a provider, pharmacist, nurse, or part of a shared medical appointment.

Patient Care Registries Aid Care Delivery and Goal Achievement

A practice can use a patient care registry to identify those with A1C above target and then both "reach in" and "reach out" to the patient for follow-up. "Reach in" allows practices to schedule diabetes care for those already in the office for other reasons (such as acute care). "Reach out" includes phone calls, portal messages, or letters to contact patients between visits.

Patient care registries can help practices reach quality improvement goals, address care gaps, and include other health maintenance and preventive care reminders to ensure high-quality care.[4] Patient care registries may be a standalone system (Table 1) or integrated into an electronic medical record, which may help streamline workflows.[4]

Patients with A1C Above Target Benefit from More Frequent Visits

Diabetes algorithms often use the HbA1C measured three months after a therapeutic adjustment to guide further care. However, more frequent visits yield better outcomes for glycemic control and comorbid conditions such as hypertension and hyperlipidemia.[1-3]

Schedule individualized follow-ups according to A1C values in relation to goals. One example of a more frequent follow-up approach based on goals includes:

- Every **4 weeks** for those at **≥9%**
- Every **2 to 3 months** for those between **7% and 8.9%**
- Every **3 to 6 months** for those **<7% or at their personal target**

Table 1. Sample Patient Care Registry

Patient Name	Provider	Next Visit/Contact	A1C	A1C Date	Eye Exam	Foot Exam	Basic Metabolic Panel	LDL	Lipid Test	Comorbidities
Black, James	Cooper	Sick visit next week/ Cooper to reach in	6.8	1/22/21	7/22/21	1/21/21	1/21/21	104	1/21/21	
Brown, Julie	Cooper	1 month	>9	1/15/22	3/18/21	2/14/21	11/11/21	99	11/11/21	Retinopathy
Green, Jane	Cooper	2-3 months	7.5	1/1/22	3/31/21	2/28/21	2/28/21	76	2/28/21	HTN, obesity
White, John	Cooper	3-6 months	5.7	1/26/22	12/11/21	2/22/21	2/22/21	91	2/22/21	

Adapted from *Patient Care Registries: Proactively Manage Chronic Conditions*[4]

For more information, access Cardi-OH's expanded resources on Clinical Inertia and Diabetes Management and the Diabetes Quality Improvement Project's Clinical Best Practices Toolkit.

References

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