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

The Centers for Disease Prevention and Control (CDC) reports that **diabetes is the seventh leading cause of death in Pennsylvania** (CDC, 2022)**.** Team-based care strategies can identify individuals at risk for diabetes and assist in managing diabetes to promote positive outcomes in every healthcare setting.

Quality Insights partners with the Pennsylvania Department of Health (PA DOH) in the CDC's A Strategic Approach to Advancing Health Equity for Priority Populations with or at Risk for Diabetes to provide technical assistance, education, and support to practices to advance this initiative and improve patient outcomes. Providers and practices can schedule a no-cost, annual workflow assessment (WFA) with a Quality Insights Practice Transformation Specialist (PTS). Please 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 Quality Insights and would like assistance, email Ashley Biscardi or call **1-800-642-8686, Ext. 2137**.

Protocol and 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 or complementary Diabetes Self-Management Program (DSMP). Locate an American Diabetes Association (ADA) or Association of Diabetes Care & Education Specialists (ADCES) Diabetes Self-Management Education and Support (DSMES) program in your area.
	Collaborate with a Quality Insights PTS to facilitate a collaborative partnership with a local DSMES or DSMP to develop a workflow for multidirectional referrals and feedback. Include community-based organizations to address patients' barriers to care, such as language, medication adherence, and social determinants of health (SDOH).

	Identify an available referral source platform, such as PA Navigate. Facilitate DSMES and DSMP use of a referral source platform and engage practice in using it for referrals. Develop a multidirectional closed-loop referral process with CDC-recognized DSMES or DSMP.
	Develop a protocol to screen for SDOH and health literacy. Develop or update a standardized workflow utilizing the Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences (PRAPARE) SDOH assessment tool or tool available in the electronic health record (EHR). Identify positive responses by adding SDOH-related Z codes and providing community-based organization referral information to assist the patient. PA Navigate is a new and excellent referral resource to support the care team and patients.
	Collaborate with Quality Insights for technical assistance for a portal message or text campaign to promote referrals to a DSMES or DSMP and community partners to provide support for SDOH positive responses.
	Monitor annual National Quality Forum (NQF) #0059: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) clinical quality measure. Create the report at the race/ethnicity level to identify high priority patients to high-priority patients and promote referrals.
	Utilize the NQF #0059 report to provide providers with feedback and missed opportunities to promote value-based care. Promote proactive outpatient management of patients not in control. Increase appointment frequency to promote guidelines-based medical management as noted in the 2025 ADA Standards of Care in Diabetes.
	Create a Screen-Test-Refer protocol for patients at risk for diabetes. The U.S. Preventive Services Task Force recommends screening asymptomatic adults aged 35 to 70 every three years who are overweight or obese with the CDC Prediabetes Risk Test or A1C lab test. Those with a score of 5 or greater or an elevated A1c of 5.7-6.4% are at risk for Type 2 diabetes and should be referred to the National Diabetes Prevention Program (National DPP). Locate a CDC-recognized National DPP.

Practice, Clinical, and EHR Solutions

Using the 2025 Bridging Gaps: Team Approaches to Diabetes Care, Prevention, and Equity Practice Module as a guide to:

	Identify available referral source platforms, such as PA Navigate. Utilize the platform to create DSMES/DSMP referrals and engage practice in using it for referrals. Develop a multidirectional closed-loop referral process with CDC-recognized DSMES or DSMP and community-based organizations.
	Enable Clinical Decision Support (CDS) reminders to facilitate proactive measures for screening, testing, and referrals for patients with or at risk for diabetes. Create a referral order/referral in structured data to the National DPP, DSMES, or DSMP.

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