

# **Hospital Quality Improvement Initiative**

## **Promoting Wellness and Preventive Health Care**

### **Aim**

Improve the quality of life for our patients and community by ensuring Gifford Medical Center provides patient care preemptively, before illness or harm occurs, through the development and implementation of proactive systems for wellness and preventive health care.

### **Time frame**

Fall 2005 to present

### **Description**

It is clear that to care for patients only when they become ill is imprudent. Preemptive, proactive health care always results in better outcomes for the patient, their families and the community. Preventive services are optimal and have been associated with substantial reductions in morbidity and mortality.

Gifford Medical Center wants to improve the care and quality of life for all patients, especially those living with chronic disease, and to proactively engage the community in wellness care. To do so, systems that engage the patients in taking responsibility for their health and that recall, remind and alert the patient and provider of needed exams, tests and care are being designed and implemented. Patients and the health care system win when opportunities for disease prevention, such as yearly physicals, annual mammograms, vaccinations and colonoscopies, are embedded into our clinical office practice systems. Gifford Medical Center, through the creation of office systems, clear goals and measures, and teamwork, will constantly improve the care we deliver.

### **Goals and measures**

For general wellness care:

- Wellness care/preventive services, such as annual exams, screenings, counseling and immunizations

For diabetes care:

- 90 percent of patients will have documentation of four process measures chosen from the American Diabetes Association guidelines. Those measures are the number of patients with:
  - Hemoglobin A1C test at least yearly;
  - LDL cholesterol measurement yearly;

- Urine microalbumin yearly; and
  - Documented blood pressure reading at most recent visit.
- Percent of diabetes patients with Hemoglobin A1C control will improve by 10 percent.

For pediatric care:

- 90 percent of patients 24-30 months of age will receive age-appropriate immunizations or have parental refusal documented.

## **Interventions**

- “Dialing for Health” campaign for diabetes and woman’s health – a pilot project for the months of June and July 2006 for women’s health issues. Measurement of success included number of women who made appointments based on number called (see graph) or sent reminder cards.
- Primary care providers receive provider specific performance data every two months to assist them in identifying patients due for recommended care.
- Flow sheets to document expected care for diabetes patients on each office visit were developed, in-serviced with providers and office staff, and put into practice.
- Development of a systematic recall postcard tickler system for health maintenance and chronic disease management.
  - The office check out process allows patients to schedule appointments well in advance or to be added to the “reminder” list. Postcards are completed and sent to patients one month prior to their needed/scheduled appointment as a reminder insuring timely follow-up and medical care management.

## **Results**

Dialing for Health initially took many man hours and support from staff in various departments. Implementing this strategy increased patient and provider awareness and has also improved compliance for self-management care.

With each dialing session, the callers are improving their strategies in order to get patients in for necessary care.

Bi-monthly reports to each provider show the provider how well he or she is doing managing the care of specific patient populations, initially patients with diabetes and childhood immunization compliance.

Woman's health data:

