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MEDTAPP Diabetes Quality Improvement Project

CARDI·OH
Ohio Cardiovascular and Diabetes Health Collaborative

The Medicaid Technical Assistance and Policy Program (MEDTAPP) Diabetes Quality Improvement Project (QIP) is the second quality improvement project that is a part of the Ohio Department of Medicaid's (ODM's) Chronic Conditions Quality Collaborative.

Diabetes is a significant public health issue and is the 7th leading cause of death in Ohio. Due to the high incidence of this chronic disease, the large-scale health and economic impacts are substantial. By using a standardized plan of care and best practice guidelines to manage diabetes, the project aims to improve identification, treatment, and management of diabetes among populations in Ohio.

The Diabetes QIP employs a quality improvement approach modelled after the Model for Improvement popularized by the Institute for Healthcare Improvement (IHI) to promote the use of evidence-based strategies known to improve glycemic control. The Specific, Measurable, Achievable, Realistic, and Time-based (SMART) aims of the project are for participating practices to reduce the percentage of patients enrolled in Medicaid with type 2 diabetes whose hemoglobin A1C (A1C) was poorly controlled (>9%) by 15% and to reduce the percentage of poorly controlled A1C in the Hispanic and Non-Hispanic Black populations by 20%. Information and best practices related to the QIP are shared in monthly interactive webinars referred to as Action Period calls. A steering committee comprised of clinical leaders and state partners along with a clinical advisory committee comprised of subject matter experts from all the colleges of medicine developed components of the Diabetes QIP, including the key driver diagram, and a quality improvement toolkit that incorporates evidence-based research interventions for the diagnosis and management of diabetes.

A total of 22 Primary Care Practices from 11 different health systems in Ohio are participating in the project. The participating practices receive monthly coaching to engage in quality improvement activities, employ the evidence-based strategies within the toolkit, and transmit Electronic Health Record data. Data from Electronic Health Records (EHRs) are submitted and analyzed twice a month to inform project progress and provide a feedback mechanism for participating clinical teams to view the success of their Plan, Do, Study, Act (PDSA) testing cycles. Improvement activities have begun and include the implementation of data driven interventions, and the consideration of the social determinants of health for each population treated by the selected Primary Care Practices. In addition, all six of ODM's contracted managed care plans are using IHI-like quality improvement science tools to test payer-based strategies for improving glycemic control, such as facilitation of A1C testing and blood sugar monitoring. Through the collaboration of clinical leaders and state partners, the project team will address the system of care for diabetes to achieve equitable health outcomes for people living with diabetes across the state.

Partners

In partnership with:

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