



The Diabetes Quality Care Monitoring System (DQCMS) provides clinicians with a tool to monitor care for individual patients and to track care for the overall practice.

The DQCMS has been enhanced from the original Diabetes Care Monitoring System (DCMS) developed and implemented in Montana since 1997. The enhanced version is programmed in Microsoft Access and tracks diabetes indicators noted in the American Diabetes Association's (ADA) Clinical Practice Recommendations. The Montana Department of Public Health and Human Services (Montana Diabetes Project) has joined with the University of North Dakota and the Energy and Environmental Research Center to improve upon the current program.

DQCMS is an **office based** patient care tracking system that allows clinicians to monitor and evaluate the level of care provided to persons with diabetes and **identify areas for quality improvement efforts**. It includes pre-programmed reports to identify patients in need of **preventive care** and **clinical** follow-up services.

The software is available free of charge.

DQCMS Goal:

To provide an office based tool to assist busy clinicians in assessment of their practice patterns and where indicated, improve diabetes management..

The software is simple to learn...use...and maintain.

It is more than just a software package...

The staff of the Montana Diabetes Project offer:

1. Initial chart review and baseline data assistance.
2. Training for office staff.
3. Feedback regarding overall clinic performance or individual practice patterns.
4. Quarterly benchmark data in the "Quality Improvement Report—QIR".
5. **Assistance in formulating QI interventions for participating practices.**
6. **Assistance in evaluating impact of QI in your setting.**

Supporting continuous, high quality diabetes care!

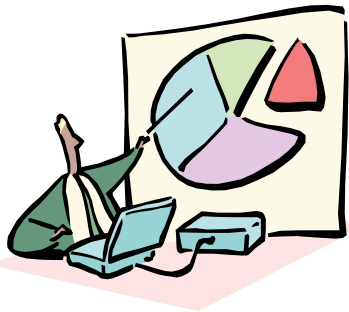
How can DQCMS help you...

During an office visit:

Identify tests/exams that are “due” by glancing at the “patient profile”

Identify areas for which treatment needs to be intensified (A1c, lipids)

Identify prevention services that individual patients are in need of: immunizations, smoking cessation, aspirin therapy)



The data that comes out of the system is only as good as what is entered!

Your data entry personnel are essential!

For the entire patient population with diabetes:

Identify all active patients who are due for tests, exams, or immunizations. The patient list assists with recalls for needed services.

Identify a subset of your patient population: for example, patients with documented proteinuria/microalbuminuria who are not receiving an ACE-I or ARB **and intervene**.

Facilitate communication from your office to patients. Recall or reminder notices can be generated from DQCMS.

Physician, nursing, and office staff all need to be committed to their role in updating and maintaining this program!

More can be accomplished by working together!

Assess your clinical performance:

The “Population Profile” will help clinicians identify specific practice patterns related to diabetes care. (e.g., many action-oriented reports can be generated with a few clicks-of-the-mouse).

Evaluate efforts to improve care:

Easily compare clinical performance during one time period to that in a preceding time period.

Provide practice performance information required by some medical specialty boards (e.g., diabetes is one of the “tracer” diseases for clinical performance assessment for the “second-generation recertification process” for the American Board of Internal Medicine [Annals Internal Medicine 2000;133:202-208].)



Commitments needed from the clinic

- **Identify target population** by ICD-9 codes for 250.xx.
- **Identify a process for updating clinical data** after office visits.
- **Role Definition:** Who is responsible for specific tasks: documentation from nursing and medical staff is critical for data entry.
- **Individual Patient Profile:** Where to file in the medical record?
- **Identification** of data entry person, dedicated time for data entry.
- **Commitment** to ongoing (weekly) data entry.
- **Willingness to share** aggregate clinical data.



Considerations before installing DQCMS

- Does the clinic have an appropriate operating system? Who needs access to the DQCMS program? Does the program need to be networked to multiple computers?



- Does the computer have MS Access 97, 2000, 2002?
- Do all “team” members understand how this system can benefit them?

Get staff buy-in at every level!

