

11-7-2025

Executive Leadership System Improvement: System- Level Program to Improve Care for Type-II Diabetic Patients

Jane Chukwura
Walden University

Follow this and additional works at: <https://scholarworks.waldenu.edu/dissertations>



Part of the [Nursing Commons](#)

This Dissertation is brought to you for free and open access by the Walden Dissertations and Doctoral Studies Collection at ScholarWorks. It has been accepted for inclusion in Walden Dissertations and Doctoral Studies by an authorized administrator of ScholarWorks. For more information, please contact ScholarWorks@waldenu.edu.

Walden University

College of Nursing

This is to certify that the doctoral study by

Jane Chinwe Chukwura

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee

Dr. Mary Catherine Garner, Committee Chairperson, Nursing Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2025

Executive Summary: Executive Leadership System Improvement
System-Level Program to Improve Care for Type-II Diabetic Patients

by

Jane Chinwe Chukwura

Executive Summary Submitted in Partial Fulfillment
of the Requirements for the Degree of
Doctor of Nursing Practice

Walden University

December 2025

Introductory Summary

The American Diabetes Association (2025) has reported that the prevalence of diabetes in America is a significant public health concern, with approximately 38.4 million individuals, or 11.6% of the population, living with the condition in 2021. This includes disparities across various racial and ethnic groups, where American Indians and Alaskan Natives face higher rates compared to non-Hispanic Whites. The economic burden of diabetes in the United States was around \$412.9 billion in 2022, encompassing both direct medical expenses and indirect costs. Given that nearly 29.2% of adults aged 65 and older are affected by diabetes, alongside a growing number of individuals with prediabetes, there is a significant need for comprehensive and integrated diabetes management programs within healthcare systems. Establishing such a program could address disparities, enhance patient care, and alleviate the economic impact associated with diabetes management, thereby improving health outcomes on a systemic level.

Impetus for Change in Practice

According to the American Diabetes Association (2025), the prevalence of diabetes is especially pronounced among seniors, with 29.2% of Americans aged 65 and older (about 16.5 million individuals), being affected by the condition. The annual incidence of diabetes continues to rise, with 1.2 million new cases diagnosed each year. An estimated 97.6 million Americans age 18 and older were reported to have prediabetes in 2021, placing them at a higher risk for developing both Type I and Type II diabetes.

Approximately 352,000 Americans under age 20 have diagnosed diabetes, with an incidence rate in 2017–2018 reflecting 18,200 cases of Type 1 diabetes and 5,300 cases

of Type 2 diabetes American Diabetes Association (2025). There are significant disparities in diabetes prevalence among various racial and ethnic groups. For instance, 13.6% of American Indian/Alaskan Native adults and 12.1% of non-Hispanic Black adults are diagnosed with diabetes American Diabetes Association (2025). This disparity extends to Hispanic adults (11.7%) and Asian American adults (9.1%), highlighting an urgent need for culturally relevant interventions American Diabetes Association (2025).

Diabetes is the eighth leading cause of death in the United States, with 399,401 death certificates mentioning diabetes as a cause in 2021. The total cost of diagnosed diabetes in the United States reached \$412.9 billion in 2022, broken down into \$306.6 billion for direct medical costs and \$106.3 billion for indirect costs as revealed by American Diabetes Association (2025).

These statistics as provided by American Diabetes Association (2025), underscore the necessity for a structured clinical practice intervention aimed at equipping healthcare providers with the knowledge and skills to manage Type II diabetes effectively. The current challenges faced by providers include outdated practices and insufficient training, highlighting a critical need for enhanced capabilities. By improving the education and training of healthcare providers, it is believed that healthcare organizations can improve patient outcomes and ensure that individuals with Type II diabetes receive the highest quality care.

Internal and Community-Level Data

Internally, patient records indicate that a significant percentage of individuals (approximately 15%–20%) visiting the practice are diagnosed with Type II diabetes.

Screenings reveal that about 10% of patients attending routine check-ups have undiagnosed diabetes or prediabetes, highlighting a critical gap in awareness and management. Clinical outcomes are concerning, as data shows that 40% of patients with Type II diabetes have HbA1c levels exceeding the recommended target of 7%, indicating poor glycemic control (Adeji et al., 2025). Internal audits reveal that around 25% of patients present with diabetes-related complications, such as neuropathy and cardiovascular issues, underscoring the need for improved management protocols. Provider training also presents challenges as surveys indicate that more than 60% of healthcare providers feel inadequately trained to manage Type II diabetes effectively, and an analysis of continuing education records shows a lack of recent training on this critical topic. Patient feedback further supports these findings, with satisfaction surveys indicating that only 45% of patients feel they receive near-adequate education about managing their diabetes.

