

### Case Study of Quality Improvement in Shepherd's Hand Free Clinic Whitefish, Montana

May 2014

### Improving Care for Diabetic Patients

1	<b>About the Clinic</b>	Page 1
2	<b>Summary of Quality Improvement Project</b>	Page 2
3	<b>General Q&amp;A with Clinic Director</b>	Page 2
4	<b>Q&amp;A Specific to Quality Improvement Project</b>	Page 4
5	<b>Appendices of Supporting Documents</b>	
	- Appendix A. Shepherd's Hand Diabetes Quality Care Monitoring System (DQCMS) Form	Page 6
	- Appendix B. Shepherd's Hand DQCMS Quarterly Summary	Page 7
	- Appendix C. Shepherd's Hand Diabetes Provider Annual Visit Form <i>(including Foot Assessment Form)</i>	Page 8
	- Appendix D. Shepherd's Hand Diabetes Management Follow-up Letter	Page 9
	- Appendix E. DQCMS Quality Improvement Report <i>(including introduction, Quarterly Report that compares Shepherd's Hand to other clinics, and Stoplight Report showing Shepherd's Hand's progress against set goals)</i>	Page 10

#### About the Clinic

Name of Clinic: Shepherd's Hand Free Clinic

Type of Clinic: Free Clinic

Location: Whitefish, MT

Year Founded: 1995 (incorporated as 501(c)(3) in 2010)

Budget: \$130,000

Unduplicated patients: 700

Patient visits: 1,700

Paid staff: 1.025 FTE (.75 FTE Executive Director/Clinical Director, .25 FTE program assistant, .025 FTE medical director for mid-week follow-up care)

Volunteers: ~ 80

Hours Open: Monday evenings

Services: medications, laboratory and imaging services, and specialty referrals

Leadership: 9-member Board of Directors; Quality Assurance and Programs Committee

For further information: Meg Erickson, RN, MSN, Executive Director/Clinical Director

## Summary of Quality Improvement Project

**The Problem:** Improve the level of care to patients with chronic illnesses and encourage their participation in the clinic's wellness program.

**The Approach:** In 2010 SHFC partnered with the Montana Diabetes Project, a statewide diabetes initiative, to obtain technical assistance, resources, and free software for identifying diabetes patients and tracking their outcomes.

### PDSA in Action

**PLAN:** The clinic wanted to improve the quality of care for their diabetic patients. In particular, they wanted to see increased compliance among their patients in following through with recommendations and wellness measures.

**DO:** SHFC requested free tracking system software from the Montana Diabetes Project (MDP). The MDP provided the software and also visited the clinic to audit their patient charts and input all their diabetic patients into the software program. The MDP trained the SHFC staff to update patient information in the system after each patient visit and how to send quarterly reports assessing the clinic's efforts back to MDP. Each chart of a diabetic patient was labeled with a 'diabetes' sticker so the clinic could easily identify diabetic patients on a clinic night. The MDP software generates a patient profile that is added to the chart and updated after each patient visit. The profile tracks health markers and indicates recommendations for ordering labs, eye exams, foot exams etc. The clinic trained key volunteers to utilize the profile in managing the care of these patients. SHFC also established a new system of having their diabetic patients see one of two providers to improve the continuity of care.

**STUDY:** It soon became apparent that the initial system developed was confusing to volunteers who only work monthly, and the information generated by the software was too cumbersome to evaluate in the regular course of a clinic night.

**ACT:** SHFC determined that we wanted to continue to utilize the MDP system, but realized that they needed to adapt their approach. They decided to train a couple of diabetes managers who could review (on Tuesday morning) all the charts of the diabetic patients who were seen during clinic the night before (Monday evening). In the course of their review, the diabetes managers determine what additional measures needed to be taken to optimize the patient's health. The diabetes managers utilize a form letter that includes a checklist of areas the patient needs to address. This is mailed to the patient along with any lab orders or referral paperwork he will

need to follow through on the requested items (e.g., dietician referral, blood work). A copy of this form is put in his chart so the next time they come to the clinic it is easy to see what needs he has and what type of follow-up is needed. A Diabetes Provider Annual Visit form was also developed in order to consistently gather the information needed to maximize follow up of the patient. The information from the annual visit and the checklist are entered into the MDP system, which then provides an updated patient profile that is included in the patient's chart. The chart is also marked with the month of the year that all preventative diabetic activities are due so that when the patient comes to the clinic for another complaint time is not spent reviewing diabetes follow-up.

