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

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DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health

Quality Insights

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Purpose of the Module

Quality Insights provides no-cost, on-site, and virtual technical assistance 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. This module supports health care professionals when partnering with people living with diabetes to manage their care. It highlights how team-based care can improve outcomes when patients are treated as active members of the care team. An emphasis is placed on understanding and addressing social determinants of health by listening to patients' lived experiences and ensuring that care plans reflect their goals, values, and circumstances.

This module is intended for health care 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.

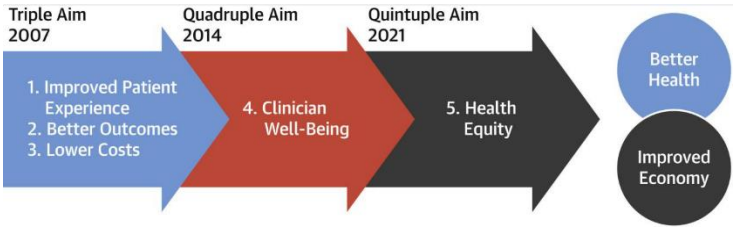
Note: Guidelines referenced in this module are provided in a summary format. Review complete recommendations in the original publication(s) and utilize recommendations with physician/clinician judgment, considering a patient's unique needs and circumstances.

Tomorrow's Prevention, Today: Partner with Quality Insights

Quality Insights is dedicated to helping your health care team prevent and manage type 2 diabetes. Through our partnership with the Delaware Department of Health and Social Services (DHSS) Division of Public Health (DPH), 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 exploring 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 has developed evidence-based transformation solutions to increase practices' proactive management of patients

with and at risk for type 2 diabetes. Workflow modifications are 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 at no cost to support your clinical quality improvement goals and improve value-based care in your practice setting.

Team-Based Care: Partnering WITH Patients

Health care is changing at a rapid pace. As health care moves from fee-for-service (FFS) to value-based models, the focus is shifting from the number of visits or procedures to what matters most: better outcomes and experiences for patients. The COVID-19 pandemic highlighted how essential it is for the whole care team to work together around each patient's needs. This shift aims to enhance individual and population health while improving the safety, quality, and efficiency of health care delivery.

> *"Patient-centered care partners with patients and families, welcomes their involvement, and personalizes care to* ***preserve patients' normal routines as much as possible.***"
>
> *Source: AHRQ, n.d.*

The American College of Physicians (n.d.) defines team-based care as a care model that "strives to meet patient needs and preferences by actively engaging patients as full participants in their care while encouraging and supporting all health care professionals to function to the full extent of their education, certification, and licensure." In this model, a variety of health care professionals – including physicians, physician assistants, nurse practitioners, pharmacists, nurses, medical assistants, care managers, social workers, community health workers, and others – work together to coordinate tasks like pre-visit planning, expanded intake activities, medication reconciliation, updating patient information, and scribing. This collaborative approach aims to enhance patient care. The patient is the center 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 Burden of Diabetes in Delaware

According to the American Diabetes Association (ADA), "**over 38.4 million Americans have diabetes** and face its devastating consequences."

The statistics are staggering. The incidence of diabetes across the country continues to rise. While Delaware saw its first decrease in diabetes rates between 2019 and 2021 since the early 2000s, this trend unfortunately did not continue in the latest statistics (Centers for Disease Control and Prevention (CDC), 2024; DHSS, 2025).

Diabetes in Delaware in 2023

- 13.3% of adult Delaware residents have been diagnosed with diabetes.
- 21.0% of Delaware residents aged 55 to 64 have been diagnosed with diabetes.
- 23.7% of Delaware residents aged 65 and over have been diagnosed with diabetes.
- There is a 35.7% obesity rate among Delaware adults.
- $982 million is spent annually in estimated total direct and indirect medical costs for diagnosed diabetes.

Source: DHSS, 2025

Combatting the Trend

Education and Self-Management

Providing patients with education about disease processes and self-management techniques has shown improvements in health outcomes. Individuals living with prediabetes may be able to prevent the development of type 2 diabetes through education and subsequent lifestyle modifications, while those with diabetes may be able to better control their disease and decrease the incidence of new comorbidities through diet, exercise, monitoring, and medication adherence.

