Best Practice for Improving Diabetes Control in Patient Centered Medical Home/Federally Qualified Health Center

EASTERN SHORE RURAL HEALTH SYSTEM, INC.

CHC LEADERSHIP INSTITUTE LEARNING PROGRAM 2018-19

CAPSTONE TEACHBACK: JUNE 12, 2019

1. Focus

Improve diabetes care as measured through decrease in hemoglobin A1c levels

Ensure patients are connected to dental care

2. Team

- Cody Evans, BS, ACSM EP-C
- Heather Fleming, BSDH, RDH
- Karina Escalante, RN
- Lori Miles, BSN, RN
- Lucas Fussell, MSN, FNP-C

3. Need

- Poorly controlled diabetes contributes to or is directly responsible for many chronic illnesses such as:
  - Stroke
  - Heart attack
  - Kidney disease
- The percentage of patients with uncontrolled diabetes at ESRHS is: 23%
- The percentage of patients with uncontrolled diabetes state wide is: 33%

- Improved control of diabetes in patients for whom we are their medical home
- Connection to dental care in an underserved, high risk population

4. Objectives

- Improve diabetes control by developing and implementing a best practice using evidence-based guidelines, best practices, and models of care
  - Goal: Over 12 months, reduce to 18% the percentage of Hemoglobin A1c levels at or greater than 9%
  - Goal: Identify patients who are not receiving routine dental care and get them connected to dentists and hygienists
- Implement initially with one provider
  - If successful, implement across the organization

5. Assets

- Chief Clinical Informatics Officer (CCIO) and Chief Information Officer (CIO) at ESRHS
- Our Team
  - Case Management Specialist
  - Clinical Nurse Educator
  - Dental Hygienist
  - Health Educator
  - Nurse Practitioner
- Center Nursing Staff
- Community Health Solutions
- Evidence-based Guidelines, Best Practices, and Models of Care

6. Action Strategies

- Identified patients with A1c greater than 9%
- Reviewed literature on diabetes care and strategies to lower A1c levels
- Reached out to assets to request assistance
- Worked collaboratively to develop the best practice
- Made sure to keep the focus small and only engage resources who were absolutely necessary for initial implementation and would be necessary for later expansion

7. Team Development

- Attended CHC Leadership meetings and webinars
- Met via teleconference with Community Health Solutions staff
- Engaged the Chief Clinical Informatics Officer and Chief Information Officer at our organization for reports and electronic health record programming
- Eventually added monthly team meetings

8. Testing & Refinement

- Scaled back our focus to simply reducing A1c levels and connecting patients with dental care
  - Initial plan was a more comprehensive program that would have been complicated to implement within this project
- The best practice was implemented on May 15, 2019
  - Clarified what the Case Management Specialist would do when a new referral was made to her
  - Still in the process of incorporating a self assessment tool into the electronic health record
- We will have the first review of hemoglobin A1c levels on or after August 15, 2019

9. Results to Date

- Implemented the best practice on May 15, 2019
- As of May 31, 2019:
  - 12 patients have been referred to the Case Management Specialist

10. Lessons Learned

- Schedule meeting times well in advance when you have team members who provide direct patient care
- Schedule time to work on the project individually from the start
- Teamwork works to accomplish diabetes control
- Have a precise/direct focus as a core
- There is always remove to improve and refine

11. Success Story

55 yo African-American Female

Very engaged in going over self-management form

Able to get in with dental care with restorative treatment

Reports better adherence to medication regimen

Significant dietary changes

63 yo Hispanic Male

Patient never checked blood sugar

Now with weekly calls from CMS he is checking Monday through Friday

Glucose levels are improving

12. Next Steps

Review hemoglobin A1c results every 3 months and finally at 12 months after implementation to determine if the Best Practice has achieved the goal of A1c reduction.

If successful, present to all providers and implement across the organization.

Meet on or around September 3, 2019 to review how implementation has gone, celebrate successes, discuss areas for improvement/refinement, and incorporate new lessons learned into the Best Practice.

Use the Best Practice as the core to a more comprehensive diabetes care program within ESRHS.

Determine how to best capture No Shows for Health Educator