

Quality Improvement Initiative – *Diabetes Care*

Aim

The aim this quality initiative is to improve diabetes control and preventive care by consistently applying the American Diabetes Association guidelines for diabetes care to all Gifford primary care patients who have diabetes.

Time Frame

This project started in 2007 and is ongoing.

Description

Gifford has implemented a two-pronged approach to diabetes care. A care management team that includes Gifford's assistant medical director for quality, Gifford's endocrinologist, a dietitian and a certified diabetes nurse educator has created part of the approach. This team has developed communication tools and protocols to ensure that the right providers are seeing patients at the right time, and that patients have access to all of the education they need to actively participate in the care of their condition. This co-management model is currently in a testing phase. In addition, for slightly more than a year, Gifford's Quality Management Department has been producing reports for providers. These reports help the providers understand the status of their diabetes patient populations, so providers can pursue interventions with the patients when necessary. Graphs shown below indicate that this approach is increasing the overall health of Gifford's diabetes patients.

Description of the problem

At Gifford Medical Center, we are committed to providing timely and quality care to our diabetes patients. Diabetes is often a disease that seems asymptomatic to those who have been diagnosed. However, failure to control diabetes over the long term creates a significant risk of co-morbidities for diabetes patients. Diabetes can lead to heart disease, stroke, nerve damage, especially in the extremities, eye conditions and blindness, kidney damage, and damage to teeth and gums, among others.

To ensure that diabetes is well controlled, it is important for diabetes patients to see their providers regularly and receive certain lab tests. If lab tests fall outside of expected ranges, changes in treatment are often warranted.

Project goals with appropriate measures

1. 90 percent of diabetes patients will have had their HgA1C tested within the last year
2. 90 percent of diabetes patients will have had their LDLs tested within the last year
3. 90 percent of diabetes patients will have had their microalbumins tested within the last year
4. 90 percent of diabetes patients will have had their blood pressure taken and recorded at their last office visit
5. The practices will realize a 10-percent improvement from baseline (in January 2007) of the percentage HgA1Cs tested within one year and less than 7.0

6. Increase the percentage of diabetes patients who have received a pneumonia vaccination
7. Increase the percentage of diabetes patients receiving assessment, care and self-management education through the Diabetes Clinic

Additionally, outside of reports provided to providers, the following two goals have been tracked internally, within the Quality Management Department at Gifford:

1. The percentage of patients with a Hemoglobin A1C score below 7.0 percent should approach or exceed the goal of the Vermont Blueprint for Health, which is 60 percent.
2. The percentage of patients with an LDL score below 100 should approach or exceed the goal of the Vermont Blueprint for Health, which is 40 percent.

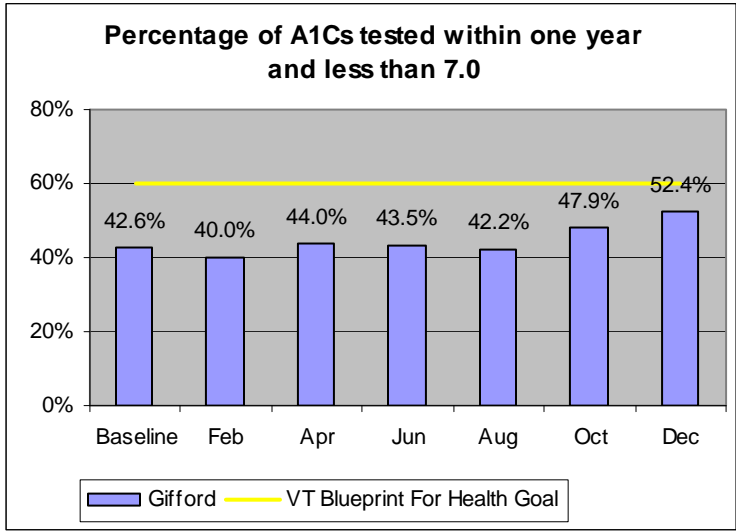
Description of the intervention(s)

