Bridging Gaps: Team Approaches to Diabetes Care, Prevention, and Equity

A Strategic Approach to Advancing Health Equity for Priority Populations with or at Risk for Diabetes

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Purpose of the Module

Quality Insights is dedicated to assisting your healthcare team in preventing and managing prediabetes and type 2 diabetes. Through our partnership with the PA Department of Health (DOH), we offer a wide variety of no-cost services designed to help you improve and reach your quality improvement goals. Quality Insights provides on-site and virtual quality improvement and technical assistance with practice transformation.

We promote improving self-care practices, quality of care, and early detection of complications among people with diabetes. Quality Insights developed this education module to support healthcare professionals in preventing, caring for, and managing diabetes. An emphasis is placed on the benefits of team-based care and the responsibility of assessing and addressing SDOH needs in patient care.

This module is intended for healthcare professionals, including physicians, physician assistants, nurse practitioners, pharmacists, nurses, medical assistants, care managers, social workers, and community health workers who care for patients with prediabetes and diabetes.

Education and Self-Management

Educating patients about disease processes and self-management techniques has shown improvements in health outcomes. People with prediabetes may be able to prevent type 2 diabetes through education and subsequent lifestyle modifications. Similarly, individuals with diabetes can better manage their condition and decrease the incidence of new comorbidities through diet, exercise, monitoring, and medication adherence.

How will patients with diabetes receive the necessary education?

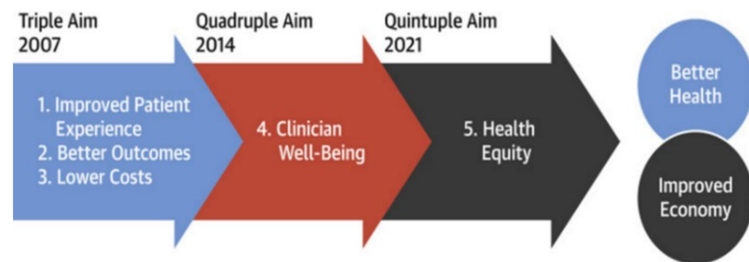
This module provides information on referrals to diabetes education programs, ways to leverage members of the care team, and shares provider and patient resources to improve diabetes outcomes. Apply the information in a way that meets your practice and patient goals.

Note: Guidelines referenced in this module are provided in a summary format. Complete recommendations should be reviewed in the original publication(s) and utilized with physician/clinician judgment, considering a patient's unique needs and circumstances.

Tomorrow's Prevention Today: Partner with Quality Insights

Key practice transformation and quality improvement services offered by Quality Insights include:

1) **Workflow Assessments:** Workflow assessments consist of exploring current workflows, protocols, and processes, including the use of health information technology, team-based care, disease management, and strategies for clinical quality improvement based on ideals within the Quintuple Aim.



Source: National Library of Medicine (NLM), 2021.

2) **Workflow Modifications:** Quality Insights developed evidence-based transformation solutions to increase practices' proactive management of patients with and at risk for type 2 diabetes. Workflow modifications can be located in the appendix of Quality Insights' Practice Education Modules and on the Quality Insights Practice Education Module web page.

3) **Technical Assistance:** Quality Insights' Practice Transformation Specialists are available to support your clinical quality improvement goals and improve value-based care in your practice setting at no cost to the practice.

The Diabetes Epidemic

According to *The Burden of Diabetes in Pennsylvania* (ADA, 2024) and the CDC, "**over 38 million Americans have diabetes** and face its devastating consequences. What is true nationwide is also true in Pennsylvania."

Prediabetes is a risk factor for the development of many chronic conditions, including heart disease, stroke, and diabetes, which in 2022 were reported as the first, fifth, and seventh leading causes of death in PA. (CDC, 2022).

The Status of Diabetes in PA:

11.5% % of the PA adult population who have been diagnosed with diabetes, which is the same as the national percentage.[1]

34.1% % of the PA adult population who have prediabetes.[2]

77 # of CDC-recognized organizations offering the National DPP.[3]

Sources:

1. *America's Health Rankings:* https://www.americashealthrankings.org/explore/measures/Diabetes/PA
2. *The Burden of Diabetes in Pennsylvania, 2023*: https://diabetes.org/sites/default/files/2023-09/ADV_2023_State_Fact_sheets_all_rev_Pennsylvania.pdf
3. *Centers for Disease Control and Prevention: Diabetes Prevention Recognition Program Registry | CDC*

Over 1.1 million Pennsylvania adults have been diagnosed with diabetes.

The statistics are staggering. The incidence of diabetes in PA and across the country continues to rise. **What can be done to combat it?**

The answer: EDUCATION and SELF-MANAGEMENT

Educating patients about disease processes and self-management techniques has been shown to improve health outcomes. Through education and subsequent lifestyle modifications, individuals living with prediabetes may be able to prevent the development of type 2 diabetes, while those with diabetes may be able to help control their disease and decrease the incidence of new comorbidities through diet, exercise, monitoring, and medication adherence.

PA has a State Health Improvement Plan (SHIP) for 2023-2028, which was developed by PA DOH in collaboration with the Healthy Pennsylvania Partnership (HPP). This multi-year strategic plan focuses on health equity, chronic disease prevention, and whole-person care.

Reducing the Diabetes Burden in PA

Diabetes in Pennsylvania: Prevention and Maintenance Programs, 2023 is a biennial report produced by the General Assembly of the Commonwealth of Pennsylvania Joint State Government Commission.

Many of the recommendations in the report are much more achievable when the whole care team is engaged in preventing and treating diabetes. When health professionals come together to care for patients, outcomes, and goals are more attainable. Some key recommendations noted:

- Limit medication step therapy regulations.
- Expand caps on out-of-pocket payments for insulin and other essential diabetes medications.
- Health plans are required to treat insulin and essential blood testing equipment as preventive coverage and require no copays.
- Providers, healthcare systems, and payers should provide patient-centered care.
- Diabetes care is based on Chronic Care Models and Minimally Disruptive Medicine.
- All patients diagnosed with diabetes should have access to DSMES programs.
- Consider network adequacy of programming and increase both DSMES and National DPP availability and include in Managed Care Organization (MCO) contracts.
- Promote diabetes prevention through DPP, including obesity treatment and identification and follow-up for women with gestational diabetes.

