Diabetes Care Guideline Checklist

Ambulatory Care Setting

Level 3

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The current state of the issue

Diabetes is a chronic disease that often results in elevated blood sugar which over time leads to serious health complications such as heart disease, vision loss, and limb amputation.[1] Diabetes is the 7th leading cause of death for Washingtonians.[2] Individuals across the age spectrum can be diagnosed, with a diagnosis among youth becoming more prevalent.[3] There are different types of diabetes. These guidelines focus on Types I, II, and prediabetes. 1One in five Americans are unaware they have diabetes and eight in ten are unaware they have pre-diabetes, with similar rates in Washington state.[4] Currently, Washington state performs below the NCQA 25th percentile for blood sugar testing for people with diabetes with disparities by race, ethnicity, and payor status.5

Team Based Care & Empanelment

- [ ] Provide a multidisciplinary coordinated care team for all patients on the registry. The team should at a minimum include the patient and/or caregiver, a clinical pharmacist, a registered nurse, and a dietician with support from the primary care provider. It should also include a certified diabetes care and education specialist (either a registered dietitian nutritionist or nurse), an individual responsible for care coordination, and other members necessary to address specific needs of patients, including mental health. Models may include: shared medical appointments for patients with prediabetes or diabetes.
- [ ] Community health workers as part of interdisciplinary teams as available. Pathways to involve community health workers may include hiring local community health workers, partnering with local community health workers, or contracting with Community Care Hubs and Community Based Organizations that house community health workers.
  - [ ] Follow the NCQA/Penn guidelines for supporting community health workers.

Referral Pathways

- [ ] Create and/or support referral systems for the diabetes care team to correspond with and connect patients with external support.
- [ ] Create and/or support pathways and/or referral systems for clinicians to correspond with dental providers, eye care professionals and other relevant specialties to provide current lab work and medication lists.
- [ ] Create and support a referral process to a recognized National Diabetes Prevention Program (NDPP) or Special Diabetes program for Indians (SDPI) and assist patients and providers in finding a program that aligns with their learning needs and is inclusive of their identities (e.g., language, culturally appropriate, or provided in connection with a faith-based organizations.)
- [ ] Create and support referral processes for nationally accredited Diabetes Self-Management Education and Support (DSMES) services and medical nutrition therapy (MNT).

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Population Health

- [ ] Co-locate resources to address food insecurity (e.g., food banks in same building and clinics) as resources allow.

Community Outreach

- [ ] Host health fairs and/or community-based screenings where glycemic testing is provided as part of the health system's community benefit work to identify individuals at risk for diabetes.
- [ ] When providing community-based screening, develop referral pathways for individuals that screen positive to connect with the appropriate level of care and/or establish with a PCP, regardless of screening location.
- [ ] Partner with external community-based organizations, including faith-based organizations, to host screening for prediabetes or diabetes.
- [ ] Partner with external, community-based organizations connected to community care hubs.
- [ ] Utilize tactics (e.g., mobile van) to reach medically underserved or rural populations (e.g., low income, migrant populations, etc.)

Resources

- The Bree Report on Diabetes Care is meant to supplement these resources.
- Full Bree Report on Diabetes Care: https://www.qualityhealth.org/bree/wp-content/uploads/sites/8/2024/01/Diabetes-Report_Draft-23-FINAL-0124.pdf
- American Diabetes Association: https://diabetes.org/tools-resources
- WA DOH Diabetes Prevention and Management https://doh.wa.gov/public-health-healthcare-providers/healthcare-professions-and-facilities/patient-care-resources/diabetes-prevention-and-management
- National Diabetes Prevention Program: https://www.cdc.gov/diabetes/prevention/index.html
- Special Diabetes Program for Indians https://www.ihs.gov/sdpi/
- YMCA Diabetes Prevention: https://www.ymca.org/what-we-do/healthy-living/fitness/diabetes-prevention

Read the full Bree Report on Diabetes Care online by scanning the QR code:

Connect with the Bree Collaborative at bree@qualityhealth.org

References: 1. American Diabetes Association. The Burden of Diabetes in Washington. ADV. Accessed November 2022. Available at: https://diabetes.org/sites/default/files/2021-10/ADV_2021_State_Fact_sheets_Washington.pdf 2. Institute for Health Metrics and Evaluation. United States of America – Washington. IHME. Accessed November 2022. Available at: https://www.healthdata.org/united-states-washington 3. Centers for Disease Control and Prevention. CDC Study Finds Youth Onset Type 2 Diabetes More Severe in Minority Youth. [Press Release]. Accessed August 24, 2021. Available at: https://www.cdc.gov/media/releases/2021/p0824-youth-diabetes.html 4. Centers for Disease Control and Prevention. National Diabetes Statistics Report, 2023. Accessed 2023. Available at: https://www.cdc.gov/diabetes/library/spotlights/diabetes-facts-stats.html 5. WHA Community CheckUp. 2022. 2022 Community Checkup Report. Washington Health Alliance. Accessed November 2022. Available: https://www.wacommunitycheckup.org/media/67048/2022-community-checkup-report.pdf