Advancing Diabetes Quality Care in Michigan RHCs

RHC

Michigan Quality Network

Diabetes Prevalence in Michigan

Diabetes is a major concern for Michigan's Rural Health Clinics (RHCs), with high prevalence driven by limited access to care and socioeconomic barriers. RHCs play a key role in early detection, management, and education, making expanded preventive services and chronic care management essential for improving outcomes.

Diabetes Economic Impact

Direct Medical Expenses

- Diabetes-related medical costs in Michigan are estimated at $7 billion annually. diabetes.org

Indirect Costs

- An additional $2.7 billion is attributed to lost productivity due to diabetes-related complications. diabetes.org

Complications and Mortality

- In 2016, diabetes was the seventh leading cause of death in Michigan. michigan.gov
- Individuals with diabetes are at increased risk for heart disease, stroke, kidney failure, lower-limb amputations, and blindness. americashealthrankings.org

2025 Goals for Advancing Diabetes Quality Care in Michigan RHCs: Kick off

Create	• Leverage our statewide network of RHCs to reducing diabetes-related complications and improving patient quality of life.
Standardize	• Standardize care practices using evidence-based guidelines while adapting to local community needs.
Secure	• Secure sustainable funding and support through state and federal partnerships.

MICHIGAN CENTER for RURAL HEALTH

Advancing Diabetes Quality Care in Michigan RHCs: Why Participate?

- **Improve Patient Outcomes:** Enhance diabetes care and management for your rural patients.
- **Collaborative Learning:** Share best practices and strategies with other Rural Health Clinics (RHCs) across Michigan.
- **Access to Resources:** Benefit from tools, training, and support tailored to rural healthcare settings.
- **Data-Driven Impact:** Utilize performance metrics to drive measurable improvements and demonstrate value to stakeholders.

Advancing Diabetes Quality Care in Michigan RHCs: Your Role?

- **Commit to the Initiative:** Engage leadership and staff in prioritizing diabetes care improvement.
- **Implement Best Practices:** Adopt multidisciplinary, team-based approaches to diabetes management.
- **Measure & Share Results:** Track patient outcomes and share successes to inspire statewide improvements.

MI RHC 2025 Quality Improvement: Key Focus Areas

1. **Hemoglobin A1C Control** (target <9% for incentives).
    - target <8% for incentives
2. **Diabetic Foot Exam** (preventative care to reduce amputations).
3. **Diabetic Eye Exam** (early detection of retinopathy).
4. **Hypertension Control** >140/90 (specific to diabetes)
5. **Statin Therapy** (reducing cardiovascular risks).
6. **Kidney Health Evaluation:**
    - **uACR (Albumin-to-Creatinine Ratio)**
    - **eGFR (Estimated Glomerular Filtration Rate)**
7. **Medication Adherence** (diabetes medications, statins).

Why Focus on These Measures?

Improve Patient Outcomes

- Prevention of complications (CVD, CKD, amputations, vision loss)
- **Incentive Opportunities**
  - Insurers reward controlled A1C levels
  - Demonstrated quality care impacts financial sustainability
- **Integrated Chronic Disease Management**
  - Patients often present with comorbidities: HTN, CVD, CKD, etc.

Collaborative Support from MCRH & RHC Network: What Can You Expect?

- **PDSA (Plan-Do-Study-Act)** templates offering a structured approach to improving key diabetes care metrics, including HbA1C control, foot and eye exams, hypertension management, statin therapy, kidney health evaluations, and medication adherence.
- **Peer-Learning & Best Practice Sharing:**
  - **Interactive sessions** for RHCs to exchange strategies, troubleshoot challenges, and share success stories related to diabetes and chronic disease management.

Project ECHO Provider Learning: Additional Resources

- The **goal of Diabetes ECHO** is to increase the capacity of primary care providers (PCPs) and clinics to empower and safely and effectively manage patients with diabetes who do not receive routine specialty care.
- This **collaborative series** will provide education on diabetes management, medications, technology, patient education, the benefit of incorporating retinopathy exam referrals, and the utilization of technology tools.
- **Supporting tools and guidance** will be provided for implementing these items within the participating Rural Health Clinic's clinical services.

Retinopathy Exam Quality Project

- MCRH has initiated a project with a small cohort of RHCs to examine current diabetes retinopathy exam referral rates.
- This collaborative effort will focus on understanding successful referral practices, identifying barriers that limit exam completion, and developing strategies to improve access to this critical screening.

Next Steps

- **Enroll in the Initiative:** Provide clinic champion contact information via survey link
- **Initial Assessment:** Submit 2024 baseline data for HbA1C metric
- **First Peer-Learning Session**: April 23rd 1 pm – in person inaugural collaborative session.
  - PDSA Template for HbA1C
  - Best Practice Sharing
  - Diabetes Billing and Coding Specific Education

Measurement Data

Advancing Diabetes Quality Care in Michigan RHCs Survey

Clinical Quality Measure (CQM) Reporting

*Practice Panel Size: Please provide the total number of adult patients in the practice's panel from January 1, 2024, to December 31, 2024 (for Patients 18-75 years old)

*Description: Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period.

Numerator: Patients whose most recent HbA1c level (performed during the measurement period) is >9.0% or is missing, or was not performed during the measurement period
Denominator: Patients 18-75 years of age by the end of the measurement period, with diabetes with a visit during the measurement period.
Exclusions: Patients with a diagnosis of gestational diabetes or steroid-induced diabetes. Patients receiving palliative or hospice care.

For the reporting period from January 1, 2024, through December 31, 2024, please provide the following information:

Number of patients who meet the measure (numerator):

Total number of eligible patients (denominator):

Number of patients excluded from the measure (ineligible/exclusions):

Timeline for 2025 Goals

- **Kick-off:** February 2025
- **Quarterly Peer-Learning Sessions:** In person: April 23rd, August 21st, Virtual: November 13th
- **Mid-Year Progress Review:** August 2025
- **Final Evaluation:** November 2025, with outcomes shared at a statewide meeting or report release.

QUESTIONS