Key Resources for Managing Diabetes in Primary Care | July 2018

NATIONAL ASSOCIATION OF Community Health Centers

Given the prevalence of diabetes among health center patients, the impact that poor control has on quality of life, health outcomes, mortality, and costs, and the salutary effects better management yields, the Health Resources and Services Administration, Bureau of Primary Health Care (HRSA BPHC) has launched a diabetes quality improvement strategy to support advancement of diabetes prevention and management. This strategy is designed to improve diabetes prevention efforts through increases in the percentage of adults and children who receive weight screenings and counseling. With respect to diabetes treatment and management, HRSA BPHC's strategy aims to reduce the proportion of patients with poor diabetes control as measured by hemoglobin A1c (HbA1c) greater than 9% and increase the proportion of health centers that meet the Healthy People 2020 goal for uncontrolled diabetes for each racial/ethnic group. The American Diabetes Association's (ADA) Standards of Medical Care in Diabetes grounds this improvement strategy in sound clinical evidence.

CASE FOR CHANGE – *"WHY IS THIS PROJECT IMPORTANT?"*

One out of every ten or 30.3 million people in the United States has diabetes. People who have diabetes are at higher risk of serious health complications, including blindness, kidney failure, heart disease, stroke, and loss of toes, feet or legs. Risk of death for adults with diabetes is 50% higher than for adults without diabetes. (Centers for Disease Control and Prevention): https://www.cdc.gov/diabetes/library/socialmedia/infographics.html

FACILITATING BEHAVIOR CHANGE IN PATIENTS

- **Online Diabetes Toolkit, National Center for Health in Public Housing-** http://nchph.org/diabetes/

  This webpage is a toolkit of data and resources such as webinars and testimonials about poor motivation in diabetes care, ways to recognize disengaged diabetes patients and methods to engage them.

- **The Migrant Clinicians Network Diabetes Program, Migrant Clinicians Network-** https://www.migrantclinician.org/toolsource/226/diabetes/index.html

  Migrant Clinicians Network developed several flyers and fact sheets available in English and Spanish on topics including oral health for the diabetic, diabetes & exercise, diabetes & depression, diabetes & high blood pressure, diabetes & kidney disease and a basic guide to health foods.

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FACILITATING BEHAVIOR CHANGE IN PATIENTS *(Continued)*

- **Keeping Diabetes Under Control (English and Spanish)- National Center for Farmworker Health-** http://www.ncfh.org/clinical-performance-measures.html

  This interactive tool in English and Spanish provides a brief overview of the most basic diabetes self-management strategies along with a health tracking tool designed for patient and provider interaction. This tool can be included in the patient welcome packet and provided during one on one education on treatment and follow-up.

- **Know Your A1c Tool / Conozca Su A1c, MHP Salud-** https://mhpsalud.org/portfolio/know-your-a1c-tool-2/

  This bilingual tool can be printed into a pamphlet that participants can use to track their A1c and other biometric data.

- **National Diabetes Prevention Program (NDDP), Centers for Disease Control and Prevention (CDC)-** https://www.cdc.gov/diabetes/prevention/index.html

  Help your at-risk patients prevent or delay type 2 diabetes by screening and referring them to a CDC-recognized diabetes prevention lifestyle change program.

- **YMCA's Diabetes Prevention Program, YMCA-** http://www.ymca.net/diabetes-prevention

  More than 200 Ys across the country help thousands of people reduce their risk for developing type 2 diabetes with YMCA's Diabetes Prevention Program. This small-group program helps people with prediabetes eat healthier, increase their physical activity and lose weight, which can delay or even prevent the onset of type 2 diabetes.

