Utilization of HIT to Standardize and Improve the Quality of Care for Patients with Diabetes Mellitus

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Organization at a Glance

- Located in Jacksonville, Florida
- Eight medical divisions and Care Partners Technology
- 50 Physicians, ARNPs and PAs
- Family Practice, Internal Medicine, and Pediatrics
- Average 116, 000 active patients
- Implemented EMR system in 2003

FCP Diabetic Care Objectives

- Develop a system to manage complex, high risk, chronic care Diabetic patients by providing medical decision making to the Clinician at the Point of Care
- Identify Preventative Care Gaps with our at-risk patients with Diabetes
- Target focused interventions to standardize and improve quality of care for patients with Diabetes
- Monitor quality Interventions using standardized performance metrics
- Provide performance feedback to the clinicians

How We Used The EMR to Achieve our Quality Goals

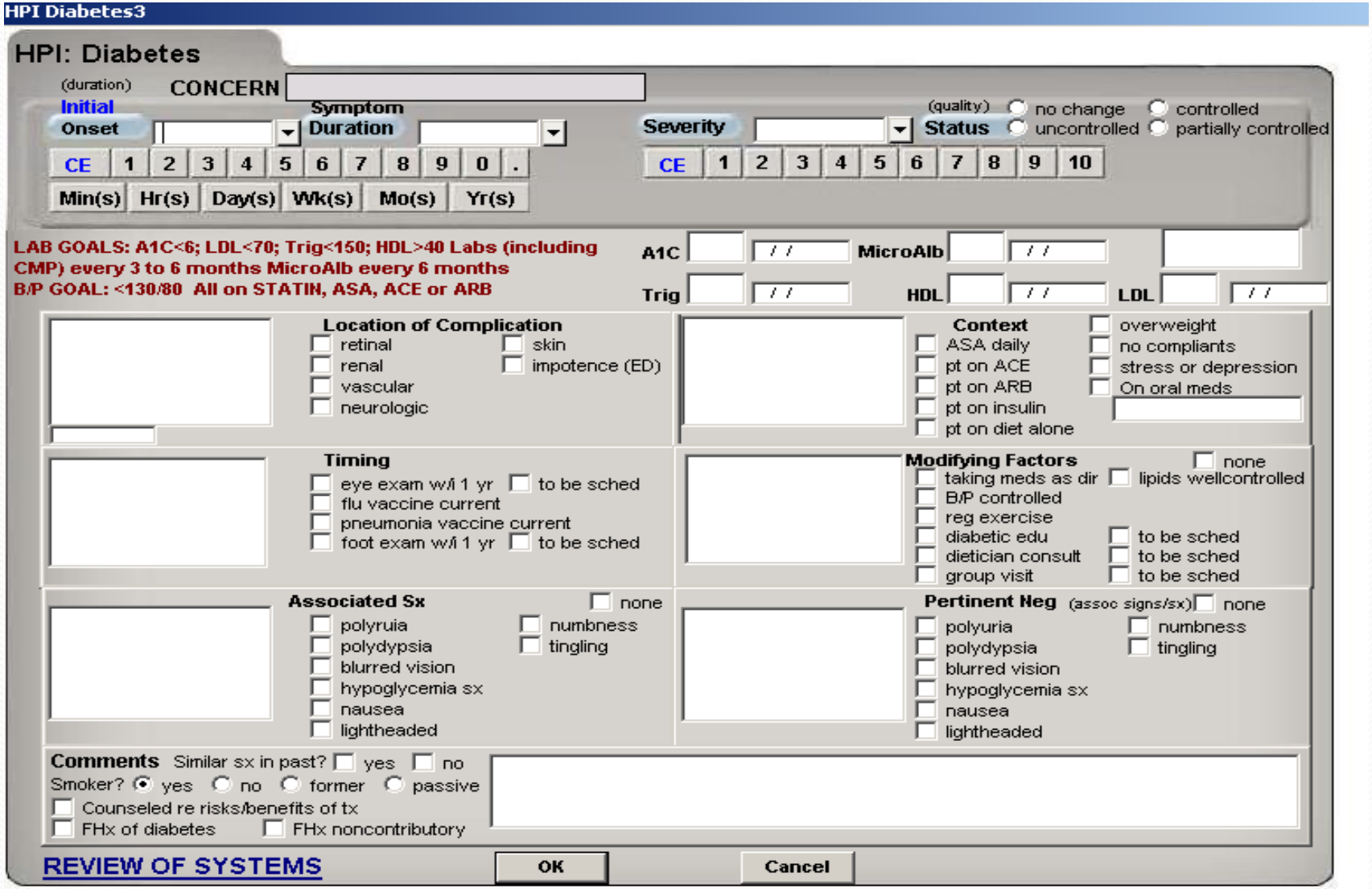
- Utilized a team approach led by the Chief Quality Officer
  - IT, Lab, and Quality Departments
  - Quality Committee
  - IT Committee
  - Clinicians

