

Diabetes Care, Management, and Education
Edmonds Family Medicine Clinic
1999 Acclaim Award Honoree

Edmonds Family Medicine Clinic developed a coordinated approach to educating practitioners and patients to improve the control of diabetes and diabetes complications. Within 12 months, they were able to significantly improve patient health and increase provider compliance with ADA Standards of Care.

Goal

To improve knowledge, compliance, glycemic control, and quality of life of diabetes patients.

Intervention

Direct patient counseling, chart audits, practitioner interaction, and continued education are the four cornerstones of the project.

Highlights

- CEO and medical director served on the Medical Quality Committee, which selected diabetes care and education as an organizational priority.
- ADA Standards of Care were used as guidelines for diabetes management.
- Diabetes educator was given adequate time and budget to implement the self-management training program; design and audit forms; and together with the physician mentor, do chart monitoring.
- Flow sheets were inserted prominently in patient folders and were used to document the care process and alert the provider about needed services.
- Practitioners are monitored every six months until they reach 90 percent compliance and then every 18-24 months to ensure continued adherence to ADA Standards of Care.

Results

- 200 percent increase in the number of patients in Excellent Control Category of their diabetes (HbA1c < 7%).
- 95 percent of patients had HbA1c test and lipid panel in the past year.
- 75 percent of the clinic's diabetes patients received eye exam, foot exam, and microalbuminuria in last year.

Concluding Remarks

First, we learned that quality improvement takes commitment. When planning any project, the time involved in getting it initiated must be given a priority for the program to succeed. We believe that the program at EFMC has been a success.

We started with a Diabetes Educator on staff who was given the time and budget to implement the self-management training program. Through our Medical Quality Committee, then later through our QI/UM committee, standards of care were addressed and a program of provider education developed to implement the standards. The Medical Quality Committee set forth a biweekly meeting schedule at its formation. The Diabetes Educator was given the time to design chart forms and audit forms, and together with the Physician Mentor of the diabetes program, granted the time to do chart monitoring. Without the commitment of our Board, we would not have been able to have a successful program.

Would we have done anything differently? That is a challenging question, as we have learned along the way. It was unexpected and significant to learn that if the flow sheets and forms are not easily retrieved in the medical record, they will not be used. In hindsight, the Health Maintenance chart divider would have been in place when we started using the flow sheets. We might also consider adding a focused patient survey to gain feedback on which educational tools, materials and methods patients found to be the most effective.

To repeat a project like this, all components of the system need attention. Issues need to be identified, and providers need to be involved in developing standards and indicators. Forms and other tools need to be designed and in place before the project is started. The organization also needs to be ready to make the time and financial commitment necessary to see the project through. We feel fortunate that Edmonds Family Medicine Clinic is such an organization, and the "work culture" of the physicians is to always strive for improvement.

Our Diabetes Care Improvement Project is still ongoing. The physicians that did not meet 90-100% compliance need to be re-monitored until compliance improves. The overall program needs occasional monitoring to make sure that the practitioners stay compliant or to evaluate the need to add more indicators.

What we have learned in the implementation and evaluation of this program will help us as we continue to choose new programs at EFMC that enhance patient care.

We have already started an on-site Coumadin clinic, an asthma education program, and are considering a pilot CHF program, as well as some community outreach in smoking prevention in youth. The indicators to monitor the programs are still being developed, but we have used much of what we learned in developing our diabetes project to get these other projects started.

Edmonds Family Medicine Clinic is a 23-provider family practice clinic located in Edmonds, Washington. The group is independent and offers appointment and walk-in services to patients of all ages. Approximately 25 percent of the payer mix is prepaid.