IMPROVING DIABETIC CONTROL AND SELF-MANAGEMENT SKILLS IN UNCONTROLLED TYPE 2 DIABETICS

Donna Mitchell, APN; Anita Varkey, MD
Lauren Montague, BA and Loyola Outpatient Center General Medicine Staff
THE PROBLEM

- Diabetes affects 11.3% of the adult US population. Poorly controlled diabetes increases risk of microvascular and macrovascular complications, leading to billions of health care dollars spent, and significant impact on patients quality of life. In general, every percentage point drop in HbA1C can reduce risk of micovascular complication by 40%.

- 2011 National Diabetes Fact Sheet
The purpose of this project is to identify patients with significantly elevated blood sugars, assess their barriers contributing to poor control, and assist patients with gaining better control of their blood sugars.
PROJECT GOALS

- To target patients with poorly controlled T2DM (A1C > 10%) and offer them barrier identification, intensive education, and self-management skills to promote improved glucose control.
- HbA1C goal < 8%.
IMPLEMENTATION

- Through an Epic search, patients with HbA1Cs >10% were identified.
- Letter and home questionnaires were mailed to each patient requesting to make initial appointment with the APN.
- Initial APN appointment was completed for 17 patients, as of 8/9/13, which provided targeted diabetes education and addressed barriers.
- A communication plan was implemented with the patient for follow-up medication management and troubleshooting problem areas.
ANALYSIS OF RESULTS

- 70 patients were identified with HgbA1Cs > 10.0
- 17 patients arrived for initial appointments with the APN
  - 6 women, 11 men
  - Average age 58 years old
  - Average HgbA1C 12%
  - 8 completed questionnaires prior to initial visit

8 patients have had repeat HgbA1Cs

A decrease of 8-30% in HgbA1c was demonstrated within the initial three months of followup with an average decrease of 21% (9.3% avg A1C)
LESSONS LEARNED

- Patients that were followed in the case management program demonstrated improvements in meeting goals for BP, LDL, Microalbumin, annual eye exams, and annual depression screening. Attention to diabetic followup helped with tracking behaviors to prevent complications.

- Relationship building with noncompliant patients made a difference in improving patient followup and successful glucose management.

- Follow up phone calls allow for more frequent medication adjustments and help patients understand the importance of glucose testing.

- While patients may express confidence in their ability to handle diabetes management they still benefited from one on one support from the nurse practitioner.
NEXT STEPS

- Formalize a diabetes case management program led by the APN for A1C over 10%
- Involve ancillary staff in follow up phone calls for reminders of appointments and for glucose readings.
- Utilize My Loyola for communication and have patients enter glucoses.
- Begin data collection on measures of lipid and BP management in same population.
- Develop an abbreviated assessment of self efficacy that can be added into the progress note.
CONTACT INFORMATION

- Donna Mitchell, APN
- Nurse Practitioner
- LUMC General Medicine Outpatient Center
- Ext. 68757
- domitchell@lumc.edu