Provider resources:

- AMA Diabetes Prevention Toolkit
- CDC Diabetes Self-Management Education and Support Toolkit

Diabetes & Prediabetes Screening: USPSTF Final Recommendations

In August 2021, the USPSTF released a final recommendation statement calling for prediabetes and type 2 diabetes screening for nonpregnant, asymptomatic adults aged 35 to 70 years who are overweight or obese (body mass index ≥ 25 and ≥ 30, respectively).

Based on data from 89 publications, the recommendations also suggested offering or referring patients with prediabetes to preventive interventions.

The summary recommendation for clinicians is provided in Table 1 on page 8.

Quality Insights

Table 1. USPSTF Final Recommendation on Screening for Prediabetes and Type 2 Diabetes, 2021

What does the USPSTF recommend?	**Adults aged 35 to 70 years who have overweight or obesity:** • **Screen** for prediabetes and type 2 diabetes, and offer or refer patients with prediabetes to effective preventive interventions. **Grade: B**
To whom does this recommendation apply?	Nonpregnant adults aged 35 to 70 years who have overweight or obesity and no symptoms of diabetes.
What's new?	The USPSTF has lowered the starting age of screening from 40 to 35 years.
How to implement this recommendation?	1. Assess risk: • Obtain height and weight measurements to determine whether patient has overweight or obesity. Overweight and obesity are defined as a BMI ≥25 and ≥30, respectively. 2. Screen: • If the patient is aged 35 to 70 years and has overweight or obesity. Consider screening at an earlier age if the patient is from a population with a disproportionately high prevalence of diabetes (American Indian/Alaska Native, Black, Hawaiian/Pacific Islander, Hispanic/Latino), and at a lower BMI (≥23) if the patient is Asian American. • Screening tests for prediabetes and type 2 diabetes include measurement of fasting plasma glucose or HbA_{1c} level or an oral glucose tolerance test.
How often?	The optimal screening interval for adults with an initial normal glucose test result is uncertain. Screening every 3 years may be a reasonable approach for adults with normal blood glucose levels.
What are other relevant USPSTF recommendations?	The USPSTF has made a recommendation on behavioral weight loss interventions to prevent obesity-related morbidity and mortality in adults with a BMI ≥30. This recommendation is available at https://www.uspreventiveservicestaskforce.org
Where to read the full recommendation statement?	Visit the USPSTF website (https://www.uspreventiveservicestaskforce.org) to read the full recommendation statement. This includes more details on the rationale of the recommendation, including benefits and harms; supporting evidence; and recommendations of others.

The USPSTF recognizes that clinical decisions involve more considerations than evidence alone. Clinicians should understand the evidence but individualize decision-making to the specific patient or situation.

Source: Screening for Prediabetes and Type 2 Diabetes: U.S. Preventive Services Task Force Recommendation Statement, USPSTF, 2021.

The National Association of Chronic Disease Directors (NACDD) created a handout of frequently asked questions about the USPSTF recommendation. Comparison with the 2022 ADA screening recommendations is specifically addressed.

At-Risk for Prediabetes or Diabetes Screening and Diagnosis Criteria

As a Healthy People 2030 Champion, Quality Insights is committed to achieving Healthy People 2030's vision, a society where all people can achieve their full potential for health and well-being across the lifespan. Healthy People 2030 has three objectives relevant to this module: one that speaks to undiagnosed diabetes, another that addresses a new diagnosis of diabetes, and a third that encourages completion of type 2 diabetes prevention programs.

Objective D-02 targets reducing the proportion of adults who unknowingly have prediabetes to 33.2%, with 2013-2016 data reflecting that 38% of adults had undiagnosed prediabetes. Reducing the number of diabetes cases diagnosed yearly is the goal of objective D-01. This particular objective is also one of 23 Leading Health Indicators (LHI), a subset of high-priority objectives that impact significant causes of death and disease in the U.S. Data from 2019-2021 reflects 5.5 new cases of diabetes per 1,000 adults, and the target is 4.8 per 1,000.

Also, directly relevant to prediabetes is a third objective, D-D01, which is currently in developmental status. There are evidence-based interventions to address the objective of increasing the proportion of eligible people completing CDC-recognized type 2 diabetes prevention programs; however, baseline data is not yet available. Other related objectives include reducing the proportion of adults with high blood pressure, reducing coronary heart disease deaths, improving cardiovascular health in adults, reducing stroke deaths, and reducing consumption of added sugars by people aged two years and over, also an LHI.

The United States has a diabetes prevention action plan. The estimated number of adults (age 18 and over) diagnosed in the U.S. in 2021 was 29.7 million. The 2021 total (diagnosed and undiagnosed) estimated prevalence was 11.6 percent (38.4 million people). An estimated 97.6 million adults over 18 had prediabetes in 2021 (CDC, 2024).

More recently, the ADA outlined the criteria for testing for prediabetes and/or type 2 diabetes in asymptomatic adults in the Standards of Care in Diabetes - 2024 (p. S27).

Table 2. ADA Standards of Care Prediabetes and Type 2 Diabetes Testing Criteria, 2024

<table>
<tr><td>1</td><td>Testing should be considered in adults with overweight or obesity (BMI ≥25 kg/m^2 or ≥23 kg/m^2 in Asian American individuals) who have one or more of the following risk factors:

First-degree relative with diabetes
High-risk race/ethnicity (e.g., African American, Latino, Native American, Asian American, Pacific Islander)
History of cardiovascular disease (CVD)
Hypertension (≥130/80 mmHg or on therapy for hypertension)
HDL cholesterol level <35 mg/dL (0.90 mmol/L) and/or a triglyceride level >250 mg/dL (2.82 mmol/L)
Individuals with polycystic ovary syndrome
Physical inactivity
Other clinical conditions associated with insulin resistance (e.g., severe obesity, acanthosis nigricans)
</td></tr>
</table>

2	People with prediabetes (A1C ≥ 5.7 % [39 mmol/mol], IGT [impaired glucose tolerance], or IFG [impaired fasting glucose] should be tested yearly.
3	People who were diagnosed with gestational diabetes mellitus should have lifelong testing at least every three years.
4	For all other people, testing should begin at the age of 35 years.
5	If results are normal, testing should be repeated at a minimum of three-year intervals, with consideration of more frequent testing depending on initial results and risk status.
6	People with HIV, exposure to high-risk medicines, and a history of pancreatitis.

Adapted from ADA Standards of Care in Diabetes – 2024, El Sayed et al., 2023.

Blood testing is the most accurate way to determine if a patient has prediabetes. Any of the following results shown in Table 3 will confirm a diagnosis of prediabetes.

