Continuing Care for Your Diabetes

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- Others involved:
  - Julie Bowers, NP
  - Michael Kimbrell, MD

Problem

- A 13% prevalence rate for diabetes currently exists nationwide with that for Lancaster County being higher than both the state and national averages.
- Continuing care can significantly reduce morbidity and mortality; however, poor data organization makes such services inefficient.

Aims

- To organize and chart continuing care services for each diabetic patient in an easily accessible format.
- To provide charting in a fashion that is beneficial to physician/ medical staff as well as comprehensible to the patient.
- To promote education for the patient by providing access to the chart and to promote active participation in continuing care.

Measures

- Medical staff will be able to access chart at time of patient visit to evaluate for continuing care services due at each visit.
- Patients will describe continuing care services and indicate frequency of such services.

Changes for Improvement

- Update Flow Sheets from patient files to determine scheduling for follow up tests and evaluations.

PDSA Cycle - Plan

- Julie provided me with sample flow sheets and made suggestions as to which tests and evaluations should be included.
- I would create a flow sheet tailored to the Palmetto Tri-County Internal Medicine Practice to organize patient information.

PDSA Cycle - Do

- I identified all tests and evaluations that are used in the practice and organized a flow sheet with the frequencies and goals included for convenience.
- I created an informative guide for patients to help them to better understand the flow sheet and the tests that are performed to help control their diabetes.

PDSA Cycle - Study

- Based on previous student projects, approximately 300 diabetic patients are due for an office visit for continuing care.

PDSA Cycle - Act

- I provided Julie with the flow sheet and patient information guide which she plans to include in the patient mailings that were organized by a previous student.
- She will inform the staff of the new flow sheet and encourage its use in following continuing care.

Lessons Learned

- Regular visits to a physician by diabetic patients is unfortunately all too uncommon, and when patients do make their visits it is difficult to find out when their last Hgb A1C or ABI was performed. Improving patient education about continuing care and the need for routine follow up should help to improve the morbidity and mortality associated with diabetes.