The Team-Based Approach to Enhancing Diabetes Care and Addressing Social Determinants of Health

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

Quality Insights

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Purpose of the Module

Quality Insights provides on-site and virtual technical assistance at no cost to engaged practices that are working to decrease the risk for type 2 diabetes among adults with prediabetes while 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 the care and management of 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 manage patients with prediabetes and diabetes.

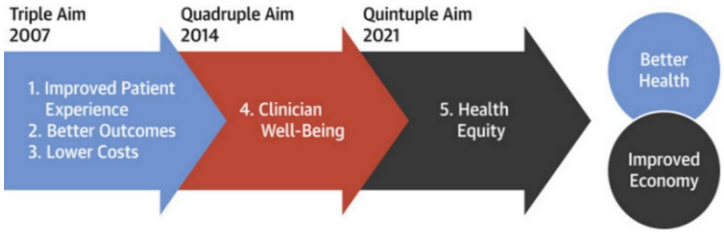
Note: Guidelines referenced in this module are provided in a summary format. Complete recommendations should be reviewed in the original publication(s) and utilized with physician/clinician judgment, considering a patient's unique needs and circumstances.

Tomorrow's Prevention, Today: Partner with Quality Insights

Quality Insights is dedicated to assisting your healthcare team in preventing and managing prediabetes and type 2 diabetes. Through our partnership with the Pennsylvania Department of Health, 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 technical assistance.

A few key services offered by Quality Insights include:

1) **Workflow Assessments:** Workflow assessments consist of an exploration of 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.

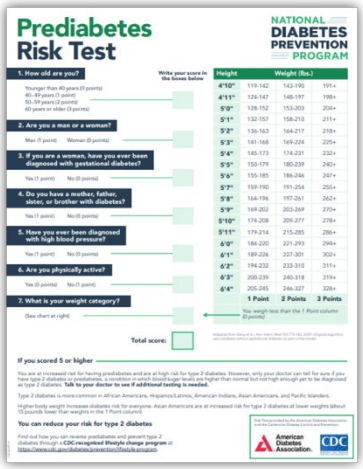
Quality Insights Assistance: Utilizing Your Care Team to Identify Strengths and Gaps

At **no cost**, Quality Insights will complete an annual Workflow Assessment with care team members identified by your practice. The annual Workflow Assessment is a baseline assessment of the current processes and protocols. Gaps in care, processes, and protocols are identified, and recommendations are made. Your practice will have a comprehensive picture of what can be improved and streamlined.

During the annual Workflow Assessment, annual metrics such as National Quality Forum (NQF) 0059: Diabetes: Hemoglobin A1c (HbA1c) Poor Control (> 9%) are reviewed at the provider level, and discrepancies at the race and ethnicity level can drive goals and priorities for the coming year.

To schedule your practice's annual Workflow Assessment, contact your local Practice Transformation Specialist or Ashley Biscardi at 302-290-9258.

Quality Insights Assistance: Connecting Patients to the National DPP


Prediabetes Risk Test

NATIONAL DIABETES PREVENTION PROGRAM

At **no cost** to your practice, your patients can receive a portal message or text message encouraging them to complete the CDC Prediabetes Risk Test and to be referred to the National DPP.

Additionally, Quality Insights can assist your practice in performing multidirectional referrals to the National DPP for your priority populations. This includes SDOH assessments, providing resources for any identified barriers, and a referral to the National DPP.

Quality Insights can also assist in helping your practice partner with a Pennsylvania Area Health Education Center (PA AHEC) to refer patients or to facilitate and host a National DPP cohort through a PA AHEC at your practice.

For more information, please contact your local Practice Transformation Specialist or Ashley Biscardi at 302-290-9258.

Setting the Table: What is Team-Based Care?

Healthcare is changing at a rapid pace. The COVID-19 pandemic, in combination with the shift from fee-for-service (FFS) payment to value-based payment models (which reward providers for the quality of care provided), highlights the importance of a team approach to improve the health of individuals and populations and to improve the safety, quality, and efficiency of health care delivery.

