Diabetes Improvement Initiative at UNITE HERE Health Center

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United Health Center

UNITE HERE Health Center

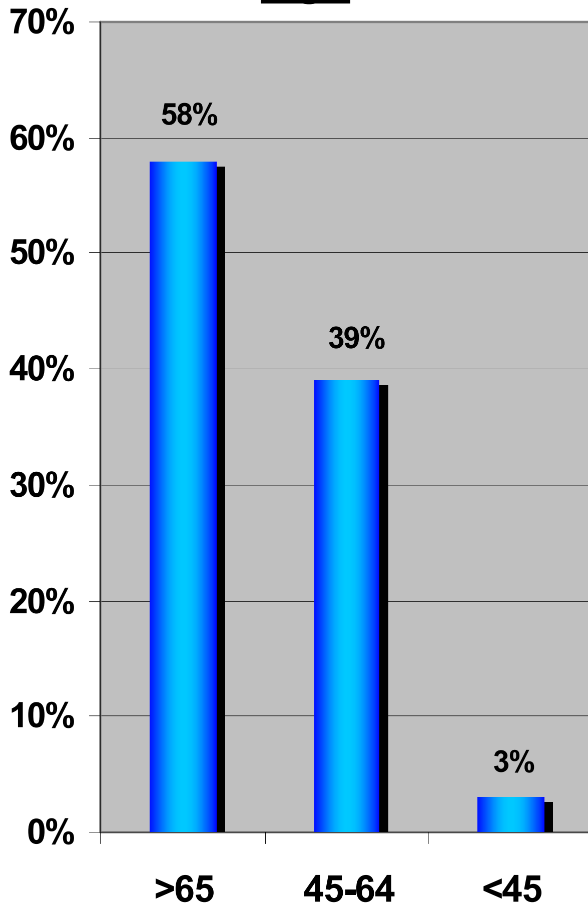
- Primary and specialty care facility with EMR (Electronic Medical Record)
- Union members and retirees in the garment, laundry, and restaurant industries
- In 2005, **12,300** active patients and **81,800** visits
- 99% of patients <200% poverty level

Background

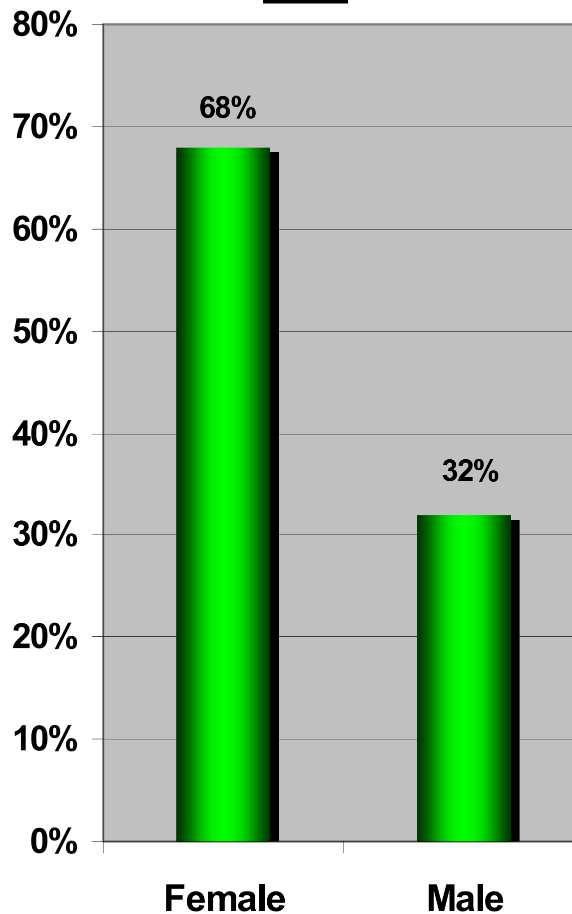
- **2000 – 2003** Redesign and re-engineering collaboratives; center-wide diabetes data
- **2003** – NYC DOHMH DM Collaborative - 3 PCP's and 112 patients
- **2005** - NYC DOHMH Diabetes and Depression Spread Initiative –10 PCP/PCA (Patient Care Assistant) Teams and >1,100 patients