- Simplified the Data Gathering and Reporting
  - Set -up triggers to populate health maintenance and HPI Template
    - Dates of lab tests
    - Dates of immunizations
    - Lab values
  - Used the Lab Orchard Harvest Reports for Clinician Education
    - Quarterly reports identifying average HbA1c and LDL by Clinician
    - Quarterly reports identifying patients with HbA1c over 7 by Clinician
    - Monthly reports of patients with Fasting Blood Sugar over 100
    - Monthly abnormal PSA, Occult Blood, and Lead Tests

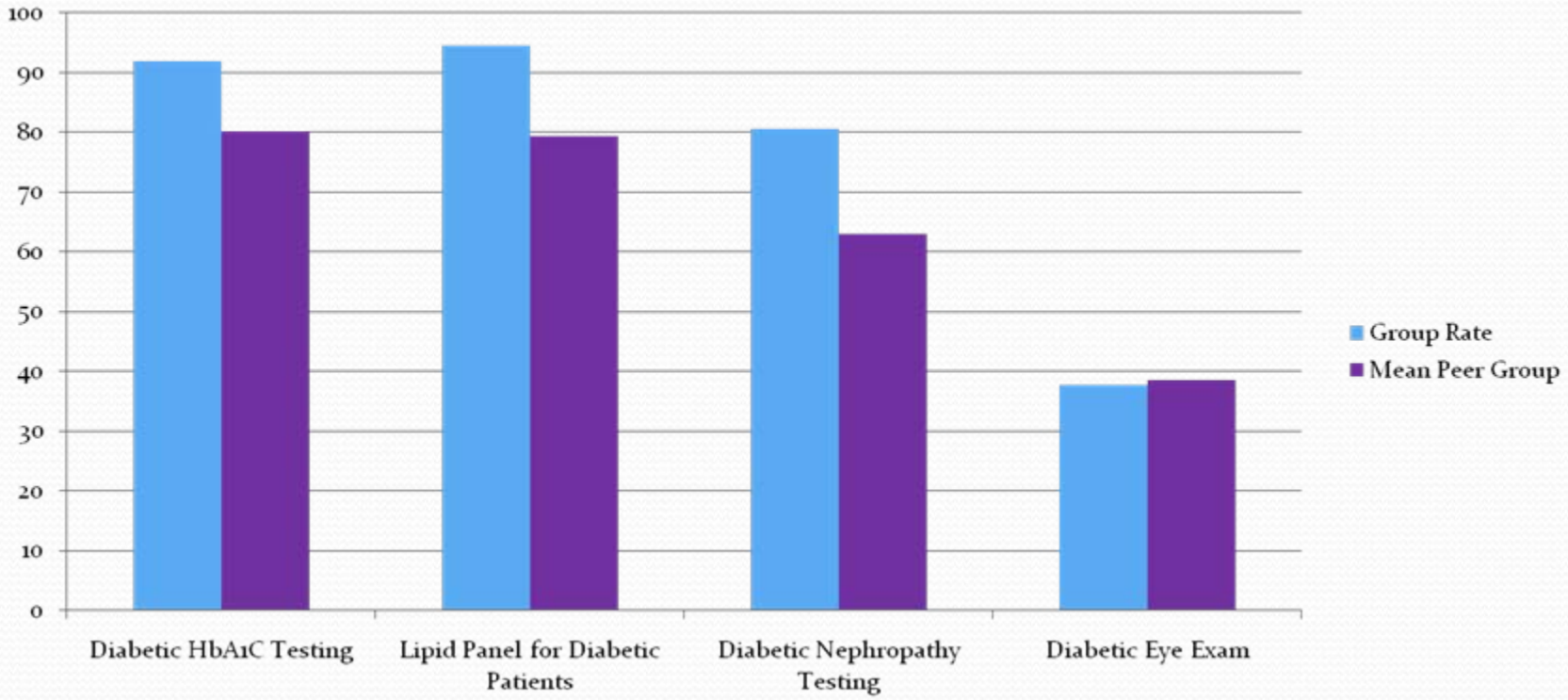
- Population Management
  - System Reports are used to direct the Care Gap Team outreach activities
    - Patient letters and calls are completed and documented in the system
      - Preventative health needs
      - Outside radiology testing
  - Partner with payers to improve Health Outcomes
    - Hospital follow-ups for Medicare Advantage Patients
    - Aetna Care Considerations

- Created a Standard Template for all diabetes related visits
  - Includes ADA treatment guidelines
  - Prompts Clinicians to order dietician visits, diabetic group visits, referrals, medications, and immunizations
  - Pre-populated with most recent lab results.

HPI: Diabetes



2008 DIABETES-RELATED PAY-FOR-PERFORMANCE MEASURES



2009 Results

Diabetic HbA1c Testing = 100
LDL Panel for Diabetic Patients = 94.6
Diabetic Nephropathy Testing = 100
Diabetic Eye Exam = 93.2

Challenges We Faced

- Ability to access data where it was stored
- Staff Not entering Information obtained into the system
- Managing inactive patients in the system
- Scanning Information in a consistent manner to allow for reporting

What We Learned And Wished We Had Known Sooner

- Data obtained from the EMR depends on the information entered
- Auto population of templates increased information exchange and retrieval
- Initial set-up and training of the staff is essential to ensure key data is collectable
- Ongoing management of the data is important
- Clinician involvement is ESSENTIAL
- Outcomes improve when templates provide clinical decision-making support