How will patients with diabetes receive the necessary education?

This module provides information on accredited diabetes education programs and ways to leverage members of the care team. It shares provider and patient resources to improve diabetes outcomes. Apply the information in a way that meets your practice and patient goals.

Reducing Diabetes Burden: Recommendations from the Impact of Diabetes in Delaware Report

The Impact of Diabetes in Delaware, 2025, is a biennial report produced by two DHSS divisions, DPH, and the Division of Medicaid and Medical Assistance (DMMA), in addition to the Department of Human Resources Statewide Benefits Office (SBO). The 2025 report uses data from 2023 and 2024.

In the report, "DPH, DMMA, and SBO make six **recommendations** to reduce Delaware's diabetes burden and improve health outcomes among adults with or at-risk for diabetes."

The recommendations are:

1) Continue to promote diabetes risk reduction through healthy lifestyle behaviors.
2) Increase referrals to the nationally recognized, evidence-based National Diabetes Prevention Program (National DPP) for Delawareans at high risk for diabetes.
3) Reduce the proportion of Delawareans with uncontrolled high blood pressure through improved medication adherence and/or referrals to lifestyle change programs like the Healthy Heart Ambassador – Blood Pressure Self-Monitoring Program (HHA-BPSM).
4) For Delawareans diagnosed with diabetes, increase referrals to evidence-based lifestyle change programs including Diabetes Self-Management and Education Support (DSMES) services, the Diabetes Self-Management Program (DSMP), Livongo® (for GHIP members covered by Highmark Delaware), and Transform Diabetes Care® (for GHIP members covered by Aetna).
5) Promote a team-based care approach to diabetes to improve clinical outcomes and reduce health care costs.
6) Use high-quality electronic health record data and claims data to inform outreach and policy.

These recommendations in the report are easier to achieve when the entire care team works together to support patients in preventing and managing diabetes. When health professionals collaborate with their patients, outcomes, and goals are more attainable. This publication and additional resources for health care professionals can be found on the Diabetes and Heart Disease Prevention and Control Program page on the DPH website.

Key Features of High-Performing Teams

As patients become more educated and engaged in the management of their condition, they will find themselves developing skills in topics such as diet, exercise, and blood-sugar monitoring. This type of mindset will provide lifelong benefits. When this patient engagement is supported by an effective and well-coordinated care team, both patient and providers experience better outcomes.

Several studies have shown that efficient and effective team-based care reduces patient costs and physician burnout. A study published by Lu et al. (2023) found that physicians and nurses who operated in an effective team experienced lower levels of workplace isolation and burnout. Participants also offered recommendations that included "creating consistent care teams, expanding interdisciplinary team members, and increasing clinical support staffing" (Lu et al., 2023). High-performing care teams create an

Team-based care has shown to be able to lower A1C levels by as much as 0.8% in patients with type 2 diabetes. Collaboration among nurses, pharmacists, and educators improves outcomes. (Levengood et al., 2019)

environment where patients feel supported, informed, and empowered to take active roles in their health.

Table 1 below examines the components and qualities that characterize high-performing teams and how they can help decrease provider workloads.

Table 1. Principles of High-Performing Teams

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 optimizes 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 American Medical Association (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.

Reach out to your Quality Insights' Practice Transformation Specialist to learn how they can make workflow modifications to incorporate more of your team in diabetes care.

The Patient as a Central Member of the Care Team

Approximately 95% of the variation in diabetes-related clinical outcomes, such as A1c Levels, results from patient behaviors that require self-management (Powers et al., 2022). Given this, empowering patients as central members of the care team is essential for improving health outcomes. The following strategies explore how to achieve this collaborative approach.

A Patient-Centered Approach

Like team-based care, patient-centered care ensures that treatment is tailored to each individual's needs, preferences, and values. This approach not only improves patient satisfaction but also encourages active engagement in their own health.

Patients should understand that their actions and choices have a direct impact on their personal health. As a provider, you play a key role in empowering and motivating them to take ownership of their well-being. A patient's lived experiences, and unique perspectives should inform and shape their care plan. By understanding and incorporating a patient's preferences, providers can enhance both the effectiveness of care and the patient's acceptance of the recommended plan.

