

Quality Improvement Report

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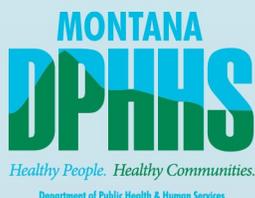
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Team Up for Diabetes

Want to make even more of a difference in the lives of your patients with diabetes? Play a bigger role in their care by teaming up with other health care providers.

To help you do this, access the newly enhanced free online resource, **Working Together to Manage Diabetes Toolkit**. The toolkit was designed especially for providers of pharmacy, podiatry, optometry, and dentistry (PPOD), and other members of the diabetes care team like you.

PPOD providers are well positioned to advise and educate patients about diabetes control and prevention. These providers may be the first to detect that a person may have—or be at risk for—diabetes.

Practitioners can use the toolkit in their practice to become better at recognizing the early warning signs of diabetes, decreasing the risk of complications, and managing medication therapy.

The toolkit features the following:

- ◆ comprehensive, easy-to-use guide;
- ◆ user-friendly patient fact sheets and checklists; and
- ◆ customizable presentation slides.

The guide includes strategies to work collaboratively with each other as well as all other members of the health care team to promote better outcomes in people with diabetes. It includes sections for each PPOD specialty with patient case examples. A medications supplement to the guide is under development and will be released soon. A sample patient fact sheet on medication management is enclosed with this report. The slides provide an overview of the toolkit and can be used to tell your colleagues about it.

You can access and download these materials at www.cdc.gov/diabetes/ndep/ppod.htm.

The material in the toolkit was written and reviewed by the National Diabetes Education Program's (NDEP) Pharmacy Podiatry, Optometry, and Dentistry Task Group and providers within each specialty.

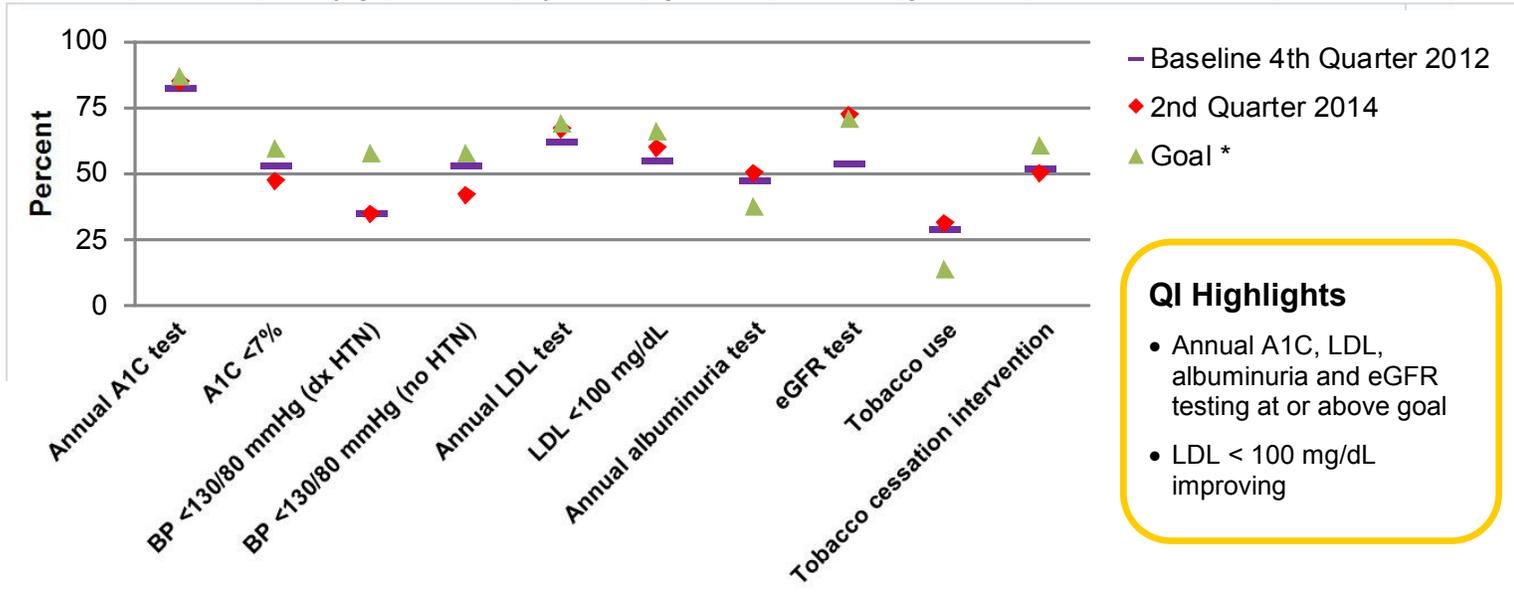
We encourage you to use the resources in this toolkit and tell your colleagues about the **Working Together to Manage Diabetes Toolkit** using the ready-to-go promotional tools available online.

