

UVM ScholarWorks

Improvement in Diabetic Care

Item Type	Presentation;Presentation
Authors	Smith, Richard
Download date	2026-05-09 14:22:41
Item License	http://creativecommons.org/licenses/by/4.0/
Link to Item	https://hdl.handle.net/20.500.14849/1955

Village Primary Care

Protocol for Diabetes Evidence Base Care & Patient Self-Management

Most diabetic patients are coming in every 3 or 4 months (mostly four)

According to office guidelines current protocol is considered to be:

Blood work

- HbA1c every 4 months with a goal of <7.0
- LDL annually with goal of < 100
- Micro albumin: annually with goal of < 30mcg/mg
- Eye exam annually

Consider

- Creatinine/GFR: every 6 months

At clinic visit

- BMI
- Blood pressure: every visit
- Diet/exercise/lifestyle at every visit
- Smoking screening at every visit
- Immunization update Influenza/pneumococcal polysaccharide
- Foot exam : quarterly**

Consider

- Depression Screening
- ACE/ARB/ASA recommendations
- Routine age/gender appropriate recommendations
- Colonoscopy/mammogram/PSA

Patient Self management and support

- Education about diabetes will be provided at each routine care visit – this will include review of the role and risks of medication (when applicable); exercise and appropriate eating patterns.
- Certified Diabetic Educator Visits q 1 year
- Dietician Visits q year
- Glucose monitoring education and review q six months
- Exercise goals discussed with patients
- Nutrition goals discussed with patients
- Weight/BMI goals discussed with patients

All recommendations are minimal baseline and recommendations for more frequent visits/lab may be made according to stability of clinical management

Resources

National Diabetes Statistics Report, 2014 (released June 10, 2014)

<http://www.diabetes.org/diabetes-basics/statistics/>

New York Department of Health Diabetes Statistics

https://www.health.ny.gov/statistics/diseases/conditions/diabetes/docs/2012-08_diabetes_mgmt_and_care.pdf

National Diabetes Statistics Report, 2014

<http://www.cdc.gov//diabetes/pubs/statsreport14.htm>

2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults Report

From the Panel Members Appointed to the Eighth Joint National Committee (JNC 8)

<http://jama.jamanetwork.com/article.aspx?articleid=1791497>

According to in house data over the past 6 months for diabetic patients:

- 100% of diabetic patients seen had their blood pressure monitored
 - 57% had a systolic pressure <130 mmHg
- 80% had their LDL cholesterol measured within the last year
 - 69% of those measured had an LDL <100mg/dL
- 67% of the diabetics seen had a hemoglobin A1c measured in the last year
 - 21% of those that were measured were >9%
- 25% were tested for micro albuminuria in the past year
- 22% had a foot exam at the last appointment
 - None of which included a monofilament examination

According to the data, less than 1 percent had an eye exam in the last year***

The major question is: is this a process/procedure problem or a data collection problem?

HbA1C not 100%?

Patients simply under control? Incorrect in problem chart?

Every 6 months a list could be populated of patients who have not received a hemoglobin a1c in the past year. Name Withheld could then work from this list to send reminder letters/flag patients two times per year

Likewise, the same can be done for lipids?

One problem is that often times they are managed by outside offices (endocrinology) so these lab results need to be accounted for. These results may not be in the chart automatically. Patients who have their diabetes followed outside the office should potentially be flagged to avoid unnecessary testing.

Eye exams: likely a data collection problem.

Streamline when reports are generated and prioritize entering data into the spreadsheet of when/if patients are seen for an eye examination.

- 1. Reminders are sent to ALL diabetic patients 2 x per year of patients who have not received eye appointments in the past year**
- 2. Data must be entered every six months on patients who HAVE received appointments to prevent over sending of reminders. Census of patient with completed eye appointments can be made, and entered by a staff member PRIOR to when reminders are sent out.**

Micro albuminuria: possibly not being ordered as often as lipids? Ensuring that this is ordered yearly.

Whenever lipids are ordered, double checking to see if urine is also collected

Census with reminder sent to patients 2 x yearly who have not had it done.

Also, when collecting lipids can simply check to see if micro albuminuria has been collected

Foot exams: the recommendation is that they should happen at every diabetic appointment

When rooming a patient for a diabetic check up can implement the practice of asking all patients in for diabetic foot examinations to "while you are waiting can you please remove your shoes"

Microfilaments are already in place in each room, this exam can then be quickly and routinely accomplished.