Enhance Your Care Team: Empowering Patients and Families

Promoting Two-Way Communication: Listening to and Learning from Patients

The most important member of the care team is the person living with diabetes. The patient achieves optimal outcomes from care team interactions with appropriate support, motivation, a trusting collaborative relationship, positive behaviors, and effective communication. The American Diabetes Association (ADA) created a guide to assist health care professionals in developing effective communication on a variety of topics related to diabetes, focusing on the emotional problems that can arise for people living with diabetes. The ADA's "A Practical Guide for Health Professionals Supporting Adults with Type 1 and Type 2 Diabetes" stresses that open communication promotes better outcomes. Using open, empathic communication with patients is important to accomplishing desired goals. Table 2 offers examples of outcomes from both open, empathic communication and closed, directive communication.

Table 2. Outcomes Resulting from Open and Closed Communication Styles

Outcomes of Open, Empathic Communication	Outcomes of Closed, Directive Communication
Increased trust in the health professional	Mistrust and lack of confidence in the health professional; desire to change care provider
Increased knowledge, confidence/self-efficacy	Not seeking further care, lack of confidence
Increased engagement in decision-making/ collaborative decision-making/better decisions	Lack of engagement in decision-making (wasted efforts and opportunities)
Increase in coping skills to overcome daily challenges (proactive coping)	Increased reliance on health professional directives
Increased motivation	Decreased motivation
Personal care plan	General care plans
Increased engagement with self-care activities (e.g., medication taking)	At best, passive "compliance"; at worst, active disregard of health professional's advice and recommendations
Increased satisfaction with the health professional/system	Increased complaints and negligence claims
Realistic expectations (for both parties)	Unrealistic expectations (by both parties)
Reduced errors/mistakes (e.g., in prescribing or taking medication)	Misunderstandings and misinterpretation of advice/recommendations

Source: American Diabetes Association, "A Practical Guide for Health Professionals Supporting Adults with Type 1 and Type 2 Diabetes."

For more practical examples of negative language, replacement language, and rationale, view Table 4 within the guide linked above. A supplemental handout, *Speaking the Language of Diabetes: Language Guidance for Diabetes-Related Research, Education, and Publications*, provides highlights of preferred communication strategies to more effectively engage with and empower people with diabetes and can be used as a reference guide for staff. Providers can also take Quality Insights' Motivation Interviewing online course for guidance on using motivating language with patients.

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" (American Academy of Family Physicians, 2011). It differs from other change strategies because it is more patient-centered and goal-directed. Motivational interviewing allows the

patient to be responsible for their goals and progress to help resolve ambivalence and 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 asking "yes" or "no" questions. Instead, use open-ended questions that provide more freedom for response without implying a right or wrong answer. For example, you might ask, "How has managing your diabetes affected your daily routine?" or "How do you feel your diabetes management has impacted your overall quality of life?"
- **A**ffirming
  - Show empathy during difficult times and celebrate patients' achievements with genuine affirmations. For example, you might say, "Thank you for completing your A1C test," or "I understand this was a lot to ask, but I appreciate you being honest about your struggles."
- **R**eflective listening
  - Allow patients to share their thoughts and steer the conversation rather than dictating actions. This approach helps them develop their own ideas for change. Acknowledge their emotions and mirror their statements to reinforce their confidence in their own abilities.
- **S**ummarizing
  - This process includes summarizing the conversation, highlighting key details, and giving the patient the opportunity to clarify any misunderstandings or provide additional information. Conclude the summary with an open-ended question such as, "I'm curious about how you're feeling right now," or "What do you think your next steps 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. Providers can also take Quality Insights' Motivational Interviewing e-learning course for guidance on how to use motivating language with patients.

Roles of Professionals and Patients in Diabetes Management

The ADA's Standards of Care in Diabetes – 2025 recognizes the important role care teams play in optimizing 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.

Throughout the *Standards,* the ADA details a variety of psychosocial factors that influence those living with diabetes and present obstacles to individuals and their families. When patients feel heard and supported in both their medical and nonmedical needs, they are more likely to engage in their care and achieve better health outcomes.

Care teams can include nurses, dietitians, medical assistants, and case managers. This care team plays an integral role in caring for people with diabetes. The team 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, creating a more patient-centered approach.

