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# Collection of Promising Practices on Diabetes Management and Prevention

National Center for Health in Public Housing

## DISCLAIMER

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## Introduction

The National Center for Health in Public Housing (NCHPH) has compiled a set of promising practices on how to improve the health of public housing residents through diabetes management and prevention strategies with health centers. These strategies were identified through various webinars and learning collaboratives conducted by NCHPH over the last three years on improving diabetes management and prevention.

The purpose of the document is to provide health center staff with easy access to diabetes promising practices. The promising practices will also be available online through a promising practices portal. Each promising practice will be tagged with key terms to make them easily searchable and accessible.

## Promising Practices Definition

Promising practices were chosen based on the following definition identified and created by the Health Center Resource Clearinghouse and the Health Resources and Services Administration (HRSA) to provide training and technical assistance to health centers. A promising practice generated at a health center must demonstrate at least three of the following:

- ***Impact/Outcomes:*** Guidelines and protocols that have been successfully used by at least one organization and with an emerging positive track record of improved clinical or operational outcomes and insights.
- ***Satisfaction:*** Approach demonstrates effectiveness in increasing overall satisfaction for patients and/or staff.
- ***Data Collection Mechanism:*** Provide initial data to support the establishment of benchmarks.
- ***Reduced Costs:*** Have the potential to lower the per capita costs of delivering care or services.
- ***Partnerships:*** The approach creates innovative, strong partnerships and maximizes efficiency.
- ***Operational Feasibility:*** Offer strategies that can be easily shared and implemented.

## Diabetes Promising Practices

This publication includes a list of promising practices on the following topics:

- Team-Based Approaches to Wellness
- Integration of Information Systems and Technology
- Implementing Medical Nutrition Therapy (MNT)
- Health Literacy Improvement Strategies
- Use of Data and Community Health Aides Program (CHAP)
- Use of the Seek, Help, Assess, Reach, Evaluate (SHARE) Approach

## Source of Information

NCHPH has catalogued promising practices on health center and diabetes management and prevention that were identified during T/TA activities. They include management and prevention strategies to improve medication adherence, health literacy, hemoglobin A1c levels, access to health care, health center outreach, and digital literacy. See Additional Resources for a list of NCHPH activities related to diabetes management and prevention or visit www.nchph.org.

# I. Diabetes Management and Prevention Strategies in Team-Based Approaches to Wellness

# Diabetes Management and Prevention Strategies in Team-Based Approaches to Wellness

**Team-Based Approaches to Wellness** takes into consideration the Chronic Care Model (CCM), which is composed of six elements that optimize the care for patients with chronic diseases such as diabetes. These elements include delivery system design, self-management support, decision support, clinical information systems for patients to access their own information, connecting individuals with community resources and policies, and health systems. Team-Based Approaches to Wellness also focuses on implementing strategies for System-Level Improvements where care teams should prioritize the intensification of lifestyle and pharmacologic therapy, specifically for patients with diabetes that have not achieved metabolic targets. Strategies for care team intensification include setting collaborative goals with patients, addressing and identifying barriers related to language, numeracy, and cultural barriers to care, integrating evidence-based guidelines and clinical information into the process of care, providing structures, obtaining feedback from patients, setting reminders that will help meet targets and incorporating care management teams.

For more information on this promising practice, go to Building an Effective Collaborative Care Team to Address Diabetes in Special and Vulnerable Populations: Tailoring Care for Social Context

Resource: Analytic Framework: Team-Based Care for Diabetes Management

# II. Diabetes Management and Prevention Through the Integration of Information Systems and Technology

# Diabetes Management and Prevention Through the Integration of Information Systems and Technology

**Fremont, California**

Health Center Program Grantee:
Bay Area Community Health Center (BACHC), formerly known as Tri-City Health Center

Bay Area Community Health Center (BACHC) in Fremont, California **established a panel** to produce better processes and results that have enhanced diabetes care among their patient population. This is managed by the health center's wellness department with case managers, Registered Nurses (RNs), Licensed Practical Nurses (LPNs), Medical Assistants (MAs) that help coach all diabetes patients at BACHC. With the use of the panel, BACHC has been able to follow up with their patients daily and set up time frames on when their case managers will follow up with patients depending on their A1C levels. The higher the A1C levels, the more frequent the follow ups are for patients and coaching is available for them through telephone.