Key Literature Supporting the Program

Research underscores the need for a comprehensive, interprofessional approach to diabetes management to enhance patient outcomes. Richardson et al. (2021) highlighted that diabetes self-management education (DSME) is crucial for improving glycemic control, but ongoing support from a multidisciplinary team, including care managers, nurses, dietitians, and pharmacists, is essential for sustained behavior change. They also stress the importance of tailoring DSME to fit patients' social and cultural contexts and coordinating care among healthcare providers for effective management of diabetes and associated conditions. The authors advocated for mental health screenings and supportive

tools like computerized tracking systems to improve care coordination. According to the American Diabetes Association (2023), a collaborative, multidisciplinary care team, including endocrinologists, primary care providers, and mental health professionals, is vital for addressing diabetes's multifaceted nature. The guidelines emphasize person-centered team care and ongoing communication to tailor treatment plans to individual needs. They also encourage healthcare systems to facilitate both in-person and virtual team-based care (TBC), utilizing patient registries and community resources.

Jacobs et al. (2024) demonstrated the effectiveness of a TBC model that integrates services across clinical and social domains, enhancing holistic diabetes management. The study showed that patients reported high satisfaction with the TBC model, which improved communication and engagement in their care. Effective teamwork and addressing barriers, such as language differences, were crucial for success, leading to significant improvements in clinical metrics like reduced HbA1c levels. Abdulrhim et al. (2021) emphasized the importance of the Collaborative Care Model, which fosters improved communication and coordinated care among healthcare providers. This shared responsibility empowers patients to manage their diabetes actively, resulting in better glycemic control and reduced healthcare visits. So, these findings highlight that an interprofessional approach significantly enhances diabetes management, improves patient outcomes, and empowers individuals to take charge of their health.

Purpose, Goals, and Projected Outcomes

This project aims to assemble an interprofessional team of healthcare professionals to develop a strategic management plan for a comprehensive diabetes

management program. The initiative seeks to create a standardized model incorporating best practices and evidence-based recommendations for A1C testing and screening tools. It will explore specialized educational programs for newly diagnosed patients and assess culturally tailored resources, such as cookbooks for Hispanic patients. Ultimately, the project aims to enhance patient education, improve health outcomes, and promote health equity across diverse populations.

Organization's Readiness to Change

The organization demonstrates a strong readiness to implement the proposed intervention, as evidenced by the Organizational Readiness for Implementing Change (ORIC) Tool assessment. Staff members express high confidence in the organization's ability to engage and support them throughout the change process, with all indicators scoring a 5 out of 5. This includes a collective commitment to the change, confidence in tracking progress, and a determination to overcome challenges. The supportive leadership within the organization further enhances this readiness, creating an environment conducive to successful implementation. However, addressing potential barriers, such as resistance to change and time constraints, will be crucial for ensuring a smooth transition.

SWOT Analysis

The organization has several strengths, including knowledgeable healthcare staff, a solid understanding of diabetes management, and evidence-based clinical guidelines that can enhance care. Supportive leadership promotes staff education, and previous successful training programs offer valuable implementation frameworks. However, challenges such as potential resistance to change, limited training time due to clinical

demands, and inconsistent application of guidelines across departments highlight the need for a tailored training approach. Opportunities exist to leverage technology through e-learning platforms and mobile applications, foster interdisciplinary collaborations, and benefit from increased public awareness of chronic disease management. Conversely, threats like high staff turnover disrupt training continuity, whereas competing organizational priorities and the risk of competitors adopting similar programs necessitate strategic planning to sustain the initiative's effectiveness.

Potential Risks to the Organization

Despite the strong rationale for the diabetes management program, several potential risks could impact its successful implementation. One significant risk is resistance to change among staff members, particularly those who are comfortable with existing workflows and may view the program as an additional burden rather than a beneficial initiative. This resistance could hinder adoption and effectiveness. Additionally, gaps in training may pose challenges, as inadequate initial training or lack of ongoing support could undermine staff confidence in implementing the program, potentially jeopardizing its overall success. Resource allocation emerges as another risk, as financial constraints may limit the ability to maintain necessary funding and resources. Furthermore, managing the diverse needs of patients is crucial; failing to address cultural and linguistic barriers effectively can lead to inequitable outcomes and patient dissatisfaction. Lastly, the sustainability of the program, particularly amid changing organizational priorities or high staff turnover, could disrupt continuity and weaken its overall impact. Addressing these potential risks through effective change management

strategies, strategic planning, ongoing staff engagement, resource allocation, continuous quality improvement processes, and proactive communication will be essential to foster a successful diabetes management program.

