Quality Improvement Storyboard

Shasta Community Health Center
Diabetes Pilot Project
PDSA Cycle 1

Plan

Aim: To decrease the percent uncontrolled diabetic patient (HBA1C >9) between the ages of 18-75 with Type I and Type II from 65% (as of Jan 2019) to a minimum of less than 26% and continue a downward trend compared to 2018, by December 31, 2019.

Measures:

- Outcome Measure: % of adult patients age 18-75 enrolled in the pilot who have an HbA1C of less than 9.0. (Baseline: 65%).
- Process Measures: % of patients who see their PCP at least twice during intervention (February – July 2019); % of patients who see the nutritionist three or more times during intervention; and % of patients who see the behavioral health consultant three or more times during the intervention.

Prediction:

- The intervention, which has four primary components of access to primary care provider, access to nutritionist, access to behavioral health consultant, and specifically designed care pathways that address key barriers to disease management, will result in 39% fewer adults with diabetes enrolled in the pilot who have an A1C greater than 9.0.

Do

Changes Being Tested:

Based on a Root Cause Analysis of what factors were contributing to diabetic patients having an elevated A1C result, the following components of the intervention were tested:

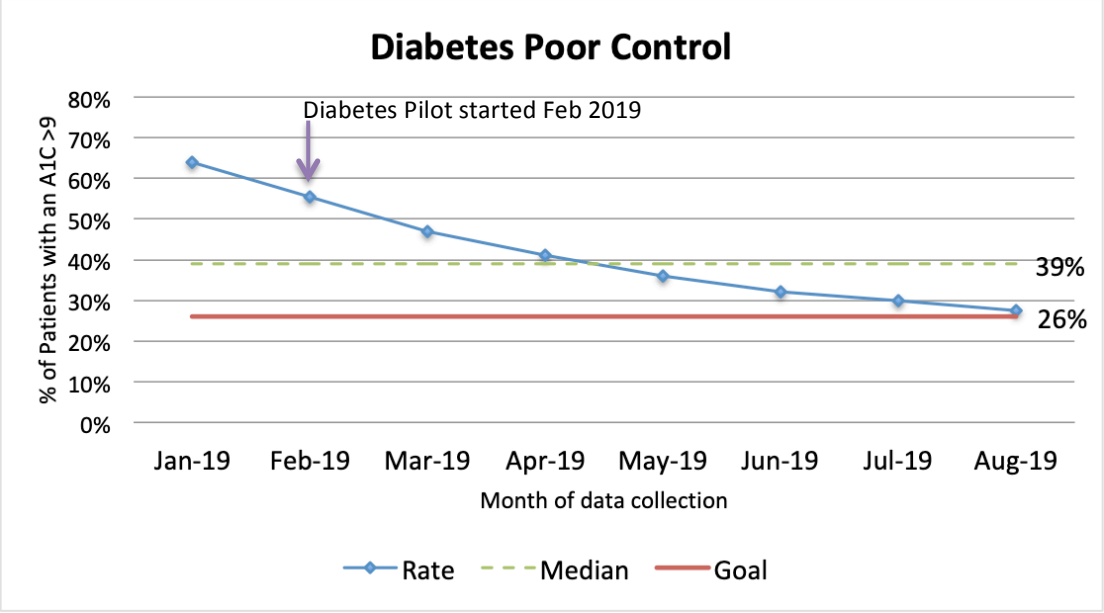
- Hosting a Diabetes Clinic two Fridays each month from 8am – 5pm to allow for frequent and focused diabetic appointments with primary care provider (PCP).
- Access to Diet/Nutrition counseling focused on behavioral changes as it related to diet and nutrition and better utilization of funding available to patients to buy food (included a food security survey).
- Access to Behavioral Health Consultant to support behavioral change related to disease management (e.g., routine blood sugar checks and medication management, distress caused by diabetes).

Results:

A total of 37 adult patients with Type II Diabetes were enrolled in the pilot; 32 patients completed the pilot. The intervention timeframe was February – July 2019. The data collection timeframe is January – December 2019. This intervention was very successful with:

Study

- Outcome Measure
  - Progress toward goal with result of 27.41% in August of 2019. This represents improvement of 37.6% over baseline.
- Process Measures
  - 78% of patients had a drop in their HbA1C levels with highest drop from 13.3 to 6.9. The mean decrease in HBA1C rates was 1.163. 62.5% of the patients had an HbA1c drop below 9.
  - Patients that experienced a drop in HbA1c had on average 4 visits with the PCP and 5 with BHC and RD in the 6-month timeframe.
  - The average **decrease in HbA1C rates of 1.163** demonstrated that the intervention was effective and the impact on rates was sustained after the intervention period.



Act

Future Plans:

Considerations for future tests and interventions include:

- Modify schedules to designate half days once a month for a diabetes clinic.
- More contact with pre-diabetic patients at the onset of diagnosis.
- Increase diversity of Diabetes Education classes with patient education.
- More publicity for education classes or distributing videos via SCHC website.
- Identify RN's/LVN's who would be interested in furthering knowledge of DM or training to become a certified Diabetic Educator.
- Having an RD on staff dedicated to this patient population.