Additionally, case managers also see patients right after their initial doctor visits to provide one-on-one counseling and hold **diabetes-related classes** that include nutrition and exercise information. This strategy has been shown to be effective as patients have seen a change in their blood glucose levels when comparing baseline glucose measurements prior to attending diabetes classes to after completing the classes.

Tools provided for their patients also included the use of **care messaging,** where messages are sent out to patients through text messages by their coaches. This campaign was a 25-week long project.

For more information on this promising practice, go to Using Information Systems and Technology to Enhance Diabetes Care.

# Diabetes Management and Prevention Through the Integration of Information Systems and Technology

**San Diego, California**

Health Center Program Grantee:
La Maestra Community Health Centers (LMHC)

La Maestra Community Health Centers (LMHC) has established the **use of clinical pharmacists** that provide support with adjusting medications as needed for their patients in conjunction with their treating providers. LMHC has also implemented **after-hour group classes** to accommodate patients with their schedules and has been shown to be successful. LMHC established cohorts of 20 patients for the after-hour group classes, and in each cohort, there was a compliance rate of about 85%. Successes that were seen as part of the after-hour group classes include weight loss of five pounds in four weeks in some patients.

Aside from managing A1C levels among their health center patients, LMHC established new **approaches for eye care**. This approach involves taking pictures with a Retinal Camera during examinations at the health center where they're sent directly to eye specialists to ensure proper follow ups are completed with patients as it has been reported that patients have struggled to follow up with eye specialists on their own. This approach is believed to help decrease no-show rates among patients with diabetes and increase compliance.

For more information on this promising practices, go to Using Information Systems and Technology to Enhance Diabetes Care.

# III. Diabetes Management and Prevention by Implementing Medical Nutrition Therapy (MNT)

# Diabetes Management and Prevention by Implementing Medical Nutrition Therapy (MNT)

Key Organization:
American Diabetes Association (ADA)

**The Medical Nutrition Therapy (MNT)** consists of using nutrition as therapy to treat a medical condition or a disease. MNT is provided by registered dietitians to engender behavior change in relation to adopting a healthier lifestyle and making better nutritional choices. MNT is a comprehensive therapy where patients follow a plan based on established goals between the registered dietitian and the patient. MNT is as service that is a Medicare covered benefit, that is cost effective and that has shown to improve A1C levels with an absolute decrease of up to 2.0% among patients with Type 2 Diabetes and up to 1.9% among patients with Type 1 Diabetes within a three-to-six-month period. The implementation of such therapy by health centers may help improve the health outcomes for patients by helping manage and prevent diabetes.

For more information on this promising practice, go to The Impact of Nutrition on Diabetes Prevention and Diabetes Management.

# IV. Diabetes Management and Prevention Through Health Literacy Improvement Strategies

# Diabetes Management and Prevention Through Health Literacy Improvement Strategies

**Morristown, New Jersey**

Health Center Program Grantee:
Zufall Health Center

The **Improving Adherence-Tool & Brown Bag/Medication Management** is a tool developed at Zufall Health Center in collaboration with health center pharmacists to help improve health literacy among health center patients at Zufall Health Center. The purpose of this tool was to serve as part of the "Teach Back" method, as a personal medication record, a medication plan, and evaluate how high the health literacy of patients was by engaging them into medication plan conversations. This medication adherence tool was implemented by following the SIMPLE steps. SIMPLE stands for:

**S** – Simplify Regimen
**I** – Impart Knowledge
**M** – Modify Patient Beliefs and Behaviors
**P** – Provide Communication and Nurture Trust
**L** – Leave the Bias
**E** – Evaluate Adherence

This tool helped patients improve their adherence to medications as they were able to understand in a simpler way the processes and what was going on with their medications for diabetes. The tool also addressed issues with cognition as some patients were forgetting their dosages, especially among elderly groups. It also helped identify solutions, mitigate literacy issues, engage patients, reduce side-effects, and enhance the acceptance of their medication regimens. The adherence tool also provided support for the Health Center with Quality Improvement (QI) initiatives and was also a tool that patients were able to take home.

