Team-Based Care: Strategies to Optimize Diabetes Care in Your Practice

The American College of Physicians (n.d.) defines team-based care as a "model of care that strives to meet patient needs and preferences by actively engaging patients as full participants in their care while encouraging and supporting all health care professionals to function to the full extent of their education, certification, and licensure." Team-based care strategies can identify those at risk for diabetes and assist in managing diabetes to benefit patient safety and outcomes in every health care setting.

Quality Insights partners with the Delaware Division of Public Health in the Centers for Disease Control and Prevention (CDC) A Strategic Approach to Advancing Health Equity for Priority Populations with or at Risk for Diabetes to provide education and support to participating practices to advance this initiative and improve patient outcomes. Providers and practices actively engaged in this work can schedule a no-cost, annual Workflow Assessment (WFA) with a Quality Insights Practice Transformation Specialist (PTS).

Contact your Quality Insights PTS to explore these workflow modifications and training opportunities that can benefit your practice. If you are not currently working with a PTS and would like assistance, email Ashley Biscardi or call **1-800-642-8686, Ext. 2137**.

Protocol & Workflow Actions	
	Create a protocol that allows care team members to refer patients with diabetes to a Diabetes Self-Management Education and Support (DSMES) program. Establish a multidisciplinary closed-loop referral process with CDC-recognized lifestyle change programs.
	Create an office workflow/protocol to discuss DSMES referrals with all patients living with diabetes. For example, the provider may discuss attending a DSMES program, and a medical assistant may complete the referral information and explain the program to their priority populations.
	Educate the care team about local evidence-based lifestyle change programs. Implement a streamlined referral process to connect individuals with CDC-approved offerings, such as DSMES and the Diabetes Support Program (DSMP).

	Collaborate with Quality Insights in a patient portal message or text campaign for referrals to DSMES or DSMP programs.
	Monitor annual National Quality Forum (NQF) #0059: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) clinical quality measure. Create the report at race/ethnicity level and utilize the CMS Disparities Impact Statement to address disparities.
	All care team members can play a role in addressing social determinants of health (SDOH) and health literacy. Learn more in the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) Implementation and Action Toolkit and consider implementing a standardized workflow utilizing the PRAPARE SDOH Assessment Tool or another assessment tool available in the electronic health record (EHR). Identify positive responses by adding ICD 10 Z-codes and providing community-based organization information to assist the patient.
	Create a workflow in your office to document and address patients' barriers to care (e.g., language, literacy, medication adherence, and SDOH).
	Partner with Quality Insights and the Community Health Worker (CHW) Association of Delaware to utilize a CHW in your practice by integrating a Quality Insights CHW or employing one in the practice.

Practice and Clinical Solutions	
	Review The Team-Based Approach to Enhancing Diabetes Care and Addressing Social Determinants of Health Practice Module at a staff meeting. Discuss how to work to be a high-performing team. Utilize the linked resources for further team development ideas.
	Participate in multi-directional referrals to DSMES programs.

Patient Education Actions	
	Recommend diabetes apps for patients to download and use to help them better manage their diabetes.
	Provide appropriate resources to diabetic patients who have low health literacy.
	Review the Delaware Diabetes Resource Guide made possible by the Delaware Diabetes Coalition in partnership with the Delaware Division of Public Health Diabetes and Heart Disease Prevention & Control Program and the Delaware Division of Services for Aging and Adults with Physical Disabilities.
	Provide materials and information to patients on the Delaware Emergency Medical Diabetes Fund.
	Assess patients' barriers to care (e.g., medication adherence, SDOH, and health literacy) and provide education and follow-up to refine processes.
	Educate priority population patients about local DSMES or DSMP near your practice and provide referrals to patients.

EHR Actions	
	Enable clinical decision support reminders to facilitate proactive measures for screening, testing, and referrals for patients with or at risk for diabetes. Create a DSMES or DSMP referral order/referral in structured data.

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