It Takes a Village:
Transforming Care for Patients with Diabetes

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Objective

- To improve outcomes for patients by utilizing all members of the healthcare team to their fullest potential
- To specifically utilize the team for patients with diabetes to
  - ✓ Increase appropriate statin use
  - ✓ Achieve A1c <8

Background

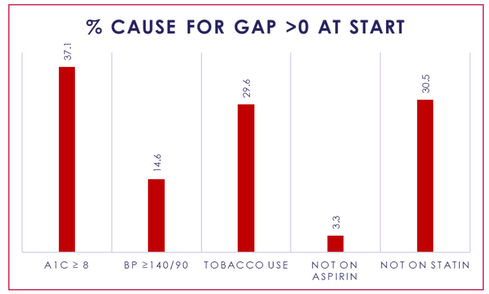
Team based care has overall been a focus of conversation and change at the Sanford Clinic – Valley City over the past 3 years. Spinning off of an enterprise diabetes project, there has been focused work over the past year on specifically how this relates to care of patients with diabetes. The diabetes quality score at the clinic had been stagnant for quite some time, hovering around 52%. Data review showed that the 2 most common gaps in diabetes care were A1c >8% and not being on a statin. The main initial focus has been on utilizing the clinic RN's to their fullest scope.

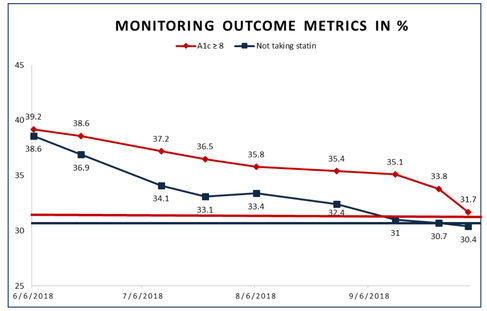
Actions Taken

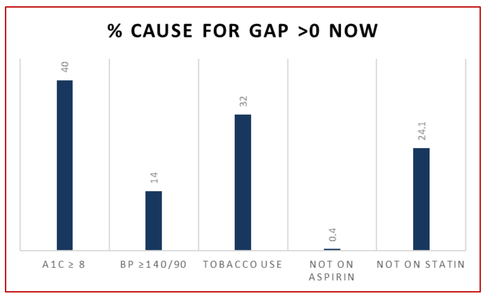
- ✓ Assigned each RN in the clinic a provider panel
  - Utilized Healthy Planet for RN's to run reports and manage panels 2 hours/week
  - Reviewed the medical record for accuracy
  - Ordered labs per Enterprise protocol
  - Recommended/scheduled visits if A1c >8 or blood pressure above goal
  - Educated patients with scripting tools on statin use and forwarding to providers to order if patient agreeable
  - Utilized the RN hypertension protocol to get blood pressures to goal
- ✓ Increased provider and nurse awareness
  - Added gap scores to schedules and calculator index to SnapShot
  - Placed gap score cards in exam rooms as a visual tool
  - Discussed barriers in diabetes care during daily huddles & quarterly team meetings

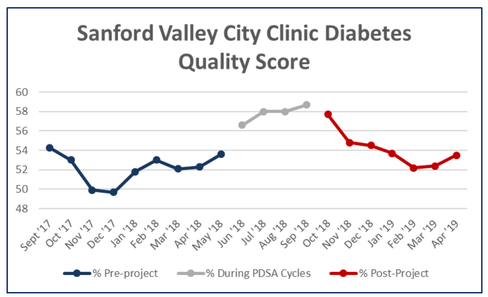
Metrics

The core project team met every 1-2 weeks during the project to troubleshoot barriers, review data, and make adjustments to the process. Since the project was completed, the team has met on 2 occasions to review the clinic's quality scores and discuss next steps.









Analysis

The clinic's quality score progressively improved through the project but then slid back to where it started after completion of the project. This was not unexpected by the team, though. The improvements in accurate statin and aspirin use as well as blood pressure control are reflected more immediately than changes in A1c.

As a clinic, we learned that some of our strategies for transforming practice are effective to help this work along:

- Quarterly Provider Team Meetings
- Book Club- developmental group reading
- Emotional Intelligence training

Some of the other projects that helped us learn to transform our practice include:

- Transitional Care Management workflows with non-affiliated hospitals
- Medicare Wellness Visit workflows and patient education
- Standardize Medication Refill process & include local pharmacies in the work.
- Asses Provider Burnout & take steps to address EMR and schedule related issues.

Next Steps

Diabetes 2.0: Putting the Pieces together

- ✓ Modify actions from original project
- ✓ Enhance application of ALL team members:
  - Empower LPN's and same day care teams to order labs per protocol
  - Utilize Integrated Health Therapist, Tobacco Treatment Specialist, Diabetes Educator, Dietitian
- ✓ Educate, educate, educate
- ✓ Maintain commitment to quality care and better health from patients and all clinic staff.

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