For more information on this promising practice, go to Association of Health Literacy With Poor Diabetes Outcomes.

# V. Diabetes Prevention and Management Through the Use of Data and Community Health Aides Program (CHAP)

# Diabetes Prevention and Management Through the Use of Data and Community Health Aides Program (CHAP)

**Anchorage, Matanuska-Susitna Borough, Alaska**

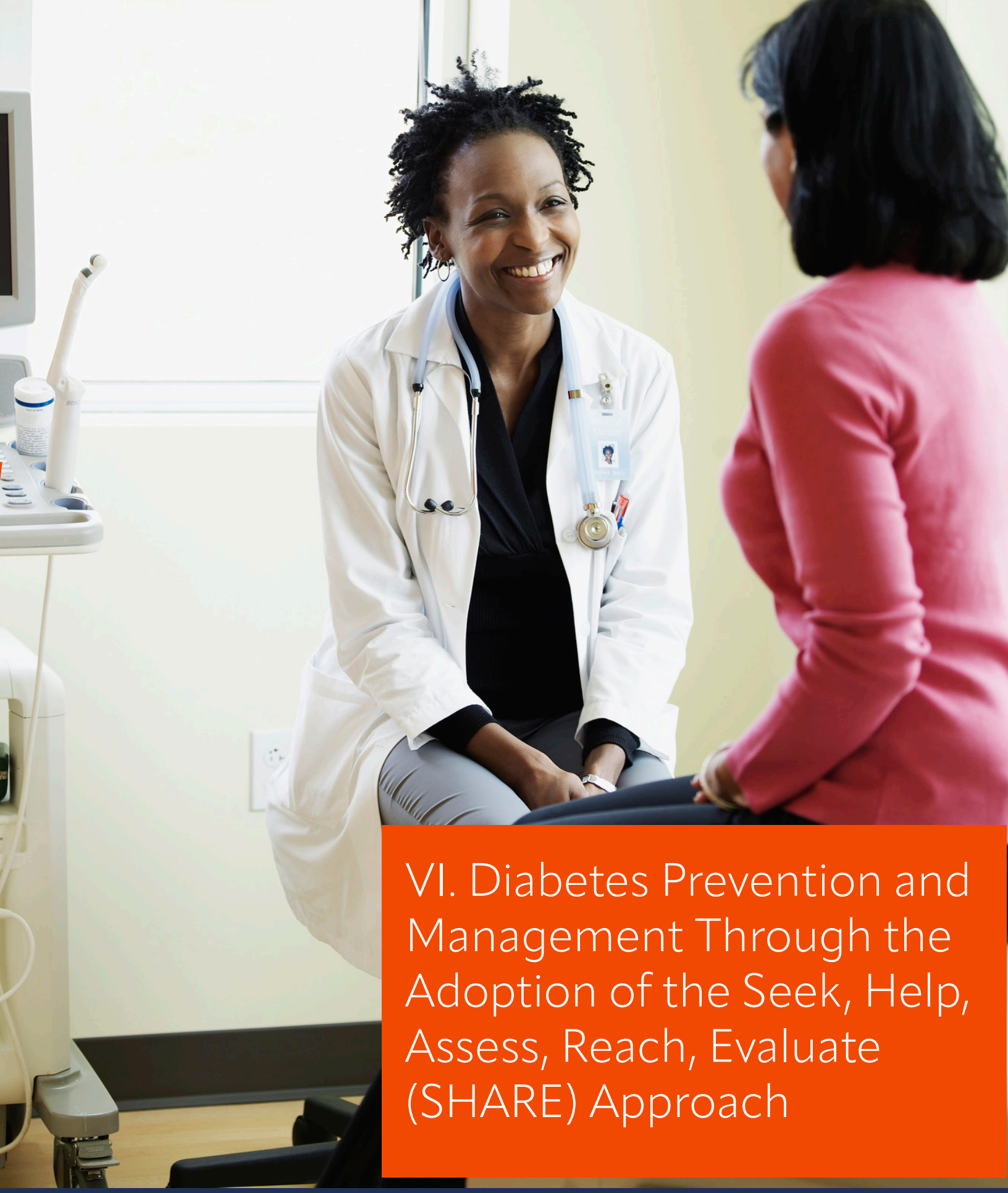
Key Organization:
Southcentral Foundation (SCF)