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 Table 3 below (CDC, 2024).

Table 3. Extended Diabetes Care Team Members and Roles

Contributor	Role
Diabetes Care and Education Specialist	Provides DSMES; assists in increasing knowledge and decision-making skills; creates an individualized plan for diabetes management based on health needs, lifestyle, and culture.
Registered Dietitian	Helps develop healthy eating patterns to: • Improve overall health. • Reach and maintain body weight goals. • Reach blood sugar, blood pressure, and cholesterol goals. • Delay or prevent diabetes complications.
Ophthalmologist or Optometrist	Performs routine diabetic eye exams to diagnose diabetic retinopathy and improve or manage eye health.
Podiatrist	Treats 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	Specializing 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.
Pharmacist	A pharmacist can tell you which medicines may affect your blood sugar. They can also let you know which over-the-counter and prescription medicines should not be used together.

Contributor	Role
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.
Mental health professional	Psychiatrists, psychologists, social workers, and counselors can all provide mental health care. They can help you manage the demands of day-to-day diabetes care, as well as mental health issues. If you're concerned about your mental health, ask your doctor to refer you to a mental health professional for help.
Exercise specialist	This person is trained in the best and safest ways to get physical activity. An exercise specialist can be a physical therapist, occupational therapist, or personal trainer. They can help you with structured physical activity, like an exercise session. They can also help you with unstructured activity, like taking a walk.

Source: The Diabetes Care Team, Centers for Disease Control and Prevention, 2024

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 teams as they provide clinical patient care services. Pharmacists can specifically serve as a drug information resource for patients and staff while providing patient education on chronic disease management. This article reports that "by the year 2032, there will be a shortage of 21,100 to 55,200 primary care physicians in the United States." This shortage can be minimized by adding health professionals to the care team and allowing all team members to function within their scope, credentials, and licensure limitations. **"Pharmacists are health professionals that can be utilized to ensure patients receive adequate care in primary care settings"** (Moreau, 2021).

The American Medical Association (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.

Evidence Confirms: Diabetes Self-Management Education and Support (DSMES) Improves Health Outcomes

DSMES is an evidence-based program accredited through the ADA and the Association of Diabetes Care and Education Specialists (ADCES). DSMES provides a foundation to empower people with diabetes to navigate self-management decisions and activities. The updated consensus statement from the ADA and the European Association for the Study of Diabetes asserts, "DSMES is a key intervention, as important to the treatment plan as the selection of pharmacotherapy" (Davies et al., 2022).

Effective education takes time to learn, self-reflect, implement, reinforce, retain, and develop a new way of life. DSMES programs are "a collaborative process between the educator and the patient that usually includes up to 10 hours of counseling in the first year to address a variety of topics in depth – from healthy eating and exercise to monitoring and medications to problem-solving" (Association of Diabetes Care & Education Specialists, 2021).

According to a 2020 Consensus Report, DSMES has been shown to improve health outcomes and is considered a critical component of diabetes care. Participation in a DSMES program "lowers hemoglobin A1C (A1C) by at least 0.6%, as much as many diabetes medications, however, with no side effects" (Davis et al., 2022). This was confirmed in a study published by Aronson et al. (2022), where individuals who participated in DSMES saw a decrease in A1C by 0.6% and an 8.1% increase in time in range. Recognized as a cost-effective tool due to reduced hospital admissions and readmissions, this program also improves medication adherence rates, enhances self-efficacy, increases physical activity, and results in less severe diabetes-related complications (CDC, 2022).

Despite the positive results of DSMES programs, according to the CDC (2022), "less than 5% of Medicare beneficiaries with diabetes and 6.8% of privately insured people with diagnosed diabetes have used DSMES services." Data reveals that a substantial gap still exists statewide. As of 2023, only 45.6% of Delawareans with diabetes have taken a course or class on how to self-manage their diabetes, with only 26.1% having taken one within the last two years (DHSS, 2025).

Contact our team today to learn how Quality Insights can strengthen your practice to bridge the referral gap between patients living with diabetes and DSMES.