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Diabetes Care Indicators

Primary Care Practices and Diabetes Education Programs

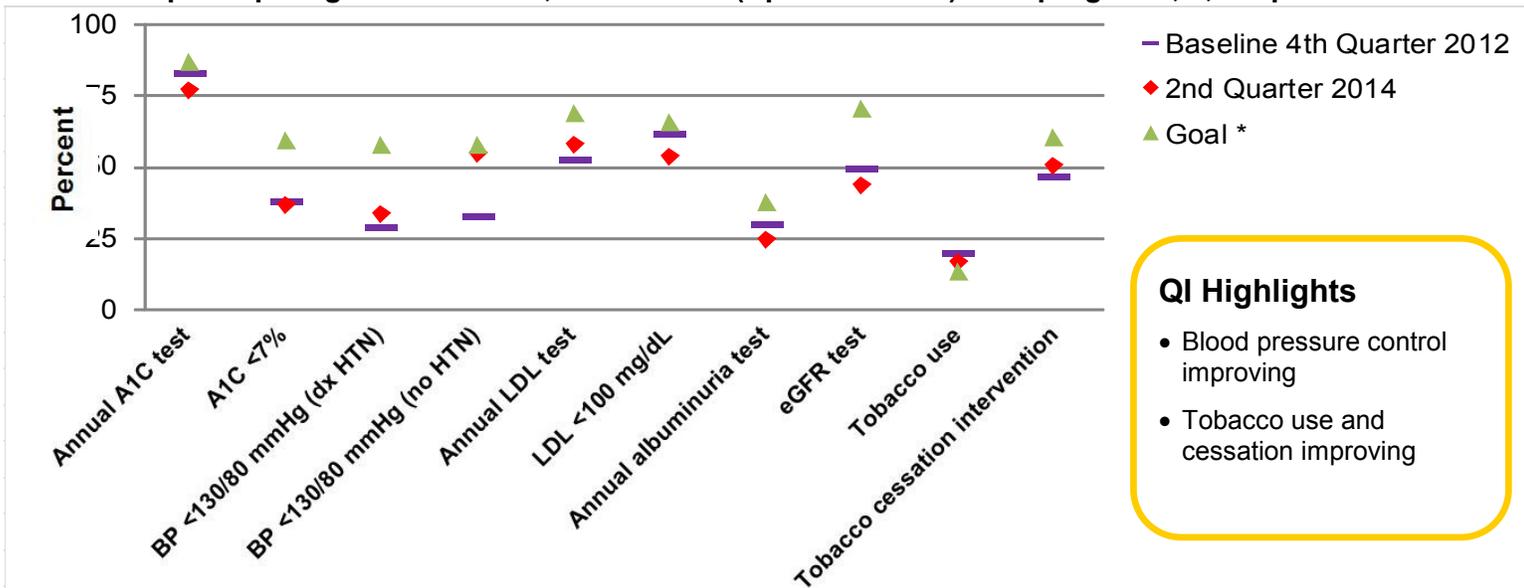
Figure 1. Diabetes care indicators from primary care practices in Montana participating in the DQCMS, 2nd Quarter (Apr—Jun 2014). N = 23 practices; 10,305 patients.



QI Highlights

- Annual A1C, LDL, albuminuria and eGFR testing at or above goal
- LDL < 100 mg/dL improving

Figure 2. Diabetes care indicators from diabetes self-management education and support programs in Montana participating in the DQCMS, 2nd Quarter (Apr—Jun 2014). N=7 programs; 2,428 patients.



QI Highlights

- Blood pressure control improving
- Tobacco use and cessation improving

DQCMS = Diabetes Quality Care Monitoring System. Data presented here are for adult patients with diabetes seen within the last year. Montana's statewide quality improvement goals for diabetes were updated in 2013 based upon Healthy People 2020 targets or a 10% improvement from baseline.

Blood Pressure and Blood Glucose Are They in Control?

Quality improvement (QI) projects are implemented to support care of patients with diabetes and to achieve the standards of care designed to do this. Collecting and analyzing data is the driver for QI. Utilizing a practice registry program, such as DQCMS, or an EHR is the means to document and abstract these data. Analyzing these data reveals areas of practice that may need improvement and identifies the patients that may need additional assistance in reaching their goals for diabetes self-management, such as control of blood pressure and blood glucose and medication management. QI strategies to improve these areas can include developing policies, procedures and protocols to better meet the needs of the patients.¹

QI Initiative with American Indians in Montana

The Montana Diabetes Program partnered with the Cardiovascular Health Program to work with Tribal Health and Indian Health Service Community Health Representatives (CHRs) and their supervisors in a QI project to:

- ◆ Develop protocols for self-monitoring of blood pressure and blood glucose with clinical support.
- ◆ Develop protocols for referrals to providers for patients with uncontrolled A1C or blood pressure.
- ◆ Use a medication adherence tool.