## Q & A with Meg Erickson Executive Director, Shepherd's Hand Free Clinic

### Quality Improvement Efforts at Your Clinic

**Q:** *What was the impetus for deciding to initiate improvement at your clinic?*

**A:** The operational systems of SHFC have always evolved based on the desire to provide the best possible patient care. Only with our application to the Federal Tort Claims Act (FTCA) and the development of our Risk Management Plan was a written Quality Assurance (QA) policy and plan put into place.

**Q:** *When did you first start focusing on improvement?*

**A:** Our FTCA application was made in 2010.

**Q:** *How were you able to achieve staff/provider/volunteer/organizational buy-in to your QI initiative?*

**A:** Quality care is one of our core values and the specific systems generated from QA are part of our orientation and ongoing training process.

**Q:** *What activities have been especially important to sustaining improvement?*

**A:** The activities that were most important were the development of our QA and Programs Committee and the development of annual goals related to patient care.

**Q:** *Was leadership important to your improvement efforts? How so?*

**A:** Yes, leadership is very important in providing the impetus to effect needed change. Our paid staff (i.e., Executive Director/Clinic Director) assesses and

<sup>1</sup>Questions were taken or adapted from Houck, S. (2004). *What Works: Effective Tools and Case Studies to Improve Clinical Office Practice*. Boulder, CO: HealthPress Publishing.

communicates the need to our QA committee members. The committee then collaborates with others as needed to develop a Quality Improvement (QI) plan.

**Q: Do you have an ongoing team that leads improvement in your organization? If so, please describe who is on it, how often they meet, and the structure for initiating improvements.**

**A:** We have a five-member Quality Assurance and Programs Committee; our co-medical directors, clinic director/executive director and pharmacy director are on the committee as well as one of our board members who is the chief operations officer at one of our local hospitals. The QA Committee meets twice annually with additional project-directed meetings throughout the year, with some members of the committee and additional relevant program volunteers. We try to conserve people's energy and bring them in only when something is pertinent to their skill set.

**Q: Have there been specific processes or ways of using resources that you have focused on?**

**A:** Once a goal is developed or a problem identified, we research available resources online and also use our local network in the medical community. We then adapt the resource/process to meet our clinical situation, implement the new process, and evaluate its effectiveness over a period of time. Often there is some additional fine-tuning necessary.

**Q: How do you track and post results or outcomes? (These include operational, clinical, satisfaction, and financial.) How do you select which metrics to use? Have you found it important to limit the number of metrics used? What metrics do you use?**

**A:** The primary clinical area we track is diabetes. We receive quarterly and annual reports on outcomes and intervention markers from the Montana Diabetes Project.

We track satisfaction (patients and volunteers) through the use of surveys. Results are shared and evaluated by the QA Committee for any problem areas that need to be studied further. We have used a scale approach with the surveys, relying heavily on the following three:

- never – sometimes – usually – almost always – always
- strongly disagree – disagree – neutral – agree – strongly agree
- very satisfied – somewhat satisfied – neutral – somewhat dissatisfied – very dissatisfied

With patient surveys it is important to keep the language simple due to some illiteracy issues.

**Q: What lessons have you learned during the QI process? If you were starting your improvement work now, what would you do differently? What would you do the same way?**

**A:** I have learned that a team approach to the QI process is very helpful. Before we had a QA Committee in place our system adjustments felt more like trial and error. The QA Committee allows for a greater depth of discussion and articulation of desired outcomes, which leads to a better initial plan.

**Q: To what do you attribute your success in your QI efforts?**

**A:** We attribute our success to development of our QA and Programs Committee and also networking with existing organizations that can help us operationalize our goals (i.e., Montana Diabetes Project).

