AHEAD Podcast 17 - QI Success Story from the Field: Tackling Uncontrolled Type 2 Diabetes, Part 1

Transcript

[Jazzy instrumental intro music]

[Voiceover] Michael Konstan: Welcome to the AHEAD Initiative podcast series focused on sharing evidence-based practical strategies to improve diabetes outcomes and advance diabetes health equity. I'm Dr. Michael Konstan from Case Western Reserve University School of Medicine and I serve as the principal investigator for the Northeast Ohio Quality Improvement Hub, a collaboration of Western Reserve University with Northeast Ohio Medical University. The Northeast Ohio QI Hub is funded by the Ohio Department of Medicaid and provides quality improvement infrastructure for primary care clinics in our region. We hope you enjoy today's AHEAD Initiative podcast.

Aleece Caron: Welcome to our Achieving Health Equity in Diabetes or AHEAD podcast series for the Northeast Ohio Quality Improvement Hub or the NEO QI Hub. My name is Aleece Caron and I am the co-lead of the Quality Improvement and Implementation Team for the NEO QI Hub and I'm a professor of medicine at Case Western Reserve University and the MetroHealth System. As part of the AHEAD initiative, 47 practices across Northeast Ohio were recruited in two waves to participate in quality improvement activities aimed at reducing the number of patients with uncontrolled type 2 diabetes. Joining me today to discuss their clinic's quality improvement journey and successes are doctors Jayne Barr and Nimet Ozbay from the MetroHealth Internal Medicine Clinic. Jayne Barr is an associate professor of internal medicine at Case Western Reserve University School of Medicine and the Metro Health System, division director for general internal medicine, associate program director for internal medicine, residency program primary care and co-director for the primary care track. Nimet Ozbay is an ambulatory care pharmacy specialist at MetroHealth. She is currently practicing as a clinical pharmacist at MetroHealth Internal Medicine. She focuses on chronic disease state management primarily on managing patients with uncontrolled diabetes to achieve better outcomes through education, medication optimization, and lifestyle support. Welcome to the podcast.

Jayne Barr: It's great to be here.

Nimet Ozbay: Yes, thanks for having us.

Aleece: So, to start off, your practice joined the AHEAD initiative in October of 2023. Can you describe what it's been like for your practice to be part of the NEO QI Hub? Nimet, let's start with you.

Nimet: It's been a really rewarding and educational experience. Being part of the NEO QI Hub gave our internal medicine team a structured way to focus on diabetes care through the data reports and regular meetings. It's also helped us see where we could make the biggest impact and compare our progress throughout the process. For me as a pharmacist, it was especially valuable because it reminded both residents and faculty about the services I can provide. Being part of this initiative really showcased how medication management, patient education, and close follow-up fit into the larger care plan. As a result, I saw a noticeable increase in referrals from our residents for diabetes medication optimization.

Aleece: Thanks, Nimet. It sounds like you've been really busy. And Jayne, how has the experience been from your perspective?

Jayne: I agree that participation in the quality improvement Hub has been a truly rewarding opportunity. The insight and training gained has been invaluable and the experience has had a positive impact on the clinic and the patients that we serve. There has been substantial educational value and positive feedback from the residents and the faculty. The residents gained an understanding of QI PDSA cycles and run chart. All of us gained an improved understanding of the importance of evaluating workflows and working together with the medical assistants to implement the point of care A1C measurements. The incorporation of morning and afternoon huddles to reinforce the workflow and discuss any obstacles was also an important learning point. As our QI coach once said, QI can be messy, but taking small PDSA steps make it much cleaner.

Aleece: Sounds like a very wise QI coach and that you've really learned a lot from participating in this project. The focus of our first project in the NEO QI Hub has been the AHEAD initiative, which works to reduce the number of patients with uncontrolled type 2 diabetes defined as a hemoglobin A1C of 9% or greater in our partner clinics. Why has this been an important issue to address in your clinic?

Jayne: Yes, this project has been extremely important to us. Before this project, our clinic had one of the highest rates of uncontrolled type 2 diabetes in Cleveland, Ohio. In Cleveland, the prevalence of type 2 diabetes is 15.8% versus 13.2% in the state of Ohio and 13.8% in the United States. In fact, the prevalence in Cleveland is higher than entire Cuyahoga County, 15.8% versus 10.1%. Through the engagement of the residents, faculty, medical staff, and pharmacists, we have significantly reduced that number.

Aleece: It sounds like this was a great opportunity for you to really drive some improvement. Jayne, Nimet, what does this mean from your perspective as a pharmacist?