Table 3. Guidelines for Diagnosing Prediabetes Via Blood Testing

Test	Prediabetes	Diabetes
A1C	5.7 – 6.4% (39-47 mmol/mol)	≥6.5% (48 mmol/mol)*
FPG (Fasting Plasma Glucose)	100-125 mg/dL (5.6-6.9 mmol/L)	≥126 mg/dL (7.0 mmol/L)*
OGTT (Oral Glucose Tolerance Test)	140-199 mg/dL (7.8-11.0 mmol/L)	≥200 mg/dL (11.1 mmol/L)*
RPG (Random Plasma Glucose)		≥200 mg/dL (11.1 mmol/L)**
*In the absence of unequivocal hyperglycemia, diagnosis requires **two** abnormal test results from the same sample or in two separate test samples.		
**Only diagnostic in a patient with classic symptoms of hyperglycemia or hyperglycemic crisis.		

Adapted from Standards of Care in Diabetes – 2024, El Sayed et al., pages S21 & S25, 2023.

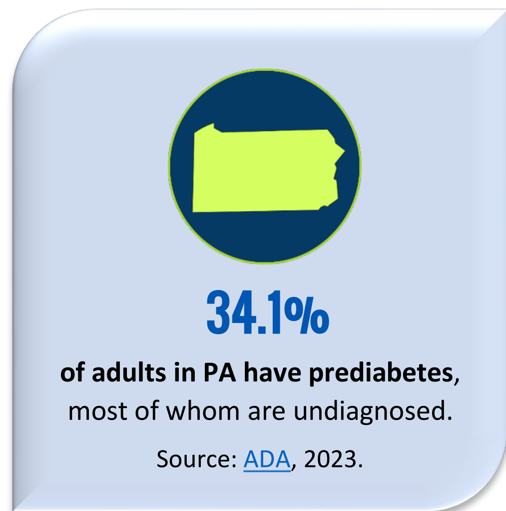
Screen for prediabetes today to help prevent diabetes tomorrow.

Offer the Prediabetes Risk Test to assist patients to help determine their risk for prediabetes. Available in English and Spanish, and available in print or online, this one-minute screening tool can be completed at a medical appointment or digitally via patient portal, text, or email.

Prediabetes-Related ICD-10 Codes

The AMA provides a myriad of helpful resources related to prediabetes, including a list of commonly used Current Procedural Terminology (CPT) and International Classification of Diseases (ICD) codes that are useful for prediabetes screening, answers to common CPT questions related to National DPP, and various tools for the health care team to facilitate screening, patient education, prediabetes management, billing and reimbursement, and referrals to CDC-recognized lifestyle change programs.

The ICD-10 diagnosis code used to identify people with prediabetes is **R73.03.**



34.1%

of adults in PA have prediabetes, most of whom are undiagnosed.

Source: ADA, 2023.

Evidence-Based Intervention: The National DPP

The progression from prediabetes to diabetes can be prevented or delayed with modest weight loss, engagement in at least 150 minutes of physical activity per week, and an improved diet. The CDC-led National DPP is a cost-effective program with proven success at helping people make the lifestyle changes needed to prevent or delay type 2 diabetes. Evidence shows that program participants can reduce their risk of developing type 2 diabetes by 58%, or 71% for those 60 years of age and older.

CDC-recognized lifestyle change programs provide approximately 24 hours of diabetes prevention instruction. Classes are accessible virtually or in person. While provider referrals are not required,

patients are more likely to enroll in a National DPP when they receive a recommendation from a trusted clinician.

In the first 6 months:

Participants meet weekly for one hour to learn to:

- Eat healthy without giving up all the foods they love
- Add physical activity to their busy schedules
- Manage stress
- Cope with challenges that can derail their hard work, like how to choose healthy food when eating out
- Get back on track if they stray from their plan — because everyone slips now and then (CDC, 2024).

In the second 6 months:

- Participants will meet once or twice a month for one hour to build on the skills they've learned and to maintain their positive changes. They will review key concepts such as setting goals, tracking food and physical activity, staying motivated, and overcoming barriers. The second six months are essential to help your patients stick with new habits (CDC, 2024).

Referring Patients to National DPP: Online or In-Person

Program Eligibility

Table 4. National Diabetes Prevention Program Eligibility

To participate in a CDC-recognized lifestyle change program, patients will need to meet ALL FOUR of these requirements:
1. Be 18 years or older. 2. Have a body mass index (BMI) of 25 or higher (23 or higher if Asian American). 3. Not be previously diagnosed with type 1 or type 2 diabetes. 4. Not be pregnant.
Patients will also need to meet ONE of these requirements (unless they are enrolling in the Medicare Diabetes Prevention Program, which has different criteria)**:**

1. Had a blood test result in the prediabetes range within the past year (includes **any** of these tests and results):
    - Hemoglobin A1C: 5.7-6.4%
    - Fasting plasma glucose: 100-125 mg/dL
    - Two-hour plasma glucose (after a 75 g glucose load): 140-199 mg/dL
2. Be previously diagnosed with gestational diabetes.
3. Received a high-risk result (score of 5 or higher) on the Prediabetes Risk Test.

Adapted from Program Eligibility, CDC, 2024.

CDC-recognized National DPPs are available statewide.

Find nearby locations by reviewing these online resources:

- CDC National DPP Locator Tool
- Young Men's Christian Association (YMCA) National DPP website)

Medicare Beneficiary Eligibility

The Medicare Diabetes Prevention Program (MDPP) allows Medicare beneficiaries to access evidence-based diabetes prevention services that aim to facilitate weight reduction, lower healthcare expenditures, and improve health outcomes.

Table 5. CDC National DPP Eligibility Requirements for Medicare Beneficiaries, 2022

Medicare beneficiaries will need to meet these eligibility requirements to participate:

• Enrollment in Medicare Part B through original Medicare (fee-for-service) or a Medicare Advantage (MA) plan.
• Body mass index (BMI) of 25 or higher (23 or higher if you self-identify as Asian).
• Results from any one of these three blood tests within a year of starting the program:
  ○ Fasting plasma glucose test result of 110-125 mg/dL
  ○ Oral glucose tolerance test result of 140-199 mg/dL
  ○ HbA1C test result of 5.7%-6.4%
• No history of type 1 or type 2 diabetes (gestational diabetes is acceptable).
• No current end-stage kidney disease.

Adapted from Preventing Type 2 Diabetes with Medicare, CDC, 2024.

Eligible patients may enroll in MDPP today and start making healthy changes. Check to see if a program is near you on this list of providers, or search by zip code.

Health Promotion Council: Your Gateway to CDC Recognition and Beyond!

