Montana
Chronic Disease Prevention
& Health Promotion Bureau

Quality Improvement Report

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MONTANA DPHHS
Healthy People. Healthy Communities.
Department of Public Health & Human Services

Quality Improvement Case Study:

Improving Care for Medicaid Patients with Diabetes at Bullhook Community Health Center

Originally presented on October 23, 2014 at the Annual Diabetes Quality Improvement Coordinators' Meeting by: Lynne Nash, FNP-BC, Bullhook Community Health Center, Havre, MT

Bullhook Community Health Center (CHC) in Havre participated in a diabetes quality improvement (QI) project in conjunction with Medicaid and the Diabetes Program at the Montana Department of Public Health and Human Services (DPHHS) to improve adherence to evidence-based medicine for patients with diabetes. The project time period was January 1, 2014 to December 2, 2014.

The QI team members were:

- Gene Powers, FNP-BC
- Sharman Dellwo, RN
- Terri Gruber, RN
- Heather Wolf, MA
- Vicki Fulwiler, MA

Bullhook CHC staff proposed to implement four distinct strategies to improve clinic procedures and improve access to information and education for patients with a diabetes diagnosis. The strategies are as follows:

1. "Huddle sheets" will be used to identify patients with diagnosed diabetes (regardless of the reason for visit) and to inform clinic staff of gaps in care (e.g., missing HbA1c, LDL, etc.).
2. Clinic staff will make appointments for ophthalmology, dental care, nutrition, education, and counseling while the patient is still in the clinic.
3. Patient-centered care planning will occur throughout the clinic visit. Patients will drive the identification of care plan priorities and goals.
4. Future plans include the implementation of a group meeting for patients with diabetes once every three months for education, testing and individual consultation.

Bullhook CHC staff utilized the PDCA (Plan-Do-Check-Act) process to develop the approaches for reaching their QI objectives.

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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, 1st Quarter (Jan—Mar. 2015). N = 17 practices; 3,161 patients.