**Q: What advice do you have for other clinics that are new to QI?**

**A:** Keep it as simple as possible. We originally tried to develop too many levels of committees and teams. It quickly became apparent that we didn't have enough people to serve in that capacity. For a small volunteer organization it is important to be realistic about the number of people you have that can contribute in specialized areas and build your teams/committees around that. Over time your teams/committees will mature and expand their scope.

It is tempting to develop a strategic plan on paper and then look for the people and resources to operationalize it, but the truth is that in a small organization the majority of your time is spent in managing the day-to-day problems that come up. It can be very difficult to take on formal QA activities. If your goals are too lofty with regard to QA policy and QI plans you feel defeated. We have found it helpful to address the day-to-day problems within a QA framework. Depending on the problem, this can be an informal or structured process. For example, we didn't have time to do any formal surveying of our patient's for the first 10 years. We did listen to people and ask how they felt things were going in an informal way. Many of the solutions we implemented were developed and discussed within the QA framework.

Keep it simple, practical and realistic and let your QA develop organically from what you are experiencing. With practice it is not too big of a leap to begin setting goals and developing a strategic plan. You will have a sense of what a realistic timeframe your goals will take and also what elements need to be included in your process in order to achieve success.

*Q: I've heard clinics say, "I don't have the time" or "I don't have the resources/staff" to do QI. What would you say to a clinic that is reluctant to start using QI?*

**A:** I would imagine most clinics are already engaging in QI in an informal way making changes to their operations based on problems as they arise. Articulating the steps taken to identify problems and resolving those problems is a good first step. Most organizations set goals for themselves annually or more often and it is not terribly time consuming to add some QI goals to the list and then develop a plan to address the area of concern.

*Q: What are the benefits and drawbacks of engaging in a QI process?*

**A:** The major benefit is the ability to anticipate challenges and possible solutions so that the clinic is proactive and moving towards excellence.

### Quality Improvement Initiative: Care for Diabetic Patients

*Q: Can you give us a "before" and "after" portrait of the problem you wanted to address?*

**A:** A good example of a before and after is our desire to provide vouchers to our diabetic patients for free flu and pneumococcal vaccines. We were able to quickly access a mailing list from the diabetes database, send a letter with the voucher, and then determine who followed through with getting their vaccines by tracking the used vouchers. At the initial chart audit it was found that none of our diabetic patients had ever had a pneumococcal vaccine and only 6.7% of these patients had had influenza vaccine the prior year. Since implementing our tracking system and having the ability to easily communicate with these patients, as described above, the percentage of patients who have had a pneumococcal vaccine increased to 19.1, and patients receiving the influenza vaccine increased to 25.5. This demonstrates a significant improvement.

We have seen improvement in other markers as well: dilated eye exams have increased from 15.6% to 46.8%; foot exams from 6.7% to 59.6%; and in the same category of foot exam patients categorized as high risk who had monofilament foot exam in the last year went from 0% to 87.5%.

*Q: What aims did you set to address your problem? Were they measurable?*

**A:** We decided it would be best to focus on one group of patients first to develop a template of care that we could then apply to other groups. We chose our diabetic patients primarily because we knew we could be doing

a better job on preventative health markers and because the Montana Diabetes Project would provide us the resources we needed to begin tracking outcomes.

We wanted to improve our level of care for our chronic patients. We aimed to be able to identify and track all of our patients that have diabetes so that we could: 1) control which provider they saw in order to improve continuity of care; 2) encourage an annual diabetes visit where medications are reviewed labs ordered and other recommended referrals offered; 3) encourage our diabetic patients to participate in our wellness program.

*Q: What was your theory (reasons) why you were experiencing this problem?*

**A:** We didn't have an adequate system in place to identify or track our diabetic patient population which made it difficult to identify the obstacles they were experiencing in accessing care and in following through on wellness measures.

*Q: What did you need to change?*

**A:** We needed to develop an effective system for identifying our diabetic patients and tracking their outcomes.

*Q: Who was involved in the QI process? Who were the key players? Was leadership important? How so?*

**A:** The key players were our co-medical directors, executive director/clinic director, program assistant and the Montana Diabetes Project. Leadership is important because it provides the vision, helps set the goals, and keeps the team focused.