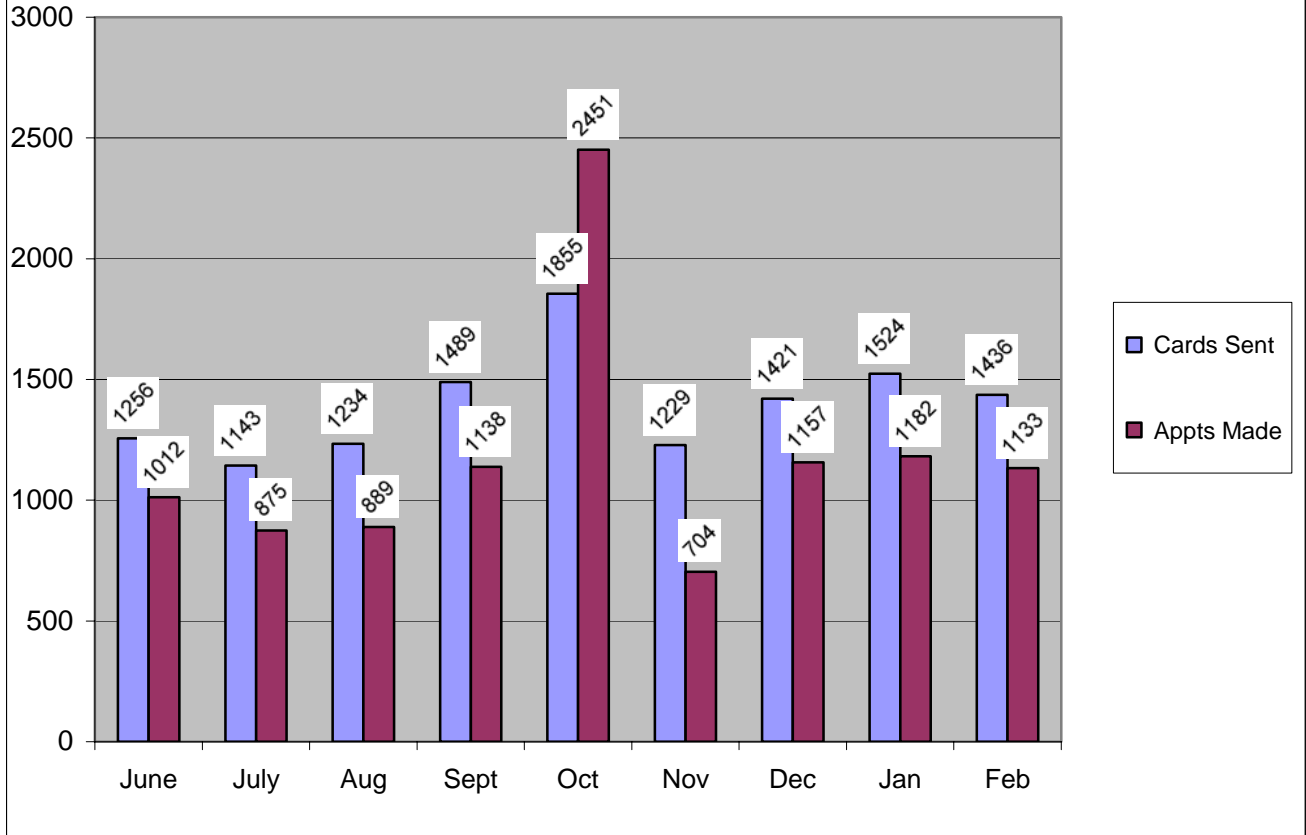
Total women in need of care	1901
Total calls made	1542
Total women who booked appointments	100
Total reminder cards sent	100
Total calls not answered	1179
Total people declining to book	43
Ladies First	7

Diabetes health data:

Total patients identified in need of care	272
Total calls made	202
Total appointments booked with primary care provider	20
**Total appointments booked with Diabetes Clinic	0
**Total lab appointments booked	0
Total people declining to book	18

Reminder/recall card data (next page):

### Appointments from Reminder/Recall Cards June 2006- Feb 2007



Diabetes care baseline data (next page):

