Pre-diabetes Screening and DPP Enrollment in Rural Communities

PREVENTIVE CARE

Employee Owned Thrifty White PHARMACY

PROVIDER

Thrifty White Pharmacy

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CHALLENGE

Diabetes is one of the largest and fastest growing health concerns in the U.S.. There are over 30 million patients with diabetes, alongside an estimated 86 million Americans with pre-diabetes, according to the American Diabetes Association. This amounts to direct and indirect costs totaling over $322 billion annually. The typical patient with diabetes spends $7,900 more on health care annually than a comparable patient without. By enabling patients to better manage their condition, we can more efficiently utilize these health care dollars and reduce overall health care costs. When you extend those savings across the 30 million patients with diabetes today, and look at the 1 in 3 people who have pre-diabetes, that's a huge opportunity for us to make an impact.

PROCESS FOR CHANGE

We created a screening and referral program to identify patients at risk for pre-diabetes and educate them on the risks, complications, and positive changes they can make. We also help patients create self-management action plans, and refer them to local providers who offer CDC-approved diabetes prevention programs. Additionally, we performed A1C tests on patients who were candidates to asses their status and communited updates with their providers. Our initial screening program was hardcopy based, but we created an electronic referral tool to streamline identification, screening, and linkage to care.

RESULTS

- We began the pilot in March of 2018 and in the first 2 months we have identified 368 patients, screened 67 of them, and referred 56 to CDC DPP programs
- Of the patients scoring >4 on the CDC test, 12 completed self-management action plans
- We performed in-pharmacy A1C testing for 70 patients

ADOPTION CONSIDERATIONS

- Ability to access data needed for identification and screening of patients
- Motiviational interviewing techniques were important in creating a trusting relationship with each patient

RECOMMENDATIONS FOR SUSTAINING THE GAINS

- Creation of the electronic referral tool will streamline the process and allow us to scale to additional locations
- On-going diabetes-focused education for pharmacists

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Well Child Checks for our Younger Population

PREVENTIVE CARE

CentraCare Clinic

PROVIDER

CentraCare Health

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CHALLENGE

The well child check by 15 months measure was a MN Community Measure. However, working the patient registries for this measure was time consuming and challenging for staff to complete.

PROCESS FOR CHANGE

We implemented the recall system for all age's well child visits. This is essentially a reminder system in our EMR. We worked with front desk staff, our nursing staff, and our information systems staff to implement this change. Our goal was to use this method to get kids in for their visit, without having to work the patient registry associated with our report and measure.

RESULTS

- In 18 months', we had an overall increase in well child visits for 15-month-old individuals. In December 2016, our rate was 89.2 percent and by June of 2018 our rate climbed to 95.1 percent
- Our work is more automated as we no longer have to spend time working monthly registries
- From June 2017 to May 2018 our immunization rates for our 2-year-olds went from 70.8 percent to 73.1 percent. We attributed this increase to getting the children in for all or most of their well child checks, allowing them to get the vaccines they needed

ADOPTION CONSIDERATIONS

- Barriers that patients experienced in trying to come in for their well child visits
- Patients who moved never came off our data lists

RECOMMENDATIONS FOR SUSTAINING THE GAINS

- Continue to monitor data
- Continuously train new staff on our process

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Protecting our Adolescents: One Immunization at a Time

PREVENTIVE CARE

CentraCare Clinic

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CHALLENGE

Adolescent rates for our 13-year-old patients were lower than we wanted. Our Tdap and Meningococcal rates were stable, but our Human Papillomavirus (HPV) series completion seemed to be bringing us down. Our current process for monitoring patients was to work the registries; in other words, look through lists of patients to see who is due and then call them to come in. However the process was time consuming and staff had a hard time keeping up with these lists. Additionally, this process also only looked at the 13-year-olds and no one was following up with patients outside of this age group.

PROCESS FOR CHANGE

Our goal was 71 percent completion for all 3 HPV vaccines. In looking at workflow, we discovered we did not have a good system in place for reminding patients they needed to come in for their second or third HPV vaccine. While researching new processes we also discovered the effectiveness of strong scripting from providers and nursing staff to encourage patients to come back in.

RESULTS

- In May 2017 our HPV completion results were 64 percent; by May 2018 they rose to 74.3 percent
- Our overall completion vaccine rates were 73.6 percent in June of 2018, exceeding our 71 percent goal
- Our process became more automated by implementing the recall system

ADOPTION CONSIDERATIONS

- Awareness of the barriers patients face when trying to come back in for follow-up vaccines
- Timing of when the second, or in some cases the third, HPV vaccine could be given and which patients needed three doses versus two

RECOMMENDATIONS FOR SUSTAINING THE GAINS

- Continuously monitor rates
- Random checks to make sure that recalls are placed

