Improving Quality Measures with Patient Engagement and Education

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Objective

1. Improve blood pressure and diabetes control for at risk patients through education and patient engagement
2. Decrease ER over-utilization by educating patients about options

Background

We identified target populations using reports generated by our EMR and from our local Emergency Dept.
Many of our patients with HTN or DM were only being seen every 3-4 months, and often had other health conditions to discuss, so blood pressure and sugars were not being addressed.
We also knew that getting blood pressure monitors covered by insurance was a difficult, time-consuming task.
Despite having an Immediate care facility in our clinic with extended hours, we had patients going to ER for ear infections, or fevers.

Actions Taken

At risk patients were mailed letters, discussing grant and encouraging them to schedule appointments. At visits, they were given educational folders with information on diet, exercise, sodium intake, and forms for recording BP and sugars. Patients were scheduled for monthly follow up visits,and asked to bring folder to each visit.

We also collaborated with local YMCA staff to offer 2 classes in our lobby; one was aimed at healthy grocery shopping habits, the other was directed at reading labels and cooking for a low-sodium diet. Patients were notified of classes and encouraged to attend.

ER over-utilizers were given resources on local urgent care clinic hours as well as our own Immediate care hours. Booklets also had dosing charts for tylenol/ibuprofen, and information on managing colds/fevers at home.

Metrics

- 21 patients enrolled in HTN cohort:

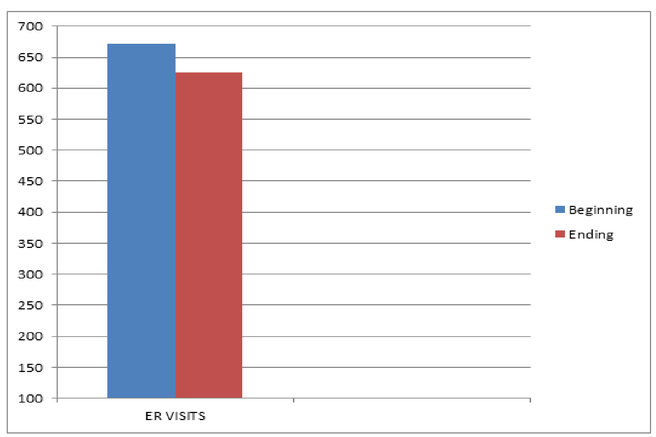
18 have completed >1 visit
Average starting BP: 157/90
Ending average BP as of 5/21/19: 141/81
55% of the patients have reached goal 140/90 or less

- 5 patients w/ DM: 4 have completed >1 visit

50% are now at a1c <9.0%.

- ER overuse: We began with 57 patients who were identified as High Risk patients. Those patients had a total of 671 ER visits in the previous 12 months. After additional follow-up and education to the 57 patients, the ER visits were reduced to 625 in the four month period.

Graphs, Pictures, Supporting Documents



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Analysis

Hypertension and Diabetes are multifactorial diseases. However, we have learned that by engaging patients in their health care using education, classes and follow up calls, we were able to help them improve their health. They became empowered to make better choices, ask more questions and become active participants in the management of their health.

We also learned that by scheduling patients for 3 monthly follow ups at the first visit, we avoided longer gaps between appointments.

Next Steps

1. Continue with booklets for patients with uncontrolled HTN or DM.
2. Collaborate with YMCA/other resources to facilitate classes or support groups where patients can learn self-management skills.
3. Consider other disease states that would benefit from this approach (asthma, chronic pain, depression).

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