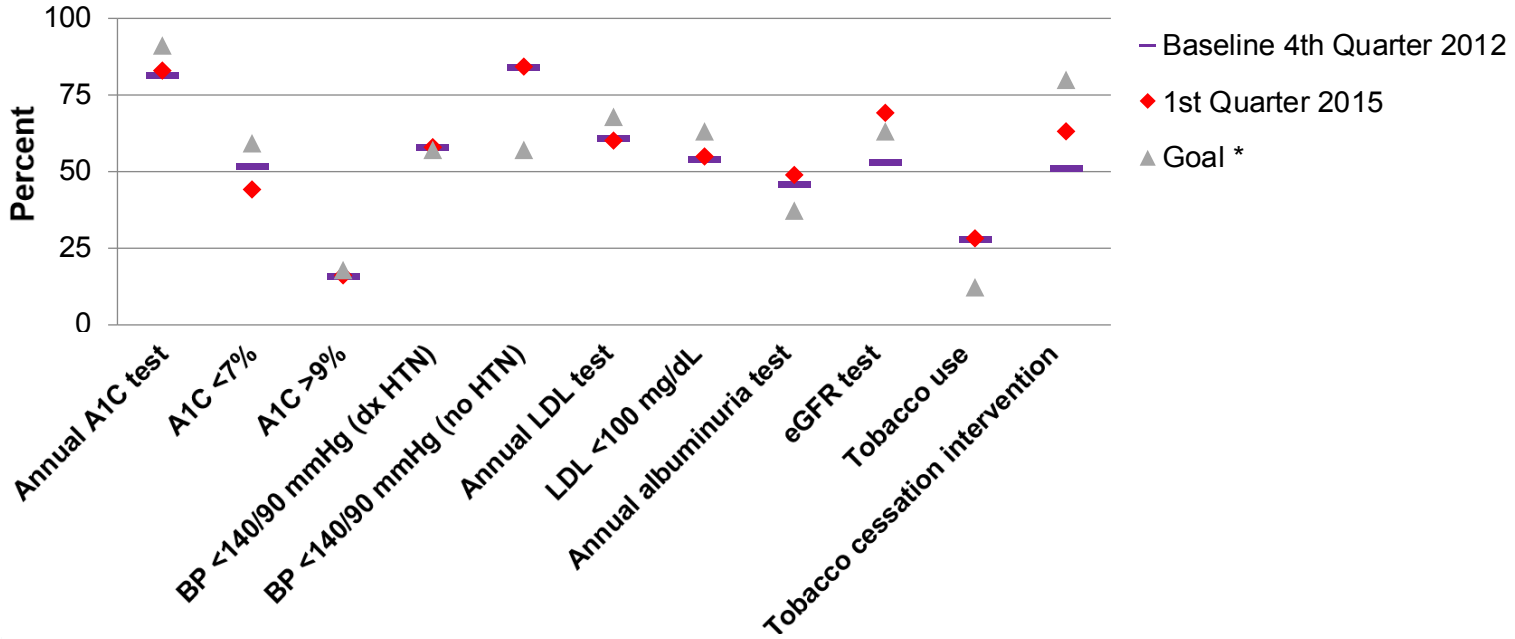
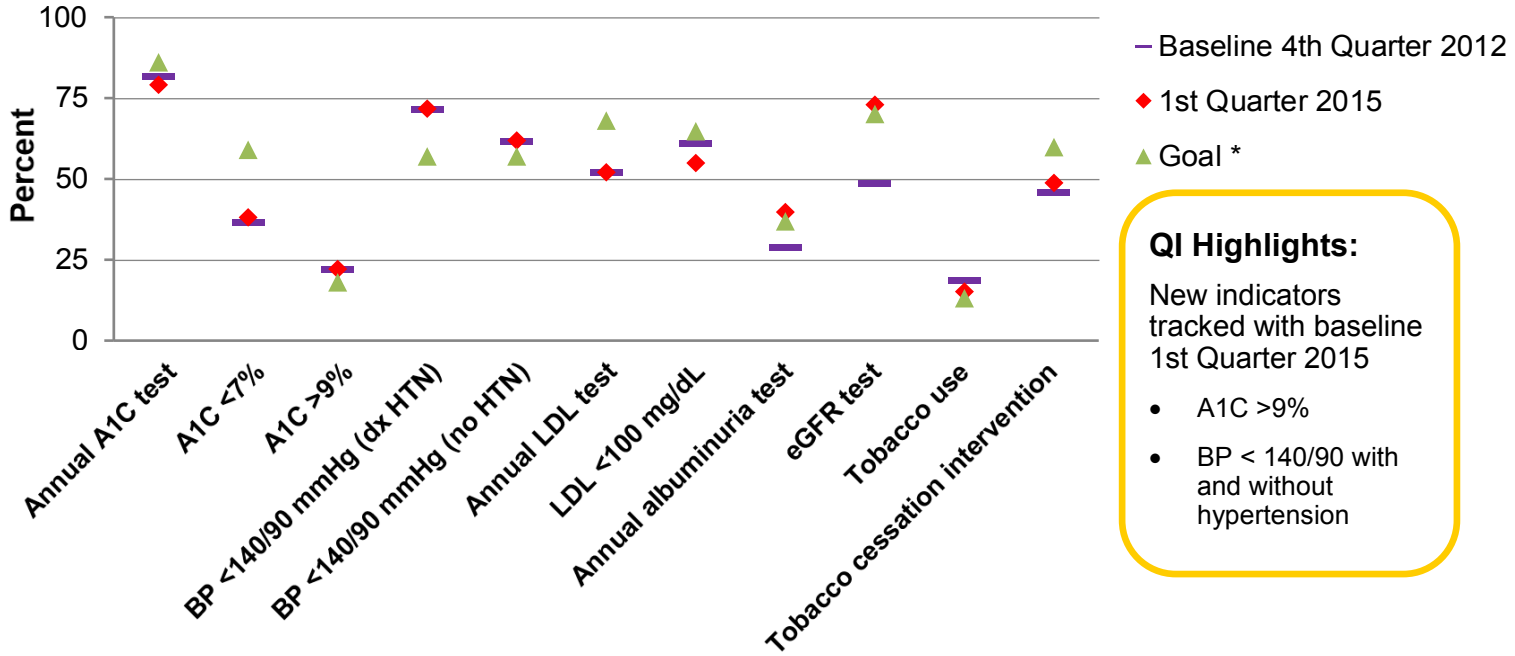


Figure 2. Diabetes care indicators from diabetes self-management education and support programs in Montana participating in the DQCMS, 1st Quarter (Jan—Mar. 2015). N=7 programs; 2,686 patients.



QI Highlights:

New indicators tracked with baseline 1st Quarter 2015

- A1C >9%
- BP < 140/90 with and without hypertension

DQCMS = Diabetes Quality Care Monitoring System. Data presented are for adult patients with diabetes seen within the last year. Montana's statewide quality improvement goals for diabetes were updated in 2015 based upon Healthy People 2020 targets or a 10% improvement from baseline.

