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| **Assessment and Screening** | | | | | | |
| **Goal** | **Rationale** | **Timeline** | **QI Team** | **Population Involved** | **Measurement** | **Additional Notes** |
| Understand the demographics and comorbidities of patients (pts) of color with Type 2 diabetes (T2D) and A1c>9 | Pts of color have higher T2D prevalence, comorbidities, and risk of poor outcomes. Understanding your pt population may help you treat your pts in a culturally sensitive fashion | 2-3 weeks | Physician and allied health care provider champions, practice manager, and/or IT | Review of all pts seen in the last 6 months | **Strategy:** Run Electronic Health Record (EHR) report or conduct chart review  **Measures**: # of pts, by race, ethnicity, and co-morbidity | Consider how information about race and ethnicity are gathered and entered in the medical chart |
| Understand barriers to medication adherence, including costs for Black/Hispanic pts with T2D and A1c>9 | Lack of insurance and out of pocket costs can be a barrier to medication adherence; based on the information  from this PDSA, practices can adjust prescriptions and identify financial support for their pts' medication | 6 weeks | Champions, front desk staff person, diabetes educator, or medical assistant | All Black/Hispanic pts with T2D and A1c >9 OR All Black/Hispanic pts with T2D and A1c>9 who come in for an office visit | **Strategy:** Survey via pt portal OR paper survey during check-in/rooming  **Measures**: # of pts given survey of those eligible; # of completed survey responses; descriptive statistics on barriers identified | Short surveys are best; for pts who have literacy issues, the survey can be conducted orally in the exam room |

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| **Goal** | **Rationale** | **Timeline** | **QI Team** | **Population Involved** | **Measurement** | **Additional Notes** |
| Identification of pts with low medication adherence and most common medication adherence issues in the practice | Lack of insurance and out of pocket costs can be a barrier to medication adherence | 2 months | Champions, patient navigator(s) and or diabetes educator and/or medical assistants (MAs) | All Black/Hispanic pts with T2D and A1c>9 who come in for an office visit | **Strategy**: Pt survey (BMQ-Specific) https://www.ncbi.nlm.nih.gov/pmc/article s/PMC6510353/  **Measures**: # of eligible pts given survey; # of completed survey responses; results of survey |  |
| Depression screening | Many people with diabetes suffer symptoms of depression | 1 month | Champions, front desk staff person, diabetes educator, or medical assistants | All Black/Hispanic pts with T2D and A1c>9 who come in for an office visit | **Strategy**: Pt Health Questionnaire - 2 (PHQ-2)  https://cde.drugabuse.gov/instrument/fc 216f70-be8e-ac44-e040-bb89ad433387 and education of staff about depression in diabetes  **Measures**: # of eligible pts given questionnaire; # of completed responses; results of PHQ-2; staff educated | Results may lead to follow-up effort to improve referral for behavioral health care |

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| **Prevention (some of these goals can be achieved in parallel to one another)** | | | | | | |
| **Goal** | **Rationale** | **Timeline** | **QI Team** | **Population Involved** | **Measurement** | **Additional Notes** |
| Increase recommended vaccinations among Black/ Hispanic pts with T2D to 80% (influenza, COVID-19, hepatitis B, pneumonia, shingles, Tdap) | People of color typically have lower rates of vaccination and greater risks of vaccine-preventable disease | 3 months | Champions, front desk staff, nurses, medical assistants, physicians | All Black/Hispanic pts with T2D and A1c>9 who come in for an office visit | **Strategy**: Telehealth/pt portal outreach to discern vaccine status and recruit pts to be vaccinated; provide pt education materials on vaccines  **Measures**: # of pts reached through telehealth appts, # of pts vaccinated; # of vaccines administered by type; # of pts given educational materials | Physicians have the most influence over pt vaccination and recommendation/ provision of vaccines is the most impactful approach. The whole team can work to make a strong recommendation. Documentation of vaccination may be an issue |
| Increase foot exams to 90% of T2D pts of color | Black/Hispanic pts with diabetes are at higher risk of amputation | 3 months | Champions, nurses | All Black/Hispanic pts with T2D and A1c>9 who come in for an office visit | **Strategy**: Adjust rooming practice to incorporate automatic removal of shoes for pts with T2D during visit  **Measures**: # of eligible pts; # of pts asked to remove shoes | Be sure to let your pts know why shoe removal is important |

