

## 2009 IHS Diabetes Best Practices Short Descriptions and Key Measures

Best Practice	This BP describes...	Key Measure 1	Key Measure 2
Adult Weight Management	Recommendations to achieve and maintain a healthy weight for adults with diabetes, regardless of duration of diabetes.	Percentage of diabetes patients with documented nutrition education from a Registered Dietitian or other provider in the past twelve months.	Percentage of diabetes patients with a documented assessment for overweight or obesity in the past twelve months.
Breastfeeding	Clinical tools and technical resources to effectively support breastfeeding.	Number of policies and procedures that are in place which promote and protect breastfeeding.	Percentage of mothers (who have delivered in the past twelve months) who breastfeed for two months postpartum, for six months, and for more than twelve months.
Cardiovascular Disease (CVD)	CVD risk reduction and care recommendations for any person with type 1 or type 2 diabetes.	Percentage of diabetes patients who have recent blood pressure measurements that are at goal in the past twelve months.	Percentage of diabetes patients with documented CVD or hypertension education in the past twelve months.
Case Management	Case management recommendations for any person with pre-diabetes or diabetes—regardless of age or duration of pre-diabetes or diabetes.	Multi-disciplinary Case Management Team is established and its effectiveness is being evaluated through data review and satisfaction surveys.	Improvement in two or three clinical goals for patients who receive case management services (compared to individuals who do not receive case management services).

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Chronic Kidney Disease (CKD)	Guidelines for programs that seek <i>either</i> to maintain the kidney health of diabetes patients <i>or</i> to improve the care of individuals with established diabetic kidney disease.	<p><b>Maintain Kidney Health</b> Percentage of diabetes patients whose most recent blood pressure was &lt; 130/80.</p> <p><b>Improve CKD Care</b> Percentage of diabetes patients whose eGFR is &lt; 60ml/min in the past twelve months, that met recommended therapeutic goals:</p> <ul style="list-style-type: none"> <li>• BP &lt; 130/80 mmHg</li> <li>• Use of renin angiotensin system antagonists (e.g. ACE inhibitor, ARB)</li> <li>• A1c &lt; 7.0 mg/dL</li> <li>• LDL &lt; 100 mg/dL or &lt; 70 pending risk factors</li> <li>• TG &lt; 150mg/dL</li> <li>• Control phosphorus (bone disease)</li> <li>• Hgb 11-12 g/dL (when treating anemia with an erythropoietin stimulating agent)</li> </ul>	<p><b>Maintain Kidney Health</b> Percentage of diabetes patients with hypertension who have been prescribed a renin angiotensin system antagonist (e.g. ACE inhibitor, ARB) in the past twelve months.</p> <p><b>Improve CKD Care</b> Number of diabetes patients started on dialysis and their circumstances:</p> <ul style="list-style-type: none"> <li>• Early access versus emergency access will be assessed along with cost analysis</li> <li>• Patient signed up in advance for medical assistance (e.g. Medicare, Medicaid)</li> </ul>

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Community Advocacy	Recommendations for developing public policy, raising awareness, and building support for individuals and families at risk of diabetes or living with diabetes.	Members of a local community diabetes advocacy group include, at a minimum, a community member who has diabetes, the family member of a person with diabetes, and representatives from three community entities and/or health care facilities.	Number of health-related policies that are implemented as a result of action by the community advocacy group.
Community Screening	Recommendations for community screening of adults at risk of developing diabetes.	Written policies and procedures are in place that detail referral processes for individuals with abnormal blood glucose results who are identified through community screening.	A memorandum of agreement (MOA) exists between the programs that provide community screening, clinical services, and (if applicable) the SDPI Demonstration Project. The MOA lists the key responsibilities of each entity.
Depression	Depression screening and treatment options for persons with type 1 or type 2 diabetes.	Percentage of diabetes patients who were screened for depression in the past twelve months.	Percentage of diabetes patients with depression diagnosed in the past twelve months who received appropriate treatment.

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Diabetes and Pregnancy	Guidelines for programs that seek to improve screening for and care of women with gestational diabetes.	A registry is in place that is used to track patients, their needs and clinical outcomes.	Percentage of women with diabetes of childbearing age and women with diagnosed gestational diabetes who have had documented diabetes and pregnancy education in the past twelve months.
Diabetes Systems of Care	An organized approach to providing quality diabetes care, prevention, and treatment through an integrated, multi-disciplinary approach.	Diabetes Team demonstrates ongoing communication and active interaction among multi-disciplinary clinic and community members.	Percentage of diabetes patients with improved results in at least six indicators of the IHS Diabetes Care and Outcomes Audit in the past twelve months.
Diabetes Self Management Education (DSME)	Key elements that are needed to build and sustain a quality diabetes self-management education program.	Number of patients who completed or partially completed the DSME process in the past twelve months.	Changes in patients' clinical and behavioral outcomes.
Eye Care	Guidelines for programs that seek to improve individual's diabetic eye health status and to enhance the delivery of effective diabetic eye care.	Percentage of diabetes patients with a documented qualifying eye exam in past twelve months.	Percentage of diabetes patients receiving appropriate retinal treatment in the past twelve months: <ul style="list-style-type: none"> <li>• retinal laser treatment</li> <li>• vitrectomy procedure</li> </ul>

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Foot Care	Foot care guidelines for clinical providers caring for persons with type 1 or type 2 diabetes.	Percentage of diabetes patients receiving documented foot exams in the past twelve months.	Percentage of diabetes patients with documented risk-appropriate foot care education in the past twelve months.
Nutrition	Nutrition recommendations that target people who are at risk of developing diabetes or currently living with diabetes.	Percentage of pre-diabetes and diabetes patients with documented medical nutrition treatment (MNT) or nutrition education in the past twelve months.	Number of documented partnerships that enhance the provision of nutrition education to families and communities.
Oral Health	Oral health care recommendations for any person with type 1 or type 2 diabetes.	Percentage of diabetes patients who had a dental exam in the past twelve months.	A dental provider actively participates with the Diabetes Team to address oral health-related issues.
Pharmaceutical Care	Guidelines and clinical resources to identify, manage, and educate patients regarding pharmaco-therapeutic problems due to type 2 diabetes.	Documentation of ongoing medication reconciliation and poly-pharmacy concerns by pharmacy staff through chart reviews.	Percentage of diabetes patients who had documented medication education in the past twelve months.
Physical Activity	Physical activity recommendations for any person at risk for developing diabetes or living with diabetes.	Percentage of pre-diabetes and diabetes patients who have had level of physical activity documented in the past twelve months.	Number of documented partnerships that enhance the provision of physical activity education and opportunities to individuals, families, and communities.

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School Health & Diabetes	Recommendations for comprehensive school health programs that serve youth of all ages.	Number of students who receive culturally appropriate education about nutrition, physical activity, and diabetes.	School staffperson actively participates with the Diabetes Team in school health-related activities.
Youth & Type 2 Diabetes	Recommendations for health care that serves youth with type 2 diabetes and those at risk for developing type 2 diabetes.	Percentage of diabetes patients aged six through seventeen years with documented nutrition and physical activity education in the past twelve months.	Percentage of diabetes patients aged six through seventeen years with A1c less than 7.0 mg/dl in the past twelve months.