

SOC Planner for Diabetes

Present?

0-2

<p>1. Well-defined health problem</p>		<p>There is a very high prevalence in West Virginia. Many diabetics are poorly controlled with the consequences of excess premature mortality and morbidity such as blindness, amputation and renal failure. Primary care practices need a well organized, systematic approach to diabetes to maintain > 75% of patients at A1C < 8.0% and to achieve early detection and treatment of diabetic complications.</p>
<p>2. Standards of Care that are evidence based</p>		<p>Clinical Guidelines adopted by the WV Diabetic Comprehensive Project which will be based on WVPCA Recs, ADA, State Programs in Oregon, ND, TX.</p>
<p>3. Staff Agreement on Objectives and Interventions</p> <p>Analysis of Costs and Preparation of Budget by Management</p>		<p>Clinical Director must obtain support for all or selected elements of guidelines from all clinical leaders and all providers.</p> <p>Address how and by whom patient education will be done. Budget time and cost of this.</p>
<p>4. Interdisciplinary Team with clear staff roles</p>		<p>Practice needs a person who is responsible for coordinating, evaluating and troubleshooting diabetic care. The Interdisciplinary Team at the clinic-wide level is the DM coordinator, the Director of Nursing, and the Clinical director. At the micro patient visit level, the team is the patient, the nurse, the provider supported by the diabetes coordinator. Depending on the size of the clinic or the network, the diabetes coordinator may be a part-time position.</p>
<p>5. Decision to proceed</p>		
<p>6. Presence of necessary tools to accomplish care</p>		<p>Medical Records System A diabetic flow sheet Practice Guidelines distributed and available to all providers and nurses. Educational and key materials (to be provided by Goal I of WV Diabetic Comprehensive Project) A Snellen Eye Chart A regularly updated List of Diabetics</p>
<p>6a. Mechanism for case finding.</p>		<p>CEO and Clinical director commit and deliver on promise MIS produces a diabetic list of least annually and this is used for recall and clinical audit.</p>
<p>7. Care provided according to standards</p>		<p>Teams (pt, nurse, provider) perform care with knowledge of the accountability for meeting agreed upon guidelines and objectives.</p>
<p>8. System of care coordination in place with tracking</p>		<p>Limited coordination as described for Step 4 in place at system level. Few practices have sufficient staff or resources for true universal diabetes care coordination. Selective care coordination and case management are a practical approach.</p>
<p>9. Periodic measurement and reports</p>		<p>Clinical Performance Measures are linked to target set by practice in steps 2 and 3.</p> <p>Examples:</p> <ol style="list-style-type: none"> 1. List of diabetics, names and record number is on hand and less than a

		<p>year old N=X.</p> <p>2. 90% of diabetics have had A1C in past 6 or 12 months.</p> <p>3. 90% of diabetics have had visual acuity check in past year.</p> <p>4. 4. 90% of diabetics have had any formal education or diabetic review in past year.</p>
10. Regular staff education and program revision based on evaluation from step 10		Clinical director and coordinator are responsible that audits be performed and be reported and discussed with staff. New objectives, new initiatives, , agreed on at least annually.

(0=not at all; 1=partly; 2=fully)

Items in bold are required for a Basic SOC.

Items not in bold are added over time to achieve an Advanced SOC.