> *"Of all the changes envisioned as part of the transformation to improved and more patient-centered primary care, perhaps none is more promising and more challenging than the transition to team-based delivery of care."*
>
> Source: AHRQ, 2016.

The AMA (2015) defines team-based care as "a collaborative system in which team members share responsibilities to achieve high-quality and efficient patient care." 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 provide better patient care. The patient is at the center as the fulcrum 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. The diabetes care team will be further examined later in the module. The following section will spotlight the burden of diabetes and prediabetes in Pennsylvania.

Diabetes in PA

- **13%** of PA residents **aged 45-64** have been diagnosed with diabetes
- **22%** of PA residents **age 65 and over** have been diagnosed with diabetes
- **303,000** PA adults have **undiagnosed** diabetes
- **3,484,000** PA residents reported being told they have **prediabetes**
- **31% obesity rate** among PA adults
- **$9.3 billion** in **estimated total direct medical costs for diagnosed diabetes** in 2017

Sources: PA Department of Health, 2023 and American Diabetes Association, 2023

The Burden of Diabetes and Prediabetes in Pennsylvania

According to "The Burden of Diabetes in Pennsylvania" and the CDC, "**over 37 million Americans have diabetes** and face its devastating consequences."

Trends are developing simultaneously nationwide and in Pennsylvania. The statistics are alarming as the incidence of diabetes continues to rise.

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, COVID-19 highlighted the challenges faced when administrative burden, sub-optimal communication systems, and unbalanced teams collide with an extended crisis.

In addition to healthcare staff burnout, patients experienced significant barriers to care during the pandemic. Lockdowns affected those with diabetes, making self-management more difficult. Access to routine diabetes care and medications was limited (Khunti et al., 2022). The traumatic impact of COVID-19 has amplified the need for support and efforts to improve wellness and well-being, especially for people living with prediabetes and diabetes.

Evidence-based practices can help create a cohesive organizational culture that prioritizes and promotes well-being. Released in February 2021, the AHA's *Well-Being Playbook 2.0* offers resources on mental well-being, addressing burnout, and operationalizing peer support, as well as a guide to well-being program development and execution.

A 2018 NAM Discussion Paper, *Implementing Optimal Team-Based Care to Reduce Clinician Burnout*, highlights several studies providing evidence in support of high-functioning teams and their link to increased physician well-being, as well as their cost-effectiveness resulting in reduced emergency department utilization and hospital readmissions.

The chart below examines the components and qualities that characterize high-performing teams and how they offload provider workloads.

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. The 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 American Diabetes Association (ADA)'s *Standards of Care in Diabetes – 2024* (*Standards)* recognizes the important role care teams play 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 who have not achieved the recommended metabolic targets.

According to the *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 health care 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 the 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 the table below (CDC, 2023).

Contributor	Role
Diabetes Care and Education Specialist	Provides diabetes self-management education and support (DSMES); assists in increasing knowledge and decision-making skills; creates individualized plan for diabetes management around health needs, lifestyle, and culture.
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	Specialized 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.

AMA STEPS Forward® Team-Based Care and Workflow Toolkit

AMA STEPS Forward® Team-Based Care and Workflow Toolkit includes the recently updated *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 to 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
- Medical Assistant Professional Development: Enhance the Skills and Roles of the Care Team*
- Team-Based Care
- Pre-Visit Planning: Save Time, Improve Care, and Strengthen Care Team Satisfaction*
- Pre-Visit Laboratory Testing: Save Time and Improve Care*
- Daily Team Huddles: Boost Productivity and Teamwork*
- Advanced Rooming and Discharging: Optimize Team-Based Visit Workflows*
- Team Meetings: Strengthen Relationships and Increase Productivity*
- 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* (ABFM) 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.