Stakeholders and Expertise

To develop a comprehensive diabetes management program model, I assembled an interprofessional team of stakeholders with diverse expertise. This collaborative approach ensures that all aspects of diabetes management are thoughtfully addressed to enhance the program's effectiveness. The team includes healthcare providers, such as endocrinologists and primary care doctors, who are crucial for diagnosing and managing diabetes through individualized care plans. Diabetes educators guide patients in self-management practices, while registered dietitians create personalized meal plans to support glycemic control and weight management. Mental health professionals, including social workers and psychologists, address social determinants and mental health concerns that affect diabetes management. Wound care experts focus on preventing complications like foot ulcers, and nurses provide ongoing monitoring and education to foster effective management. Data analysts and quality assurance professionals ensure the program is evidence-based and compliant with best practice standards. This diverse team collaboratively develops a comprehensive diabetes management program model that effectively addresses the complexities of diabetes care, promoting better health outcomes for patients.

New Technologies and Software Requirements

The plan enhances the electronic health record (EHR) to support integrated diabetes care workflows, featuring automated order sets, customized data fields for DSME participation, and decision support alerts. A central care coordination platform will display HbA1c levels, screening adherence, and risk stratification tools. Telehealth tools will enable secure video visits and remote glucose data sharing, while a patient-facing digital platform will offer educational materials, appointment reminders, and self-management trackers. The analytics and reporting suite will standardize dashboards for quality metrics and ensure data governance for quality, privacy, and security. HIPAA-compliant messaging and secure data exchange among team members and community partners will facilitate seamless interactions with external labs and agencies. Vendor contracts should include provisions for user training, data migration, and ongoing optimization to support these initiatives.

Training Needs

Core interprofessional training will cover diabetes care guidelines, structured DSME delivery, and cultural safety training. Role-specific training will focus on advanced skills for dietitians, social workers, wound care specialists, and clinicians. Self-management training will include structured DSME modules and culturally tailored materials, with assessments to ensure understanding. A 6- to 12-month training calendar will align with the phased rollout, incorporating competency assessments and multilingual resources.

How the Plan Will Be Used by the Organization

The organization will utilize this action plan as a foundational framework for developing and implementing the diabetes management program. Specific aspects of the plan will guide how the interprofessional team collaborates, ensuring that each member's expertise is leveraged effectively in the creation of the strategic management model. The insights gathered from the team will inform the establishment of best practices and guidelines, helping to standardize care delivery across the healthcare system. By articulating clear recommendations for A1C testing, screening, and patient assessments, the organization will be better equipped to enhance its diabetes care initiatives. Moreover, the action plan will support ongoing staff training and education efforts, ensuring that healthcare providers are knowledgeable about the new protocols and are empowered to deliver effective care to patients with diabetes.

Accreditation Standards

For our interprofessional diabetes management project, we will adhere to accreditation standards set by The Joint Commission and similar national organizations, as well as guidelines from the American Diabetes Association and care-coordination advice from the Institute for Healthcare Improvement. Our plan involves aligning each program element with key accreditation domains, including patient-centered care, interprofessional collaboration, care transitions, data privacy, patient education, performance measurement, and governance. We will create standardized protocols and care pathways, establish a governance structure with clear leadership, and implement secure health information technology systems. A formal gap analysis will pinpoint any

missing requirements, assigning owners and timelines for each action. To ensure readiness, we will conduct regular internal audits, mock surveys, and continuous improvement cycles. Additionally, we will customize the standards to fit our jurisdiction, clearly mapping them to our procedures and policies. Performance metrics, such as hemoglobin A1c targets and patient satisfaction, will be established to demonstrate compliance during accreditation surveys.

Regulatory and Legal Issues

We anticipate various regulatory and legal issues, including privacy protection under laws like the Health Insurance Portability and Accountability Act and the General Data Protection Regulation, consent for education and remote monitoring, and compliance with data-sharing regulations among the care team. We must also consider scope-of-practice regulations for healthcare professionals, as well as accessibility and nondiscrimination laws. Union-related issues may involve staffing ratios, overtime, compensation for additional duties, and ensuring alignment with collective bargaining agreements. Furthermore, we must address data governance, audit trails, security for remote monitoring and EHR systems, and liability concerns.

Addressing Issues

To address regulatory and legal challenges, we will conduct a regulatory gap analysis and create data-sharing agreements, consent forms, and privacy impact assessments, involving legal and compliance teams early in the process. We will review collective bargaining agreements to identify allowable scopes of practice and negotiate necessary role and compensation changes, along with providing training on privacy and

security. Standard operating procedures will be established for data handling, consent processes, and audit trails in EHRs and remote-monitoring systems, along with risk management processes for clear reporting. A governance lead will monitor regulatory changes, track compliance metrics, and ensure timely policy updates to maintain ongoing readiness.