1. Every other month, primary care providers receive a two-part report regarding their diabetes patients. The first part of the report is a set of graphs that show how the provider is doing versus the goals defined above, and how that provider compares with the average across all of Gifford's providers. The second part of the report is a color-coded patient listing that shows patients who are overdue for lab tests, patients who will be due shortly for tests and patients who are "out of range" on some lab test results. The providers can use the color-coding to quickly determine which patients need to be contacted to set up an office visit and lab tests.
2. Gifford's endocrinologist developed a Diabetes Flow Sheet for voluntary use by providers, so they could quickly review diabetes care from visit to visit. This flow sheet is stored at the beginning of the patient's chart, making it easier for providers to quickly see recent visit dates, lab test status and other critical clinical data.
3. Letter templates were drafted to recall diabetes patients in need of care and follow-up.
4. Providers followed up with patients who had not been seen for a long time to verify that they were still receiving diabetes care, even if it was not at Gifford.
5. A Diabetes Clinic Tool Packet was created for providers. This packet includes:
 - a. Diabetes Clinic Care Plan and plan follow-up
 - b. Diabetes Clinic Lab Order set
 - c. Order set for Diabetes Clinic and/or Nutrition Referral
 - d. Summary of Medications for Blood Glucose Control and an Algorithm for introducing these medications for Blood Glucose Control
6. A tool was created to generate a current status sheet for each diabetes patient at the time of his or her office visit. This sheet can then be given to the patient so the patient knows exactly when certain exams are next due and what the latest lab results were.

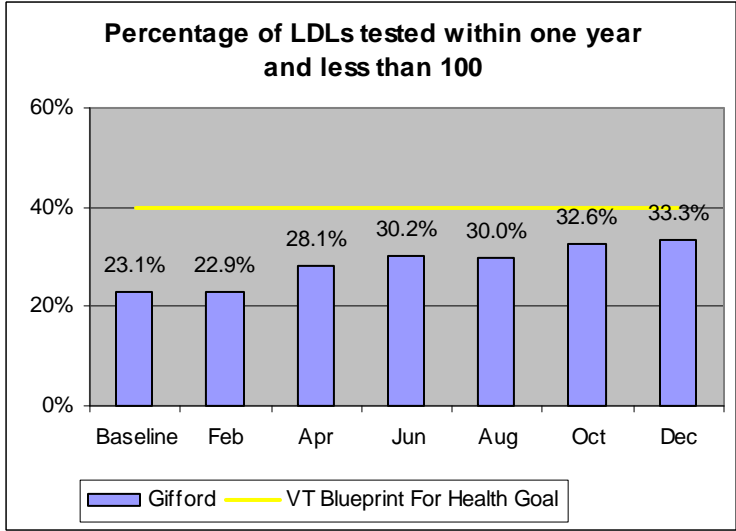
Evaluation Process and Results

Proper care of diabetes patients is a team process. The patient works with a primary care provider, a diabetes nurse educator, a nutritionist and sometimes with an endocrinologist to get the information and medications needed to manage the disease. In this treatment model, no one member of the treatment team is fully responsible for the care of the patient, but it is patient-centric care, and the outcomes depend on the patients and the health-care providers.

In the past year, Gifford has made steady progress toward two of the goals of the Vermont Blueprint for Health, but we have not yet hit those goals at the organizational level. Here are two graphs that show Gifford's progress toward the Blueprint goals:



Gifford has 15 distinct providers with a diabetes patient panel of 15 or more patients. Of those providers, five have a patient panel that has met the 60-percent goal shown above.



Nine of Gifford’s providers with 15 or more diabetes patients have currently met the 40-percent goal shown above.

In both cases above, the Gifford providers who have met certain goals are being asked to present information to their peers, outlining the techniques they have used to achieve the goal.

Since this program has started, Gifford patients are clearly receiving improved diabetes care, and their lab scores verify this fact.

Contact

Quality Management Department
Gifford Medical Center
P.O. Box 2000
Randolph, VT 05060
Phone: (802) 728-2329
Fax: (802) 728-2613
E-mail: QualityDepartment@giffordmed.org