How one practice improved its diabetes quality numbers through team work and population management.

A team was responsible for 140 patients with diabetes. They identified and provided care for those patients with the help of an internet based diabetes registry. The initial numbers for yearly activities and other quality numbers are listed next to the numbers at follow up 8 months after they began their team activity.

There team plan was as follows:

- Meetings monthly to review reports and discuss additional strategies
- Phone calls (no more than 4 a day) to patients who had missing data
- Increased use of patient report cards at time of the visit
- Office protocol for a patient with diabetes to include, role of medical assistant during visit, screening foot exam with monofilament by medical assistant, basic handouts on nutrition and exercise.

Quality items	Initial data	8 months later
EyeCheck	2 %	59 %
FootCheck	10 %	82 %
HbA1c<	7.8	7.4
Total Chol	189	184
LDL	112	106
HDL	43	45
Non-HDL	146	139
Triglycerides	175	166
U Micro Alb	6 %	63 %
Pneumovax	32 %	76 %
FluShot	1 %	66 %
Daily ASA	45 %	65 %