Nimet: So, reducing the number of patients with an A1C of 9% or greater has been a major priority for our clinic because those individuals face the greatest risk for serious complications such as heart attack, stroke, kidney disease, and vision loss. So, when we reviewed our own

data, we realized that even a small percentage of patients above that threshold drives a disproportionate share of hospitalizations and emergency visits. From a pharmacist perspective, it's also an opportunity for high impact intervention. Many of these patients struggle with complex medication regimens, cost barriers, or side effects that make adherence very difficult for them. By identifying them early, we can step in to simplify the therapy, adjust doses, or add newer agents that improve glycemic control and cardiovascular outcomes. Addressing this group doesn't just improve lab numbers. It also improves their quality of life. We've seen patients who, after closer follow-up and medication optimization, experience fewer symptoms, and feel empowered to manage their diabetes day-to-day. So, focusing on uncontrolled A1C isn't just a metric. It's a way to prevent complications, reduce health care costs, and keep our patients healthier and more active.

Aleece: Oh, it sounds like focusing on diabetes can be really impactful for the health care system as a whole, too. Since participating in the QI Hub project, your site has shown great improvement in the percentage of patients whose hemoglobin A1C is 9% or greater. Can you provide a brief description of some of the quality improvement projects that you think were most successful in decreasing the percentage of patients with high A1C?

Nimet: So, we approached this from several angles. We worked to increase referrals to diabetes education and to our pharmacist-led disease management services, which meant more patients were getting dedicated counseling on medications, nutrition, and lifestyle changes. We also addressed a prescribing gap by raising our GLP-1 receptor agonist utilization when clinically appropriate. This is important because these agents improve glycemic control and they have the proven cardiovascular benefits. Each of these projects built on the others. Faster testing informed better prescribing, stronger follow-up kept patients engaged, and increased education plus pharmacist involvement helped sustain improvements.

Aleece: Really, you focused on education and workflow. So that's really important in quality improvement. So, it's really great that you did all of that. Nimet, thanks for sharing. Jane, what else contributed to your success?

Jayne: Thanks, Aleece. In addition to what Nimet had stated, first engagement by the site leadership was crucial. There was administrative support for time as well as financial support for the point of care A1C machines. Second, engagement by the residents was critical. When a patient missed an appointment, our residents did outreach calls to secure a follow-up in the resident clinic right away. So, care didn't stall for weeks. The residents met monthly and were engaged with the processes and reviewing the data. Third, addressing and improving the workflow for point of care testing was critical to our success. This involved communication with the medical assistants as well as dedicated training for them in order to place the order and perform the test as part of the rooming process. We also placed reminder cards in the room to emphasize the importance of doing the point of care A1Cs. We started office A1C testing for any patient whose last A1C was above 9% and more than 3 months old. That gave us up-to-date results on the spot and allowed us to adjust therapy immediately instead of waiting for an outside lab. We educated the providers about the process and about placing the appropriate referrals. At Metro Health, we can do referrals to diabetes education and to our pharmacist-led

disease management service. We can also e-consult endocrinology which can assist primary care physicians with appropriate management as well as appropriateness of referral to endocrinology.

Aleece: Thanks Jayne. It's really important that you pointed out about leadership buy-in. It's really hard to get anything done if you don't have the buy-in from leadership to make time for you to do the projects to make time for the residents really foster that interprofessional collaboration. So, I really appreciate the fact that you made that point, but you've also been successful in sustaining and keeping the gains from your improvement. Can you share what you've done to sustain your success? Jayne, why don't you start?

Jayne: Thanks, Aleece. Success was using the quality improvement project and transforming that into everyday practice. This includes the workflows, huddles, medical assistant training, referrals to diabetes education and pharmacy disease management and making follow-up appointments prior to leaving the clinic with texts and phone call reminders. As with any quality improvement project, monthly meetings with the QI group and the site to celebrate successes helps keep the team excited. Engagement of the residents was important. This project started with addressing the A1C at the time of visit and now has extended to increase GLP-1 receptor agonist prescribing among guideline eligible patients with type 2 diabetes. This additional aspect assuring medication management created educational material that was presented during outpatient didactics. This intervention increased GLP-1 receptor agonist prescribing from 5.69% to 8.19%. Barriers to prescribing GLP-1 receptor agonist included availability cost, insurance coverage, and patient preference.

Aleece: Thanks, Jayne. I think it's really important that you pointed out that you need to celebrate your successes because a lot of times we overlook that and we don't take time to really recognize ourselves and all the hard work that we've done, right? So, I love the fact that your team did that. Nimet, anything you would like to add about sustainability?

Nimet: I think what's been key is that all these elements support each other. The faster testing informs better prescribing decisions. Stronger follow-up keeps patients engaged in the increased education plus pharmacist involvement helps sustain improvements over time. It's become part of how we practice now, not just a temporary project.

Aleece: That's a great point too, Nimet. You know, building in that culture of quality will really help you not just sustain this project, but you know, really get other projects going as well, too. And I'm sure there's lots of other things you guys want to work on. What barriers have you encountered when trying to implement your quality improvement projects or PDSA cycle? Some common barriers we've noticed across the QI Hub sites include being short staffed and having difficulty finding time to conduct the project, difficulty obtaining buy-in from providers or other staff and lack of consistency of implementation across staff or providers. Did you encounter any of these barriers? And if so, can you give an example of how you navigated these challenges? Nimet, let's start with you.

