# Iowa Diabetes Statewide Strategy

***Mission**: Improve diabetes care and outcomes in Iowa.*
***Vision**: Improve diabetes outcomes in quality, patient safety, patient experience, and cost.*

## 1. Prevent diabetes from occurring in Iowans (primary prevention).

- Objective 1.1: Advance primary prevention efforts to reduce the number of Iowans who develop diabetes.
  - Tactic 1.1-A: Align with the existing statewide prevention-focused efforts, including the Iowa Healthiest State Initiative, I-Smile Dental Home, State Innovation Model related activities, Transforming Clinical Practice Innovation, Iowa Department of Public Health Diabetes Prevention Programming, and Association of Diabetes Care & Education Specialists (ADCES).
  - Tactic 1.1-B: Identify and collaborate with health care providers, partners and stakeholders to implement effective evidence-based primary prevention efforts, including those who address oral health and diabetes risk factors.
  - Tactic 1.1.-C: Identify, promote and use a venue for sharing of successful interventions, best practices and policy efforts related to prevention of diabetes.

- Objective 1.2: Increase healthy behaviors in Iowans to prevent or delay the onset of diabetes.
  - Tactic 1.2-A: Create and sustain healthy environments that promote health and wellness for all Iowans.
    - Address social determinants of health that impact opportunities to adopt healthy behaviors.
    - Leverage the work of other concurrent efforts (Healthiest State Initiative, Healthy Iowans plan, I-Smile initiatives, Healthy Hometown, etc.) to support local access to healthy foods and built environments to promote active lifestyles.
    - Address emerging initiatives to combine fragmented health delivery systems such as the inclusion of oral and behavioral health.
  - Tactic 1.2-B: Increase participation in diabetes primary prevention programs, including, National Diabetes Primary Prevention Program (NDPP) and YMCA Diabetes Prevention Program (YDPP), and emerging adult disease prevention programs.
    - Educate providers and consumers about the purpose and locations of the primary prevention programs inclusive of oral health prevention programming such as I-Smile and I-Smile Silver in Iowa.
    - Increase patient referral to primary and oral health prevention programs.

- Objective 1.3: Increase the number of Iowans who receive a pre-diabetes risk assessment.
  - Tactic 1.3-A: Educate Iowans on pre-diabetes and diabetes risk factors.
  - Tactic 1.3-B: Disseminate tools for pre-diabetes risk assessment to provider and community stakeholders.

## 2. Ensure detection of diabetes in its earliest stages (detection).

- Objective 2.1: Educate the public on diabetes screening recommendations.

- Tactic 2.1-A: Disseminate diabetes screening recommendations and self-administered diabetes screening tools and information to providers and community partners.
- Tactic 2.1-B: Incorporate diabetes screening and dental assessment recommendations as part of existing public awareness and education platforms.

- Objective 2.2: Increase access to quality recommended diabetes screenings and healthcare services.
  - Tactic 2.2-A: Promote diabetes screening, following national recommendations and tools from the United States Preventive Services Task Force, the Centers for Disease Control and Prevention, American Diabetes Association, ADCES, Community Pharmacy Enhanced Services Networks (CPESN), and American Dental Association, etc.
  - Tactic 2.2-B: Increase opportunities for accessible diabetes screening through community, employer, pharmacy, school, and workplace-based outlets.

- Objective 2.3: Implement health-care system-based strategies to detect undiagnosed diabetes.
  - Tactic 2.3-A: Encourage the use of risk stratification tools to identify appropriate patient populations for diabetes screening.
  - Tactic 2.3-B: Promote mechanisms for communication between pharmacists and other care providers to ensure a streamlined approach to identify and screen across the continuum of care.
  - Tactic 2.3-C: Educate and equip medical and dental providers to address diabetes risk factors and screening with patients.
    - Incorporate standardized glucose testing at annual physical appointments.
    - Identify barriers within primary care and dental practices to addressing diabetes screening with patients.
    - Promote and implement the use of technology to support diabetes detection and diagnosis.

