Fighting for the People: The War on Diabetes

Targeting Those Most in Need

Sam Ravenel, MS-3

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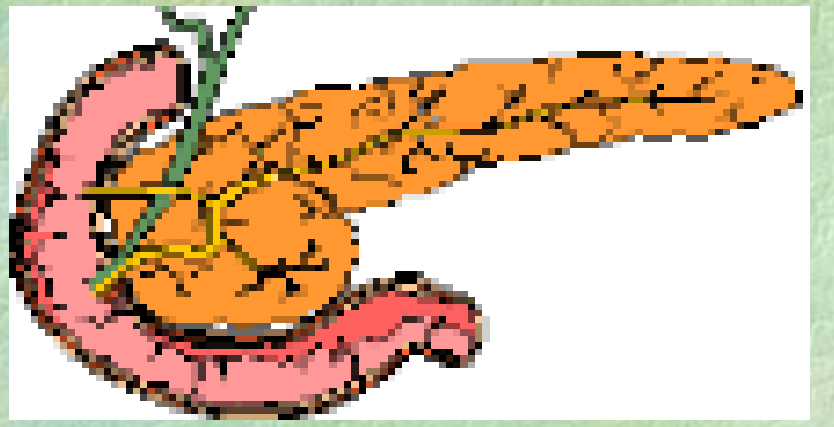
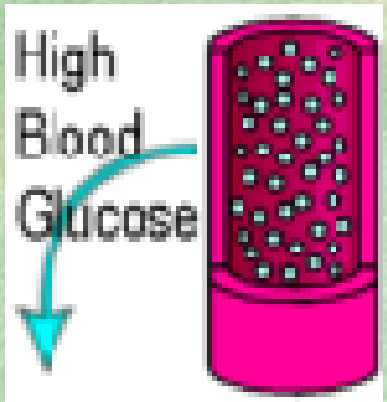
- Others involved:
  - Julie Bowers, RN
  - Dr. Michael Kimbrell, MD
  - Marian Renfrow, TCIM Billing Manager

The Enemy: Diabetes & Ignorance

- 13% prevelance rate nationwide.
- Lack of education and follow up are major contributors to morbidity and mortality





Joining Forces

- Julie Bowers, RN, has been tasked with developing a community education-oriented program for Lancaster County's diabetics

- This project was constructed with the aim of making positive strides for both the quality of care for Lancaster residents as well as for Julie's Diabetes Initiative project

Situation Report #1:
Problem

- As identified by the previous student, a large percentage of Tri-County Internal Medicine (TCIM)'s patients have not been seen in the ADA's recommended interval of 6 months. Many have not been seen in a year or more.

Situation Report #2:
Problem

- Julie Bowers' education project is in its initial stages of development, and will need names and addresses of local diabetic patients for whom education and needs assessments will be conducted

Mission Objectives:
Aims

- To remind those diabetic patients who have not had regular follow up of the nature and potential complications of their condition, and to encourage them to see their physician

- To generate a list of names and addresses of these patients for future use in the developing Diabetes Initiative education project

Plan of Attack:

Change for Improvement

- Draft a brief letter reminding diabetic patients of the importance of regular healthcare visits
- Letter to be sent to as many patients as can be identified as being:
  - Still alive
  - Diabetic
  - Continuing as patients of TCIM

Measures:

- Number of diabetic patients for whom a mailing is prepared
- Number of diabetic patient names and addresses given to Julie for future contact regarding her project

Mission Debriefing:
PDSA Cycle - Plan

- Billing office provided me with a list of all patient accounts (by number) with a diagnosis of Diabetes since the practice opened.

- I would use that to create my list of names and addresses

Mission Debriefing
P**D**SA Cycle - Do

- I identified all patients with the Diabetes diagnosis code on the list seen from Jan ‘97 to Sep ‘99 for all 3 doctors in the practice, and drafted a brief reminder letter to be sent to them

- I then used that list of account numbers to create a list of names and addresses as well as a mailing label for each one

Mission Debriefing

PD**S**A Cycle - Study

- I found approximately 300 diabetic patients who were due for an office visit with their physician

Mission Debriefing
PDS**A** Cycle - Act

- Julie Bowers requested that I give her the mailings so that she could include her own materials and info about her project

- I also photocopied the list of names and addresses for her, and gave her a disc with the list of account numbers on it

Post Mission Intelligence
Lessons Learned

- Diabetes and its complications, as well as the lack of knowledge and education that many patients have about them, is a significant problem facing health care today. It is unfortunate that many patients do not follow up regularly with their doctors, contributing to the problem. It is a daunting problem that must be faced one step at a time.

Post Mission Intelligence
Conclusion

- Identifying diabetic patients in Lancaster who are not making regular trips to their physician and then targeting them for follow up reminders and educational activities will hopefully prove to be a necessary early step in the ongoing process of improving their care and quality of life for the future.