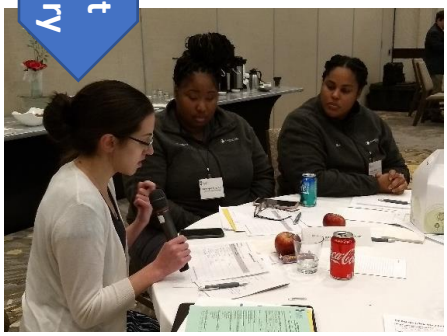
The ABCS of Managing Patients with T2DM: A Patient-Centered QIE Initiative

Project Summary



This initiative sought to measurably improve the management of type 2 diabetes (T2DM) in primary care practices in New Jersey and Delaware. Practices spent 12 months working to improve A1c, blood pressure and cholesterol control. A1c and blood pressure control are high-priority MIPS measures and better outcomes means better payment. The project followed a traditional learning collaborative model. Practices formed QI teams, submitted baseline data, attended three face-to-face events and participated in webinars. They submitted monthly data to track improvement and completed three rounds of PDSAs to implement interventions designed to drive improvement. The Chronic Care Model is the foundational change package, emphasizing pro-active team-based care, a patient registry, patient self-management education training, and clinical/community linkages.

Learning Objectives

- Create patient-centered care plans to reduce complications
- Follow evidence based guidelines
- Recognize the importance of treating to patient-centered goals and act when necessary to intensify therapies
- Recognize and mitigate patient, physician and system barriers to medication use
- Counsel patients on physical activity, weight management, and healthy lifestyle choices
- Implement diabetes self-management plans, patient education, and patient engagement tools to engage patients

Data Collection Sources

Reported Monthly

Reported Quarterly

PRACTICE ASSESSMENT
- 8 care delivery questions
- 8 care management questions
- Pre/post activity

VIGNETTES
- 3 cases
- Pre/post activity

QUALITY MEASURES
- A1c testing
- A1c >9
- BP <140/90
- LDL <100
- Tobacco
- Referral loop
- Statins

REGISTRY
- 25 patients with A1C>9
- Track care plans, clinical indicators
- Report numerators, denominators

PRE/POST-TESTS & EVALS
- Learning sessions
- Webinars

Curriculum

February – May 2017
- Clinical education on guidelines, treatment and titration
- Process education about AAR and DSME
- Monthly webinars carried forward those themes
- Initiating and intensifying treatment in partnership with patients

PDSA Activity: AAR implementation or DSME referral

June – August 2017
- Focus on patient centered care plans
- Introduced the patient registry to begin an in-depth look at 25 patients with care plans
- Monthly webinars continued education about treatment adherence and impactful care planning

PDSA Activity: Managing the project registry

September 2017 – January 2018
- Motivational interviewing and self-management support to help drive lifestyle changes

PDSA Activity: Mitigating Barriers to Lifestyle Change

BONUS! DSME Webinars
April: DSME PDSA
April: Communicating A1C Targets to T2DM Patients
May: Older Adults with T2DM and Patient Education
May: Obese Patients with T2DM and Patient Education

Community/clinical linkages were a key element of the project. NJAFP partnered with the New Jersey Department of Health to connect practices to diabetes self-management education (DSME) programs in their communities.

Results

- More A1c testing typically results in discovering more patients with unmanaged A1c.
- BP control is only 2% from distal goal.

Measure	Baseline	Jan-18	Percent Change	Expected Change	Difference Actual/Expected
A1c Testing	29.02	58.88	103% 👍	10%	93% 👍
BP Control	71.21	73.61	3% 👍	5%	-2%
LDL Control	10.67	34.04	219% 👍	5%	214% 👍
Tobacco screen	68.8	89.03	29% 👍	10%	19% 👍
Measure	Baseline	Dec-17	Percent Change	Expected Change	Difference
A1c Control	34.99	42.33	21%	-5%	-26%
Closing referral loop	12.5	24.27	94% 👍	10%	84% 👍