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

In Pennsylvania, **diabetes is the seventh leading cause of death.** Team-based care strategies can identify those at risk for diabetes and assist in managing diabetes to positively affect patient safety and outcomes in every healthcare setting.

Quality Insights partners with the Pennsylvania Department of Health (PA DOH) 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).

Please contact your Quality Insights Practice Transformation Specialist (PTS) to explore these workflow modifications and/or 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. 137**.

Protocol & Workflow Actions	
	Create a screen-test-refer protocol for patients at-risk for diabetes with the CDC Prediabetes Risk Test and the A1C (fasting glucose) lab test. Refer all patients with a score of 5 or greater on the risk test, an A1C blood test of 5.7% to 6.4%, or a glucose level of 100-125 milligram/deciliter (prediabetes) to the National Diabetes Prevention Program (National DPP).
	Create a protocol that allows care team members to refer patients with diabetes to a Diabetes Self-Management Education and Support (DSMES) program. Find an ADA or ADCES program in your area. Establish a multidisciplinary closed-loop referral process with CDC-recognized lifestyle change programs. Collaborate with Quality Insights in a referral letter, portal message, or text campaign for referrals to programs and community partners to provide support for SDOH positive responses.

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	Create an office workflow/protocol to discuss DSMES referral with all patients living with diabetes. For example, the provider discusses attending a DSMES program and a medical assistant completes the referral information and explains the program with 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 the National DPP, DSMES, and Diabetes Support Program (DSMP).
	Collaborate with your Quality Insights PTS to facilitate a collaborative partnership with a local National DPP and DSMES. Develop an office workflow/protocol to discuss referrals with all patients living with or at risk for diabetes. For example, the PTS and care team develop a workflow that identifies patients eligible for either program and assists with developing a protocol that allows members to refer patients with prediabetes/diabetes to the lifestyle change program best suited for their diagnosis.
	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 Quality Insights SDOH Practice Module and consider implementing a standardized workflow utilizing the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (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. PA Navigate is a new and excellent resource to support the care team and patients.
	Create a workflow in your office to document and address patients' barriers to care (e.g., language, literacy, medication adherence, and SDOH).

Practice & Clinical Solutions

	Review the Quality Insights' DSMES Practice Education Module and "*Key Features of High-Performing Care Teams*" section on page 7 in the Quality Insights Diabetes Care Teams 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.
	Partner with a local DSMES and create a multidirectional referral process to include community-based organizations to address patients' barriers to care (e.g., language, medication adherence, and SDOH). Explore and utilize PA Navigate to support referrals to community-based organizations in your area.

Patient Education Actions	
	Recommend diabetes apps for patients to download and use to help them better manage their diabetes.
	Encourage your patients to take advantage of the CDC Prediabetes Risk Test, available in both English and Spanish. Please consult with your Quality Insights PTS to request laminated or paper copies of the risk test for your office waiting and/or exam rooms.
	Assess patients' barriers to care (e.g., medication adherence, SDOH, and health literacy), and provide education and follow up in order to refine processes.
	Educate priority population patients about local National DPP or DSMES in close proximity to your practice and provide referrals to patients.

Electronic Health Record (EHR) Actions	
	Enable clinical decision support (CDS) reminders to facilitate proactive measures for screen, testing, and referrals for patient with or at-risk for diabetes. Create a referral order/referral in structured data to National DPP, DSMES, or DSMP.