

Diabetes Statewide Strategic Plan

Mission: Improve diabetes care and outcomes in Iowa.

Vision: By 2019, 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, SIM, TCPI, HPCDC, AADE, ADA, etc.
 - Tactic 1.1-B: Collaborate with partners and stakeholders to implement effective evidence-based primary prevention efforts, focusing on target conditions of obesity, tobacco use, etc.

- **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, Wellmark Blue Zones, etc.) to support local access to healthy foods and built environments to promote active lifestyles.
 - Tactic 1.2-B: Increase participation in diabetes primary prevention programs, including National Diabetes Primary Program (NDPP) and YMCA Diabetes Prevention Program (YDPP).
 - Educate providers and consumers about the purpose and locations of the primary prevention programs in Iowa.
 - Increase patient referral to primary 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 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 USPSTF, CDC, ADA, etc.
 - Tactic 2.2-B: Increase access to diabetes screening opportunities through community, employer, and workplace-based outlets.

- Objective 2.3: Implement health-care system-based strategies to detect undiagnosed diabetes.
 - Tactic 2.3-A: Encourage use of risk stratification tools to identify appropriate patient populations for diabetes screening.
 - Tactic 2.3-B: Educate and equip providers to address diabetes risk factors and screening with patients.
 - Incorporate standardized glucose testing at annual physical appointments.
 - Identify barriers within primary care offices 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.
 - Create and disseminate provider toolkit to identify and connect essential resources.
 - Tactic 3.1-B: Engage providers and patients in glycemic management and best practices.
 - Promote medication effectiveness to optimize medication management and minimize hypoglycemic harm related to insulin.
 - Tactic 3.1-C: Equip providers to recognize and address social determinants of health.
 - Tactic 3.1-D: Promote a culture of 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 referral of patients to necessary community resources to address social determinants of health.
 - Tactic 3.2-D: Ensure providers are aware of and refer patients to 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.

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

- **Objective 4.1: Develop common diabetes measure set across the Iowa provider community.**
 - Tactic 4.1-A: Align measures and data collection with national quality measure conventions (e.g. CMS, National Quality Forum (NQF)).
 - Tactic 4.1-B: Identify set of common diabetes care measures.
 - Tactic 4.1-C: Encourage provider monthly tracking and utilization of diabetes data

- Objective 4.2: Enhance diabetes surveillance through development of an “Iowa suite” of standardized measures.
 - Tactic 4.2-A: Utilize diverse sources of available data, including surveillance and claims/service-based reporting, to capture ongoing execution of diabetes strategies.
 - Tactic 4.2-B: Support public availability and access of diabetes surveillance data through establishment of a report highlighting current state of diabetes in Iowa.

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