Discover more about the efficacy and benefits of DSMES by reviewing these resources:

- Podcast – Benefits of Diabetes Educator Referrals.
- Diabetes Self-management Education and Support in Adults with Type 2 Diabetes: A Consensus Report.

Join Quality Insights for our DSMES Collaborative

Whether you are just in the contemplative stages or have started taking steps to establish your own DSMES, Quality Insights invites you to join our DSMES Collaborative! Since 2023, Quality Insights has worked alongside DPH to discuss DSMES topics such as program recruitment, patient retention, and barriers affecting the programs. This collaborative, which meets quarterly, brings stakeholders to the table and creates program goals while providing meaningful and tangible ways for Quality Insights and DPH to increase program utilization. To join our next meeting, email Ashley Biscardi.

Medical Nutrition Therapy (MNT)

The original ADA *Standards of Care* from 1989 mentioned nutrition only twice in the four-page document. In the 2025 edition, nutrition and Medical Nutrition Therapy (MNT) now take up nearly 10 pages. For many individuals with diabetes, the most challenging part of the treatment plan is diet.

Nutrition therapy plays an integral role in an individual's ability to maintain proper diabetes management. With this in mind, providers should consider integrating registered dietitians on care teams. The 2025 standards refer to the 2019 ADA *Diabetes Care* article on nutrition therapy, stating that all individuals with diabetes should be referred for "individualized MNT provided by a registered dietitian nutritionist (RD/RDN) who is knowledgeable and skilled in providing diabetes-specific MNT at diagnosis and as needed throughout the life span, similar to DSMES." (ADA, 2019)

MNT can often be combined with DSMES to offer even more education and support. The CDC DSMES Toolkit provides more information about MNT, including Medicare considerations. Patient-facing nutrition resources are found on the ADA website.

Managing Diabetes: Diabetes Self-Management Program

The Stanford Diabetes Self-Management Program (DSMP), also known as Better Choices, Better Health-Diabetes (BCBH-D), is a diabetes management program offered through an online platform or in-person with small community groups. Unlike the DSMES program, DSMP is an abbreviated program, with a weekly 2.5-hour session hosted by trained leaders over a six-week period. Often, one leader is an individual living with diabetes who provides first-hand insight into diabetes self-management. Participatory classes allow registrants to better understand their condition and engage in healthier lifestyles. Explore Delaware's own Diabetes Self-Management Program offerings at Healthy Delaware and Milford Wellness Village.

Contact our team today to see how Quality Insights can assist your practice with referrals between patients living with diabetes and DSMP in Delaware for more support.

Understanding Social Determinants of Health (SDOH)

What are SDOH?

Social determinants of health (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 factors have a large influence on health outcomes and contribute to health inequities both within the United States and abroad. A pattern has emerged showing that individuals with lower socioeconomic status tend to experience worse health outcomes. SDOH can include, but are not limited to, the following (WHO, 2023):

- 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, especially for those living with chronic diseases, and combating and reducing health inequities.

Diabetes and SDOH: ADA Publications

"Putting the person, rather than their diabetes, at the center of health care can help improve person-provider relationships and physical and mental health outcomes" (Kenney & Briskin, 2022). The ADA continues to recognize the critical role that vital conditions and patient-centered care play in the health outcomes of those with diabetes (ADA, 2025).

The ADA convened a writing committee to help advance opportunities for diabetes population health improvement by 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 targeting amelioration of SDOH on diabetes outcomes" (Hill-Briggs et al., 2021). 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 (Hills-Briggs & Fitzpatrick, 2023):

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 health care sector to mitigate adverse SDOH.

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, socioeconomic, and political context to SDOH frameworks as SDOH root causes and drivers.

SDOH and Diabetes in Delaware

Here in Delaware, the effects of SDOH and their connection to diabetes can be readily observed in the 2023 Behavioral Risk Factor Surveillance System (BRFSS) as reported by the CDC (BRFSS, 2023). As seen in Tables 4 and 5 below, an individual's education level and socioeconomic status are closely tied to their chances of developing diabetes.