Patient Self-Management: Diabetes Smartphone Apps

Smartphone apps can be great tools to promote daily patient self-management, which is especially important for patients with diabetes. To assist practices in identifying apps that are most beneficial to their patients, Quality Insights created the Free Apps to Help You Better Manage Your Diabetes patient handout. This handout lists various nutrition, glucose tracking, and healthy living resources designed to help your patients succeed.

Download the flyer here.

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

- Patient Resource, ADA: Get to Know Your Diabetes Care Team
- Diabetes Self-Management Education and Support (DSMES) Practice Module: Review this Quality Insights resource to learn about connecting your patients with diabetes self-management education and support (DSMES) services.

PPCN

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 the Commonwealth of Pennsylvania.

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

Additional Team-Based Care Resources and Toolkits

AAFP: Myth-Busting Success Story

Team-Based Care: Do What You Do Best, a web page from the American Academy of Family Physicians (AAFP), shares that "effective team-based care looks different for different practices." Using certain fundamentals, practices can create successful models given their practice size, staffing levels, and employee skill sets. Some common myths that may affect staff and provider buy-in were also discussed.

In addition to sharing a brief description of the aspects of successful team-based care visit in Dr. Peter Anderson's office, the web page links to a *Family Practice Management* article that further details how Dr. Anderson's practice transformation improved the job satisfaction of nurses, quality of care, patient visit volume, and financial performance.

AHRQ: Team-Based Care Resources

TeamSTEPPS® for Office-Based Care

TeamSTEPPS® is an evidence-based set of teamwork tools to optimize patient outcomes by improving communication and team skills among healthcare professionals. Access the entire curriculum, and download the TeamSTEPPS® Pocket Guide App as a quick-reference tool.

Interprofessional Primary Care eLearning Modules: Team-Based Care

Arizona State University's Interprofessional Primary Care Modules emphasize team-based decisions and skills required for primary care practice and the continuum of care. They provide tools and information regarding implementing team-based approaches to enhance patient care and team performance. The standalone modules will be phased out this summer and replaced with a full e-Learning course.

ACP: Team-Based Care Toolkit

The ACP provides a toolkit that shares best practices and examples of successful models implemented in internal medicine offices. The toolkit offers numerous resources to aid in developing an effective team-based care model, and the information can be adapted to meet the needs of other provider offices. As your practice explores opportunities for growth and change, consider utilizing the appreciative inquiry approach, one of the many suggestions in the toolkit's resources.

NAM: Discussion Paper

The NAM's 2018 Discussion Paper, *Implementing Optimal Team-Based Care to Reduce Clinician Burnout*, encourages team-based care as a way to improve the experience of both the patient and the members of the care team as they work together in the prevention of disease, disease management, and health promotion. "A team-based model of care strives to meet patient needs and preferences by actively engaging patients as full participants in their care while encouraging all health care professionals to function to the full extent of their education, certification, and experience" (Smith et al., 2018). The paper shares principles of high-performing teams and how to address digital, workforce, and payment barriers. Key takeaways include the importance of training, coaching, clear goals, effective communication, good leadership, and defined individual and shared roles.

Understanding SDOH

What are 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), 2023).

SDOH 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, 2023). 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 while combating and reducing health 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 (ADA Professional Practice Committee (PPC), 2022).

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

> “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.

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:

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 (Hill-Briggs and Fitzpatrick, 2023).

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 and Fitzpatrick, 2023). The findings also support the addition of 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 management requires the recognition of SDOH's role in successful disease management. Medical care is estimated to account for 10 to 20% 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 organizations 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

Below are other SDOH screening tools, how they are administered, and the number of questions (Moen et al, 2020):

- **Iscreen** – Self-administered or face-to-face with a research assistant, computer-based, 23 questions (each with two follow-up questions)
- **WE CARE** – Self-administered, paper-based, six questions
- **HealthBegins** – Paper-based, 15 main questions and 14 optional/additional questions
- **Health Leads** – Paper-based, available in Spanish, nine questions plus general additional questions per domain
- **WellRx** – Self-administered or by a medical assistant, paper-based, 11 questions
- **The Accountable Health Communities (AHC)** – Self-administered or by a staff member, paper and computer-based, 16 health-related social conditions questions, 26 total questions
- **HelpStep** – Self-administered or by a healthcare provider, computer-based, 12 main questions/domains with follow-up questions
- **AAFP Social Needs Screening Tool; The EveryONE Project** – Paper-based, 14 questions in long form

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*.

