ABCS of Diabetes

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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

PDSA Activity #1
AAR implementation or DSME referral

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

PDSA Activity #2
Managing the project registry

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 PDSAs

Webinars
February: Diabetes Treatment Options
March: Patient Goals and Adherence to Therapy
March: Reaching Treatment Goals
Using PDSA 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
December: Best Practices for Self- Management

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 Type 2 Diabetes Mellitus and Patient Education

Measured Data

SURVEY TOOLS	1. Practice assessment: Online survey • 8 care delivery questions • 8 care management questions • All participating *learners* submit a completed assessment
	2. Vignettes: case-based survey • 3 cases • All participating physicians and providers submit a completed survey
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) • Reported out of the practices EHR, preferably the T2DM patient registry • Report numerators/denominators
POPULATION OF FOCUS REGISTRY	1. ABCS Project Registry • 25-50 patients with A1C>9 • Track care plans and clinical indicators • Report numerators/denominators

Community/clinical linkages were a key element of the project, connecting practices with local community-based programs to support patients. For this project, NJAFP partnered with the New Jersey Department of Health to connect practices to diabetes self-management education (DSME) programs in their communities. This is part of a nationwide effort by CDC to improve the quality and quantity of DSME and diabetes prevention programs (DPP). The American Diabetes Association found that accredited DSME programs lower A1c by more than 1 point and that improvement is sustainable if supported by diabetes patient education in the practice.

It can be difficult to manage DSME "referrals," but whether you do so via the "closing the referral loop" quality measure or some other workflow, documentation and follow-up are important. If DSME is important enough to recommend, it's important enough to find out if the patient attended and what the results were so you know what next steps are for that patient – medication changes, additional self-management education, etc.

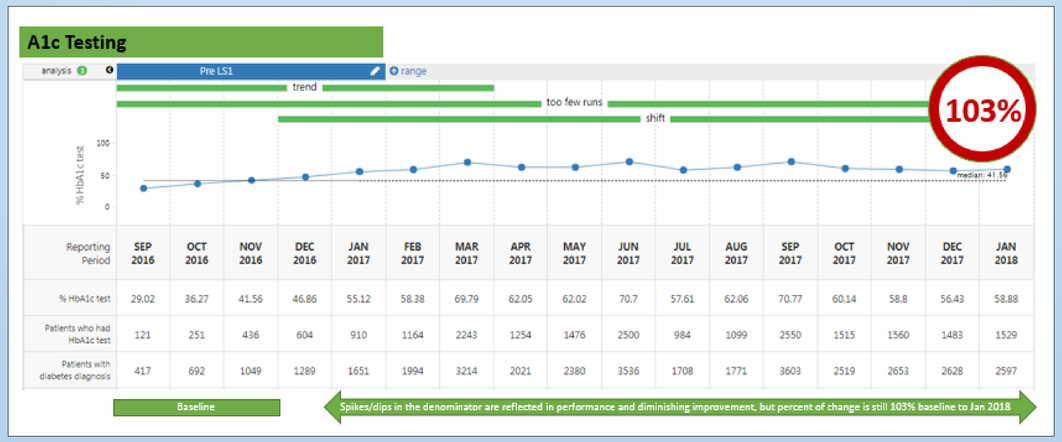
Results

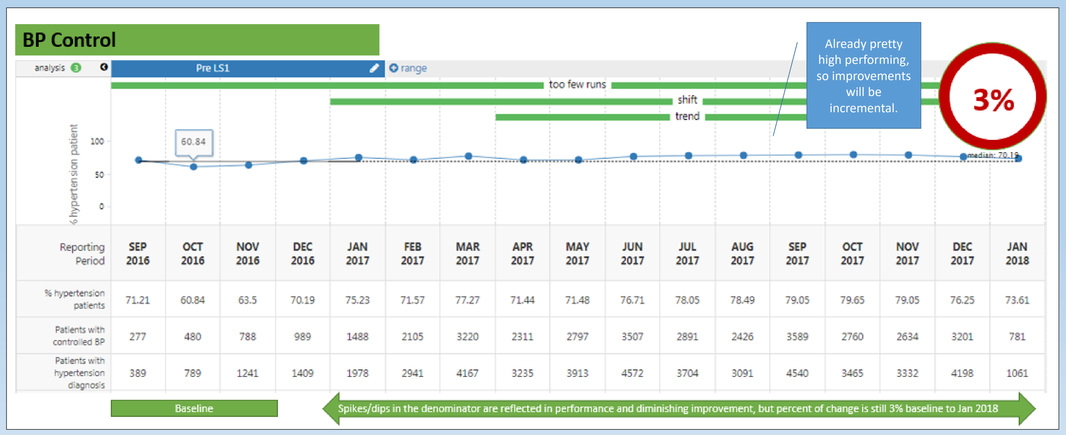
Challenges

- 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.

Measure	Baseline	Jan-18	Percent Change
A1c Testing	29.02	58.88	103%
BP Control	71.21	73.61*	3%
LDL Control	10.67	34.04	219%
Tobacco screen	68.8	89.03	29%
Measure	**Baseline**	**Dec-17**	**Percent Change**
A1c Control	34.99	42.33	21%
Closing referral loop	12.5	24.27	94%

* Already high performing





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