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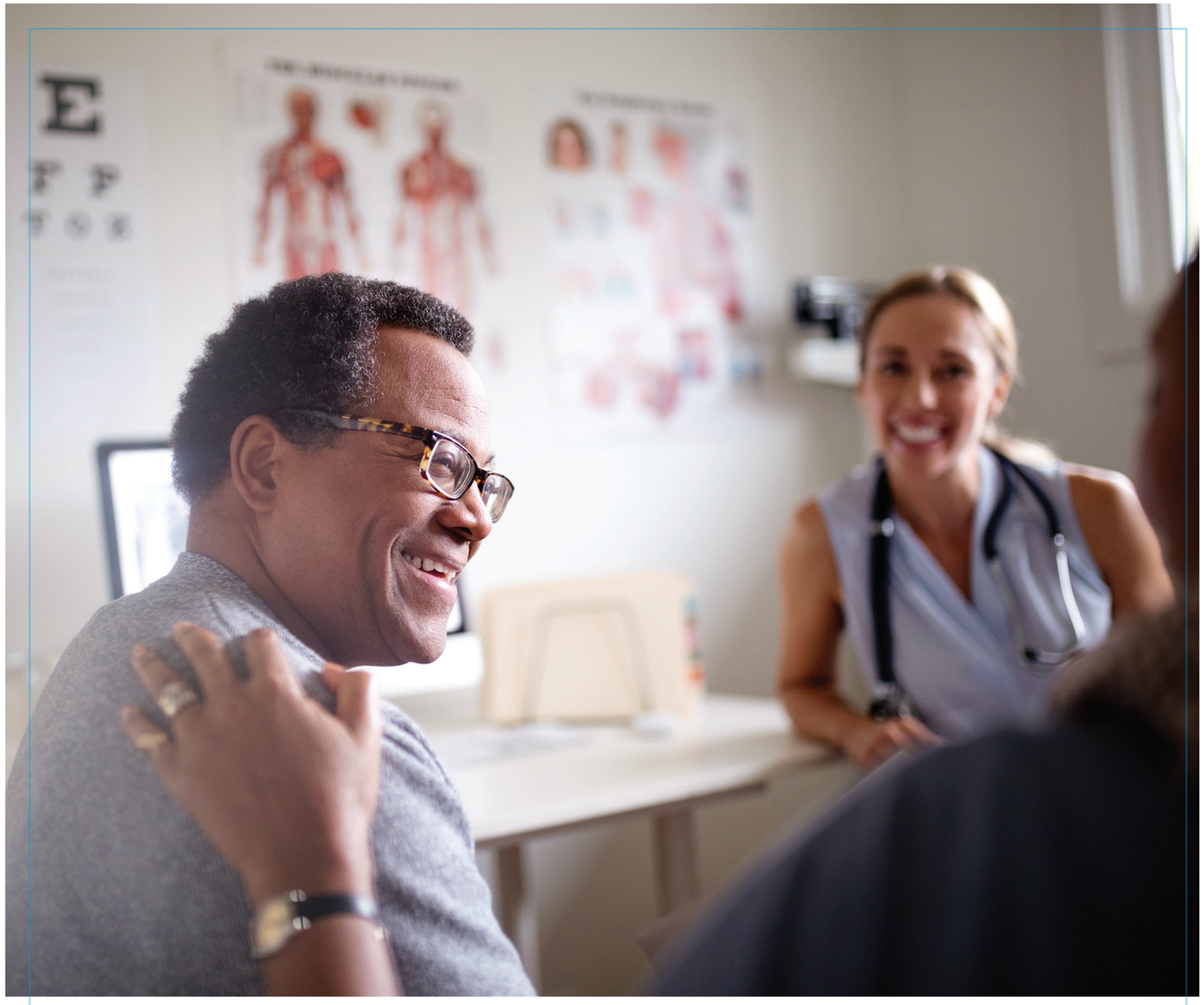

Diabetes Quality Improvement

PREVENTIVE CARE

Family Care Partners of the Quad Cities, PC

PROVIDER

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CHALLENGE

Recognizing the rapidly escalating rates of diabetes and changing diagnosis criteria, our team saw an opportunity to interject and positively change our patients' lives and overall health by communicating and assisting patients with their diabetic care. However we faced the challenge of assuring all diabetic patients were identified. We recognized the need to devise a plan to avoid any patient from "falling through the cracks" due to lack of screening or ongoing disease management.

PROCESS FOR CHANGE

We began by building an Excel spreadsheet with patient names, date of birth, blood pressure, LDL, and HbA1c values. We implemented staff education regarding diabetes and increased patient education and awareness. And, we developed chart documentation requirements to set and maintain our goals.

RESULTS

We achieved goals of keeping patient HbA1c and LDL noncompliance at no more than 19 – 20 percent of the diabetic population and by keeping mindful of the following:

- Setting Goals = Challenge
- Keeping Goals = Success

ADOPTION CONSIDERATIONS

- How to obtain the data you are using to achieve your goal either electronically or manually
- Staff managing the data portion of the initiative will require basic logic and data management skills

RECOMMENDATIONS FOR SUSTAINING THE GAINS

- Set initial goals as reasonable and likely obtainable, increase goals in the future to sustain overall success.
- Recognize that change is likely and challenging, and embrace it

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