The **Use of Data and Community Health Aides Program (CHAP)** is part of a 2-pronged approach diabetes management program utilized by the Southcentral Foundation (SCF). SCF is an Alaska-Native owned, non-profit health care organization that concentrates on providing health care services to Alaska Natives and American Indian people living in 55 rural villages in the Anchorage Service Unit located in Southcentral Alaska. SCF uses "the Using Data approach" to create a diabetes registry and action list that help identify elements that contribute to patient care, risk factors, co-morbidity conditions, test results and more. The CHAP approach focuses on the use of high-school graduates that have unique training and responsibilities to provide diabetes care to patients in hard-to-access areas of Alaskan communities. The aides receive training to provide remote care to patients such as diabetes management, they also live and work in the remote areas where they provide their services. The aides also connect patients with specialty services with the use of telehealth and help coordinate health educator visits to remote sites. In addition to serving as aides that bridge the gap between patients and diabetes health care services, they also encourage people to use an app called My Alaska Wellness app that facilitates the communication between health care providers and patients, and where they can access their own medical records and keep track of their diabetes management.

This promising practice can be adapted in health center programs by following the steps provided below:

1. Update clinical data from the Electronic Health Records (EHR) system into a database.
2. Create action lists in the EHR, to get a snapshot of a patient's overall health and actions.
3. Review data on a regular basis to keep track of patients that need follow ups.
4. Have at least one on-site staff member in remote clinics that are trained to assess and refer patients.
5. Encourage patients to use technology such as apps and patient portals to improve communication with practitioners and have access to resources.
6. Bring health educators to remote sites on a regular basis.

For more information on this promising practice, go to CHWs of the Future – Virtual Visits and Technology.



# VI. Diabetes Prevention and Management Through the Adoption of the Seek, Help, Assess, Reach, Evaluate (SHARE) Approach

# Diabetes Prevention and Management Through the Adoption of the Seek, Help, Assess, Reach, Evaluate (SHARE) Approach

Key Organization:
Agency for Healthcare Research and Quality (AHRQ)

The **Seek, Help, Assess, Reach, Evaluate (SHARE) Approach** is a process of five-steps developed by the Agency for Healthcare Research and Quality (AHRQ). The SHARE Approach may be adapted by health centers to help improve health literacy for patients with diabetes and increase their knowledge about diabetes, self-efficacy, self-care behaviors and how to control their glycemic levels. This approach has been well-received by educators and patients in past trainings that have focused on medication adhesion.

The five steps to this approach include:

1. Seek for your patient's participation
2. Help patients explore and compare treatment options
3. Assess a patient's values and preferences
4. Reach a decision with the patient
5. Evaluate the patient's decision

This tool contains a facilitator's Training Guide that is readily available for users with step-by-step guidance and tips on how to communicate with patients effectively in a culturally competent way can be accessed in the AHRQ website.

For more information on this promising practice, go to The Impact of Health Literacy on Diabetes Mellitus.

# VII. NCHPH Resources on Diabetes Management and Prevention

# NCHPH Resources on Diabetes Management and Prevention

**Webinars:**

Diabetes Self-Management: Education and Support
This webinar addressed the importance of Diabetes Self-Management Education and Support (DSMES) as a critical element of care for all people with diabetes. DSMES is the ongoing process of facilitating the knowledge, skills, and ability necessary for diabetes self-care, as well as activities that assist a person in implementing and sustaining the behaviors needed to manage his or her condition on an ongoing basis, beyond or outside of formal self-management training.

Diabetes Continuum of Care: Increase Patient Technology and Digital Health Literacy
In this webinar, participants learned about telehealth and the different forms of service delivery, identifying barriers to technology and digital literacy for diabetes-related interventions, and how to provide strategies and tools to address barriers in implementing diabetes-related interventions.