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Objectives:
- Increase the number of patients with diabetes that received an A1C at least once in the past year.
- Increase the number of patients with diabetes that received an LDL test in the past year.

Indicators:
- Number of patients with diabetes with an A1C test prior to or at the visit
- Number of patients with diabetes with an A1C test after the visit
- Percent of patients with diabetes with an annual A1C test.
- Number of patients with diabetes with an LDL test prior to or at the visit
- Number of patients with diabetes with an LDL test after the visit.
- Percent of patients with diabetes with an annual LDL test.

Changes Tested

Reformatted Huddle Sheet:
- Implemented on April 1.
- Steps, processes or inputs were required to introduce change:
  - ⇒ Nursing staff met with providers to determine needs.
  - ⇒ Nursing staff developed new huddle sheet.
  - ⇒ Morning huddle was scheduled daily using new huddle sheet with team members, including front office staff, as well as case management.
- No major barriers were encountered.

Applied Teach-back Technique:[1]
- Implemented on June 1.
- Steps, processes or inputs were required to introduce change:
  - ⇒ Team leader conducted research for education program.
  - ⇒ Notified staff of expectation and time limit for education to occur.
  - ⇒ Established go-live date for implementation.
  - ⇒ Developed and implemented tracking form.
- A barrier encountered was staff time to complete education in the teach-back technique. To overcome this barrier, the staff schedules were adjusted to provide coverage so each team member could complete the training by June 1.

Additional Factors

Staffing:
The Bullhook CHC patients had been served by locum tenens providers for awhile until two permanent providers were hired in late January and February. Since then, the providers and staff teams have been working to build the clinic base and provide quality care with timely follow-up.

Reminder Letters:
Letters are sent out each month for the patients with diabetes who are due for physical exams or lab work. The process for this mailing was evaluated in August, and new procedures were instituted in September to ensure a better work flow and timelier follow-up.

Results

Data on the indicators were collected from the EHR by the medical assistant on a monthly basis, verified and scrubbed by the QI team leader, and submitted to DPHHS. The Bullhook CHC providers saw 8 to 43 patients with diabetes per four week period with an average of 24 patients per period. Improvements were seen in shifting the number of lab tests for A1C and LDL that were completed prior to or at the visit versus after the visit with the provider (Figure A). This process change made it easier to provide appropriate education and adjust treatment at the time of the visit.

However, there was little movement in the overall number of patients with diabetes that had an A1C or LDL test performed within the last year (Figure B). The overall number of patients with an A1C test increased but decreased for LDL.

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Resources:
1. Teach-back Training Toolkit. Available online at: http://www.teachbacktraining.org/

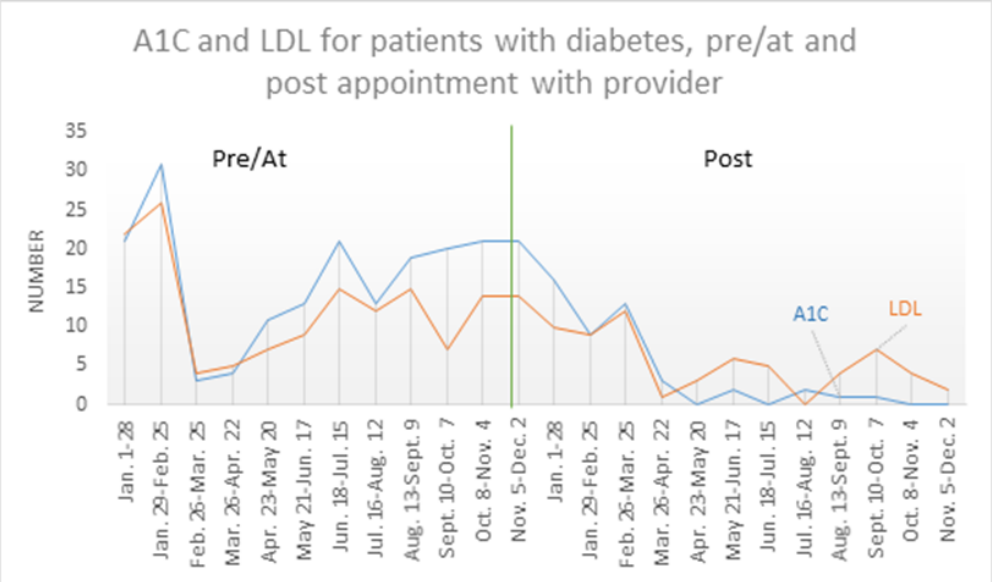


Figure A. Number of patients with diabetes with an annual A1C test or LDL test before or during versus after the visit with the provider, Bullhook Community Health Center, January 1 to December 2, 2014.