Since 2020, the Health Promotion Council (HPC) has been recognized as a CDC Umbrella Hub Organization (UHO) in PA. This designation underscores the Council's commitment to health promotion and signifies its ability to offer a range of essential services to its partners.

What Does This Mean for You? The HPC is an approved MDPP supplier in PA. The UHO provided by HPC can be your guide to establishing your National DPP, obtaining CDC recognition, and streamlining billing processes. They offer three levels of service: contracts and payer management, data administration and technical assistance, and CDC Diabetes Prevention Recognition Program Registry (DPRP) liaison.

Quality Insights is committed to onboarding subsidiary organizations and facilitating efforts to increase access to and referrals for the National DPP. For more information about future opportunities for practices to receive support from the Pennsylvania Umbrella Hub, contact Eric Bumbaca with the HPC.

Latino Connection and National DPP

Latino Connection states, "Pennsylvania ranks #13 in the nation in total Hispanic population with over one million residents of Latino/Hispanic origin." Latino Connection is a National DPP provider and has expanded the CDC's program to include lifestyle coaching and community health workers, weekly telephonic coaching sessions, weekly incentives for each class attended, and inclusion of not only those with prediabetes but also children and families of participants. They report excellent recruitment and retention rates due to the methods mentioned.

Patient-facing resources:

- Recruitment Flyer
- ¡Vive Tu Mejor Vida Ahora! Booklet
- Live Your Best Life Now! Booklet

AMA Diabetes Prevention Toolkit

The AMA Diabetes Prevention Toolkit provides resources for patients and care team members to aid in the education, promotion, outreach, and implementation associated with diabetes prevention strategies. A few toolkit resources include:

- Optimize Your EHR to Prevent Type 2 Diabetes
- Prediabetes Identification and Management Protocols
- Promoting Prediabetes Awareness to Your Patients (English and Spanish)
- Sample Patient Letters and more to conduct follow-up and referral of patients who have been identified as having prediabetes

Patient Education Resources in Multiple Languages

- The ADA Patient Education Library provides prediabetes and diabetes education resources that can be downloaded for free (after registration) in Arabic, Chinese, English, French, Haitian Creole, Korean, Portuguese, Russian, Spanish, Tagalog, and Vietnamese.
- MedlinePlus® is a service of the National Library of Medicine (NLM) and an online health information resource for patients and members of their support system. Information is offered in both English and Spanish. Review the prediabetes resources. Using the *Health Information in Multiple Languages* web page, one may browse the resources that are available in a variety of other languages.
- *Public Libraries: Health Information in Multiple Languages* is an NLM web page containing links to health information education websites that provide information in various languages.

Additional Patient Resources

- What is Prediabetes? (also available in Spanish)
- So You Have Prediabetes…Now What? (also available in Spanish)
- Prediabetes: What Is It and What Can I Do?
- Your Game Plan to Prevent Type 2 Diabetes

Need assistance? Let Quality Insights do the work for you!

If you need help locating a National DPP or MDPP in your area, please contact your Quality Insights Practice Transformation Specialist or email Ashley Biscardi.

Evidence Confirms: DSMES Improves Health Outcomes

DSMES is an evidence-based program recognized by the ADA or accredited through the Association of Diabetes Care and Education Specialists (ADCES). DSMES provides a foundation to empower people with diabetes to navigate self-management decisions and activities. The updated consensus statement from the ADA and the European Association for the Study of Diabetes asserts that "DSMES is a key intervention, as important to the treatment plan as the selection of pharmacotherapy" (Davies et al., 2022).

According to a 2020 Consensus Report, **DSMES has been** shown to improve health outcomes and is considered a critical component of diabetes care. Participation in a DSMES program "lowers hemoglobin A1C (A1C) by at least 0.6%, as much as many diabetes medications – however, with no side effects" (Davis et al., 2022). Recognized as a cost-effective tool as a result of reduced hospital admissions and readmissions, this program is also known to improve medication adherence rates, enhance self-efficacy, increase physical activity, and result in less severe diabetes-related complications (CDC, 2024).

How can DSMES services help your patients manage diabetes?

The CDC highlights several success stories of patients who have participated in DSMES and achieved decreased blood glucose levels, a healthier lifestyle, and a better understanding of how to live with diabetes.

Despite the positive results of DSMES programs, according to the CDC (2024), "**less than 5% of Medicare beneficiaries with diabetes and 6.8% of privately insured people with diagnosed diabetes have used DSMES services**." Data from the PA DOH (2021) reveal that a substantial gap still exists statewide, as only 52% of Pennsylvanians with diabetes have taken a class on how to self-manage their disease.

Discover more about the efficacy and benefits of DSMES by reviewing these resources:

- Podcast – Benefits of Diabetes Educator Referrals
- Diabetes Self-Management Education and Support in Adults with Type 2 Diabetes: A Consensus Report

DSMES Referral Solutions

In keeping with the new Standards of Care in Diabetes - 2024, "Essential to achieving these goals are DSMES, medical nutrition therapy (MNT), routine physical activity, counseling and treatment to support cessation of tobacco products and vaping, health behavior counseling, and psychosocial care."

They additionally state that "the overall objectives of DSMES are to support informed decision-making, self-care behaviors, problem-solving, and active collaboration with the health care team to improve clinical outcomes, health status, and well-being in a cost-effective manner" (ADA, 2023).

Further, the Standards recommend evaluating the need for DSMES at the following times: at diagnosis, annually or when not meeting goals, when complications develop, and when life or care transitions occur (ADA, 2023).

Quality Insights can help!
Contact our team today to see how Quality Insights can strengthen your practice and bridge the referral gap between patients living with diabetes and DSMES.

Medical Nutrition Therapy

For many individuals with diabetes, the most challenging part of the treatment plan is diet. Nutrition therapy plays an integral role in overall diabetes management. The 2024 Standards refer to the 2019 ADA *Diabetes Care* article on nutrition therapy, citing that all individuals with diabetes should be referred for "individualized MNT provided by a registered dietitian nutritionist (RD/RDN) who is knowledgeable and skilled in providing diabetes-specific MNT at diagnosis and as needed throughout the life span, similar to DSMES."

Find more information about MNT, including Medicare considerations, by visiting the CDC DSMES Toolkit website.

Patient-facing nutrition resources can be located on the ADA website.

The following DSMES referral guidance is based on recommendations from the ADCES.

Locate a DSMES Program

Certified DSMES programs are those that have ADA recognition or ADCES accreditation, which ensures the program meets the evidence-based National Standards for DSMES.