Addressing Barriers to Diabetes Prevention for Older Residents of Public Housing
Older adults living in communities with limited access to healthy foods or safe places to exercise can be at an increased risk for developing diabetes. This two-part webinar series reviewed behavioral interventions that incorporate age-specific considerations for public housing residents to delay or prevent type 2 diabetes.

Diabetes Resources for Health Centers Serving Special and Vulnerable Populations
In this webinar, NCHPH hosted a dynamic introduction to the rich collection of resources on diabetes prevention and management for Health Center Programs. In this webinar, participants learned about existing resources pertaining to diabetes and receive guidance and instruction on how to identify resources that fit individual Health Center needs.

The Impact of Health Literacy on Diabetes Mellitus
In diabetes, health literacy is related to diabetes knowledge, self-efficacy and self-care behaviors and glycemic control. Health literacy may also provide a better understanding of racial disparities observed in patients with diabetes. This webinar described the concept of health literacy and its assessment and the evidence of its impact on patients with diabetes and offered suggested methods and tools that may be implemented to improve clinical care.

# NCHPH Resources on Diabetes Management and Prevention

**Learning Collaboratives:**

Building an Effective Collaborative Care Team to Address Diabetes in Special and Vulnerable Populations: Tailoring Care for Social Context
This session focused on the necessary elements to develop a high functioning patient-centered team for diabetes prevention, management, and treatment in primary care. The session addressed the roles of all members of the team including the critical role of leadership and clinical champions to building an effective collaborative team. This session laid the groundwork for the full series by engaging participants in a discussion of how to tailor diabetes care for social context. The conversation focused on the key elements needed for treating diabetes in the primary care and community setting with an emphasis on team-based approaches to wellness.

Developing the Role of Community Health Workers and other Support Staff in Diabetes Prevention, Treatment, and Follow-Up
Community Health Workers (CHW) have been shown to be especially successful reaching hard to access populations such as agricultural workers and their families as well as the homeless and residents of public housing. In this session, participants and faculty explored the role of CHWs in the diabetes care team. Case studies and real-world discussion provided examples of both effective and ineffective integration of CHWs into the clinical care team. Participants discussed the scope of practice and most effective roles for CHWs within the diabetes care team as well as the role of clinical champions and leaders in effectively mobilizing the skills of CHWs and other team members.

Diabetes Continuum of Care: Using Behavioral Health and Substance Use Disorder Integration to Address Older Adults with Cognitive Impairments and Diabetes
Diabetes affects more than 30 million people in the United States. Multi-tiered efforts to prevent, treat and manage diabetes are critical in reducing the burden of diabetes, particularly for medically underserved racial and ethnic minority populations. In addition to higher prevalence, ethnic and racial minority patients with diabetes have higher mortality and higher rates of diabetic complications.

Identifying and Treating People with Prediabetes
Prediabetes is a serious health condition where blood sugar levels are higher than normal, but not high enough yet to be diagnosed as type 2 diabetes. According to the Center for Disease Control and Prevention (CDC), approximately 84 million American

# NCHPH Resources on Diabetes Management and Prevention

adults—more than 1 out of 3—have prediabetes. Of those with prediabetes, 90% don't know they have it. In this session participants discussed statistics of prediabetes and conversion rates from prediabetes to diabetes, identify patients at risk for diabetes, resources to screen and test for prediabetes and the use of EHRs to identify people with prediabetes.

Patient Engagement Strategies for the Collaborative Care Team: Group Visits
This session explored strategies and tools for diabetes pre-visit planning that can be successful for vulnerable populations. Participants and faculty brought case studies and real-life scenarios to the discussion in order to facilitate problem-solving conversations about how to address challenging scenarios. The session also addressed how to best incorporate pre-visit planning into a team-based setting that includes CHWs.

Phases of Diabetes Care
Diabetes care can be organized into three phases: pre-visit, intra-visit, and post-visit. Opportunities exist during each phase to introduce practice changes that can help engage and support patients in their diabetes care and management. Health care teams can optimize diabetes encounters by taking a planned, continuous improvement approach to visits, which includes pre-visit preparation (by both patients and practices), intra-visit coordination (among practice team members), and post-visit follow-up (among the practice team and with patients).