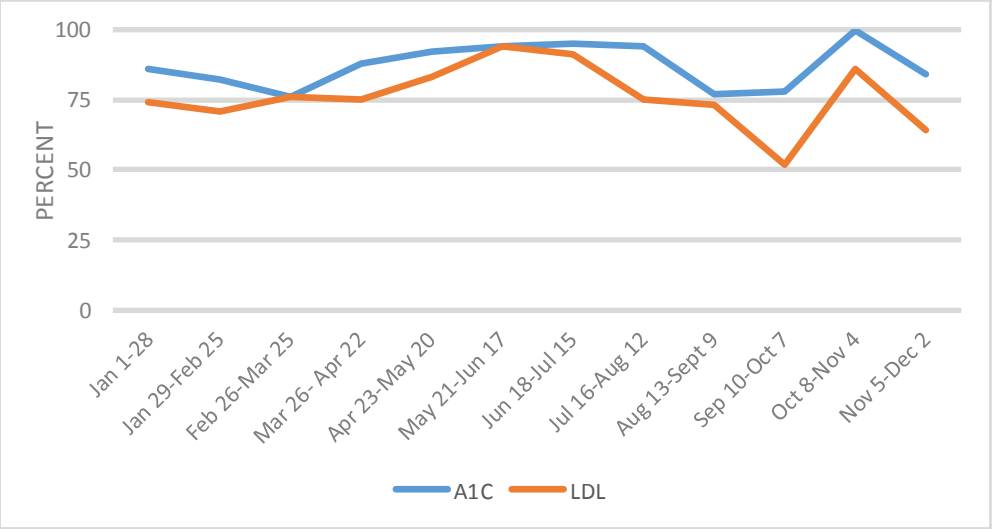


Figure B. Percent of patients with diabetes with an annual A1C test or LDL test, Bullhook Community Health Center, January 1 to December 2, 2014.

Discussion

Barriers to achieving the objectives were training time with newly hired permanent providers, a small patient population, patient refusal to have the lab tests at visits for reasons other than diabetes management, and inability to pay although a sliding fee schedule was available.

The Bullhook CHC staff implemented the teach-back technique with all patients across different demographics and diagnoses. They observed benefits such as greater participation in self-care.

Recommendations

Team work is essential for any QI project, not only for staff buy-in but for the day-to-day operations necessary to achieve the goal. Inclusion of all staff, no matter the extent of their role in the project, can have a significant impact on the success of the project and encourages adoption of changes in a timely manner.

Staff can diagram what typically happens in the process and help formulate strategies for possible changes to the process. Bullhook CHC staff suggest strategizing with team members in an organized fashion, keeping minutes of the meeting, and documenting all ideas as some may not seem plausible at the time yet may be critical later. Staff involvement throughout the process encourages them to continually follow through with the changes as well as suggest new potential adjustments in a timely manner. Other staff not on the team can be reached for assistance with overcoming barriers. Rapid cycle testing helps keep the process from stagnating due to competing priorities.

These elements helped the implementation go smoothly because staff were very supportive and actively involved in the process.

Diabetes Quality Improvement

Report Survey Summary

86% Survey response rate

Organizations represented:

- 43% Clinics
- 30% Community Health Centers
- 14% Hospitals
- 8% Medical/health professional associations
- 6% Others

Personnel responded:

- 24% Administrators
- 22% Diabetes educators
- 22% Nurses/CMAs
- 11% Quality improvement coordinators
- 5% Mid-level providers
- 21% Others

97% Read the Diabetes Quality Improvement Quarterly Reports!