The following websites offer DSMES location assistance and contact information:

- Association of Diabetes Care & Education Specialists
- American Diabetes Association
- PA Pharmacists Association

Quality Insights can help you locate a DSMES near you.

Promote DSMES Education

Provide **free** resources to your patients to help them understand their diagnosis and reinforce the importance of diabetes education.

Diabetes Education is for You: Download and share this flyer with your patients who are eligible for a DSMES referral.

Living with Type 2 Diabetes: Where Do I Begin?: This ADA booklet may be ordered in English or Spanish for free.

Diabetes in Older People: This booklet from the National Institute on Aging (NIA) promotes diabetes education services as covered by Medicare (DSMT).

Offer DSMES in Your Local Community

Want to learn more about the steps required to launch a DSMES in your community?

Access the CDC DSMES Toolkit for important details about accreditation, recognition, reimbursement, and more.

Make a Referral

Learn more about when, how, and for whom to make referrals to DSMES!

Visit the Know Diabetes by Heart™ "DSMES Services" and the ADCES "Make a Referral" websites.

PA Nutrition Education Network

The Pennsylvania Nutrition Education Network (PA NEN) works with individuals and organizations to provide evidence-based nutrition education and resources, primarily for low-income populations throughout PA. PA NEN offers engaging resources and tools that support patients in preparing healthy meals, increasing physical activity, and improving overall well-being. Search tools are provided to aid with locating nearby nutrition classes and food assistance.

Multilingual Diabetes Patient Education Materials

The ADA Patient Education Library offers free, downloadable diabetes education resources that can be filtered by category and language. Eleven language options are available, including Spanish and Haitian Creole.

Some items to select from include:

- Prediabetes: What Is It and What Can I Do?
- Are You at Risk for Type 2 Diabetes?
- Factors Affecting Blood Glucose
- Diabetes: An Introduction
- Diabetes Symptoms (describes symptoms of Type 1 and Type 2 diabetes)

For additional multilingual education resources covering a variety of health topics, please visit MedlinePlus® (arranged by language). EthnoMed also provides diabetes resources that can be filtered by language.

AMA STEPS Forward® Team-Based Care and Workflow Toolkit

AMA STEPS Forward® offers a collection of educational toolkits that provide a framework for transforming and improving your practice. Toolkits include steps for implementation, informative question-and-answer sections, success stories, and links to applicable resources. Some toolkits offer CME credit. Enhance your care team's delivery of diabetes care by completing these modules:

- Managing Type 2 Diabetes: A Team-Based Approach
- Sharing Clinical Notes with Patients: A New Era of Transparency in Medicine
- Pre-Visit Planning: Save Time, Improve Care, and Strengthen Care Team Satisfaction
- Racial and Health Equity: Concrete STEPS for Smaller Practices
- SDOH: Improve Health Outcomes Beyond the Clinic Walls
- Medication Adherence: Improve Patient Outcomes and Reduce Cost

ADA's Focus on Diabetes® Initiative

Focus on Diabetes® is a collaborative initiative between the ADA and Visionary Partners to increase awareness about diabetes-related eye disease (DRD) and its associated personal and economic costs.

Annual eye exams are a critical part of diabetes care. "Early detection, timely treatment, and appropriate follow-up care can reduce a person's risk for severe vision loss from diabetic eye disease by 95%," according to the ADA.

Below are some helpful resources:

- For additional facts about DRD and those at greatest risk, view this 2022 flyer from the ADA.
- To emphasize the value of annual eye exams, the free RetinaRisk™ calculator may be a useful tool. The tool could be incorporated into office visit discussions, as a recent blood pressure measurement and hemoglobin A1C are needed for the calculator.
- Read the ADA article "A Practical Guide to Diabetes-Related Eye Care" or listen to the podcast series.

Setting the Table: What is Team-Based Care?

Healthcare is changing rapidly. The post-COVID-19 pandemic era, in combination with the shift from fee-for-service payment to value-based-service payment (which rewards providers for the quality of care provided) models, highlights the importance of a team approach to improving health, promoting preventive care of individuals and populations, and improving the safety, quality, and efficiency of health care delivery.

> *"We know that team-based care leads to better outcomes for patients and better experience for staff. It is one of the most effective things you can do to improve all aspects of care delivery."*
>
> Source: CMS, 2024.

The AMA defines team-based care as "a collaborative system in which team members share responsibilities to achieve high-quality and efficient patient care"(2015). In this model, physicians, physician assistants, nurse practitioners, pharmacists, nurses, medical assistants, care managers, social workers, community health workers, and other healthcare professionals coordinate responsibilities such as pre-visit planning, expanded intake activities, medication reconciliation, updating patient information, and scribing to the full extent of their licensure to provide more comprehensive patient care. The patient is at the center of the care team, and each provider plays

a role in caring for and treating the patient. This dynamic plays a crucial role in diabetes care and prevention.

Key Features of High-Performing Teams

According to the American Hospital Association (AHA)(2021), "Even before COVID-19, the rapid pace of change in healthcare was significantly contributing to burnout".. While provider burnout is not new, the COVID-19 pandemic highlighted the challenges faced when administrative burden, sub-optimal communication systems, and unbalanced teams collide with an extended crisis.

Several studies have shown that efficient and effective team-based care support of high-functioning teams and their link to increased physician well-being and their cost-effectiveness results in reduced emergency department utilization and hospital readmissions. A 2022 study published by the Journal of General Internal Medicine found that physicians and nurses who operated in an effective team experienced lower workplace isolation and burnout levels. Participants also offered recommendations, including "creating consistent care teams, expanding interdisciplinary team members, and increasing clinical support staffing."

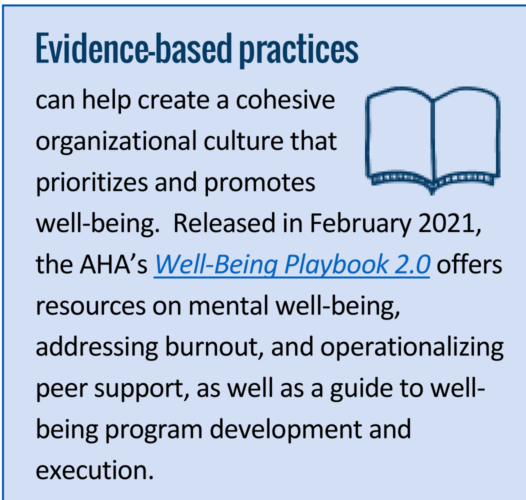


Table 6 highlights the components and qualities that characterize high-performing teams and how they offload provider workloads.