Nimet: We definitely face some of those common barriers you mentioned like many clinics we are busy and staffing can be tight. So, carving out that time for quality improvement work was challenging. One example was improving no-show rates. So, due to staffing being tight, it was difficult to get staff on board to perform appointment reminders and no-show phone calls. Instead, we utilized our IT department. And through our IT department, we were able to identify that numerous patients were actually not getting text or call alerts for their upcoming appointments or their appointments. This was fixed by our IT department. By creating an automated notification system, it helped prevent increased workload for staff while ensuring patients were aware of their appointments to improve show rates.

Aleece: Thanks, Nimet. I think it's really important that you pointed out that you involved IT. I think a lot of times people don't think about IT as part of their quality improvement team members. So, the fact that you included them really just helped to make your project stronger. Jayne, is there anything you'd like to add?

Jayne: Yes, Aleece, we did have one of our point of care A1C machines break as well as inadequate testing supplies. This caused us an inability to perform A1C test on every patient and having to rely on patients going to the labs. We also experienced staff turnover and having to train new staff on the workflow. Having to train new staff often led to inconsistency with the implementation. To overcome these barriers, we tried to do as many of the point of care A1Cs as we could, but when we were unable, we would have the medical assistants draw the labs in the room if it was felt that going to the lab was going to be a barrier for the patient. We had staff that would make sure that the new medical assistants felt comfortable with the workflow. The staff also would have morning and afternoon huddles to address any concerns and to serve as reminders to reinforce the workflow. The residents were very engaged and presented updates of the project to the noon conference residents.

Aleece: Sounds like you spent a lot of time really thinking through how you were going to address those barriers. That was great about how you adjusted the workflow to meet the patient needs. So, we're going to move on. What strategies or factors helped you successfully implement your quality improvement projects or PDSA cycles? Some common factors that have supported successful implementation at QI Hub sites include developing a process that makes implementation easier, adapting PDSAs to fit the local context, having dedicated staff time for QI or leveraging team members for support, using user-friendly technology tools that improve efficiency, having a project champion, and seeing visible impact on the dashboard, which can energize the team. Did any of these factors play a role in your own QI work? Can you share an example of how they helped? Nimet, why don't you kick us off?

Nimet: Many of these common factors have supported successful implementation at our site. For example, utilizing office A1C testing made it easier to make medication adjustments during the same appointment. Increasing pharmacy disease state referrals helped get patients on sooner with closer follow-ups to improve their diabetes control. We also utilize technology to improve our no-show rates by sending out automated appointment reminder texts and calls. During most of our monthly meetings, we reviewed the dashboard which helped keep us on track and see if we needed to make adjustments to our PDSA for more improvements.

Aleece: Reviewing the data can be really really helpful to see if you're making progress even if it's with your process measures and not your outcome measure. Jane, what would you add?

Jayne: It is so important to have site buy-in to ensure that the PDSA cycles are implemented. The buy-in provided the administrative time to be able to attend monthly NEO QI Hub webinars and meetings. One of the best factors that helped our team be successful was our QI coach, Caroline Carter, who met with our team every five weeks. She approached QI very systematically, keeping us on time, setting smaller goals with timelines, focusing on PDSAs, focusing on accountability for us, and closely following up with us regarding what we were doing. We also took feedback from the community patient advisory group. They provided input as to the barriers of transportation and food insecurity through the medical assistant screening for transportation. The medical assistants could discuss use of the MetroHealth Metro Van or make social work referrals if the patient uses a walker or wheelchair. If food insecurity was present, referrals could be made to the food as medicine program. Patients qualify for the food as medicine program if they have either poorly controlled diabetes defined as A1C greater than seven or poorly controlled hypertension or recent admission for heart failure. We also had dedicated medical staff, medical clinicians, and a pharmacist as well as the administration who supported our QI initiatives and interventions. Having the pharmacists embedded within the clinic was an added benefit to this QI project. Medication management and teaching could be performed at the initial encounter and follow-up appointments could be scheduled prior to the completion of the appointment.

Aleece: Well, this has been a great discussion. Thank you both for sharing your insights and experiences.

Jayne: Thanks for the opportunity to be part of this discussion.

Nimet: Yeah, it was great to be here. Thanks for having us.

Aleece: And thank you for listening to the AHEAD podcast. As always, please find more resources on neoqiHub.org and subscribe to your favorite podcast platform so you never miss an episode.

[Voiceover] Michael: This concludes today's AHEAD initiative podcast. To learn more about the Northeast Ohio QI Hub, visit NEOQIHub.org. The Northeast Ohio QI Hub is part of the regional quality improvement Hub project funded by the Ohio Department of Medicaid and administered by the Ohio Colleges of Medicine Government Resource Center. Views stated in this podcast are those of the presenters only and are not to be contributed to the Ohio Department of Medicaid or to the federal Medicaid program.

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