Diabetes Care and Prevention Grant Projection

San Juan County Health

5 Year Continual Application

Purpose

The goal of UNHS's Diabetes Care and Prevention (DCP) program is to strengthen self-care practices by improving access, appropriateness, and feasibility of DSMES services and Diabetes Prevention (DPP) services for San Juan County. UNHS understands the difficulties our patients have receiving medical care and acknowledges the role UNHS plays in overall community health. UNHS is dedicated to the goal of Diabetes Care and Prevention to all patients living with diabetes or are at risk of diabetes because UNHS sees the direct effect on individual health.

Research

As of today, Aug. 26th 2024, UNHS has 1,692 persons living with diabetes (PWD), 36% have an A1c at target of less than 7%, 54% of PWD are above target range, and 9% of PWD have not received an A1c in the past 6 months. UNHS currently has 489 persons with a diagnosis of prediabetes, UNHS is aware that this number does not directly reflect the number of persons living with prediabetes. According to the CDC more than one in three US adults are living with prediabetes 80% of people with prediabetes are unaware they have it and 1 in 4 adolescents in the US have prediabetes, this number has more than doubled since 1999.

Implementation

UNHS DCP team will work directly with the providers to streamline the DSMES referral process, and will identify needs related to increasing referrals. The DCP team meets monthly and will develop a CQI project to address the identified needs. UNHS offers an accredited DSMES program, we will maintain this accreditation with the American Diabetes Care and Education Specialists (ADCES) to continue to offer a quality DSMES program. UNHS has pending recognition for The CDC Diabetes Prevention Program, we are working towards full recognition. UNHS DCP team will work at branding their DPP and increase the number of trained lifestyle coaches in order to offer the program to more participants.

Your support will allow UNHS to reach these heavy goals set out and overall improve community health.

Sincerely,

Megan Burke, RN CDCES
Diabetes Care and Prevention Coordinator
Utah Navajo Health Systems

Diabetes HEAL Meeting w/ Megan B. 8/12/24

(1) strengthen self-care practices by improving access, appropriateness, and feasibility of DSMES services for priority populations.

(A) engage referring providers and community/clinical partners (i.e. DSMES providers) in streamlined referral processes to DSMES/other diabetes support programs; and

(B) work with DSMES providers to identify needs related to increasing referrals (i.e. marketing materials, communication efforts, etc.).

(2) improve acceptability and quality of care for priority populations with diabetes.

(A) support existing or new clinic partners to implement diabetes care practices through QI projects, improving interpretation services offered, clinic workflow and follow up procedures, implementing team-based care, etc.

(3) increase enrollment and retention of priority populations in the National DPP lifestyle intervention and the MDPP by improving access, appropriateness, and feasibility of the programs.

(A) partner with new organizations (i.e. senior centers) to offer the National DPP LCP and assist organizations in registering to become CDC-recognized National DPPs through the Diabetes Prevention Recognition Program; and

(B) identify geographic areas that have gaps in access to culturally appropriate services, by using the information gleaned in 2.1. Additionally, find opportunities to use the Utah Healthy Places Index to expand health equity efforts in diabetes prevention.

3.2 For the National Cardiovascular Health Program the Subrecipient shall:

(1) track and monitor clinical and social services and support needs measures shown to improve health and wellness, health care quality, and identify patients at the highest risk of cardiovascular disease with a focus on hypertension and high cholesterol.

(A) work with local primary care clinic to implement or improve their SDOH screenings.

(2) implement team-based care to prevent and reduce cardiovascular disease risk with a focus on hypertension and high cholesterol prevention, detection, control and management through the mitigation of social support barriers to improve outcomes.

(A) build the capacity of clinical teams to provide and connect patients with social services to help with reducing hypertension and high cholesterol. This shall include conducting formal and informal assessments of the current multidisciplinary team employed by the clinic, and planning how to improve the team based on the assessment results;

(3) link community resources and clinical services that support bidirectional referrals, self-management, and lifestyle change to address social determinants that put the priority populations at increased risk of cardiovascular disease with a focus on hypertension and high cholesterol.