Missouri

Establishing Electronic Registries to Monitor Indicators of Health Behaviors

Public Health Problem

In Missouri, where nearly 400,000 adults have diagnosed diabetes, African Americans are more likely than others to be affected by this disease. One of every 14 adults in the overall population has diagnosed diabetes compared with 1 of every 10 African American adults, according to data from the 2002 Behavioral Risk Factor Survey. Improved health care is needed to decrease health disparities and prevent devastating diabetes complications for at-risk, medically underserved, and racially and ethnically diverse populations. Studies have shown that complications such as blindness, kidney failure, and amputations can be prevented or delayed by programs that help people with diabetes to improve nutrition, increase physical activity, improve blood glucose control, and have better access to preventive care, such as eye and foot examinations.

Program Example

Initially, the Missouri Diabetes Prevention and Control Program collaborated with five Federally Qualified Health Centers (FQHCs) and one National Health Service Corps site that participated in the Bureau of Primary Health Care's National Diabetes Collaborative. Currently, seven health centers participate in the collaborative. The centers formed teams of diabetes-related health-care specialists in clinics. Each center established an initial "population of focus" registry of patients with diabetes. Additional provider and site registries were added as the year progressed. The electronic registries were used to monitor indicators of health behaviors, health status, and services received. The Missouri Diabetes Prevention and Control Program provided the FQHCs with financial support, a local learning session, technical assistance on registry development, maintenance, health system redesign, monthly review of reports, and evaluation skills. The state diabetes program also evaluated aggregate data from the combined diabetes registries of the six health centers participating in the Midwest Cluster of the National Diabetes Collaborative. Preliminary results indicate that from June 2000 to May 2003, the health centers significantly improved 12 of 16 diabetes-related care measures, including increases in the prevalence of at least 2 A1c tests at least 3 months apart (15%), dilated-eye examinations (190%), foot examinations (47%), influenza vaccinations (76%), and setting of self-management goals (37%).

Implications and Impact

Participation in the National Diabetes Collaborative, patient monitoring with a diabetes registry, and the formation of teams of health care specialists have improved the level of diabetes-related care and services. Future efforts will focus on maintaining these improvements and extending the collaborative's activities to other health care sites.

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