Continuous Quality Improvement Plan

Plan

Improve problem-solving skills and provide patient/family support through timely post-hospitalization diabetes self- management training (DMST) in a population of pediatric and adolescent patients with newly diagnosed diabetes.

Do

1. Collaborate with pediatric endocrinology department to establish a care standard that patients return for follow-up DSMT within 4 weeks of discharge.
2. Create a process for inpatient diabetes educators to notify the Diabetes Centers support staff when a patient with newly diagnosed diabetes is discharged.
3. Train/encourage endocrinology providers to accurately complete DSMT orders that comply with outpatient billing requirements.
4. Call family to schedule outpatient DSMT follow-up education.
5. Assess visit and call data to evaluate if follow-up occurs within 4 weeks of discharge.
6. Evaluate results and continue to work on process improvement.

Study

Data was collected on new diagnosis, inpatient education sessions, scheduling calls, outpatient visits, and the associated timelines.

Time period	New diabetes diagnosis	Follow-up appointment scheduled	Patient attended follow-up appointment within 4 weeks of discharge
Baseline	10	1 (10%)	1 (10%)
Period 1	62	52 (84%)	38 (61%)
Period 2	46	37 (80%)	33 (72%)
Period 3	41	37 (90%)	34 (83%)
Period 4	30	28 (93%)	26 (87%)

Act

- Baseline data confirmed the need for timelier outpatient follow-up for newly diagnosed patients/families to provide better support and reinforce problem-solving skills.
- Implemented the new standard of care in Period 1.
- Worked with pediatric endocrinology to change their post-hospitalization follow-up protocol. Wait time for a new patient physician appointment post-discharge was 8-12 weeks. New protocol was to schedule a Nurse Practitioner appointment the same day as diabetes education appointment within 2-4 weeks of discharge. This was implemented in Period 2. The education show rate improved allowing the educators to assess more families' need for support and reinforce their problem-solving skills.
- In Period 3 the inpatient diabetes educators implemented an electronic handoff in the EMR to Diabetes Centers support staff and pediatric endocrinology. This improved continuity of care documentation.
- The Diabetes Center continues with outreach to families to assist with problem-solving and provide support after new diagnosis.
- Consider implementing a similar standard of follow-up care for patients with DKA readmissions and those with steroid-induced diabetes.