Project Outcomes

The model aims for a 0.5%–1.0% reduction in mean HbA1c and an increase in patients achieving HbA1c < 7%, along with fewer diabetes-related complications over 18–24 months. It will expand DSME reach using culturally and linguistically appropriate materials, promote health equity through standardized care pathways, and enhance system efficiency via standardized testing and data-driven coordination. A sustainable, cost-neutral or cost-saving operation is expected within 24 months, with potential applicability to other chronic

Social Change, Diversity, Equity, and Inclusion

The project integrates diversity, equity, and inclusion into governance, design, and outcomes reporting, incorporating patient input through established advisory channels. It engages an interprofessional team (dietitians, social workers, wound care experts, and diabetes educators), to develop resources that reflect best practices and community needs. Language-concordant education and accessible DSME are essential for closing outcome gaps, with transparent disparity measurements to ensure accountability and inclusive impact.

References

- Abdulrhim, S., Sankaralingam, S., Ibrahim, M.I.M., Diab, M. I., Hussain, M. A. M., Reay, H. A., Ismail, T., & Awaisu, A. (2021). Collaborative care model for diabetes in primary care settings in Qatar: A qualitative exploration among healthcare professionals and patients who experienced the service. *BMC Health Services Research*, *21*, Article 192. <https://doi.org/10.1186/s12913-021-06183-z>
- American Diabetes Association. (2023). Standards of care in diabetes: 2023 abridged for primary care providers. *Clinical Diabetes*, *41*(1), 4–31. <https://doi.org/10.2337/cd23-as01>
- American Diabetes Association. (2025). *Statistics about diabetes*. <https://diabetes.org/about-diabetes/statistics/about-diabetes>
- Adjei, S. K., Adjei, P., & Nkrumah, P. A. (2025). Poor glycemic control and its predictors among Type 2 diabetes patients: Insights from a single-centre retrospective study in Ghana. *Health Science Reports*, *8*(3), Article e70558. <https://doi.org/10.1002/hsr2.70558>
- Jacobs, J., Dougherty, A., McCarn, B., Saiyed, N. S., Ignoffo, S., Wagener, C., Miguel, C. S., & Martinez, L. (2024). Impact of a multi-disciplinary team-based care model for patients living with diabetes on health outcomes: A mixed-methods study. *BMC Health Services Research*, *24*, Article 746. <https://doi.org/10.1186/s12913-024-11062-4>

- Miller-Rosales, C., & Rodriguez, H. P. (2021). Interdisciplinary primary care team expertise and diabetes care management. *Journal of the American Board of Family Medicine*, 34(1), 151–161. <https://doi.org/10.3122/jabfm.2021.01.200187>
- Moghaddam Tabrizi, F., Rasmi, Y., Hosseinzadeh, E., Rezaei, S., Balvardi, M., Kouchari, M. R., & Ebrahimi, G. (2021). Diabetes is associated with higher mortality and severity in hospitalized patients with COVID-19. *EXCLI Journal*, 20, 444–453. <https://doi.org/10.17179/excli2021-3403>
- Mogre, V., Johnson, N. A., Tzelepis, F., & Paul, C. (2019). Attitudes towards, facilitators and barriers to the provision of diabetes self-care support: A qualitative study among healthcare providers in Ghana. *Diabetes & Metabolic Syndrome: Clinical Research & Reviews*, 13(3), 1745–1751. <https://doi.org/10.1016/j.dsx.2019.03.041>
- Otovwe, A., Stella, O., Rume, O. O., Akpojubar, H. E., & Tonbra, H. N. (2020). Pattern of diabetes mellitus-related complications and mortality rate: Implications for diabetes care in a low-resource setting. *Sahel Medical Journal*, 23(4), 206–210. https://doi.org/10.4103/smj.smj_64_19
- Richardson, C. R., Borgeson, J. R., Van-Harrison, R., Wyckoff, J. A., & Yoo, A. S. (2021). *Management of Type 2 diabetes mellitus*. Michigan Medicine University of Michigan. <https://www.ncbi.nlm.nih.gov/books/NBK579413/>
- Torti, J. M. I., Kennett, S. L., & Bell, N. R. (2022). Interprofessional care of patients with Type 2 diabetes mellitus in primary care: family physicians' perspectives. *BMC Primary Care*, 23 Article 74. <https://doi.org/10.1186/s12875-022-01688-w>