Diabetes Driver Diagram

Drivers that reduce patient HbA1C

Developed by the Massachusetts League of Community Health Centers

Massachusetts League of Community Health Centers

Primary Drivers	Secondary Drivers	Specific Ideas to Test or Change Concepts
Activated Patient	Promotion of Self-Management	Refer patient to Diabetes Self-management Education and Support (DSME/S) programs
		Use motivational interviewing strategies to foster empowering environment for patient and improve provider interactions
		Introduce system to measure patient activation/empowerment to inform treatment options. Include quality of life, both in general and diabetes related
		Create patient self-management toolkit (i.e., "Diabetes Passport" serves as a patients personal record of blood pressure, HbA1c levels, weight, cholesterol, goals and plans.)
		Offer onsite exercise classes or skill-based learning sessions on healthful cooking modifications for traditional foods
		Provide self-management tools (eg, blood pressure cuffs, glucometers, culturally sensitive diets)
	Patient Education/Health Literacy	Provide culturally appropriate health education and information
		Encourage knowledge and skill building through referral to community-based classes
		Employ "teach back" method in diabetes education sessions
		Review and update internal resource materials
		Posters and videos are visible in waiting rooms, exam rooms, and other patient areas
		Create health center-tailored visual displays for patient audience that focus on changing targeted behavior
	Case Management	Create case management plan with patient (shared decision making)
		Patients are a part of the goal selection process. Set small goals with clear action steps (self-selected goals vs provider-selected goals)
		Encourage patient to evaulate their efforts and identify lessons learned during process
		Identify personal caregiver/champion and include that person in service provision and care planning. Assess caregiver needs
	Care Extenders	Provide diabetes-specific education to CHWs/MAs/Patient navigators and incorporate into team workflows
		Offer health coaching during home visits
		Offer health coaching in health center
		Provide information to families to support lifestyle changes
		Providers use "warm handoffs" to introduce patients to care extenders
Decrease Health Disparties	Improved Access	Follow national standards for Culturally and Linguistically Appropriate Services (CLAS)
		Allocate health center resources for translation and interpretation
		Expand health center hours to reflect patient population needs
		Practice redesign to encourage group visits for diabetic patients
		Use telemedicine to connect with diabetes specialists
	Culturally Competent Care	Use of culturally sensitive programming for target populations (i.e., Project Dulce)
		Use of graphic illustrations (fotonovellas) to present patient education messages
		Patient education materials (small media) are available and presented to patients in preferred languages.
		Hire and retain multilingual clinicians and staff
	Social Determinants of Health	Assess and address Social Determinants of Health through internal programs and external referrals. Diabetes-relevant factors consist of food insecurity, housing insecurity, finacial barriers, transportation, childcare, and eating disorders
		Conduct mental health screening and referrals. Support diabetic patients in addressing depression and motivation.
		Provide financial supports and sliding fee scale for patients with financial barriers
		Assess and leverage family, psychosocial, peer and community supports
	Community Resources/Involvement	Develop pathways for referral to nutrition education and/or counseling
		Create partnerships with gyms, peer support groups, shelters and faith-based organizations
		Develop referral pathways to community resources (development and maintenance of communication channels and networks)
		Host community health fair focused on diabetes
		Assess and develop catalogue of community resources available to patients and train staff to use

Health Center Systems	**Provider Education**	Train staff in health behavior change methodology and motivational interviewing
		Train/retrain staff on ADA standards of care/guidelines
		Have provider champions reinforce guidelines and lead educational sessions for practice teams
		Develop annual competencies for staff
	Provider Feedback	Generate and disseminate provider-specific reports on diabetes measures
		Meet with physicians to give feedback on measures reports
		High performing providers/teams share best practices
		Orienting new providers and staff on diabetes policies & workflows
	Health Information Technology/Information Systems	Use a diabetes patient registry to track clinical measures
		Identify and develop interventions for elevated risk patients
		Use a registry to print out summary for specific patients (a prioritized list of all elements of care the patient should receive)
		Generate patient performance reports for both patients and providers
	Team Based Care	Incorporate and build workflows for a diabetes educator/diabetes nurse/CHW into primary care team
		Redefine or expand health care team roles (eg, nurses, instead of PCPs become responsible for foot exams)
		Develop standing orders to allow nurses or pharmacist case managers to make some independent medication changes without waiting for provider approval
	Decision Support Tools (Provider Reminders)	Embed evidence-based care guidelines and protocols in EMR
		Activate EMR alerts to recall patient-specific information and prompts to perform tasks
	Patient Reminder Systems	Script reminder calls to patients
		Use HIPAA compliant automated (prerecorded) telephone calls or texts to send reminders and follow-up with patients
		Conduct staff calls to remind patients about appointments and important aspects of self-care
		Use template letters in EMR for patient reminders

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Diabetes Driver Diagram References

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