

Improving Diabetes Quality of Care in Your Practice

Introduction

According to the American College of Physicians (ACP), high quality diabetes care requires a systematic and organized team-based approach. The first step in improving the quality of diabetes care is to assess current processes and identify areas that need improvement. Next, it is important to enlist the support of a champion for organizational change. The role of the champion is to advocate for improvement and spread enthusiasm to the rest of the practice. Change should start with one important area and build from there.

Specific steps to develop a Diabetes Care Team include the following:

- Assign responsibilities.
- Develop a patient registry.
- Track progress in improving care.
- Implement a system for planned visits for diabetes care.
- Incorporate diabetes education and support into every visit.
- Support the use of evidence-based guidelines.

For more information about ACP's team-based approach and to order a Diabetes Care Guide (A Team-Based Practice Manual and Self-Assessment Program), go to the ACP Web site at <http://diabetes.acponline.org>.

Successful Diabetes Practices in New Mexico Clinics

Practitioners throughout New Mexico are challenged with managing the care for their patients with diabetes. Several clinics and practices in New Mexico have been very successful in improving the care they provide. Read more about these successes on the pages that follow.

El Centro Family Health—Northern New Mexico (Formerly Health Centers of Northern New Mexico)

El Centro Family Health is a medical practice that consists of 15 medical clinics, 2 dental clinics, and 2 school-based health centers, all located in Northern New Mexico. El Centro's staff also includes Certified Diabetes Educators (CDE), Promotoras, health educators, and bilingual professionals. Various grants help fund the efforts of the clinic.

El Centro Practice Highlights

Along with its team-oriented approach, El Centro uses electronic record keeping and provides diabetes education. Following are some of the methods El Centro uses to help patients with diabetes stay healthy.

- Use of Patient Electronic Care System (PECS) as a disease management registry. PECS drives the delivery of all care, including prevention. An encounter form that reflects the patient's current needs is printed at each visit.
- Promotoras, or community healthcare workers, serve as a liaison between the community and the clinical team. At El Centro, Promotoras run reports from PECS to determine which patients are due for a medical visit and if they need lab work or other assessments. The Promotora then calls patients either to schedule a visit or to remind them of an upcoming visit. Medical records staff flags all disease management charts.
- A1C point-of-care testing is available at all clinics.
- Patient education materials are available at all clinics.
- CDEs, health educators, and/or specially trained nurses provide diabetes education. CDEs travel to the various clinics at appointed times each month.
- A registered pharmacist is available to provide medication oversight.
- Team meetings occur twice a month to discuss ongoing quality improvement activities.

El Centro Clinic Locations

Española Embudo Chama Coyote Highlands University	La Loma Las Vegas Peñasco Roy	San Miguel Springer Truchas Wagon Mound
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La Clinica de Familia—Las Cruces

La Clinica de Familia in Las Cruces consists of 23 medical practitioners at 7 sites in southern New Mexico. Staff includes a full-time Certified Diabetes Educator (CDE) and a CDE in training. Carmella Eagan, M.D., FACP, is the diabetes physician champion and has earned a Certificate of Recognition for diabetes care from the American Diabetes Association/National Committee for Quality Assurance. Both the La Clinica physicians and the CDE coordinate patient scheduling to reinforce treatment regimen and to ensure regular follow-up visits.

La Clinica Improves Diabetes Health Care

La Clinica has implemented several processes to improve the care they provide to their patients with diabetes.

Staff Training. La Clinica provides staff training for patient intake and for administering a neuropathy screening test before the physical examination.

Standing Orders. La Clinica staff provides comprehensive diabetes care based on American Diabetes Association standards.

Flow Sheets. La Clinica staff has developed flow sheets to record patient care for lab and routine diabetes care. They also have developed a foot examination and neuropathy screening exam sheet.

Computer Tools. La Clinica medical staff uses the federal chronic disease database PECS and offices use DART software.

In-Office Testing. Patients with diabetes have an in-office A1C test completed before the physician examination. The A1C value is recorded on both a billing sheet and a flow sheet before the patient leaves. If the A1C value is missing from the billing sheet, the office staff contacts the physician via an in-office walkie-talkie to obtain the A1C value.

Appointments. Follow-up appointments are scheduled before patients leave the office. If patients do not keep their appointments, the practitioner determines if the patient should be contacted to reschedule.

Diabetes Education. Each La Clinica location provides glucose meters and nutritional consultation onsite. Patient education sheets are available in both English and Spanish.

Coding. Specific diagnosis codes are used to address non-diabetic conditions or abnormal glucose/prediabetes.

Community-based Resources (Promotoras). Promotoras, or community healthcare workers, serve as a liaison between the community and the clinical team. Promotoras are available for education services and home visits. La Clinica has established outreach educational curricula that Promotoras follow to instruct patients and their families.

Funding. La Clinica has received funding through federal funds, the New Mexico Department of Health, and an “Alliance for Healthy Border” grant from drug manufacturer, Pfizer, to develop family support programs for individuals with diabetes.

