

Diabetes Registry & Education Collaborative

Is Your Practice Ready for a Diabetes Care Registry?

If you answer **yes** to any of the following questions, your practice may be ready for a registry:

- Are you ready to learn how to use an electronic clinical decision support system (i.e. registry) to improve the quality of care for your patients with diabetes?
- Is everyone in your office (from senior management, direct care and front office staff) ready to embrace a culture of technology-assisted quality and improvement?
- Is your practice willing to re-organize workflow so that care is provided by a care management team?
- Could using a robust chronic illness registry help improve care for your all of your chronically ill patients?

If you answer **no** to the following questions, your practice may be in need of a registry:

- Do you know how many patients in your practice have diabetes?
- Do you know if your patients with diabetes have been receiving screenings and tests, and meeting the treatment goals recommended by the American Diabetes Association?

A Free Health Information Technology Opportunity for Primary Care Practices

The NYDC is currently seeking practices interested in implementing an electronic clinical decision support system, (referred to as a “registry”) to improve their system of diabetes care. All practices are eligible to receive the web-based DocSite® Registry and interactive clinician education. The registry includes a diabetes care management module, as well as other chronic disease and preventive care modules.

The NYDC team will guide you through implementation and provide ongoing support at NO COST for eighteen months.

The NYDC will:

- Pay for the cost of the DocSite license and centralized data entry service for each participating physician for the first 18 months of the project.
- Provide practice level implementation support including registry training and workflow redesign.
- Provide clinicians with education to improve skills, address implementation barriers and improve patient communication.
- Conduct an evaluation including a focus on measures of implementation, uptake and utilization of the registry.
- Provide phone support to troubleshoot or answer questions.
- Provide a forum or process for input by participants.

The Project Participants will:

- Complete the McColl Institute Chronic Illness Assessment Survey and share the results with the NYDC project staff.
- Make available physicians and other staff for training and education purposes and for pre- and post-intervention surveys.
- Appoint one or more staff members to be the “go-to” contact(s) and champion(s) on the project.
- Assist the NYDC to initially identify their patients with diabetes. Methods may vary from practice to practice.
- Add new patients with diabetes as they are identified.
- If possible, abstract data from the prior diabetes visit for each patient record for the purpose of loading baseline clinical data into the registry.
- Provide aggregate data to the Coalition on a regularly scheduled basis.

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Why Do It?

Improve Health Outcomes and Improve Quality of Care

The ability to measure and analyze the care being given will improve efficiency and effectiveness.

The education we will provide to your health care professionals will address why a registry is important, how to implement, how to overcome barriers and how to motivate patients to adherence. The education modules can be delivered without commitment to registry implementation.

The registry will help to organize the practice around patient outreach activities and planned visits, meet the needs of individual patients through point-of-care reminders and provide perspective on the practice's whole diabetes population.

"It's a shock when you find out that you weren't doing what you thought you were in treating a disease."

D. Kelling, MD, Northeast Medical Center, Concord, NC
(Early adopter of registry systems (1994))

Facilitate Involvement in Quality Improvement Incentive Programs

Be prepared with a quality improvement tool and reporting system for Pay for Performance (P4P) and other incentive programs. Examples of P4P in New York include:

- Bridges to Excellence*, www.bridgestoexcellence.org
- New York State Department of Health P4P Demonstration Project
- Physician Quality Reporting Initiative*, www.cms.hhs.gov/pqri/
- Individual health plan P4P programs

*DocSite has special reporting arrangements with these programs.

NEW YORK STATE DIABETES STATS

- An estimated 1.1 million people diagnosed with diabetes (7.7% of the population).
(Source: BRFSS, 2005)
- An estimated 450,000 people have undiagnosed diabetes.
(Source: BRFSS, 2005)
- An estimated 13,000 people with diabetes are under 18 years of age.
(Source: SEARCH for Diabetes in Youth Study)

If you are interested, please contact:
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About the NYDC

The New York Diabetes Coalition (NYDC, the Coalition) is a unique collaboration of volunteer representatives from health plans, professional medical societies, departments of health, community-based organizations, quality improvement organizations, health care providers and diabetes care vendors. The primary mission of the NYDC is to improve the health of people who live with diabetes. The Coalition seeks to accomplish this by helping health care providers deliver state-of-the-art care for diabetes through the promotion of tools and technology and by helping patients by providing tools for self-management and resources to eliminate barriers to care and close gaps in services.

Please visit us at www.nydc.org