Table 6. Principles of High-Performing Teams

Principle	Definition	Impact on Clinician Well-Being
Shared Goals	The team establishes shared goals that all members can clearly articulate, understand, and support.	Shared goals lead to division of work and ownership across the team, reducing provider burden.
Clear Roles	Clear expectations for each team member's function, responsibilities, and accountabilities to optimize team efficiency and effectiveness.	Role clarity has been associated with improved clinician well-being. A fully staffed team that is not over patient capacity is associated with decreased burnout.

Mutual Trust (psychological safety)	Team members trust one another and feel safe enough within the team to admit a mistake, ask a question, offer new data, or try a new skill without fear of embarrassment or punishment.	A strong team climate promotes clinician well-being and member retention.
Effective Communication	The team prioritizes and continuously refines its communication skills and has consistent channels for efficient, bidirectional communication.	Effective communication is associated with decreased clinician burnout. Participatory decision-making is associated with lower burnout scores.
Measurable Processes and Outcomes	Reliable and ongoing assessment of team structure, function, and performance that is provided as actionable feedback to all team members to improve performance.	Emotional exhaustion is associated with low personal accomplishment, so reiterating accomplishments could decrease burnout.

Adapted from "Implementing Optimal Team-Based Care to Reduce Clinician Burnout" by Smith et al., 2018.

Effective leadership is key to a successful team. AMA recommends physician-led team-based care in which "members of the team share information and assist in decision making based on their unique skills – all with the common goal of providing the safest, best possible care to patients." The care delivery model will vary based on the clinical situation and the team's composition.

Interdisciplinary Team Roles in Diabetes Management

The most important care team member is the patient living with diabetes. With appropriate support, motivation, a trusting, collaborative relationship, positive behaviors, and effective communication, the patient can achieve optimal outcomes from care team interactions.

The ADA's *Standards of Care in Diabetes – 2024* (*Standards)* recognize care teams' important role in optimal diabetes management. Ideally, care teams function best when they are:

- Patient-centered
- Void of therapeutic inertia (failure to initiate or intensify therapy when therapeutic goals are not reached)
- Providing timely and appropriate lifestyle and/or pharmacologic therapy intensification for patients without the recommended metabolic targets.

According to the ADA *Standards*,

- There are a variety of psychosocial factors that influence living with diabetes, and this presents obstacles to individuals and their families.
- There is a place for healthcare professionals to monitor these psychosocial factors, and qualified behavioral health professionals can be incorporated into the care team.

Nurses, medical assistants, and case managers also play an integral role. They can provide diabetes education, perform medication reconciliations, and connect people with diabetes to resources and programs to help them manage their condition and live healthier lives.

In addition to care team members within the primary care setting, patients with diabetes will have an extended care team of specialists, as outlined in Table 7 (CDC, 2024).

Table 7. Extended Diabetes Care Team Members and Roles

Contributor	Role
Diabetes Care and Education Specialist	Provides DSMES; assists in increasing knowledge and decision-making skills; creates an individualized plan for diabetes management based on health needs, lifestyle, and culture.
Registered Dietitian	A dietitian is a nutrition expert. They can help you develop healthy eating patterns to improve your overall health. They also help patients: • Reach and maintain body weight goals. • Reach blood sugar, blood pressure, and cholesterol goals. • Delay or prevent diabetes complications.
Ophthalmologist or Optometrist	Perform routine diabetic eye exams to diagnose diabetic retinopathy and improve or manage eye health.
Podiatrist	Treat the feet and lower legs where diabetes can harm blood vessels and nerves, leading to persistent wounds. People living with diabetes should see a podiatrist at least yearly to prevent chronic issues.
Audiologist	Specializing in hearing and balance disorders, people with diabetes should have a hearing screen performed at diagnosis and follow-up with an audiologist at least yearly.
Dentist	People living with diabetes are at higher risk for gum disease and should visit the dentist at least yearly.
Nephrologist	Diabetes can damage the kidneys over time. People living with diabetes may be referred to a nephrologist based on lab results that represent kidney function.

Source: The Diabetes Care Team, CDC, 2024

AMA STEPS Forward® Team-Based Care and Workflow Toolkit

AMA STEPS Forward® Team-Based Care and Workflow Toolkit includes the *Saving Time Playbook* and several modules to assist organizations in implementing team-based care, sharing responsibilities, and facilitating better and more timely care. The major themes discussed in the *Saving Time Playbook* include stopping unnecessary work, sharing the necessary work, and making the case for leadership.

Some of the associated toolkit modules include:

- Team-Based Care of Type 2 Diabetes and Prediabetes: Approaches to Help Patients Reach Their Glycemic Goals
- Patient Care Registries: Proactively Manage Chronic Conditions
- Medication Adherence
- Pre-Visit Planning: Save Time, Improve Care, and Strengthen Care Team Satisfaction
- Daily Team Huddles: Boost Productivity and Teamwork
- Team Documentation: Improve Efficiency of EHR Documentation
- Telemedicine and Team-Based Care: Improve Patient Care and Team Engagement by Using Team-Based Care in Telemedicine

Engaging a Pharmacist as Part of the Care Team

A February 2021 commentary feature in *The Journal of the American Board of Family Medicine* reports that pharmacists are well prepared to serve in primary care settings as part of the care team, providing clinical patient care services. Pharmacists can specifically serve as a drug information resource for patients and staff while providing patient education on the management of chronic disease states. This feature also reports that "by the year 2032, there will be a shortage of 21,100 to 55,200 primary care physicians in the United States."

Adding additional health professionals to the care team and allowing all team members to function within their training, credentials, and licensure limits can support this shortage. **"Pharmacists are health professionals that can be utilized to ensure patients receive adequate care in primary care settings"** (Moreau, 2021).

The AMA also affirms pharmacists and pharmacy technicians as valuable contributors to a team-based care model. AMA's Steps Forward™ module, *Embedding Pharmacists into the Practice*, assists pharmacists in collaborating to improve patient outcomes.

Some ways pharmacists can assist your practice with diabetes management are:

- Optimize drug therapy according to agreed-upon protocols.
- Advise on substituting medications with safer and/or less costly alternatives.
- Manage drug interactions.
- Improve patient and team education.
- Improve medication adherence.

The PPCN works to enable and support quality pharmacy care and outcomes in collaboration with patients, practitioners, and stakeholders involved in overall patient care. PPCN pharmacists are highly trained, motivated, and committed to delivering high-quality patient care through comprehensive medication management. PPCN's network of pharmacies reaches across PA.