*Q: What tools/templates/worksheets/diagrams/instruments/charts/data/metrics did you use in your improvement efforts (in each of the PDSA stages)?*

**A:** We used the free tracking system software developed by the Montana Diabetes Project. We receive a quarterly summary from the MDP about how the clinic is doing. Most helpful has been comparing ourselves to ourselves [over time], specifically choosing markers that we hold as a priority and want to get better at. For example, one of the measures that the MDP tracks is how often we interact with patients about smoking. We're hitting tobacco hard. We interact almost 100% (with every smoker). And we've improved on that. We were probably at 50% when we started. I'm not as concerned about another measure, the percentage of patients with A1c below 7%, because our physicians probably view that as too aggressive for our patient population. I want to know whether the A1C test was done in the past year because it shows us if our patients are being compliant and following through on getting their lab work done.

**Q: What did you propose to do (want to change) to address the problem?**

**A:** We believed that if we could identify and track our diabetic patients we could impact their compliance with established care markers improving their overall health.

**Q: How did you go about testing the change(s)?**

**A:** The initial audit from the MDP yielded 65 patients with diabetes in our patient population. We believed that if we knew who are diabetic patients were and could assess what areas of follow-up each person needed before he presented at the clinic on Monday night then our interventions with each patient would be more productive and hopefully impact outcomes. This required setting up a new process for tracking patient charts and identifying who would manage our diabetic patients' follow-up care. We initially thought we could do this all on a Monday night but soon discovered that it was too time intensive. Instead, we had to add a new layer of care that happens mid-week.

**Q: What were the results of your intervention?**

**A:** We send a quarterly report to the MDP, who analyze and report back our outcomes and intervention levels. We also analyze informally every time we review a diabetic patient's chart.

We scrapped the most of the initial system and refined our process in order to meet our objectives. The process testing is ongoing.

**Q: How did you spread the change? What are the lessons learned?**

**A:** We developed a specific diabetic annual visit treatment form to increase consistency to our process; identified specific providers to manage the care of our diabetic patients; increased hours for our Health Information Coordinator to input data; recruited and trained a volunteer to work with the clinic director in managing the diabetes care process; and made some minor changes in patient flow.

We have seen significant improvement on our intervention levels and a gradual improvement in outcomes.

A lesson learned is that QI initiative requires intentionality and the objective must be held as a high priority.

**Q: What have been the implications of your QI initiative(s)?**

**A:** We are providing more consistent and better quality care for our diabetic patients. We have developed a

process of identifying and tracking patients that can be expanded to include other high risk patient groups. This has provided the ability to connect patients with wellness opportunities and education that we believe will decrease their risk of morbidity and mortality from chronic disease.

Appendix A. Shepherd's Hand Diabetes Quality Care Monitoring System (DQCMS) Form

Most Recent Office Visit:		Diabetes Quality Care Monitoring System v3.0.4		Date Generated: 02/06/12	
<b>SHEPHERD'S HAND FREE CLINIC</b>					
Patient:		DOB:		Additional Diagnoses	
Medical Record #:		Age:      Years		Other:	
Diabetes Type:		Height:      Inches		<input type="checkbox"/> HTN <input type="checkbox"/> CAD <input type="checkbox"/> Renal <input type="checkbox"/> Neuropathy    _____	

