Wheeler | COMMUNITY | HEALTH | CARE

Improving Diabetes Control

Team Members: Maria Banevicius, Lead Primary Care Nurse Practitioner; Linda Russo, VP of Quality; Lisa Roth, Senior Director of Health Center Operations; Jessica Masterson, Registered Dietician Nutritionist; Camila Molina-Rubino, Senior Director of Nursing; Ryan Carzello, Quality Specialist II; Dr. Corrie Thompson, Integrated Care Supervisor Psychologist; Deborah Daniel, APRN, Psychiatric Nurse Practitioner; Dr. Teresa Domack, Director of Medical Education; Juliet Austin, Healthcare Analyst II

CY2024 Goals: 1) Decrease the percentage of health center patients aged 18-75 with diabetes who had a hemoglobin A1c greater than 9.0% or who had no hemoglobin A1c test conducted during the year, and 2) Increase the patient attendance rate for nursing visits.

WHAT WE DID

- Wheeler's Information Technology Department developed a new report to identify Wheeler's diabetic population, which the nursing team used to conduct patient outreach and engagement.
- Established new "SmartPhrases" which shortens providers' documentation time and supports referrals of diabetic patients to nursing for Diabetes Care Management.
- Set goals and acted to improve the patient nursing visit show rate on a monthly basis and monitored the percentage of all visits that involved diabetic patients.
- Enhanced workflows for data mining resulting in the location of missing A1c test results in external systems.
- Strengthened procedures which encouraged primary care involvement for behavioral health and psychiatry patients.
- Drafted a clinical protocol and workflow for the care team to follow.

WHAT WE LEARNED

- It is critical for psychiatry patients with chronic medical diseases to be established with a Wheeler primary care provider to achieve optimal health outcomes.
- Nursing plays a critical role in patient engagement, and some of their work is not easily captured in data on patient visits.
- Close follow up and the establishment of appointment routines with nursing and providers improved patient outcomes.
- Increasing use of external electronic information systems such as CONNIE, results in a more complete patient medical record.
- The team developed a useful model for care management which can be replicated for other chronic health conditions.
- A team-based approach is essential for patients with chronic diseases to improve their health outcomes.
- Keeping things simple level drives results.

LOOKING AHEAD IN 2025

- Nursing team will continue to utilize the diabetic patient report and perform outreach as well as monitor nursing visit volume and show rates.
- Wheeler will continue to enhance its data mining capabilities with CONNIE.
- Staff will continue to require primary care involvement for behavioral health and psychiatry patients.
- Bristol leadership team will explore reasons for decreased performance and take steps to improve health outcomes for diabetic patients.

RESULTS

- During 2024, Wheeler's five Health & Wellness Centers (HWCs) collectively decreased (improved) the percentage of health center patients with diabetes who had a hemoglobin A1c greater than 9.0% or who had no hemoglobin A1c test conducted during the year. The overall score for 2024 was 28%, which is an improvement of 8% over 2023.
- In 2024, four out of Wheeler's five health centers (Hartford, Waterbury, New Britain, and Plainville) decreased (improved) their individual scores compared to 2023, and exceeded their goals for 2024.
- The patient show rate for nursing visits generally improved during 2024, going from the baseline of 64%, peaking at 74%, followed by an expected seasonal decline to 70% at the end of the year.