## 3. Improve the quality of diabetes management and treatment services and programs (management/treatment).

- Objective 3.1: Implement clinical, systems-based healthcare strategies to improve quality diabetes care.
  - Tactic 3.1-A: Implement evidence-based interventions to enhance diabetes management inclusive of oral health services.
    - Enhance and disseminate provider toolkit to identify and connect essential resources.

  - Tactic 3.1-B: Engage providers, staff, and patients in glycemic management and best practices.
    - Promote medication adherence and access to optimize medication management and

minimize hypoglycemic harm related to insulin.
    - Actively demonstrate the role of pharmacists in clinic settings to optimize medication management services.
  - Tactic 3.1-C: Equip providers to recognize and address social determinants of health.
  - Tactic 3.1-D: Promote a culture of inclusion and safety throughout provider settings supportive of patient and family engagement and activation.

- Objective 3.2: Increase coordination of diabetes management and treatment activities.
  - Tactic 3.2-A: Promote care coordination across community of providers.
  - Tactic 3.2-B: Increase provider and consumer awareness and use of diabetes resources, including community-based and virtual offerings.
  - Tactic 3.2-C: Promote bi-directional patient referral and follow-up to necessary community resources to address social determinants of health using available community health workers and other provider extenders.
  - Tactic 3.2-D: Ensure providers are aware of and provide linkage to care with appropriate resources to address social determinants of health barriers to management and treatment.

- Objective 3.3: Engage patients and families as the center of their diabetes care.
  - Tactic 3.3-A: Increase diabetes health literacy for patients, caregivers, and their providers.
  - Tactic 3.3-B: Champion shared decision-making principles and practices as a fundamental component of care for persons with diabetes and their caregivers.
  - Tactic 3.3-C: Identify and address barriers to patient care impacting diabetes management and treatment.
    - Encourage patient and provider discussions to identify social determinants of health and patient needs impacting care.
    - Incorporate referrals to community-based services to assist in addressing barriers to care.

- Objective 3.4: Increase access to diabetes management, treatment, and support services.
  - Tactic 3.4-A: Identify and support existing resources to assist patients in locating and accessing diabetes care services.
  - Tactic 3.4-B: Maximize effectiveness and use of diabetes self-management education and training.
    - Support increased access and use evidence-based, endorsed diabetes self-management education and training curriculum.
    - Educate providers and consumers about the purpose and locations of diabetes self-management education and training offerings in Iowa.
    - Increase provider referral of diagnosed patients to diabetes self- management education and training.
  - Tactic 3.4-C: Increase the number of diabetes self-management education and training programs across Iowa to improve access to those services for all persons with diabetes.

- Tactic 3.4-D: Engage health plans and managed care organizations to include coverage for prevention programming and management support such as education, medications and supplies, and elimination of co-payments.

**4. Use data to drive population-based diabetes strategies (data)**

- Objective 4.1: Utilize common diabetes measures across Iowa healthcare systems.
  - Tactic 4.1-A: Align measures and data collection with national quality measure conventions (e.g. CMS, National Quality Forum (NQF), and CDC).

- Objective 4.2: Utilize diverse sources of data to ensure ongoing execution of diabetes strategies.
  - Tactic 4.2-A: Promote provider tracking and utilization of diabetes data to inform quality improvements.
  - Tactic 4.2-B: Encourage transparency in public reporting of diabetes quality improvement metrics to highlight the current state of diabetes in Iowa.

- Objective 4.3: Use data to drive diabetes quality improvements in Iowa healthcare systems.
  - Tactic 4.3-A: Facilitate improvements in chronic care across healthcare settings through diabetes quality improvement and tracking activities.
    - Promote expansion of clinical care process measures beyond diabetes, to include other chronic conditions and comorbidities.
    - Encourage surveillance of diabetes as part of the chronic care continuum, inclusive of related conditions and social determinants of health.