Clinical Exam		Previous Dates and Results				Office Visit Date:	
Weight (lb)	( BMI )	( )	( )	( )	( )	(lb)	(kg)
Blood Pressure (mmHg)		/	/	/	/	/	/
Foot Exam	Visual					Type:    Visual    MUA	
	Monofilament					Active Prob:    Yes    No	
						Risk Level:    High    Low    Unknown	
						Recommend:    Therapeutic    Referral	
Dilated Eye Exam						Retinopathy:    None    MUI	
						Severe    Unknown	
Dental Referral							
Laboratory Data		Previous Dates and Results				Laboratory Update	
A1C							%
Lipid Panel	HDL						
	LDL						
	Triglyceride						
Kidney Tests	Creatinine						
	e-GFR						
Proteinuria: Microalbumin							
Current Medications		Diabetes Medications		Immunization Status		Immunization Update	
<input type="checkbox"/> ACE-I or ARB		<input type="checkbox"/> Alpha-Glucosidase <input type="checkbox"/> Glinides		Influenza <input type="checkbox"/> Declined		Influenza <input type="checkbox"/> Received <input type="checkbox"/> Declined	
<input type="checkbox"/> ASA/Anti-Coag		<input type="checkbox"/> TZD <input type="checkbox"/> Sulfonylureas		Pneumo <input type="checkbox"/> Declined		Pneumo <input type="checkbox"/> Received <input type="checkbox"/> Declined	
<input type="checkbox"/> Lipid Lowering		<input type="checkbox"/> Biguanides <input type="checkbox"/> Insulin		Smoking/Tobacco Status		Smoking/Tobacco Update	
		<input type="checkbox"/> Incretin		Smoker/Tobacco User    Intervention		Smoker/Tobacco User    Intervention	
				Yes    No    Yes    No		Yes    No    Yes    No	
Education		Previous Dates				Education Update	
Nutrition							
Personal Goal							
Physical Activity							
SBGM							
Medication Counseling							
Foot Care Education							
Insulin Counseling							
Other							

**Potential Action Steps**

**Other Comments**

Appendix B. Shepherd's Hand DQCMS Quarterly Summary

Date Generated: 07/11/13		<b>Quarterly Summary</b>		DQCMS V.0.4	
<b>SHEPHERD'S HAND FREE CLINIC</b>					
Number of patients with office visits in the last year: 46		Total active patient population: 47			
All Active Patients		QV Past Year		All Patients	
		%	#	%	#
<b>A1C</b>					
Patients who have had an A1C test in the last year		80.4	(37/46)	78.7	(37/47)
Of patients with A1C in the last year, the percent whose most recent result is less than 7.0%		37.8	(14/37)	37.8	(14/37)
Median level of most recent A1C results in the last year			8.0		8.0
Mean level of most recent A1C results in the last year			8.1		8.1
Patients who have had 2 or more A1C results separated by more than 3 months in the past 12 months		43.5	(20/46)	42.6	(20/47)
<b>Lipid Profile</b>					
Patients ≥ 18 who have had an LDL in the last year		65.2	(30/46)	63.8	(30/47)
Of patients with LDL in the last year, the percent whose most recent LDL < 100 mg/dl		53.3	(16/30)	53.3	(16/30)
Of all patients with most recent LDL result ≥ 100 mg/dl, percent having lipid lowering medication prescribed		35.3	(6/17)	35.3	(6/17)
<b>Kidney</b>					
Patients who have had a creatinine test in the last year		69.8	(32/46)	34.0	(18/47)
Patients who have had an e-GFR test in the last year		65.2	(30/46)	63.8	(30/47)
Patients who have had albuminuria tested in the last year		34.8	(16/46)	34.0	(16/47)
Of patients with "+" albuminuria ever, percent having ACE I/ARB prescribed		75.0	(3/4)	75.0	(3/4)
<b>Blood Pressure</b>					
Patients with diagnosed HTN		50.9	(23/46)	51.1	(24/47)
Patients with Dx=HTN, the percent having ACE-I/ARB prescribed		62.6	(19/23)	79.2	(19/24)
Of patients with Dx=HTN, the percent whose average of the three most recent systolic < 130 and diastolic < 80		16.7	(3/18)	16.7	(3/18)
Of patients without Dx=HTN, percent whose average of the three most recent systolic < 130 and diastolic < 80		37.5	(8/18)	37.5	(8/18)
<b>Foot Exam</b>					
Patients who have had any foot exam in the last year		60.9	(28/46)	59.6	(28/47)
Patients who have had a monofilament foot exam in the last year		58.7	(27/46)	57.4	(27/47)
Of patients categorized as high risk ever, the percent who have had a monofilament foot exam in the last year		100.0	(8/8)	100.0	(8/8)
<b>Dilated Eye Exam</b>					
Patients with a dilated eye exam in the last year		50.0	(23/46)	48.9	(23/47)
<b>Prevention Services</b>					
Patients who have ever had a pneumococcal vaccine		8.7	(4/46)	8.5	(4/47)
Patients who have had a influenza vaccine from 09/01/12 to 03/31/13		6.5	(3/46)	6.4	(3/47)
Patients ≥ 30 who have ASA/Anti-coagulation therapy prescribed		15.9	(7/44)	16.6	(7/45)
<b>Tobacco Use</b>					
Patients currently smoking/ using tobacco		43.6	(20/46)	44.7	(21/47)
Of patients currently smoking/ using tobacco, the percent receiving cessation intervention in the last year		85.0	(17/20)	81.0	(17/21)
<b>Education</b>					
Patients who have received any diabetes education in the last year		54.3	(25/46)	53.2	(25/47)

