The Institute for Healthcare Improvement (IHI) model for Delivery of high quality diabetes care is providing patient engagement: Diabetic patients referred for Team engagement played a crucial role. Incorporate the engagement tool and DCMC into the EMR. No standard routine best practices were followed for diabetic patients. Evidence has shown decreased mortality and improved diabetic patient outcomes when evidence-based clinical practice guidelines are followed (1).

Plan

The aim of this quality improvement project was to improve the percentage of diabetic patients receiving standardized, appropriate diabetic care to 90% over 90 days.

Aim

The Institute for Healthcare Improvement (IHI) model for quality improvement (QI) was used to guide this project.

Four rapid cycles of Plan, Do, Study Act (PDSA) were conducted:

1. Team engagement: Education on diabetes preventative care measures, educational sessions, team meetings, morning huddles.
2. Patient engagement: Engagement tool created to make patients aware of their numbers and empowered to create 1-3 goals.
3. Process changes: Diabetic Care Measure Checklist (DCMC) and Preventative care referrals.
4. Contextual elements associated with success:
   - Team engagement played a crucial role, demonstrating the importance of team confidence, but the team’s sense of confidence had even greater impact.
   - There was a direct correlation between team cohesiveness and overall team engagement, affecting all tests of change interventions, processes, and outcomes.
   - Morning huddles was the turning point for this QI project.
   - A diabetes sticker system created for the charts made it a visual reminder for the team to place forms on charts.
   - The prepping and prefilling of forms increased utilization of patient engagement tool and DCMC with it being done prior to the visit.

Results

The BHWC team for all their hard work and dedication to this project. Dr. Meier for providing scholarly feedback and support. Lessons Learned:

The interventions were successful by PDSA 4.

Team confidence increased to 4.5 on the Likert scale.

Diabetic patients were empowered to create goals 95% of the time.

Diabetic care measures were reviewed via checklist 92% of the time.

Diabetic patients referred for ophthalmology and podiatry 81%.

BHWC diabetic patients received appropriate care 91.25%.

Conclusion

Key Findings:

- This project increased patient centered standardized care for diabetic patients at BHWC.
- This project highlights that a team has significant power for achieving better diabetes outcomes.
- The major success of this project was the process of change affecting the overall team with improved cohesiveness, confidence, and communication, thus resulting in improved diabetic patient care.
- Delivery of high quality diabetes care is providing patient-centered care with individual support, improving diabetic patient clinical outcomes.

Implication of Practice:

- Increased awareness with the utilization of a patient engagement tool coupled with leadership support can empower diabetic patients to improve their numbers.
- Using a standardized checklist

Sustainability and Spread:

- Continue morning huddles as a focal point for favorable team dynamics and leadership support can empower diabetic patients to improve their numbers.
- Engage tool can be used by other primary care clinics.

Next Steps:

- Incorporate the engagement tool and DCMC into the EMR

References


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