Implementing Effective Diabetes Care in a Mobile Clinic for a Rural Community

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Background

- In the United States, diabetes is the primary cause of kidney failure and blindness in adults. Diabetes is a progressive disease which contributes to poor health outcomes, and places a significant financial burden on the healthcare system.[1]
- Best practice includes enhancing the current surveillance system to include personalization of patient's goals, risk factors measures to assist clinicians in providing the appropriate treatment and improved patient outcomes. [4]
- The implementation of evidence-based tools combined with shared decision making can promote patient adherence and improve the effectiveness of diabetes management. [3]
- An audit of 20 charts at Family Health Services identified a 51% gap for improvement with diabetic screening; 35% with labs, and < 48% at goal per BP guidelines, podiatry and retinopathy screening.
- Prior to implementation, standardized team engagement, patient engagement and screening tools were unavailable.

Aim

- The aim of this project was to increase by 50% the number of adult diabetic patients receiving effective diabetes care within 8 weeks.

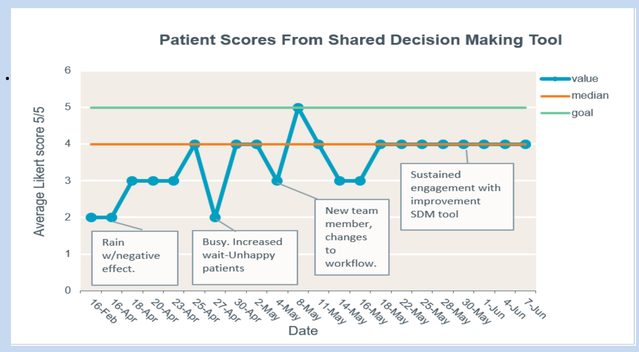
Planned Improvement

The eight-week project utilized four-two-week PDSA rapid cycle methodology, with iterative changes focused on team engagement, patient engagement, screening, and referral to care for high risk diabetic patients

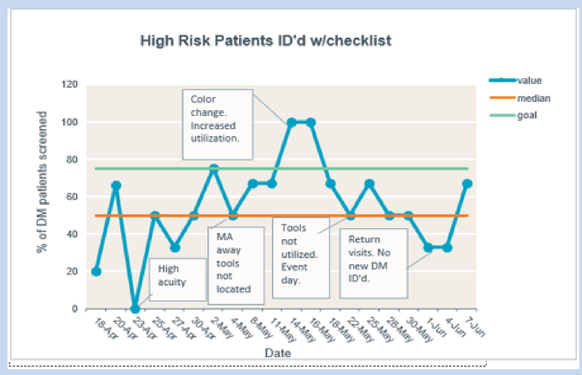
- Engage staff through weekly team meeting and daily huddles.
- Engage patients through use of shared decision making tool.
- Implement diabetic screening checklist tool.
- Implement case management tracking log.

Focus	PDSA #1	PDSA #2	PDSA #3	PDSA #4
Screening	Implementation of risk assessment.	Modify risk assessment. Provide screening at check in.	Increase visibility of tool. Create policy/tool folder.	Decrease prompts and checklist reminders.
Patient Engagement	Implementation of SDM.	Add handouts. Add SDM tool in Spanish. Add another provider.	Provide SDM at end of triage. Pt to bring on return visits.	Encourage patients to set achievable goal. Encourage exercise regimen.
Referral for Right Care	Implement tracking log.	Team reminders. Follow up calls to patients.	F/u on referrals from last cycle. Add transportation to log.	Highlight calls to increase visualization. Letters mailed if # disconnected.
Team Engagement	Weekly meetings and daily huddle.	Email reminders. Add incentives.	Frequent check in w/ team individually. Updates on statistical data.	Change huddles to end of shift. Inspirational board.

Results



Run chart: Patients scores from the shared decision making tool.
Overall patients were engaged when utilizing the SDM tool
Patient satisfaction with use of the SDM increased as evidenced by baseline changes from 2/5 to 4/5 on Likert Scale.
Patient involvement is important for patient centered care.



Run chart: High risk patients identified with a checklist tool.
Increased utilization of screening checklist resulted in increased identification of high risk DM patients. In cycle 4, decrease in identification of at risk patients corelated with return patients.

Run chart: Right care for T2DM
Progress made in cycle 1 to 55%, with additional progress made to 70%
Final goal 80% of diabetic patients receiving effective right care achieved.

Measures

Process Measures	Outcome Measures
Screening Utilize tool to identify patients with DM risk/gaps # of times screen tools used/Total # of diabetic patients encounters	**Screening** Increase the ID of DM patients at risk # of high risk patients identified using tool/Total # of diabetic patients screened
Patient Engagement Surveys utilized # of SDM tools used /# of diabetic patients seen that day	**Patient Engagement** Increased engagement in their health care Average score of patients who utilized the SDM tool
Referral Utilization of referral log in CML #of DM ID'd with a gap in care who are in the log/total # DM ID'd with a gap	**Referral** Increase the # of patients receiving right care – (Screening, labs, meds, referrals, appts. The average score of patients referred to right care
Team Engagement Utilize team building tools # of team in attendance/total #of team	**Team Engagement** Increased team attitude. Average score on Likert scale weekly

Balancing Measure: Time spent on the project

Conclusions

- Mobile clinics with few resources and small teams are faced with challenges unlike those at a traditional clinic, but with robust organizational commitment best practice can be achieved and sustained.
- Project limitations include implementation in a mobile clinic where patients were not confined to a time constraint comparable to a traditional clinic.
- Limitations include the short duration of the project and small sample size.
- The project can be easily replicated in other outpatient clinics.
- This project improved the delivery of evidence-based care for adult diabetic patients and has the potential to positively impact the current diabetes epidemic and diabetic burden.
- Highlights the benefits of incorporating the evidence based check list tool as a template in the electronic health record.

Lessons Learned

- Strong support from stakeholders enabled this project to be successful.
- It is necessary to provide evidence-based services to manage the challenges of diabetes.
- Utilizing an evidence-based ADA checklist was instrumental in improving patient self-advocacy.
- It is important to recognize individual contributions and celebrate team accomplishments regularly.
- Barriers to care in a mobile clinic for a rural area includes the weather and lack of transportation for patients.

References

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