Find a PPCN Pharmacy and become a member to access the variety of resources PPCN offers.

Pharmacy-Based National DPP

Pharmacies in your local community may offer National DPP services. Providers can locate these programs by visiting the CDC website or utilizing the search tool on the Pennsylvania Pharmacists Association website. Encourage your patients to connect with their local pharmacist to discuss enrollment in these evidence-based lifestyle change programs by sharing the following infographics developed by the CDC:

- Prediabetes: Could It Be You? (English)
- Prediabetes: Could It Be You? (Spanish)

Learn how pharmacists can participate and access the "Rx for the National Diabetes Prevention Program: Action Guide for Community Pharmacists," which is designed to help community pharmacists and members of the pharmacy workforce reach people at high risk of developing type 2 diabetes who could benefit from the National DPP lifestyle change program.

Take the Next Step: Access the following resources to learn how you can promote optimal diabetes care and prevention to the patients you serve through enhanced care team collaboration.

- Patient Resource, ADA: Get to Know Your Diabetes Care Team

Understanding SDOH

SDOH are "the non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems" (World Health Organization (WHO), 2025).

SDOH factors influence health inequities – unfair and avoidable differences in health status seen within and between towns, cities, states, and countries. A social pattern has emerged regarding SDOH; the lower the socioeconomic position, the worse the health (WHO, 2025).

SDOH can include, but are not limited to, the following:

- Income and social protection
- Education
- Unemployment and job insecurity
- Working life conditions
- Food insecurity
- Housing, basic amenities, and the environment
- Early childhood development
- Social inclusion and non-discrimination
- Structural conflict
- Access to affordable health services of decent quality.

Assessing and addressing SDOH is crucial for improving health outcomes, especially for those living with chronic disease, and combating and reducing inequities.

Diabetes and SDOH: ADA Publications

"Putting the person, rather than their diabetes, at the center of healthcare can help improve person-provider relationships and physical and mental health outcomes" (Kenney & Briskin, 2022). The ADA continues to recognize the critical role that SDOH and patient-centered care play in the health outcomes of those with diabetes (2022).

> *I have come to realize that meaningful change in the numbers and in the lives of people with diabetes hinges on improving upon the social determinants of health.*

Source: *Diabetes is Not Just an Outcome*, Paul Reed, MD, Deputy Assistant Secretary for Health, Director, Office of Disease Prevention and Health Promotion, 2021.

The ADA convened a writing committee to help advance opportunities for diabetes population health improvement through addressing SDOH. The SDOH and diabetes writing committee reviewed the literature on: "1) associations of SDOH with diabetes risk and outcomes and 2) impact of interventions targeting amelioration of SDOH on diabetes outcomes" (Hill-Briggs et al., 2020). Read the scientific review in ADA's *Diabetes Care* to learn more.

In *Diabetes Care 2023*, an overview of SDOH in the development of diabetes was examined.

The review states that their objectives are (Hills-Briggs & Fitzpatrick, 2023):

1. To give an overview of the socioeconomic status of SDOH and racism in the development of diabetes.
2. To discuss racism and socioeconomic and political systems and key additional upstream drivers of SDOH that need attention within U.S. governmental SDOH frameworks.
3. To demonstrate the role of these drivers in the cyclical, intergenerational, and population-based nature of SDOH.
4. To examine current and emerging actions within and beyond the healthcare sector to mitigate adverse SDOH.

The overview found that "current data reaffirm longstanding associations of low socioeconomic status and non-White race/ethnicity with higher diabetes prevalence and incidence" (Hill-Briggs & Fitzpatrick, 2023). The findings also support adding racism and socioeconomic and political context to SDOH frameworks as SDOH root causes and drivers.

Care Team Workflow for PRAPARE Tool Utilization and Other SDOH Assessments

Optimal care team management requires the recognition of SDOH's role in successful disease management. Medical care is estimated to account for 10 to 20 percent of a person's health, while non-medical factors (SDOH) account for the remaining 80 to 90% (Magnan, 2017). Healthcare organizations nationwide are increasingly looking to integrate SDOH and health equity into value-based strategies. Organizations must identify social needs via screening tools, implement standardized, closed-loop workflows, and connect patients to local assistance resources to achieve the Quintuple Aim, described by Oyekan et al. (2022) as "better care; healthier people; smarter spending; care team well-being; and health equity."

The PRAPARE tool is a national standardized tool designed to aid healthcare and community-based organizations in assessing SDOH to improve health equity.

A successful, integrated workflow that prioritizes SDOH screening, coding, and referrals to community resources necessitates the coordination of the entire care team. Access the following resources to learn more about the PRAPARE tool and find workflow recommendations:

- PRAPARE Implementation and Action Toolkit - See Chapter 5 for workflow implementation.

SDOH Podcast

For additional information on the value of screening for SDOH, listen to the February 2023 AMA STEPS Forward® Podcast: *The Importance of Screening for Social Determinants of Health*.

Health Disparities: Racial and Ethnic Minorities are at Higher Risk for Developing Diabetes

The CDC National Diabetes Report confirms that racial and ethnic minority Americans had a higher prevalence of diagnosed diabetes with American Indian or Alaska Native, non-Hispanic crude prevalence at 16% and Black, non-Hispanic at 12.5%.

According to 2023 data in the Joint State Commission Diabetes in Pennsylvania: Prevention and Maintenance Programs, Black/non-Hispanic Pennsylvanians experience diabetes at a rate significantly higher at 17.4%, followed by the Asian/non-Hispanic group (16.7%), the Hispanic group (15.5%), and the White group/non-Hispanic group (13.6%). Many who are diagnosed experience challenges managing their diabetes and are more likely to experience complications.

Below are a few resources to help healthcare professionals, patients, and their families manage diabetes. To review the full suite of online tools, visit the CMS OMH website.

- As of January 2023, following the implementation of the Inflation Reduction Act, insulin products are capped at $35 per month per product under a Medicare prescription drug plan. Part D deductibles do not apply to these covered insulin products. Visit Medicare.gov for more information for patients needing assistance comparing Medicare plans and associated insulin costs.
- Review the Diabetes Management: Directory of Provider Resources guide from CMS OMH to identify valuable resources for providers and care teams on managing type 2 diabetes.
- Download Managing Diabetes: Medicare Coverage and Resources, an updated resource that provides steps for improving one's health and information on services available through Marketplace plans and Medicare. This resource is also available in seven additional languages.