The program included an education session with the CHRs and supervisors to teach their clients the proper technique to self-monitor blood pressure and blood glucose. It also included information on how to develop protocols for referrals to the clients' providers when the blood pressure and blood glucose levels are not in control.



In this article, we provide key action steps that we shared during the education session. Health care providers and CHRs or other ancillary staff can take these steps to support a patient with diabetes to

better self-monitor their blood pressure and blood glucose levels as well as manage their medications. We highlight the importance of referring patients to their provider and other members of the diabetes care team for follow-up care.

Blood Pressure Control:

Self-measured blood pressure monitoring with clinical support is effective in controlling blood pressure.²

- ◆ Develop a blood pressure cuff loan program.
- ◆ Instruct the patient on the proper use of the blood pressure cuff and in tracking the results.
- ◆ Develop a protocol for referring the patient to their provider when the tracking results show blood pressure is not in control.

Blood Glucose Control:

Self-monitoring of blood glucose assists people with diabetes in achieving a specific level of glycemic control.

- ◆ Instruct the patient on the proper use and techniques for testing blood glucose in the home.
- ◆ Develop a mechanism for tracking blood glucose and instructions of how often and when to test.
- ◆ Develop a protocol for referring the patient to their provider when the tracking results show uncontrolled blood glucose.

Medication Adherence:

Uncontrolled blood pressure or blood glucose are often associated with not taking prescribed medications as ordered.³ Identifying barriers to following these directions can be extremely helpful in working with patients to achieve controlled blood pressure or blood glucose.

- ◆ Identify a medication adherence tool to measure a patient's barriers to taking medications as prescribed.
- ◆ Administer the tool and use the results to make adjustments to a medication regimen, provide education to better understand how the medication works and why it is important, or help meet financial needs if indicated.

All of the above processes should be implemented in addition to education on other behavioral practices including diet and physical activity. Referrals to a diabetes educator should be made when possible.

For more information on QI projects, contact Chris Jacoby, RN, Quality Improvement Coordinator, at cjacoby@mt.gov or (406) 444-7324.

References

1. U.S. Department of Health and Human Services Health Resources and Services Administration. (2011). *Quality Improvement*. Retrieved from: <http://www.hrsa.gov/quality/toolbox/methodologyqualityimprovement/>
2. Centers for Disease Control and Prevention. *Self-Measured Blood Pressure Monitoring: Action Steps for Public Health Practitioners*. Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services; 2013.
3. Inamdar SZ, Kulkarni RV, Karajgi SR, Manvi FV, Ganachari MS, Mahendra Kumar BJ. Medication adherence in diabetes mellitus: an overview of pharmacist role. *AJADD* 2013;1(3):238-250.

Report Highlights

- Team Up for Diabetes
- Blood Pressure and Blood Glucose Are They in Control?
- Diabetes Care Indicators:
 - Primary Care Practices
 - Diabetes Education Programs

Upcoming Events

Montana Diabetes Educators Network Meeting

7:30 AM - 3:00 PM on October 23, 2014

Diabetes QI Coordinators Meeting

3:30 PM - 4:30 PM on October 23, 2014

17th Annual Montana Diabetes Professional Conference

4:15 PM - 6:45 PM on October 23, 2014

7:00 AM - 3:45 PM on October 24, 2014

<http://www.umt.edu/sell/cps/diabetes>

The above meetings and conferences will be held at the Fairmont Hot Springs Resort, Fairmont, MT

For more information, contact Susan Day (406) 444-6677

November is National Diabetes Month

www.YourDiabetesInfo.org/DiabetesMonth2014

World Diabetes Day

November 14, 2014

Announcements

Team Up for Diabetes

The NDEP is hosting a webinar on the newly enhanced free online resource.

Working Together to Manage Diabetes: Tools and Strategies for Pharmacy, Podiatry, Optometry, and Dentistry

10:00 AM - 11:00 AM

Monday, September 8, 2014

This webinar will provide a “quick course” on diabetes and how providers in pharmacy, podiatry, optometry, and dentistry (PPOD) can collaborate and make cross-disciplinary treatment referrals. The webinar will include a provider from each of the PPOD specialties and authors of the toolkit.

For more detailed information and to register, visit the NDEP’s webinar site <http://bit.ly/1v9fAYq>.

Online Resources

www.diabetes.mt.gov

- Montana Diabetes Program State Plan 2009-2014
- Report on the Burden of Diabetes
- Archived Diabetes Quality Improvement Reports and Surveillance Reports from 1998 to present
- Resources for clinicians, diabetes educators, and schools

DQCMS Information

www.risprojects.org/dqcms

- User Manual
- Training Videos
- Helpful Hints
- Help Sheets