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| **Goal** | **Rationale** | **Timeline** | **QI Team** | **Population Involved** | **Measurement** | **Additional Notes** |
| Increase annual kidney disease assessment through measurement of urinary albumin and estimated glomerular filtration rate (GFR) | Chronic kidney disease is more common in Black/Hispanic pts | 3 months | Champions, nurses | All Black/Hispanic pts with T2D and A1c>9 who come in for an office visit | **Strategy**: Automate EHR to note when pt is due for kidney disease screening; in morning huddle, identify which pts are due for kidney disease screening  **Measures**: # of eligible pts; # of pts assessed; assessment outcomes | Pre-visit blood tests can be utilized |
| Recommend continuous glucose monitoring (CGM) for pts on insulin | CGM use can help better manage blood sugar in pts using insulin, and some data suggest pts of color have less access to CGMs | 3 months | Champions, physicians, advanced practice staff and nurses, diabetes educators | All Black/Hispanic pts with T2D and using insulin who come in for an appointment | **Strategy:** Recommend CGM for pts on insulin, educating them about its use  **Measures**: # of eligible pts; # of educational materials distributed; number of pts who receive CGM | Identification of reimbursement options may be needed |

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| **Improved Medical Treatment** | | | | | | |
| **Goal** | **Rationale** | **Timeline** | **QI Team** | **Population Involved** | **Measurement** | **Additional Notes** |
| Increase adherence rates by 50% percent in populations identified as having low medication adherence in the assessment and screening activity | Medication adherence is often 50% or lower | 6 months | Champions, nurses, medical assistants, pharmacists | All Black/Hispanic pts with T2D and A1c>9 OR all Black/Hispanic pts with T2D and A1c>9 who come in for an office visit and identified as having low medication adherence | **Strategy**: Implement medication review upon in-person visit or via telehealth  **Measures**: # of pts eligible for review, # of pts who received a medication review | Medication review is a good opportunity to understand a pt's concerns and knowledge of their treatments |
| Increase sodium-glucose cotransporter-2 (SGLT2) inhibitor use in appropriate pts with T2D by 50% | SGLT2 inhibitors can reduce heart failure and chronic kidney disease; commonly seen in people of color | 6 months | Champions, physicians, pharmacists, nurse practitioners | All Black/Hispanic pts with T2D and A1c>9 who come in for an office visit and qualify for SGLT2 inhibitor use | **Strategy**: Identify pts who may benefit from an SGLT2 inhibitor; educate clinicians about SGLT2 inhibitor use in diabetes; provide pt education on SGLT2 inhibitors  **Measures**: # of eligible pts; # of pts educated of those eligible; % increase in SGLT2 inhibitor use; provider educational gains | As new recommendation, provider education is key |

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| **Goal** | **Rationale** | **Timeline** | **QI Team** | **Population Involved** | **Measurement** | **Additional Notes** |
| Educate staff about appropriate use of insulin | Clinical inertia and lack of knowledge can delay insulin use in pts who can benefit from it | 3 months | Champions, physicians, advanced practitioners, nurses | All clinical staff at clinical practice | **Strategy**: Presentation on appropriate insulin use in diabetic pts  **Measures**: # of providers educated; gain in knowledge, practice and attitudes |  |

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| **Patient Education** | | | | | | |
| **Goal** | **Rationale** | **Timeline** | **QI Team** | **Population Involved** | **Measurement** | **Additional Notes** |
| Enroll 30 Black/Hispanic pts with T2D and A1c>9 in self-management education program | Diabetes education can promote pt activation and effective self-management | 6 months | Champions, patient navigators, front desk staff, practice managers | Black/Hispanic pts with T2D and A1c>9 | **Strategy**: Identify education programs and create a connection to the program leaders  **Measures**: # of pts referred to program; # of pts enrolled | National organizations may be able to help you find programs |
| Train physicians and nurses in social determinants of health (SDOH) and motivational interviewing (MI) | Pt-centered care using SDOH and MI improves adherence and satisfaction | 3 months | Champions, physicians and advanced practice staff and nurses | Black/Hispanic pts with T2D and A1c>9 | **Strategy**: Training presentation and role-playing with SDOH and MI  **Measures:** # of trained staff; pre- and post-test of knowledge, practice, attitudes, and barriers | SDOH and MI are practices that apply across medical conditions |