Table 4. Chances of Developing Diabetes Based on Education Level

Educational Attainment Level				
	Less than High School	High School	Some Post-High School	College Graduate
Percent (%)	13.6%	12.8%	16.6%	10.7%
95% CI	7.6% to 19.5%	10.3% to 15.2%	13.3% to 20.0%	8.9% to 12.6%

Source: Centers for Disease Control and Prevention, BRFSS, 2023

Table 5. Chances of Developing Diabetes Based on Household Income

Household Income						
	<$15,000	$15,000 to $24,999	$25,000 to $34,999	$35,000 to $49,999	$50,000 to $99,999	$100,000 to $199,999
Percent (%)	19.0%	23.6%	18.2%	14.9%	12.0%	8.4%
95% CI	8.7% to 29.4%	15.3% to 31.9%	12.9% to 23.4%	10.9% to 19.3%	9.0% to 15.0%	6.0% to 10.8%

Source: Centers for Disease Control and Prevention, BRFSS, 2023

Individuals whose income is less than $15,000 experience diabetes at a rate more than twice of those who earn more than $100,000. Several factors, including lack of access to health care, quality of care received, and socioeconomic status, are barriers to preventing diabetes and having effective diabetes management once diagnosed. These inequities are even more prevalent when looking at non-White individuals.

Health Disparities: Racial and Ethnic Minorities are at Higher Risk for Developing Diabetes

The Centers for Medicare & Medicaid Services Office of Minority Health (CMS OMH) confirms that racial and ethnic minorities are at a higher risk of developing diabetes. According to 2023 data, Black Delawareans experience diabetes at a rate of 19.1%, which is significantly higher than the rate of 12.5% of their White counterparts (BRFSS, 2023). Many who are diagnosed experience challenges managing their diabetes and are more likely to experience complications.

View a full suite of online resources to help health care professionals, patients, and their families manage diabetes at CMS OMH.

- As of January 2023, following the implementation of the Inflation Reduction Act, insulin products are capped at $35 per month per product under a Medicare prescription drug plan. Part D deductibles do not apply to these covered insulin products. Visit the Insulin page on Medicare.gov for more information for patients needing assistance comparing Medicare plans and the associated costs of insulin.
- Review the Diabetes Management: Directory of Provider Resources guide from CMS OMH to identify useful resources on the management of type 2 diabetes for providers and care teams.
- Download Managing Diabetes: Medicare Coverage and Resources, an updated resource that provides steps for improving one's health as well as information on services available through Marketplace plans and Medicare. This resource is also available in seven additional languages.

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 is largely accountable for self-management. Primary care providers bear a great responsibility to educate patients of all backgrounds and cultures.

The CDC defines cultural competence as "deliver services that are respectful of and responsive to the health beliefs, practices, and cultural and linguistic needs of diverse patients" (2023).

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 & Shubrook, 2021). The disproportionate effect that diabetes has on non-White populations in the United States supports the importance of cultural competency in diabetes care.

Dragomanovich and Shubrook state that:

- Diabetes prevalence is two to six times higher among African American, Native American, Asian, and Hispanic populations than the White population, and these populations experience a 50% to 100% higher burden of illness and mortality from diabetes than the White population.

- Minority populations also have a higher mean hemoglobin A1C and higher rates of diabetes-related complications.
- Racial and ethnic minorities (non-White) have a higher prevalence of diabetes at a lower body mass index 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).

Utilizing Members of the Community: Community Health Workers

A community health worker (CHW) can be a valued part of any health care team. They can be a key link, helping individuals and families navigate health, social, and community services to enhance overall well-being. As a trusted community member, the CHW understands the unique demographics and experiences of those they serve, offering culturally and linguistically appropriate support. Equipped with the skills to address SDOH, the CHW works to improve health outcomes and promote health equity and patient-centered care within the communities they serve (Ignoffo et al., 2023).

Especially in communities with a high Social Vulnerability Index (SVI) score, providers and community-based organizations should work alongside CHWs to leverage their connection and understanding of the community. Especially with intricate chronic diseases such as diabetes, CHWs could be a great resource to elevate a patient's understanding of their condition and increase their involvement in their care.

Learn more about CHWs here in Delaware on the Community Health Workers Association of Delaware's website or connect with Quality Insights to learn more about how CHWs can help your patients.

Partnering with Patients to Address SDOH Together

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*.

