COLLABORATIVE VENTURES NETWORK

Improving the Control of Diabetes

Why should CVN focus energy on a notoriously difficult-to-control condition like diabetes? Many barriers to good control are complex and have no easy fixes; they may be patient-based as is the case when a patient has a low level of health literacy, or health system-related as happens when high out-of-pocket costs for medications and test strips are encountered by a patient. Yet thoughtful, multifaceted diabetic interventions are observed to make dramatic improvements in the health of targeted populations. An example is the Special Diabetes Program for Indians (SDPI). Over the course of seven years, 780,000 patients annually treated under the program improved diabetes and blood pressure control. The benefits included a 50% decrease in vision loss and blindness, 54% decline in kidney failure, and ten-year plateau in the rates of obesity and new diagnosis of diabetes. The dramatic results argue for a focused CVN effort toward improved diabetes care.

CVN Quality committee has placed a priority on improving glucose control, patient self-management, and treatment standardization consistent with national guidelines. A review of the evidence as well as best practices across the Network supports the following strategies:

1. Reduce or eliminate patients who do not have an A1c determined recently (3-6 months). The Universal Data Set (UDS) reported annually to HRSA, tracks diabetes control. Per UDS guidelines, "Patients whose most recent HbA1c level performed during the measurement year is greater than 9.0 percent or who had no test conducted during the measurement period" are considered to be in poor control. Therefore, health centers must make sure all diabetics get interval A1C testing. Point-of-care A1c testing coupled to standing orders that allow clinic staff to test patients regardless of reason for the clinic visit will ensure testing is completed in the recommended time frame. Better diabetic control will follow from targeted interventions based on the A1c data.

2. Educate and persuade providers to be more aggressive with treatment: As an example, when a patient has an A1c greater than 9, treatment with 2 or 3 agents should be initiated. Possibilities include metformin plus a second oral medication or long-acting insulin. Following the intervention, a follow up visit should be scheduled (including A1c) within 4-6 weeks to adjust medicines as appropriate. If not controlled by 3 months, insulin should be added followed by Q 4-6 week visits until goal values are reached. For patients on insulin, self-management ought to include instructions for how to gradually increase insulin every 3 days based on home glucose testing.

3. Involve the entire care team: Collaboration is necessary among diabetic educators, social workers, RNs, MAs, and medical specialists to help patients establish lifestyle goals. The Motivational Interview should be employed when appropriate.

4. Establish and maintain registry of all diabetes patients: CHCs participating in CVN's AZARA population health software are able to create patient lists that allow direct outreach to those who are not returning for care. Other useful lists consist of patients overdue for A1c testing or who have results greater than 9. Provider and site-specific reports enable targeted interventions by healthcare teams who--standing orders in place--may monitor sugars, order A1c testing, adjust insulin levels, and schedule follow up visits with medical providers.

A coordinated and focused effort to improve diabetes control is clearly worth the expense and effort. The nearly half-a-million patients treated by Network CHCs deserve the health benefits that stem from excellent diabetic care.