- Develop a plan for DQCMS: update clinical data, data entry, report generation (IPP), and quality improvement.

Frequently Asked Questions:

How much extra work will this be for nursing and medical staff?

Everybody needs to be committed to updating clinical information on the “Patient Profile”. Without updated clinical information the data entry person will not have accurate information.

*The team at the Montana Diabetes Project can offer to review charts and enter baseline data into the DQCMS program. After this is done, it takes about **one minute** to update clinical information.*

Who enters data into the DQCMS system?

Anybody can enter the data if they have dedicated time and have the documentation on the “patient profile” to go from. In addition to data entry, these reports also need to be generated and re-filed in the medical record.

How does the Montana Diabetes Project (DPHHS) offer this program?

The MDP is funded by a grant from the Centers for Disease Control, Division of Diabetes. We are committed to assist clinicians in assessing and evaluating care for persons with diabetes. It is our goal to help busy clinicians throughout Montana improve the care they are able to offer.

Supporting continuous, high quality diabetes care!

DQCMS Patient Profile (IPP):

Most Recent Office Visit: 02/05/06		Diabetes Quality Care Monitoring System v1.6.2		Date Generated: 08/10/06	
LIZ CLINIC					
Patient: ACTIVITY, PHYSICAL		DOB: 01/05/50		Primary Physician: MOUSE MD, MICKEY	
Medical Record #: 9009		Age: 56 Years		Additional Diagnoses	
Diabetes Type: 2		Height: 68 inches		<input checked="" type="checkbox"/> HTN <input checked="" type="checkbox"/> CAD <input type="checkbox"/> Renal <input checked="" type="checkbox"/> Neuropathy <input type="checkbox"/> Other	
Clinical Exam				Office Visit Date:	
Previous Dates and Results				Clinical Update	
Weight (lb)	12/01/05	12/02/05	02/05/06	(lb)	(kg)
(BMI)	235 (35.7)	230 (35.0)	225 (34.2)		
Blood Pressure (mmHg)	12/01/05	12/02/05	02/05/06		
	160 / 80	130 / 80	145 / 80		
Foot Exam			Type: Visual Mono		
Visual			Active Prob.: Yes No		
Monofilament	08/01/05	12/01/05	02/05/06	Risk Level: High Low Unknown	
Low	Low	Low	Recommend: Therapeutic Referral		
Dilated Eye Exam			12/12/05	Retinopathy: None Mild	
			No Retinopathy	Severe Unknown	
Dental Referral					
Laboratory Data				Laboratory Update	
Previous Dates and Results					
A1C	12/01/02	02/05/05	11/01/05		
	7.5	8.0	8.6	%	
Lipid Panel	11/04/03	11/01/05	12/01/05		
HDL	25	25	20		
LDL	156	150	150		
Triglyceride	325	390	220		
Urine					
Proteinuria					
Microalbuminuria	12/01/05	02/05/06			

Nursing and medical staff **must** update this patient information in order for accurate data to be reflected in reports!

The patient profile also trends:

- Lab data: (A1c, HDL, LDL, TRIG, UA protein and Microalbumin)
- Medication information: ACE-I /ARB, ASA, lipid lowering
- Prevention Services
- Education



Now everybody can keep an eye out for what the patient needs during their next clinic visit!

A New Opportunity for tracking education

The DQCMS now offers the ability to track:

1. Comprehensive Initial Education
2. Post Program Education
3. Data for the ADA Recognition Report

Patient lists can also be generated.

ADA Recognition

To Add
Scroll to the very last empty row and enter the information.

To Modify
Click on the field and make the necessary changes.

To Delete
Select the record and click on the arrow to the left of the Type and press the delete button.

Select Patient: ACTIVITY, PHYSICAL

Most Recent Contact Date: []

Total Comp/Initial Hours: [] Comp/Initial Completed:

Type	Date (mm/dd/yy)	Hours
Comp/Initial Recvd	[]	[]
Post Prog Inst	[]	[]

Record: 1 of 1

Close

For more information about DQCMS or the Montana Diabetes Project Contact:

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