Patient Education and Empowerment

Tailoring Education to SDOH Factors

The Association of Diabetes Care & Education Specialists (ADCES) recommends the following strategies for understanding socioeconomic factors and promoting improved outcomes for patients living with diabetes:

1. 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.
2. Ensure that patient materials are language- and reading-level-appropriate.
3. Use motivational interviewing techniques to facilitate difficult conversations with patients.
4. Identify patients' feelings or attitudes around a problem and help them plan solutions that might work in the future.
5. Offer other resources, such as healthy cooking classes, support groups, smoking cessation programs, and the National DPP.

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% reported thinking about the risk of hypoglycemia at least monthly, and 64% felt worried or anxious about the risk of hypoglycemia. 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.

Motivational Interviewing Technique: OARS Model

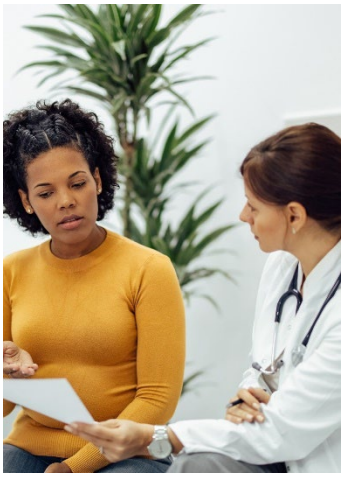
Motivational interviewing is "a method for changing the direction of a conversation to stimulate the patient's desire to change and give him or her the confidence to do so" (AAFP, 2011). It differs from other change strategies because it is more patient-centered and goal-directed. Motivational interviewing is designed to allow the patient to be responsible for their goals and progress, to help resolve ambivalence, and to create positive momentum that behavior change is possible (AAFP, 2011). Providers can use the OARS model to include motivational interviewing within the practice.

"OARS" stands for the following steps (AAFP, 2011):

- **O**pen-ended questions
    - Avoid "yes" or "no" questions. Broad questions allow more freedom to respond without fear of a right or wrong answer. Examples are "What has managing your diabetes been like over the last few months?" or "If you had one habit you wanted to change to improve your health, what would that be?"
- **A**ffirming
    - Express empathy during challenging times or in celebrating patients' accomplishments. Affirmations should be genuine and express joy. You may say, "Thank you for following through on completing your A1C test." or "I know this was a challenging task for you, and I appreciate your honesty."
- **R**eflective listening
    - Let patients express their thoughts and guide the conversation instead of telling them what to do. This aims to help the patient arrive at an idea for change. Acknowledge the patient's mood and reflect their statements back to them to reinforce self-efficacy.
- **S**ummarizing
    - This involves recapping the conversation, calling attention to important details, and allowing the patient to correct any misunderstandings and add any details that may have been missed. End the summary with an open-ended statement such as "I am wondering what you're feeling at this point" or "I am wondering what you think your next step should be."

Following the OARS model can help patients achieve specific and achievable goals. Motivational interviewing is about the spirit that the provider brings to the conversation, and it can empower patients to pursue behavior changes deliberately.

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."

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 and 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 and 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% 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" (Dragomanovich and Shubrook, 2021).

Cultural Competency Resources for Healthcare Providers

- 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 – 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 your patients' health and help them thrive.
- Culturally and Linguistically Appropriate Services (CLAS) – National resources available through the Pennsylvania Department of Health to guide efforts towards cultural and linguistic inclusivity and outreach, including a toolkit and fact sheets about CLAS standards.

Contact Quality Insights

If your practice would like additional guidance or information about team-based care or needs help implementing new workflow processes, please contact Ashley Biscardi or call **302-290-9258**.