Quality Improvement Initiative. Chart audits are conducted monthly in all La Clinica offices (10 charts per clinic per month). This enables La Clinica to assess individual practitioner practices and clinic compliance with quality measures. La Clinica provides feedback quarterly to practitioners, nurses, and other staff.

Written with permission of Dr. C. L. Gismondi-Eagan MD, FACP.

Piñon Family Practice—Farmington Electronic Medical Record Best Practice

Dr. Sean Faherty and his colleagues at Piñon Family Practice in Farmington, New Mexico, lead their practice with comprehensive care for their patients with diabetes and cardiac conditions. The practice consists of both family practice physicians and mid-level practitioners. In addition, a Piñon physician assistant is studying to become a Certified Diabetes Educator and provides much of the patient education.

Realizing that many diabetes and cardiac patients have special needs, Dr. Faherty and his staff implemented a process to better meet these needs and to improve upon national standards of care.

Electronic Medical Record

In 2003, Piñon purchased Practice Partner® for electronic medical records capability. The Piñon staff uses the same system for electronic billing and scheduling. With electronic capability in place, the Piñon staff was able to input educational materials for diabetes, cholesterol, and heart disease into the system. Practitioners can then print these materials for their patients in a format that is easy for them to understand.

Having records electronically has helped the Piñon practitioners improve both patient care and office functions through better organization of and easy access to health histories, test results, and educational materials. All the information is literally at their fingertips. Following are more examples of ways the Piñon practice has updated their processes to improve both patient care and office functions.

Patient Report Card

The Piñon practice created a “report card” for each patient that includes lab tests and markers of diabetes and/or cardiac care. When a patient checks in, a nurse prints the report card. The patient can review his or her personal report card while waiting to be seen.

Some advantages of the electronic record and report card are:

- Computers are available in the exam rooms for practitioners to access the patient’s records during the patient’s visit.

- Practitioners can print patient education during the visit on topics such as managing A1C and LDL levels.
- The practitioner can “grade” the patient using the report card and flag the need for further patient education. Patients can relate to having a passing or failing grade.
- Staff can run reports from Practice Partner to tell who has not been seen, who needs an A1C, LDL, or other tests and screenings.

Other Highlights

- Piñon staff schedules appointments with the Piñon Patient Educator or refers patients to a Certified Diabetes Educator, as necessary.
- Piñon staff schedules follow-up visits with patients before they leave the office.
- When a patient calls for medication refills and is due for an office visit, the office staff schedules an appointment before refills are approved (maintenance medications are filled but patient is encouraged to keep the scheduled appointment).

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Presbyterian Medical Group-Isleta (Albuquerque)

Presbyterian Medical Group (PMG) Isleta team is dedicated to providing excellent diabetes care. Many members of the team, including the Promotora, live in the Isleta community and have known some of the families they serve for years.

In 2005, PMG-Isleta implemented a diabetes pilot project to reduce patient LDL and A1C levels. The result was a \$45,000 in health care cost savings! Following are some of the processes PMG-Isleta follows to provide excellent care.

Staffing

- An onsite Case Manager provides coordination of care for medication, transportation, and other needs. In addition, the patient is given the Case Manager’s direct office phone number.
- Care Managers are located near the medical assistants and providers. They provide immediate in-office diabetes education when a new diabetes patient is identified. The patient receives a meter and is shown how to use it.
- PMG Isleta has a Promotora available. Promotoras, or community healthcare workers, serve as a liaison between the community and the clinical team. The day before the appointment, the Promotora calls and reminds patients of their scheduled visit. The Promotora then prepares the chart and identifies whether a CDE appointment might be needed. If the clinic staff is unable to reach a patient that is due for labs or an office visit, the Promotora may go to the patient’s home. The Promotora’s direct office number is available to patients for any issues that arise.

- Certified Diabetes Educators (CDE) are available either twice a week or through the Diabetes Network. For Spanish-speaking patients, the Promotora translates during the CDE visit.

Charting

All diabetes charts have a blue card on the front to help staff quickly identify a patient with diabetes. It also serves as a reminder to staff to check that the following standards of care are addressed: An A1C every 3-6 months, LDL and urine microalbumin tests, eye and foot exams, blood pressure checks, use of Aspirin.

DocSite Database

PMG-Isleta uses the DocSite computer database to enter all current diabetes assessments. Both Care Managers and Promotoras print lists of patients monthly that are due for labs. These charts are reviewed and patients are called to come in for needed labs (staff leaves slips at TriCore). Follow-up appointments are made for at least 2 days after the estimated lab is drawn. DocSite visit planners are placed in the in the charts and updated before the patient's visit.

Insulin

If insulin is initiated at the visit, Care Managers explain about insulin use and assist with the first injection. Patients are given the Care Manager's direct phone number to call and report blood sugars.

Urgent Care Facility

Many PMG-Isleta patients use the Urgent Care clinic for routine care. A printed list of all the patients with diabetes is given to the PMG Urgent Care clinic each month. The Care Manager also checks all charts in Urgent Care to make sure there is a current A1C and if not, it is drawn at that visit. Staff also checks that eye and foot exams are current.

*Written with permission of Sharon Thompson, PMG Case Management Supervisor.
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