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| **Goal** | **Rationale** | **Timeline** | **QI Team** | **Population Involved** | **Measurement** | **Additional Notes** |
| Refer to diabetes educator | Diabetes education can promote pt activation and effective self-management | 6 months | Champions, patient navigators, front desk staff, practice managers | Black/Hispanic pts with T2D and A1c>9 | **Strategy**: Identification of diabetes educator in health system, local clinic, or community; referral of eligible pts to the program  **Measures**: # of pts eligible; # of diabetes educators; # of pts referred; # of pts who complete appointment | Follow-up with pts to learn about their views of the program |

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| **Identify and Address the Social Determinants of Health & Improve Access** | | | | | | |
| **Goal** | **Rationale** | **Timeline** | **QI Team** | **Population Involved** | **Measurement** | **Additional Notes** |
| Identify barriers to care in all  Black/Hispanic pts with T2D diabetes and A1c>9 | Short surveys are effective in identifying pt SDOH needs | 2 months | Champions, nurses, medical assistants, pharmacists | Black/Hispanic pts with T2D and A1c>9 | **Strategy**: Apply SDOH screening tool in EHR or at [National Association of Community Health Centers PRAPARE Tool](https://protect-eu.mimecast.com/s/ZE7GCnzwLS7om45tZbZbB?domain=nachc.org/); implement during in-person or telehealth visits. Can be administered by medical assistant or nurse  **Measures**: # of surveys administered and completed; results of survey |  |
| Increase access to affordable  medications by 50% | Some pts find paying for prescriptions for multiple conditions impossible | 6 months | Champions, practice managers, nurses, medical assistants | All Black/Hispanic pts with T2D and A1c>9 who have barriers to affordable medications as assessed in first activity | **Strategy**: Identify resources for covering prescription costs and share the information with pts (either in pt portal/telehealth or at visit)  **Measures**: successful identification of resources, # of eligible pts; # of pts guided to accessing resources; # of pts who access resources | Drug manufacturers, insurers and state, county and local health departments may have pt assistance programs |

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| **Goal** | **Rationale** | **Timeline** | **QI Team** | **Population Involved** | **Measurement** | **Additional Notes** |
| Increase access to resources that improve the SDOH by 100% | Transportation, healthy food access, access to a nutritionist, safe places to exercise, and diabetes education are significant barriers to good outcomes for people of color with diabetes | 6 months | Patient navigators | All Black/Hispanic pts with T2D and A1c>9 | **Strategy**: Identify and direct pts to community resources; work, eat, play, and pray to improve health outcomes  **Measures**: # of eligible pts; # of pts directed to resources in the community | Local health and public health  departments may have resources |

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| **Improve Team-based Care and Staff Burn-out** | | | | | | |
| **Goal** | **Rationale** | **Timeline** | **QI Team** | **Population Involved** | **Measurement** | **Additional Notes** |
| Increase efficiency through team-based diabetes care | By engaging the whole team, efficiencies in care delivery can be found, reducing provider burden | 6 months | Champions and lead/ representative practice staff | Clinical staff | **Strategy**: Conduct a workflow analysis for diabetes pts; project team meets to discuss opportunities for efficiency  **Measures**: Recommended workflow changes identified and implemented | Share analysis with all staff for optimal insights and buy-in |
| Destigmatize depression among clinical staff | By destigmatizing depression among clinical staff, the risk of mental health crises and staff burnout is diminished. Thus, creating a healthy clinical environment | 6 months | Champions and health system | Clinical staff | **Strategy**: Provide educational material and presentation to staff about burn-out and mental health along with resources  **Measures**: # of clinical staff receiving materials and attending the educational session |  |

**NOTES**

Multi-step PDSAs could be done with cycle 1 being assessing baseline; cycle 2 pilot implementation of an improvement strategy; cycle 3 broadening implementation of the improvement across the practice; another cycle that may be included is improvement of medical record documentation.

Results from the PDSAs should be reviewed by the champion/QI leaders; shared with staff at regularly scheduled meetings; posted in staff common areas; and brought to the attention of leadership so as to share identified needs and improvements.

All pt education resources should be in the language spoken/read by the pt.

Champions are part of each of the PDSA, leading efforts to design, implement, and assess. Clinic leadership and physician buy-in is key to success as well as staff engagement.