Appendix C. Shepherd's Hand Diabetes Provider Annual Visit Form

**SHEPHERD'S HAND FREE CLINIC**  
Diabetes Provider Annual Visit

**Screeners:**  PMH Reviewed  Soc Hx. Reviewed  FMHx Reviewed

**Labs Date:** HBA1c: \_\_\_\_\_ LDL: \_\_\_\_\_ HDL: \_\_\_\_\_ Triglycerides: \_\_\_\_\_ Creatinine: \_\_\_\_\_

**Nurse Interview:** Recent Average Home BS: \_\_\_\_\_  
AM Fasting: \_\_\_\_\_ PM & Inpatient/Grandiat: \_\_\_\_\_  
Current Medications: \_\_\_\_\_

**Comments:** Has Patient missed any doses of their medications?  YES  NO

**Vitals:** BP: \_\_\_\_\_ Goal (<130/75) Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_ Pt. Goal: \_\_\_\_\_

**Foot Exam (date):** \_\_\_\_\_ **Active Concerns:**  YES  NO

Does patient smoke?  YES  NO **Past smoker?** YES  NO  
Cessation plan in place?  YES  NO **Compliant with plan?** YES  NO

**Provider**  
**S:** Patient Concerns:  
  
**ROS:**  
  
**O:**  
  
**A:** 1) DIABETES MELLITUS II: Control is Good (<7.0) Fair (<8.0) Poor (>8.0)  
Comments:  
Additional Diagnosis  
2)  
3)

**P:** **MEDICATION CHANGES:**  
LABS:  
**REFERRALS:**  
SHFC Nutrition/Diabetes Education  YES  NO  
Ophthalmology  YES  NO  
Other \_\_\_\_\_

**IMMUNIZATIONS:** Pneumovax \_\_\_\_\_ Flu \_\_\_\_\_ Tetanus \_\_\_\_\_  
Next Planned Visit \_\_\_\_\_ YES \_\_\_\_\_ NO \_\_\_\_\_ Monthly/Year? N/A  
Smoking Cessation /QUITLINE REFERRAL \_\_\_\_\_ YES \_\_\_\_\_ NO \_\_\_\_\_  
Patient Education Information Given \_\_\_\_\_ YES \_\_\_\_\_ NO \_\_\_\_\_ [NOT NEEDED]

**NEW SELF-MANAGEMENT GOAL:** \_\_\_\_\_

Foot Assessment				
Name:	Date:	MR#:		
<b>History</b>	<input type="checkbox"/> Peripheral neuropathy (pain, numbness) <input type="checkbox"/> Peripheral vascular disease (claudication) <input type="checkbox"/> Appropriate footwear <input type="checkbox"/> Inappropriate footwear			
	<b>Exams</b>			
<b>Appearance</b>	<b>Sensory</b> (10 gram monofilament)		<b>Pulses 0-3+</b>	<b>LT</b> <b>R</b>
<input type="checkbox"/> Active problem <input type="checkbox"/> callus or pre-ulcer <input type="checkbox"/> ulcer <input type="checkbox"/> redness or swelling <input type="checkbox"/> BUBBLING	right  left <input type="checkbox"/> NA _____ (date last foot exam). In shaded areas indicate sensation to monofilament (v = sensate; X = non-sensate) Draw in: <input type="checkbox"/> Callus <input type="checkbox"/> Ulcer	<input type="checkbox"/> U/P <input type="checkbox"/> PT	<b>Footwear modifcat.</b> <input type="checkbox"/> None <input type="checkbox"/> Athletic shoes <input type="checkbox"/> Inserts-depth shoes <input type="checkbox"/> Therapeutic shoes	
<input type="checkbox"/> Low Risk <input type="checkbox"/> Preventive ed. <input type="checkbox"/> Next risk assessment Date: _____	<input type="checkbox"/> High Risk <input type="checkbox"/> Loss sensation <input type="checkbox"/> Deformity <input type="checkbox"/> Hx of ulcer or amp. <input type="checkbox"/> PVD	<b>Recommendations</b> <input type="checkbox"/> Callus/nail trimming <input type="checkbox"/> Intensive foot education <input type="checkbox"/> Ulcer Rx follow-up date: _____ <input type="checkbox"/> Referral: _____		
Provider: _____				

