

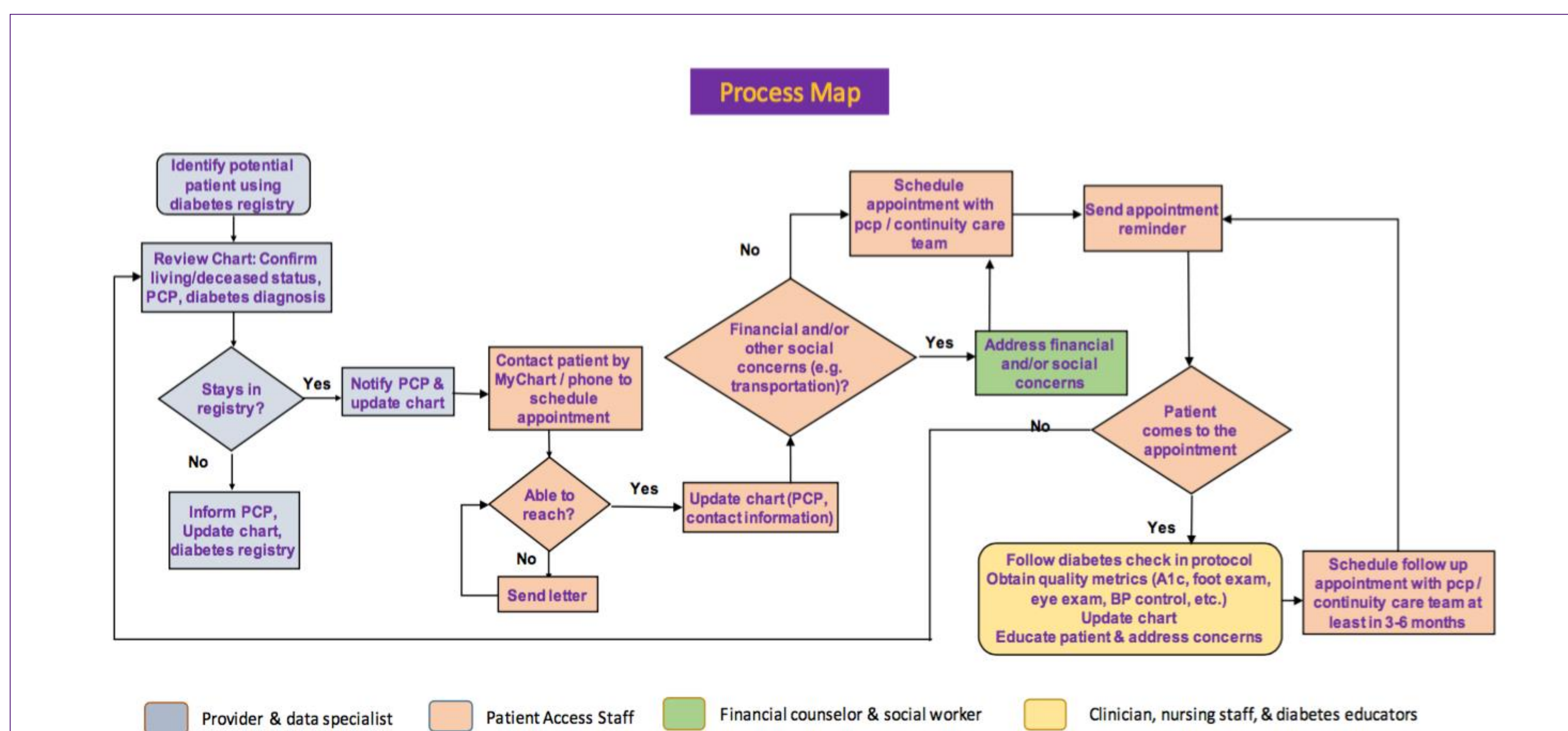
CARE SETTING

- Despite advancements in the treatment and prevention of diabetes, care gaps have been identified at various levels of health systems.
- At the ECU Family Medicine Center (FMC), a disease registry was created using electronic health record (EHR) data to organize patients and then track metrics in order to identify deficiencies in care and schedule appropriate follow-up treatment.
- 3146 patients were included in this diabetes registry, 1003 of which are assigned as Accountable Care Organization (ACO) patients. 81 ACO patients in this diabetes registry did not have A1c done during the measurement year (2016), highlighting a gap in diabetes management.

