ABCS of Diabetes

This initiative aims to measurably improve the management of type 2 diabetes (T2DM) in primary care practices in New Jersey and Delaware. Sustainable changes in primary care practices will result in:

- improved outcomes for patients with T2DM through identification of physician and patient barriers to medication use and intensification,
- implementation of strategies to break down those barriers,
- use of patient-engagement resources, and implementation of self-management plans,
- along with referral to formal diabetes self-management education programs, to control A1C, blood pressure, LDL and support smoking cessation and weight loss.

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.

Expected Change

- 20% improvement in physician knowledge and confidence gaps regarding T2DM treatment methodologies
- 10% improvement in the process measures such as A1c testing, statin prescribing, and tobacco cessation counseling
- 100% engagement on process changes such as measuring adherence, addressing barriers, and providing lifestyle change counseling
- 5% improvement in outcome measures such as A1c and blood pressure control

Curriculum

- February 2017 Learning Session
  - Implementing the Guidelines in the Treatment and Management of Type 2 Diabetes
  - The ABCS of Diabetes Management
  - Breakout Session For Non Physicians – Motivational Interviewing in the Primary Care Setting
  - Using Diabetes Self-Management Education to Improve Outcomes
  - Tobacco Dependence and Smoking Cessation
  - Ask Advise Refer Training

- June 2017 Learning Session
  - Data Review
  - Practice Updates: Tests & Lessons
  - Breakout 1: Patient-Centered Care Plans
  - Breakout 2: Shared Decision Making
  - The Model for Improvement
  - Planning a Test of Change
  - Project Planning
  - Evaluations and Review of Next Steps
  - Individualized Practice Coaching

- October 2017 Learning Session
  - Motivational Interviewing and Self-Management
  - PDSA Review: Success and Challenges
  - Suggested Changes: Making MI work in Primary Care
  - PDSA Activity: Mitigating Barriers to Lifestyle Change
  - Presenting PDAs

Measured Data

- BONUS! DSME Webinars
  - February: Diabetes Treatment Options
  - March: Patient Goals and Adherence to Therapy
  - March: Reaching Treatment Goals
  - Using PDAs Cycles to Implement DSME
  - April: Understanding Barriers to Medication Adherence
  - June: Mitigating Barriers to Medication Adherence
  - July: Measuring Impact of the Care Plan
  - August: Weight Management Counseling Strategies for Patients with Diabetes
  - September: Engaging Diabetic Patients in Self-Management

- Survey Tools
  - Practice assessment: Online survey
  - 8 care delivery questions
  - 8 care management questions
  - All participating learners submit a completed assessment

- Practice-Level Measures
  - 1. A1c documentation
  - 2. T2DM patients with A1c >9
  - 3. T2DM patients with BP >140/90
  - 4. T2DM patients with LDL >100 [not required]
  - 5. Tobacco cessation counseling
  - 6. Closing the referral loop
  - 7. Statin prescribing [not required]

- Population of Focus Registry
  - 25-50 patients with A1c >9
  - Track care plans and clinical indicators
  - Report numerators/denominators

Results

- Challenges
  - Large increases in denominators in summer 2017 watered down early improvement trends
  - Outliers caused denominators to swing from the 1600s to 4000 and back again, impacting aggregate outcomes
  - NJAFP countered with practice-specific run charts and unblinded internal reporting
  - EHRs are a significant barrier to QI work. MIPS measure reports ought to be freely available in all MU-certified EHRs. But some practices in this project could not find the reports or the EHR would not provide monthly reports, just quarterly.

- Measured Data

Interventions tested by practices in the NJAFP’s ABCS of Diabetes project:

- Change: send patients to diabetic nutrition/education
- Result: patients who are attending classes have shown improved Hemoglobin A1C

- Next: Continue diabetic education and increase follow-up appointment for patients not at goal. Use our patient navigation system for patient follow up phone calls.

- Change: develop a registry of diabetes patients who are not optimally controlled, or have not had A1c in a year
- Result: improved levels of diabetic control

- Next: continue to focus on patients in registry to improve outcomes among all patients and meet target goals set by the practice and value-based payer programs

- Change: promote self-management
- Result: patients have done well with action-oriented learning

Next: open a lab in the office to improve patient compliance with testing.