## Appendix D. Shepherd's Hand Diabetes Management Follow-up Letter

Diabetes Management | 2013



5150 River Lakes Parkway  
Whitefish, MT 59937

Date:

RC Diabetes Management

Dear:

To ensure the best quality of care for you and the proper management of your diabetes we are asking you to follow up on the items checked below. Your participation in the management of your health is an important part of the eligibility criteria for receiving free services at Shepherd's Hand Free Clinic. All of the items listed are part of the free care you receive as a Shepherd's Hand patient.

- Blood work and urine as specified (paper work included check for fasting instructions)
- Annual visit with SHFC Provider (call to set up an appointment on a Monday night 260-3502)
- Annual medication review with Becky Stillo Pharm D (call to set up appointment 260-3502)
- Annual visit with SHFC Wellness Leader (call to set up appointment 260-3502)
- Eye Exam Referral (call to set up an appointment as directed by enclosed paperwork)
- Dietician Referral (call to set up an appointment as directed by enclosed paperwork)

If you have any questions please call us at 260-3502 and we will be happy to help you. Failure to follow up on this request will be an indication to us that you are choosing to receive your health care elsewhere. Our goal is to provide quality care and to maximize our patient's health through preventative measures, good nutrition, an active lifestyle and the cessation of smoking. Our hope is that you will be excited about partnering with us in this way.

Sincerely,

Meg Erickson, RN, MSN  
EXECUTIVE DIRECTOR

## Appendix E. DQCMS Quality Improvement Report



Department of Public Health and Human Services  
 Chronic Disease Prevention & Health Promotion Program  
 Cogswell Building C-314B  
 PO Box 202951  
 Helena, MT 59620-2951  
 406-444-6677 FAX: 406-444-7465

*The quarterly Quality Improvement Report graphs present data for your patients with diabetes and are specific to your medical facility. It is generated by the Montana Diabetes Project at the Department of Public Health and Human Services for your staff review and quality improvement planning.*

*Also enclosed is a stop-light report which takes the data and presents it in a fashion that represents where the data is according to goal.*

