

# Change in Diabetes Outcomes as a Result of Self-Management Support by Health Coaches

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- The Health Coach role was and is vital in patient self-management support in primary care clinics.
- Disease registry data capabilities led to improved chronic disease management processes and outcomes.

Mercy Clinics, Inc.(MCI) is a primary and specialty clinic system in Des Moines, IA and the suburbs and is made up of 40 clinics, employs 145 physicians; our services are 70% primary care, with 877,808 patient visits in FY07.

Triggered by the Institute of Medicine's book, *Crossing the Quality Chasm*, we set out to improve the health status of our clinic patients with diabetes by providing consistent and proactive treatment using the evidence-based standards of care recommended by the ADA. To do this, we redesigned the clinic system and added a measurement tool. We identified two problems to explore:

- How to *measure* our performance on diabetes care at the clinic level. We knew we gave good care, but measures had not been in place to quantify this.
- How to *improve* the level of care, based on the data, the following year.

We would like to share our success story. We showed how we quantified nursing care to change chronic disease outcomes, built a business case, and used data to have a voice within the health care and insurance community.

Health Coaches, mostly registered nurses, were the key in making our system redesign work. Decision Support: We put into place *Practice Guidelines* and *Standing Orders* for diabetes. Clinical Information Systems: A *Disease Registry* for diabetes was established. Delivery System Redesign included training Health Coaches who facilitate planned care visits for patients with diabetes. They maintain the *Disease Registry* and proactively contact patients who have care opportunities or who are not meeting goals. They conduct pre-visit chart reviews to evaluate and ensure patients are current within the standards of care. They place a *Diabetes Flow Sheet* on each chart, and use a *Diabetes Office Visit Form* checklist so all critical elements are addressed. Health Coaches provide Self-Management Support (SMS) by using a behavioral change focus.

Health Coaches enter data in a *Disease Registry* (Care Measures) to track diagnoses, appointments, lab tests, and process and outcome measures for over 9,000 patients living with diabetes. They partner with patients in using resources to optimally manage diabetes.

We knew we gave good care, but measures had not been in place to quantify this. Hemoglobin A1c, blood pressure, lipids, and urine microalbumin results were entered into the Care Measures registry. Integrity of the data was monitored and maintained by our Director of Quality. Descriptive statistical analyses were used. Monthly, transparent processes' and outcomes' reporting to physicians and the clinics revealed the status of their own diabetic patient population. This allowed MCI to compare results for the clinics and identify annual trends as a gauge for progress in disease management. We used the *National Quality Forum* [NQF] measures which are the national benchmark for performance in key areas such as process and outcome quality measures.

We were concerned patients might resist more frequent office visits and lab tests, but they appreciated the extra support in meeting their self-identified goals. The system redesign involved coordination of all the team members to ensure efficient, thorough, patient-centered care. When processes were retooled, diabetes outcome measures significantly surpassed the 90th percentile

NQF measures for quality of care over one year. Our primary intent was to improve quality, but we discovered positive patient satisfaction and increased ancillary revenue which yielded a strong business case for our project. We were able to overcome these barriers to clinic practice change: information explosion, time, lack of measurement, the current reimbursement system, and medical system culture.

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