Washington State Hospital Association

RURAL QUALITY

Action Bundle
Type 2 Diabetes

Background

- The prevalence of diabetes mellitus in the United States increased 40% between 2007 and 2010.
- A total of 29.1 million people or 9.3% of the United States have diabetes
  - 21 million of those are diagnosed
  - 8.1 million (27.8% of people, or one out of every 4) are undiagnosed
- Risk of death for adults with diabetes is 50% higher than for the adults without diabetes.
- People who have diabetes are at a higher risk of serious health complications such as:
  - Blindness
  - Kidney Failure
  - Heart Disease
  - Stroke
  - Loss of toes, feet or legs
- Every 24 Hours:
  - 4,557 Adults are diagnosed with diabetes
  - 136 people being treatment for end-stage renal disease
  - 200 non-traumatic lower-limb amputations are performed
  - 641 people die from diabetes, or diabetes is a contributing cause of their death
- The medical costs and lost work with wages for people with diagnosed diabetes is $245 Billion.

Aim

To see a 5% decrease in the number of poorly controlled diabetic patients.

Measures

Outcome: Diabetes HbA1c {Poor Control} per NCQA / HEDIS/NQF
Process: Regular and annual checks at admission or provider visit. Referrals, self-management goals, and other tools for improvement in poor control.
Submit: QBS

Change Strategies

Leadership	○ Set aims, goals and timelines for change ○ Identify clinical and provider leaders to champion ○ Educate care providers on the need for checking A1c and assessments for other factors affecting diabetic outcomes.
Clinical Priorities at each visit - ABC's	○ Check to see if **A**1c in the last 12 months for values >9 ○ **B**lood pressure check. BP should be no more than <140/80 with individual adjustment as appropriate ○ **C**holesterol should be no more than goal of < 100 mg/dl LDL. If <130 mg/dl, there is a need for improvement ○ **S**moking cessation counciling as needed
Other Exams/Tests each visit	○ Foot exam at each diabetic planned visit
Lab Tests	○ HbA1c at least annually and more frequently (4-6 months) if not controlled ○ Fasting Lipid profile annually ○ Urine Microalbumin/Creatinine ratio annually ○ Creatine annually
Immunizations	○ Flu shot annually ○ Td every 10 years ○ Pneumococcal Vaccine (one time dose)
Refferals	○ Opthalmology dilated exam annually
Self Management Goal Setting and Support	○ Set self management goals(s) (ex: activity, nutrition, self glucose monitoring, etc) with patient that they agree upon and feel they can achieve ○ Follow up in 2-3 weeks to review and refine goals as needed (phone)
Other	○ Information on diabetic classes in your community ○ Schedule 4 month visit ○ Other strategies as needed.

Adapted from St. Peters Family Medicine, Olympia, WA and Newport Hospital and Health Services

Helpful links:

www.hanys.org/population-health
Article *"Moving Toward Population Health"*; an interview with David Nash, M.D., M.B.A.

http://www.swselfmanagement.ca/smToolkit/login.aspx
You will need to create a sign in (free) to watch a series of short videos on helping patients self-manage their diabetes

http://www.doh.wa.gov/DataandStatisticalReports/DiseasesandChronicConditions/ChronicDiseaseProfiles
You can find diabetes statistics in your county on this site

http://www.hrsa.gov/quality/toolbox/508pdfs/diabetesmodule.pdf
38 page booklet from HRSA on "*Diabetes HbA1c (Poor Control)* "; HRSA

http://www.tdctoolkit.org/wp-content/themes/tdc/algorithms/08_NutritionRecommendations.pdf
Texas Department of State Health Services; Texas Diabetes Council have published some good information in the supplement called "*Nutrition Recommendations and Interventions for Diabetes."* Pages 5 and 6 are excellent printouts to provide patients regarding diabetic food choices.