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IMPROVING HEALTH SYSTEMS & INFRASTRUCTURE

- **Health Outcomes & Data Measures: A Quick Guide for Health Center & Housing Partnerships, Corporation for Supportive Housing and National Health Care for the Homeless Council-** http://www.csh.org/wp-content/uploads/2017/04/CSH-Data-Elements-Outcomes-Final.pdf

  This guide provides an overview of how health centers and supportive housing providers are tracking and utilizing data to demonstrate progress with the most medically and socially complex patients. As more health and housing partnerships develop across the country, providers are looking to demonstrate the impact of housing on physical health outcomes. With little literature existing in the field, determining which outcomes to track can prove to be a challenge. This guide is designed to help communities identify health conditions that may be positively impacted by stable housing and leverage existing data to show impact with reduced administrative burden.

- **2017 Diabetes Improvement Toolkit, HITEQ-** http://hiteqcenter.org/Resources/Health-IT-Enabled-QI/Improving-Performance/ArtMID/849/ArticleID/1414/Improving-Diabetes-Outcomes

  This toolkit includes curated expert guidance, tools, and resources on improving diabetes outcomes, including patient-specific activities, population-oriented activities, and foundational work.

- **Mobile Phone Applications Used Within Healthcare Systems for Type 2 Diabetes Self-Management, Community Preventive Services Task Force-** https://www.thecommunityguide.org/findings/diabetes-management-mobile-phone-applications-used-within-healthcare-systems-type-2

  This is a recent recommendation from the task force related to the use of digital technology to support patient self-management.

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OPTIMIZING PROVIDER & MULTIDISCIPLINARY TEAMS

- **Improving Care for Medically Complex Patients: Medical Respite & Supportive Housing, Corporation for Supportive Housing-** http://www.csh.org/wp-content/uploads/2017/04/Profile-Y3-Medical-Respite-Final.pdf

  This profile highlights two programs that have exemplified how medical respite care can be an effective bridge to supportive housing. Strong involvement between the health center and their local Continuum of Care, including through the coordinated assessment process, results in high rates of discharge to supportive housing.

- **Integration of Promotores(as) onto Clinical Care Teams, MHP Salud-** https://mhpsalud.org/portfolio/integration-promotoresas-onto-clinical-care-teams/

  This video provides background on the benefits of clinically integrating your Promotores(as), and outlines the free and low-cost tools MHP Salud offers to assist your clinic throughout the process.

- **Diabetes Pathway and Checklist, Indiana Primary Health Care Association-**
  http://c.ymcdn.com/sites/www.indianapca.org/resource/resmgr/High_Risk_Diabetes_Pathway.pdf
  https://cdn.ymaws.com/www.indianapca.org/resource/resmgr/New_Diagnosis_Diabetes_Path.pdf
  http://c.ymcdn.com/sites/www.indianapca.org/resource/resmgr/Diabetes_Pathwaystable.pdf

  These separate tools were created for seeing a patient with a high risk of diabetes, with a new diagnosis of diabetes and with diabetes who is stable.

- **Online Diabetes Resource Toolkit, Migrant Clinicians Network-** https://www.migrantclinician.org/issues/diabetes/online-toolkit.html

  The purpose of this online toolkit is to offer a free, central & easily accessible place with information and quality tools and resources around diabetes care for migrants and other mobile underserved individuals. This is a collection of resources, which have been gathered from various sources.

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- **Diabetes Discoveries & Practice Blog, National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)-** https://www.niddk.nih.gov/health-information/professionals/diabetes-discoveries-practice

  Engage in dialogue with thought leaders on emerging trends in diabetes care though NIDDK's blog.

- **National Diabetes Education Program (NDEP), Centers for Disease Control and Prevention (CDC) and National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK)-** https://www.cdc.gov/diabetes/ndep/index.html

  NDEP works with partners to reduce the burden of diabetes and prediabetes by facilitating the adoption of proven approaches to prevent or delay the onset of type 2 diabetes and the complications of diabetes. NDEP is a joint program of CDC and NIDDK and provides clinical practice tools and patient education materials that can help health professionals effectively meet the needs of people with or at risk for diabetes.

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