Recognizing the role of SDOH means understanding each patient's lived experience and partnering with them to create care plans that are both realistic and supportive of their daily lives. 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). Health care 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 standardized tool designed to aid health care organizations and community-based organizations to assess SDOH and improve health equity and outcomes.

A successful, integrated workflow that prioritizes SDOH screening, coding, and referrals to community resources necessitates the coordination of the entire care team. See Chapter 5 of the PRAPARE Implementation and Action Toolkit for more in-depth implementation steps and workflow ideas.

Contact your Quality Insights' Practice Transformation Specialist to learn more about implementing screening for SDOH in your practice, including information on reimbursement.

Cultural Competency Resources for Health Care Providers

- Cultural and Linguistic Competence Health Practitioner Assessment from the Georgetown University National Center for Cultural Competence
- Promoting Cultural and Linguistic Competency Self-Assessment Checklist for Personnel Providing Primary Health Care Services from the 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
- The EveryONE Project Toolkit from the American Academy of Family Physicians.

American Academy of Family Physicians: Myth-Busting Success Story

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

American Medical Association (AMA) STEPS Forward® Team-Based Care and Workflow Toolkit

AMA STEPS Forward® Team-Based Care and Workflow Toolkit includes the updated *Saving Time Playbook* and several modules to assist organizations in implementing team-based care, sharing responsibilities, and facilitating better and more timely care. Major themes discussed in the playbook include stopping unnecessary work, sharing necessary work, and making the case to leadership.

In addition to the playbook, the AMA has released multiple self-study modules on a wide variety of topics, including team-based care and diabetes (some include CME credit).

Agency for Healthcare Research and Quality (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 health care professionals. Access the full curriculum, and download the TeamSTEPPS® Pocket Guide App as a quick reference tool.

Centers for Disease Control and Prevention (CDC)

Enhance your professional development with CDC webinars and videos. Learn approaches for engaging patient-centered care, increasing cultural competence, and promoting diabetes prevention and management. Some webinars offer CME credit.

- Compassionate Communication to Reengage People with Diabetes in DSMES
- Utilizing the 2020-2025 Dietary Guidelines for Americans (DGAs) to Tailor and Deliver Type 2 Diabetes Prevention Programs
  Quick Learn: Cultural Adaptation of Materials
- Sharpening Your Vision: DSMES Services as a Connector to Better Eye Health
- Food Insecurity and Its Impact on Diabetes Management
- Community Collaboration to Prevent and Manage Diabetes

Know Diabetes by Heart™

The AHA and the ADA, along with sponsors, created Know Diabetes by Heart™ to reduce cardiovascular disease, heart attack, stroke, and heart failure in people living with type 2 diabetes. A small sampling of their latest cardiovascular and diabetes science patient educational and clinical care tools and quality improvement programs include:

Webinar:

- American Diabetes Association's Standards of Care in Diabetes—2025

Resource:

- Managing Cardiovascular Risk in People Living with Diabetes: Shared Decision-making Discussion Guide and Approaches for Developing a Successful Treatment Plan

Program:

- Living with Type 2 Diabetes Program is a free 12-month program available in English and Spanish. This course serves as an option for those who are unable to participate in a DSMES program.

American College of Physicians (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.

Patient Education and Empowerment

Patient Self-Management: Diabetes Smartphone Apps

Smartphone apps can be great tools to promote patient self-management daily, which is especially important for patients living with diabetes.

To assist practices in identifying apps that are of the most benefit to their patients, Quality Insights created the Phone Apps to Help You Better Manage Your Diabetes patient handout. This flyer provides a general listing of various nutrition, glucose tracking, and healthy living resources designed to help your patients succeed.

Patient Resources

Patient Assistance: Insulin Cost Savings

According to a 2022 study published in *Annals of Internal Medicine*, researchers analyzed the CDC's 2021 National Health Interview Survey data and found that 1.3 million people in the United States, or about 16.5% of those who use insulin, rationed it. Rationing, which includes skipping doses, delaying the purchase, and taking less than indicated, was most common among those without health insurance by almost a third. Nearly 20% of those with private insurance also rationed. The least likely to ration were adults aged 65 and older and people who enrolled in Medicare or Medicaid (Tucker, 2022).

