Adult Primary Care Diabetes Management Improvement:

Identifying Trends/Gaps in Patient Care.

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Objective

Sanford has an organizational goal of 60% optimal diabetes management. This project aimed to improve diabetes management scores by 5% or to reach goal by provider in Oakes area clinics.

Background

Baseline optimal diabetes management scores for the primary care providers ranged from 31.3% to 55.6% prior to any process improvements. Previous processes included running registry reports, analyzing fallouts patient by patient and reviewing line by line with providers. Despite these actions, data had shown optimal diabetes management scores remained stagnant for several months.

Actions Taken

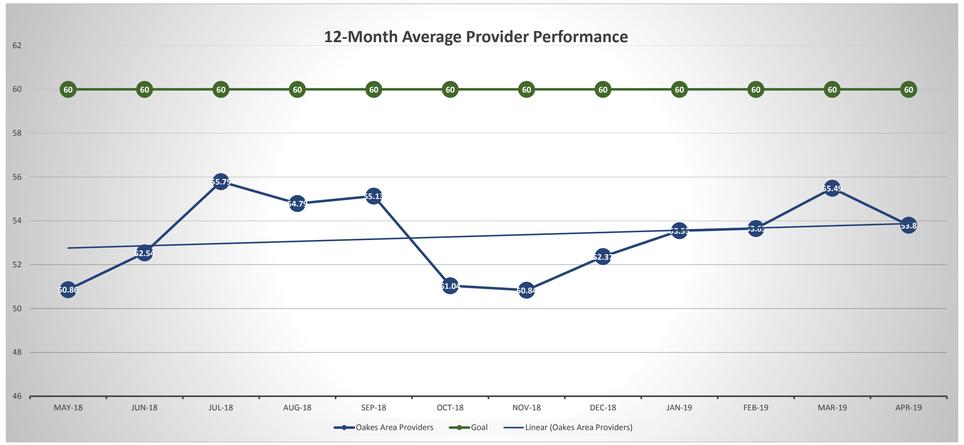
► Registry reports were ran and filtered:
- By patients with a GAP score of 1 or 2 to identify easy fixes
  - Overdue lab work
  - Recommended medications
  - High blood pressures
- By provider to identify care tendencies. These were depicted in graph form and given to each provider

► Reviewed diabetes standard treatment regimen, nursing protocols. This helped to identify each care team member's role in supporting optimal diabetes management.

► Challenged the care team to take advantage of encounters that historically would have been "missed opportunities".

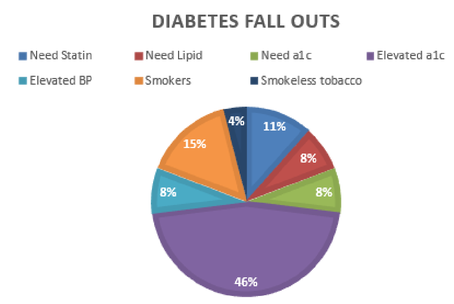
Metrics

During the duration of this project, the clinic was able to improve 8 out of 11 provider scores; 6 providers by >5%; two providers surpassed the 60% goal.



EXAMPLES OF DATA GIVEN TO PROVIDERS

Patients with a GAP of 1 or 2	20
Need Statin	3
Need Lipid	2
Need a1c	2
Elevated a1c	12
Elevated BP	2
Smokers	4
Smokeless tobacco	1



The Compass Practice Transformation Network is supported by Funding Opportunity Number CMS-1L1-15-003 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. The contents of this publication are solely the responsibility of the authors and do not necessarily represent the views of the U.S. Department of Health and Human Services or any of its agencies.

Analysis

► Some providers were surprised by the analysis of care tendencies leading to individual areas of concentration and improvement.

► Many patients had contacts with the clinic not related to diabetes. Missed opportunities included refill requests and acute care visits. Workflows were adjusted to use these valuable contacts to address care gaps.

► Barriers to achieving goals were identified.

1) Specific visits that limited team ability to address health maintenance topics (procedures, DOT physicals, Worker's Comp visits)
2) Patients that were previously controlled but were overdue for lab work were no longer controlled. This ultimately resulted in improved patient care.

►Overall, these changes resulted in a trend towards goal after months of stagnation resulting in improved patient diabetes management.

Next Steps

►Nurses will use the health maintenance reminders on the patient snapshot during patient contacts not directly related to diabetes to remind patients of gaps in care.

►Collaboration with providers will continue to re-evaluate tendencies of care on a regular basis providing feedback on progress.

►Our practice will explore expanding Diabetic Educator services via telehealth.

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