Patient Population*

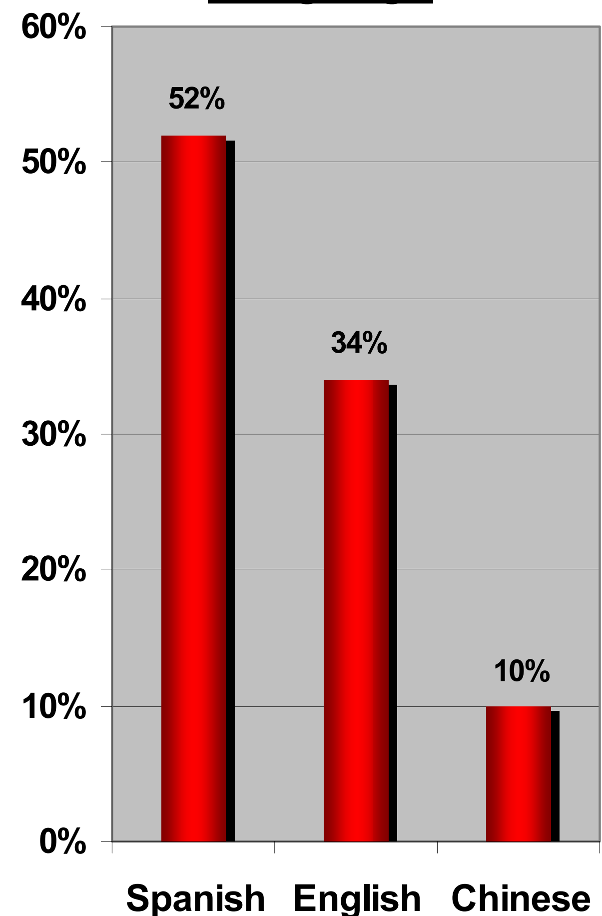
Age



Sex



Language



UNITE HERE Health Center

New York, NY, USA

***920 patients with diabetes followed from 5/05 to 5/06**

Improvement Program

- Multidisciplinary team given protected meeting time
- Diabetes template developed for EMR
- Registries and data shared monthly
- Group visits combining education and self-management support in Spanish, English and French Creole

Improvement Program

- PCA's perform annual monofilament exam
- PCA's refer for annual ophthalmology exam and pneumovax through standing orders
- PCA's trained on basic diabetes education (A1C, Hypertension, Cholesterol, and smoking cessation) and on patient education techniques

Improvement Program

- Partnered with outside agencies for staff training and CDEs to lead group visits
- Registries used to identify patients not at goal and to ensure appropriate follow-up
- Pharmacists reviewed registries and counseled patients who were not well-controlled

Results*

	May 2005		May 2006		% Change **
	N	%	N	%	
A1C < 7.0	430	47%	504	55%	17%
LDL < 100	476	52%	535	58%	12%
BP < 130/80	365	40%	539	59%	48%

*920 patients with diabetes followed from 5/05 to 5/06

** $p<.01$ for all changes based on χ^2 test of symmetry

Results*

	May 2005		May 2006		% Change**
	N	%	N	%	
Foot Exam Within One Year	568	62%	706	77%	24%
Ophthalmology Exam Within One Year	511	56%	625	68%	22%
Self-Management Goal	197	21%	388	42%	97%
Pneumovax	679	74%	813	88%	20%

*920 patients with diabetes followed from 5/05 to 5/06

** $p<.01$ for all changes based on χ^2 test of symmetry

Conclusion

- A multidisciplinary program based on the Chronic Care Model improved outcomes for patients with diabetes
- Participating in a learning collaborative provided the framework for changes to occur
- A team approach to care and redefining clinical roles of team members were key factors in our success