As health care providers and patient advocates, we are tasked with educating patients on available resources so they may overcome barriers and successfully manage their health needs and medication requirements. These resources help patients readily access medication assistance:

- Insulin Cost Savings Toolkit**:** Developed by Dr. Diana Isaacs, PharmD, BCPS, BC-ADM, BCACP, CDCES, in collaboration with the Association of Diabetes Care & Education Specialists (ADCES), this document provides access to patient assistance programs specific to manufacturer and product.
- ADA Center for Information: Call 1-800-342-2383 to speak to information specialists who can:
    - Refer to an ADA-recognized diabetes self-management education seminar in your area.
    - Assist in connecting you with the appropriate financial aid resources.

  - Assist people who believe they are facing discrimination based on diabetes.
  - Connect you with your local ADA team regarding local events, programs, and volunteer opportunities.
- Needymeds.org: This website offers the capability to search for medication assistance programs by diagnosis. It includes assistance options for diabetes medications, supplies, and laboratory services.
- GetInsulin.org: This resource helps people living with diabetes find affordable insulin access through customized action plans based on the patient's location, insurance type, income, and prescription. This is not a direct assistance program, but manufacturers, governmental agencies, non-profits, and more support it. The site and plan details are available in English and Spanish, and the solutions are available to people in the United States regardless of their citizenship status.

Patient Assistance: Medication and Supply Cost Savings

- **Healthy Delaware**: Visit this website to find a list of resources to assist in paying for diabetes supplies and medications. Diabetes is a manageable health condition. Insurance or assistance may be available to help cover the costs of health care provider visits, prescription medications, meters, or other supplies/services. Some programs are limited to specific populations.
- **Rx Assist**: This web-based medication database resource center is for consumers and caregivers. Search by medication name for available prescription savings cards, discounts, and patient assistance programs.
- **Delaware Prescription Assistance Program (DPAP)**: This program helps pay for prescription medications for elderly and disabled individuals who cannot afford the full cost of filling their prescriptions. DPAP will provide each eligible individual up to $3,000 per year toward medically necessary prescription drugs and Medicare Part D premiums. Details about eligibility requirements and how to apply for the program can be found on the linked website.
- **GoodRx**: This online tool gathers current prices and discounts to help find the lowest-cost pharmacy for prescriptions. It can be accessed on a computer or via a smartphone app. GoodRx is 100% free, and no registration is required.
- **Medicine Assistance Tool (MAT)**: This is a free search engine tool designed to provide resources available through various pharmaceutical programs, such as financial assistance programs and Rx savings cards.

Multilingual Diabetes Patient Education Materials

The ADA Patient Education Library offers free, downloadable diabetes education resources that can be filtered by category and language. Eleven language options are available, including Spanish and Haitian Creole.

Some items to select from include:

- Prediabetes: What Is It and What Can I Do?
- Are You at Risk for Type 2 Diabetes?
- Factors Affecting Blood Glucose
- Diabetes: An Introduction
- Diabetes Symptoms (describes symptoms of Type 1 and Type 2 diabetes).

For additional multilingual education resources covering a variety of health topics, visit MedlinePlus® (arranged by language). EthnoMed also provides diabetes resources that can be filtered by language.

Library Learning: Diabetes Education Resources for Patients

As a result of collaboration between the DPH, Diabetes Prevention and Control Program and the Delaware Division of Libraries, all Delaware libraries have a diabetes health information section. This section offers easy-to-read materials such as Delaware-specific diabetes information, cookbooks, diabetes prevention, information on weight management and exercise, and diabetes management. Also available are educational videos, some of which are provided in both English and Spanish, and some resources designed for the teen population.

Delaware's public libraries provide on-site computers through which patients can access additional internet resources on diabetes. For those unfamiliar with internet browsing or computer usage, library personnel can assist. The Delaware Diabetes Resource Guide, developed by the Delaware Diabetes Coalition, provides links, email addresses, and phone numbers for a host of different needs related to diabetes.

Contact Quality Insights

If your practice would like additional guidance or information about team-based care or needs help implementing new workflow processes, contact Ashley Biscardi, Practice Engagement Manager, at abiscardi@qualityinsights.org or by calling 1.800.642.8686 ext. 2137.