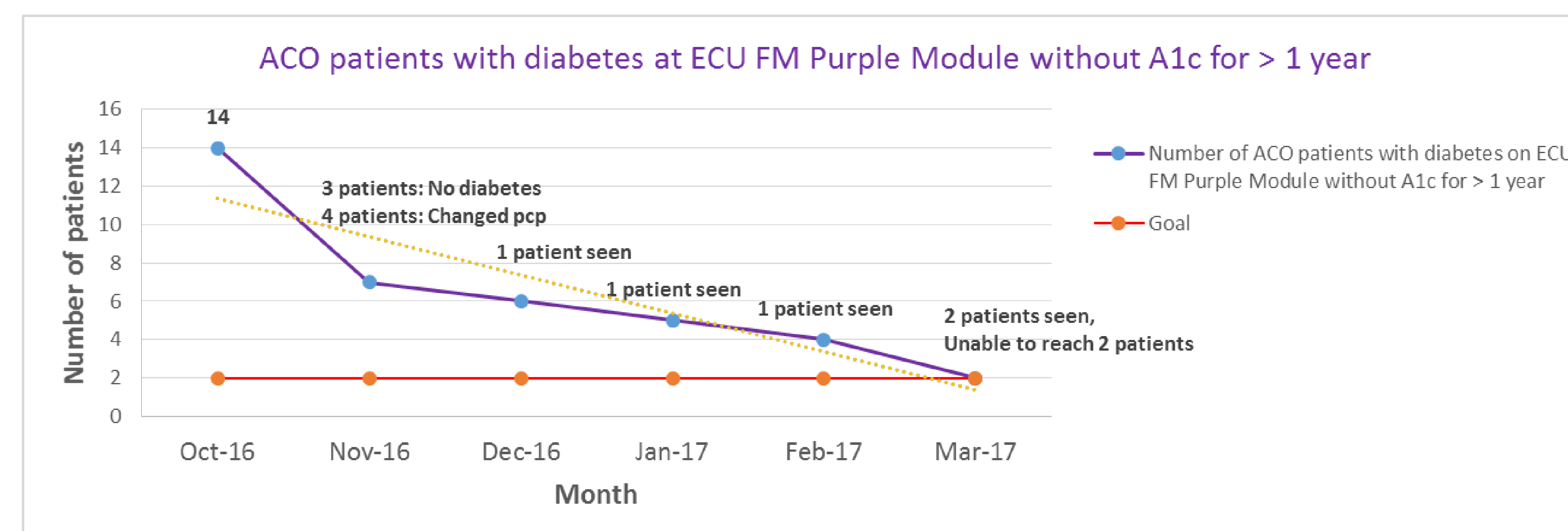
PROJECT AIM

Improve the number of ACO-patients with diabetes at ECU FMC who have not had A1c done in the measurement year 2016 by 85% by August 31st, 2017 using a diabetes registry.

DETAILS & INTERVENTIONS



A Plan-Do-Study-Act (PDSA) cycle was implemented which included 14 clinic patients only on Purple module of FMC who had not had A1c measured the previous year. Individual chart review was conducted to verify registry inclusion criteria (patient not deceased, appropriate diabetes diagnosis, etc.). Patients were contacted via phone, mail, and online patient portal to schedule an appointment, during which A1c measurements were taken. An additional PDSA cycle was conducted involving the remaining 67 patients on the rest of the modules of FMC. At the end of this cycle, the number of ACO diabetes patients at ECU FMC who had not had A1c measured in the previous year was reduced by 88%, exceeding the goal of 85%.



STRENGTHS

- A fishbone diagram was created in order to identify possible causes of gaps in diabetes management. This allowed providers to pinpoint areas for improvement and led to the creation of a diabetes registry.
- A process map was developed to outline how potential patients could schedule an appointment and complete A1c measurements. This was particularly useful in addressing possible barriers for patient follow-up.

OPPORTUNITIES

The success of using a diabetes registry illustrates the potential benefit for creation of registries pertaining to other chronic conditions in order to identify potential gaps in care. By periodically updating information in EHR, health systems can better identify potential patients who are not receiving adequate care or lacking in management of disease.

RECOMMENDATIONS

In order to ensure that patient data remains accurate, registry data should be checked and updated on a regular basis such as monthly or annually. In addition, a protocol may be implemented when adding new patients to the EHR so that the registry is updated every time a potential patient is added to the electronic health record system.