Using Information Systems and Technology to Enhance Diabetes Care
Patients and physicians require new tools to manage the growing burden of chronic illness. For providers responsible for the care of diabetic patients, developments in information management, real-time health education and feedback, and new approaches to self-monitoring and insulin delivery hold great promise to improve the quality and safety of diabetes care. In this call, NCHPH and Health Centers participants shared some of the major developments in the field, and the ways these technologies can be integrated into a typical practice.

Association of Health Literacy With Poor Diabetes Outcomes
The purpose of this session was to review the relationship between health literacy and health outcomes in patients with diabetes and discover what the potential interventions are to improve such outcomes.

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Empowerment and Self-Management of Diabetes – The Pharmacist and Diabetes Care Learning Collaborative
The goal of this learning collaborative was to discuss with pharmacists how to integrate diabetes education and management into practice, so patients can make the best use of their medications and achieve the desired therapeutic outcomes.

The Impact of Nutrition on Diabetes Prevention and Diabetes Management
This presentation covered best practices for nutrition care, top eating patterns for people with diabetes, and ADA resources that can be used in practice.

Diabetes Continuum of Care: Impact of Health Literacy on Patients' Diabetes Management and Self-Care
NCHPH partnered with members of the Special and Vulnerable Population Diabetes Task Force to provide a Learning Collaborative (LC) addressing critical issues to improve diabetes control in health centers nationally. NCHPH provided expertise in public housing primary care and provided a more in-depth exploration of strategies, tools, and resources needed to create positive change in diabetes control among health center patients. The LC sessions also provided in-depth knowledge and skills in order to address the unique needs of people experiencing homelessness, residents of public housing, migratory and seasonal agricultural workers, school-aged children, older adults, Asian Americans, Native Hawaiians and other Pacific Islanders, LGBT people, and other vulnerable populations.

Expanding Diabetes Prevention and Management Through Health Center Outreach
This learning collaborative was comprised of a mix of outreach and diabetes educators from at least 10 health centers in or immediately accessible to public housing. Utilizing evidence-based models such as those developed by the Centers for Disease Control and Prevention (CDC), Community Preventive Services Task Force or National Health, Lung, and Blood Institute (NHLBI), the four learning modules allowed for the implementation of process for weight screening and tracking patients with abnormal BMI and HbA1c.

# NCHPH Resources on Diabetes Management and Prevention

**Publications:**

Increasing Access to Healthy Food and Exercise in Public Housing Communities: Examples from Public Housing Primary Care Grantees
The National Center for Health in Public Housing convened two learning collaboratives in 2018–2019 comprised of Public Housing Primary Care Grantees to explore strategies and programs that increased access to healthy food, exercise, and weight control models. Approximately 15 participants discussed ways to manage diabetes and obesity through programs that address education and support, nutrition, and physical activity. Findings from those discussions are summarized in this report.

Diabetes and Seasonal Influenza (Flu) During COVID-19: Protect Yourself!
This infographic by NCHPH addresses the importance of influenza (flu) prevention among public housing residents with diabetes during the COVID-19 pandemic.

Social Determinants of Health for Public Housing Residents: Diabetes
Diabetes is not only more prevalent among public housing residents, but also more severe. Community assets, such as healthy food outlets and safe places to engage in physical activity, can determine diet and exercise, and in turn, obesity, and diabetes rates. This publication by NCHPH explains the prevalence of diabetes in public housing.

Social Determinants of Health for Public Housing Residents: Access to Healthy Food
Areas with insufficient access to fresh food, called food deserts, frequently include neighborhoods with public housing developments. Low-income neighborhoods often lack full-service grocery stores and farmers' markets where residents can buy a variety of high-quality fruits, vegetables, and low-fat foods. This publication by NCHPH explains the importance of public housing residents having access to healthy food.

Addressing Social Determinants of Health to Improve Diabetes Outcomes
In this blog, NCHPH discusses how various social determinants of health can affect persons living with diabetes, in addition to best practices taken to address these social determinants of health.