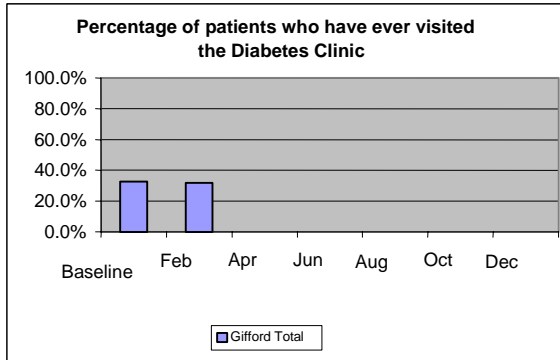
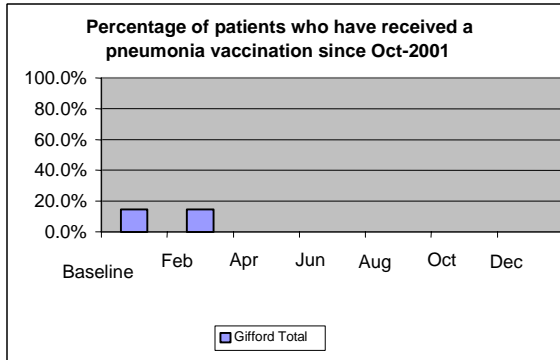
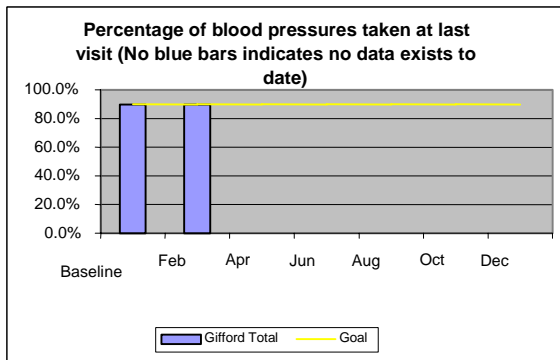
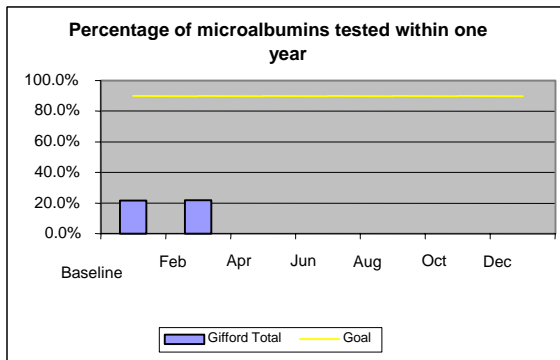
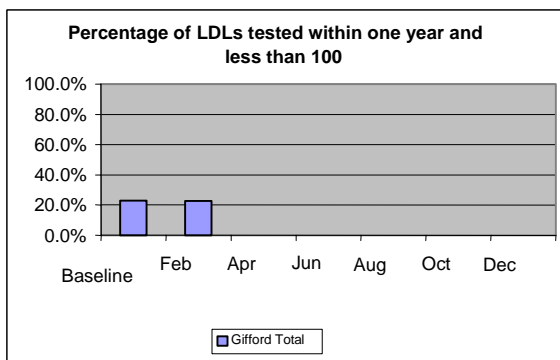
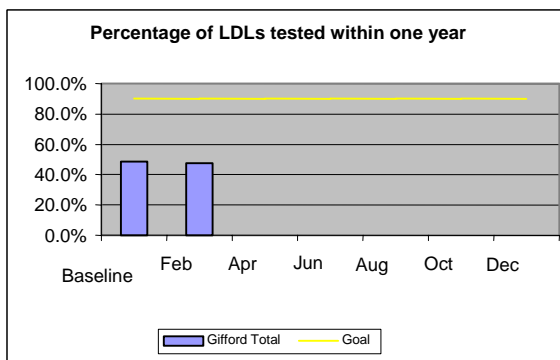
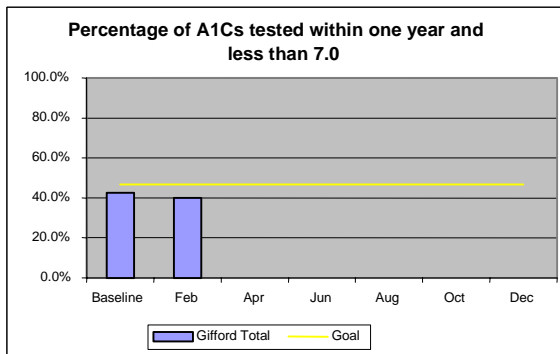
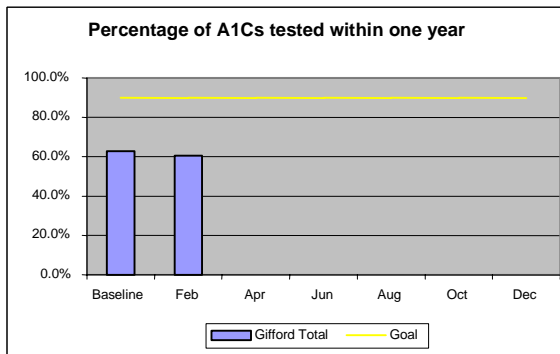
# Gifford

## All providers

5/2/2007

Providers have 1,601 diabetes patients.

This report covers the period ending Feb. 29, 2007



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