Explore PA Navigate

PA Navigate is an online tool supported by the PA Department of Human Services (DHS). According to a PA Pressroom article published on January 23, 2024, PA Navigate aims to connect individuals with community-based organizations, government agencies, and healthcare providers to address fundamental needs such as food, shelter, and transportation. The tool facilitates referrals and self-referrals to improve communication between healthcare providers and organizations supporting shared populations.

The objective is to bridge the gap between healthcare and social services, especially considering the multifaceted factors influencing an individual's well-being. PA Navigate also collects data to comprehend the health and social services needs of Pennsylvanians, identify gaps, and enhance long-term health outcomes. The initiative involves collaboration with health information organizations, state agencies, non-profits, and community organizations.

The platform is highlighted as a groundbreaking resource for fostering collaboration, reducing barriers to care, and improving the overall quality of life for Pennsylvanians. Explore resources and information on the PA Navigate platform at PANavigate.org.

Utilizing Members of the Community: Community Health Workers

A community health worker (CHW) can be a valued part of any healthcare team. CHWs can be a key link, helping individuals and families navigate health, social, and community services to enhance overall well-being. As a trusted community member, the CHW understands the unique demographics and experiences of those they serve, offering culturally and linguistically appropriate support. Equipped with the skills to address SDOH, the CHW works to improve health outcomes and promote health equity within the communities they serve (CDC, 2024).

Providers and community-based organizations should work alongside CHWs to leverage their connections and understanding of the community, especially in communities with a high Social Vulnerability Index (SVI) score. CHWs could be an excellent resource for elevating patients' understanding of their condition and increasing their involvement in their care, especially with intricate chronic diseases such as diabetes.

Learn more about CHWs training and education in PA on the PA AHEC website or connect with Quality Insights to learn more about how our CHWs can help your patients.

Patient Education and Empowerment

Tailoring Education to SDOH Factors

Quality Insights recommends the following strategies for understanding socioeconomic factors and promoting improved outcomes for patients living with or at risk for diabetes:

1. Refer patients directly to a local DSMES or National DPP.
2. Provide patients with extra resources and help connect them to organizations that can support them in areas of need, including mental health, food security, housing, and more.
3. Ensure that patient materials are language- and reading-level-appropriate.
4. Use motivational interviewing techniques to facilitate "a method for changing the direction of a conversation to stimulate the patient's desire to change and give him or her the confidence to do so" (AAFP, 2011).
5. Identify patients' feelings or attitudes around a problem and help them plan solutions that might work in the future.
6. Offer other resources, such as healthy cooking classes, support groups, or smoking cessation programs.

Family Members

A 2019 TALK-HYPO study examined the burden of diabetes on family members of people with type 1 or type 2 diabetes and found that 66 percent reported thinking about the risk of hypoglycemia at least monthly, and 64 percent felt worried or anxious about it. The authors concluded that family members are essential players in the diabetes care team, and conversations facilitated by a healthcare professional may reduce the burden.

Cultural Competence in Diabetes Care and Education

A study published in *Clinical Diabetes* (2021) looked at improving cultural competency in diabetes care. Diabetes is a chronic condition in which the patient holds increased accountability around self-management. Primary care providers bear a great responsibility in educating patients of all backgrounds and cultures due to the disproportionate impact of diabetes on non-White individuals.

The CDC defines cultural competence as “the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services, thereby producing better outcomes” (2024).

The same authors of the study published in *Clinical Diabetes* referenced above stipulate that providers should be driven and motivated to increase cultural awareness to connect with diverse patient populations. Providers should seek guidance to identify biases and gaps in knowledge and sensitivity. Doing so will enable providers to treat culturally diverse patients with empathy, understanding, and compassion (Dragomanovich & Shubrook, 2021).

The importance of cultural competency in diabetes care is highlighted by the disproportionate effect that diabetes has on non-White populations in the United States.

Dragomanovich & Shubrook state that:

- The **diabetes prevalence is two to six times higher among African American, Native American, Asian, and Hispanic populations** compared with White populations while experiencing a 50–100 percent higher burden of illness and mortality from diabetes.
- Minority populations also have a higher mean hemoglobin A1C than White populations and higher rates of diabetes-related complications.
- Racial and ethnic minorities have a higher prevalence of diabetes at a lower body mass index (BMI) than Whites.

These statistics paint the picture that “factors other than obesity play a role in disparities related to diabetes risk and care across racial and ethnic groups” (2021).

Cultural Competency Resources for Healthcare Providers

- Culturally and Linguistically Appropriate Services (CLAS) – National resources available through the PA DOH to guide cultural and linguistic inclusivity and outreach efforts, including a toolkit and fact sheets about CLAS standards.
- Georgetown University National Center for Cultural Competence – Cultural and Linguistic Competence Health Practitioner Assessment

- National Center for Cultural Competence, Georgetown University Center for Child and Human Development, and the University Center for Excellence in Developmental Disabilities, Education, Research, and Service – A checklist for evaluating cultural and linguistic competency of primary care clinics to ensure clinics are set up to serve patients of all backgrounds adequately.
- AAFP – EveryONE Project Toolkit offers strategies for use in your practice and community to improve patient health.

Podcast: Diabetes Care: Building a Foundation for Better Health

Quality Insights Practice Transformation Specialists Anna Gurdak and Robina Montague were joined by Chris Yocom, Diabetes Prevention Program Manager at Pottstown Medical Specialists (PMSI), to take a deep dive into the transformative world of PMSI's Diabetes Self-Management Education and Support (DSMES) program. This podcast episode explores the impact of DSMES across Pennsylvania, emphasizing the importance of teamwork in managing diabetes effectively. The discussion covers the core principles of DSMES, the relevance of lifestyle changes in diabetes prevention, and strategies to overcome participation barriers. It also includes insights into PMSI's Diabetes Prevention Program (DPP). This is a must-listen for healthcare providers, patients, and anyone interested in health innovation.

Quality Insights Assistance: Bridging Gaps: Team Approaches to Diabetes Care, Prevention and Equity

At Quality Insights, we understand the challenges and complexities of managing diabetes within diverse healthcare settings. Quality Insights is your partner in transforming patient care and improving health outcomes. To support your internal efforts, we offer the expertise of our Practice Transformation Specialists. Our specialists can assist your health system, Federally Qualified Health Center, or independent practice in achieving your goals of improving diabetes management and prevention.

If your practice is interested in participating in the program, email Ashley Biscardi or call **1.800.642.8686, ext. 2137.**