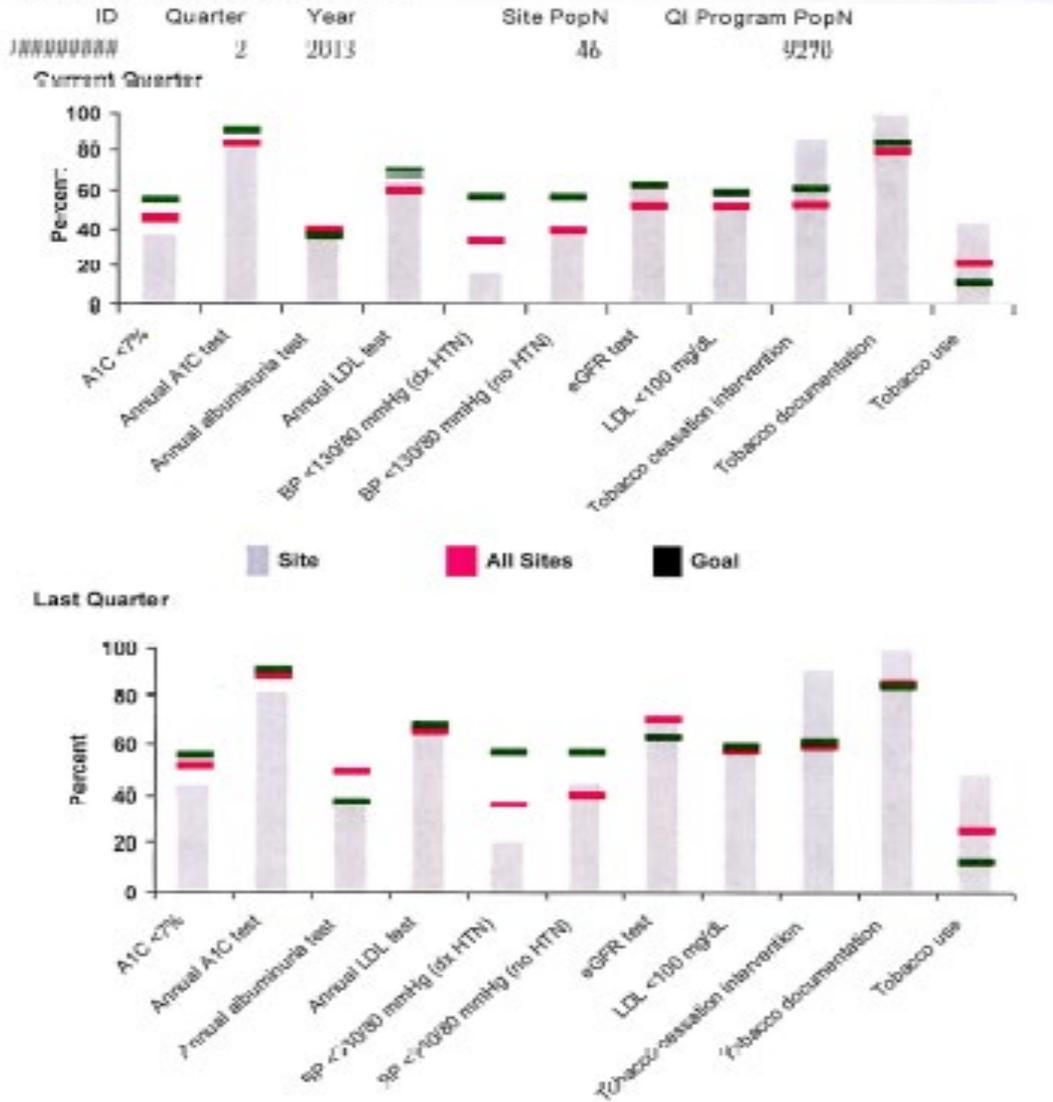
**Green light** – the data has met or exceeded goal.

**Yellow light** – the data has not reached goal but is close and with minimal focus and effort could be moved into the green light area.

**Red light** – this data is way below goal and could represent an area of concern for the patients represented in this data.

Appendix E. DQCMS Quality Improvement Report

Shepherd's Hand Free Clinic



This report presents site-specific and all-site data and compares it to the 2013-14 goals for patients with diabetes. It is generated by the Montana Diabetes Project at the Department of Public Health and Human Services for your staff review and quality improvement planning.

Thursday, July 18, 2013

Appendix E. DQCMS Quality Improvement Report



Red: Far from Goal  
 Yellow: Close to Goal  
 Green: Met or Exceeded Goal

### Stoplight Report

Shepherd's Hand Free Clinic

Quarter	Year	Indicator	Percent	Goal
2	2013	Annual A1C test	80.4	91.1
2	2013	Annual LDL test	65.2	68.4
2	2013	LDL < 100 mg/dL	53.3	59.7
2	2013	Annual albuminuria test	34.8	37
2	2013	eGFR test	65.2	63.4
2	2013	BP < 130/80 mmHg (dx HTN)	16.7	57
2	2013	BP < 130/80 mmHg (no HTN)	37.5	57
2	2013	A1C < 7%	37.8	55.7
2	2013	Tobacco documentation	100	84.5
2	2013	Tobacco use	43.5	12
2	2013	Tobacco cessation intervention	85	61.7