West Kendall Baptist Hospital
BAPTIST HEALTH SOUTH FLORIDA
An academic affiliate of the FIU | Herbert Wertheim College of Medicine

Using Population Health Tools and Team Based Care to Address Type 2 Diabetes in the Outpatient Setting

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Background

Type 2 Diabetes mellitus (DM2) is a complex condition that requires a multidisciplinary approach to achieve high-quality outcomes. Population health uses real time data to measure patient outcomes and identify the healthcare needs of a target population. Team based care is a model in which staff and providers work together to meet the health needs of their patients.

Project Goals/Objectives

Apply population health tools to identify and monitor uncontrolled diabetics defined as those with Hemoglobin A1c of >9% or no measurement within the last 6 months at the Family Medicine Center (FMC)

Decrease the number of uncontrolled diabetics

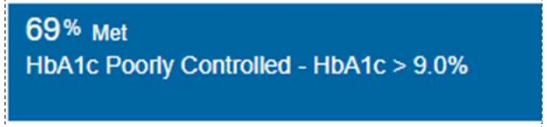
Increase adherence to preventative care guidelines among diabetics

Increase patient retention rate by improving patient outreach efforts

Improve chronic disease self-management by providing evidence-based education and services

Methods of Implementation

Population Health Registry (Cerner Healtheregistries) was used to identify poorly controlled diabetics.



Patients were either contacted by clinical team (Pharmacist or Physician) if poorly controlled or by the administrative staff if they were lost to follow up

Patients were provided education on diabetes and care was coordinated through scheduling of appointments and labs

Discussion

The team has completed the first PDSA cycle with some success and areas for improvement. Patients are being identified easily using the registry tool and staff is able to coordinate their follow up care including office visit and labs. Poorly controlled diabetics are receiving extra education outside of their office visit and are being monitored by the clinical team. It has been identified that a process is needed to identify patients following with specialist to obtain most recent labs.

Outcomes

This is an ongoing quality improvement project recently implemented therefore no results are available at this time.

Data will be collected on diabetic quality measures and compared to pre and post intervention.

Primary end points will include % decrease in HbA1c Poorly Controlled measure, % increase in preventative measures including screenings for neuropathy, retinopathy, and nephropathy screening, % increase of statin use, % Controlled Blood pressure below 140/90, and % of patients with appropriate HbA1c monitoring

References/Disclosures

Community Preventive Services Task Force. Diabetes Management: Team-Based Care for Patients with Type 2 Diabetes [Internet]. 2016 Dec

Golden SH, Maruthur N, Mathioudakis N, et al. The Case for Diabetes Population Health Improvement: Evidence-Based Programming for Population Outcomes in Diabetes. *Curr Diab Rep*. 2017;17(7):51. doi:10.1007/s11892-017-0875-2

None of the authors of this poster have had any relevant financial or other relationships with an ineligible company now or within the past 12 months.