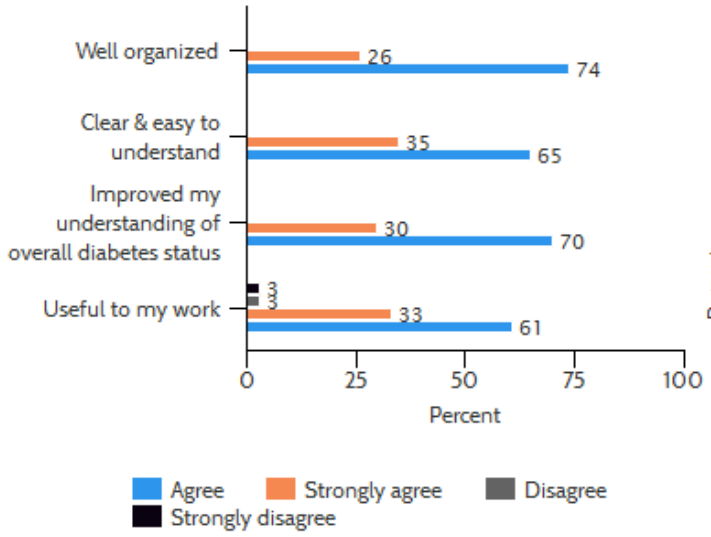
How reports are used by sites?

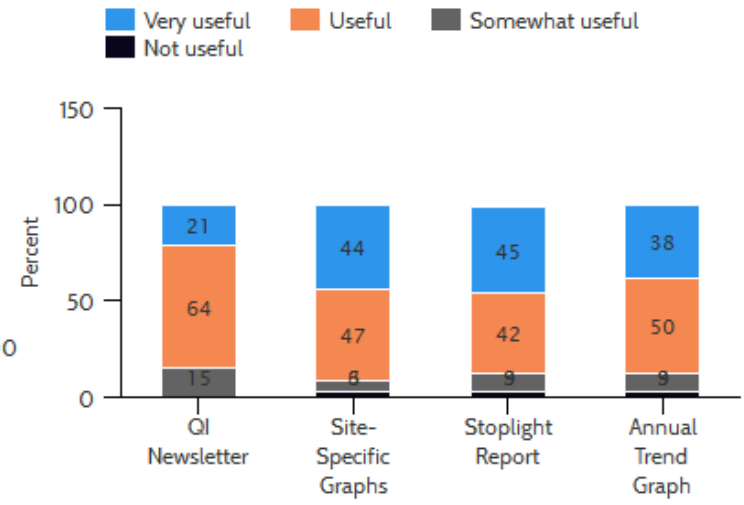
- **61%** Priority setting, planning, targeting
- **56%** Change in clinical practice (treatment, medication, referrals)
- **36%** Educational materials, awareness
- **8%** Presentations
- **6%** Grant writing

Like to receive reports by:

- Mail **79%**
- E-mail **21%**

Report Rating: Layout and Components





Comments on reports:

"Thanks for all you do"

"These quarterly reports provide a comparison for us how we are doing on managing our diabetic patients. They are that extra incentive that makes us continually re-evaluate how we are serving our patients"

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Report Highlights

- **Quality Improvement Case Study: Improving Care for Medicaid Patients with Diabetes at Bullhook Community Health Center**
- **Diabetes Care Indicators:**
  - **Primary Care Practices**
  - **Diabetes Education Programs**
- **Diabetes Quality Improvement Report Survey Summary**

Upcoming Events

Montana Diabetes Advisory Coalition Meeting
July 17, 2015
The Finlen Hotel, Butte, MT

18th Annual Montana Diabetes Professional Conference
October 22-23, 2015
Red Lion Hotel, Kalispell, MT

For more information on the above events, please contact Susan Day at (406) 444-6677

Camp Montana
August 2-7, 2015
Beartooth Mountain Christian Ranch, Fishtail, MT
For more information, visit www.diabetes.org/in-my-community/diabetes-camp/camps/montana.html

Tour de Cure Montana
September 12, 2015
Missouri Headwaters State Park, Three Forks, MT
For more information, visit http://tour.diabetes.org/

Summer Weather Safety

Prepare for Diabetes Care in Heat and Emergencies

We encourage providers and educators to remind their patients that diabetes makes it harder for their body to handle high heat and humidity. They may need to make changes in their medication and what they eat and drink when temperatures rise. During emergencies and natural disasters such as hurricanes or tornadoes, they may have other needs related to diabetes.

People with diabetes should

- Let family members, caregivers, and health care professionals know they have diabetes so they can get appropriate care.
- Keep the routine and prepare medicines and equipment for challenging conditions.
- Plan ahead for diabetes care during summer heat, storms, and emergencies when at home and while traveling.

For more information, visit www.cdc.gov/Features/DiabetesHeatTravel/

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
- Resources for clinicians, diabetes educators, and schools

DQCMS Information

www.risprojects.org/dqcms

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