

Indian Health Diabetes Best Practices: Community Diabetes Screening



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Indian Health Diabetes Best Practice: Community Diabetes Screening

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What is community diabetes screening?

Community screening is a systematic way to identify people who are at high risk for developing diabetes or who already have diabetes but do not know it. These individuals can then be linked to effective prevention and treatment programs. Settings for community screening may include health fairs, powwows, or other community events. Community diabetes screening is different from diagnostic testing for diabetes; diagnostic tests are performed when a person exhibits signs and symptoms of diabetes (ADA, 2004).

Why is community diabetes screening important?

American Indian and Alaska Native health programs interested in community diabetes screening programs may want to consider focusing efforts on the following beneficial activities:

- Conducting diabetes risk assessments using the American Diabetes Association (ADA) diabetes paper and pencil test that can be downloaded for free on the ADA website: www.diabetes.org/risk-test.jsp. Programs may also want to consider random blood sugar screening *with appropriate referral to medical care for repeat testing and follow-up*.
- Enhancing community awareness of the seriousness of diabetes and its complications.
- Educating community members on diabetes risk factors, when to seek medical assistance, and the diabetes resources available to them in the clinic and community.
- Following people who received assistance from the program to ensure that they have received appropriate medical care and follow-up.

Some American Indian and Alaska Native communities feel that random screening is an important or useful strategy in their community-based diabetes programs. However, the ADA does not recommend random blood sugar screening even in high-risk populations (ADA, 2004). The ADA is concerned that people with a positive diabetes screening test may not seek and obtain the appropriate follow-up testing and care, or that people who have a negative diabetes screening test may not obtain appropriate repeat testing.

If your program has decided to perform community screening, remember that screening results are not diagnostic for diabetes. All abnormal results should be referred to clinical care services for reassessment and further evaluation.

- Any individual with a blood sugar level over 200 mg/dl should be referred to a health care provider immediately.
- Any high-risk individual with a fasting blood sugar over 100 mg/dl or random blood sugar over 120 mg/dl should be referred to a health care provider and be seen within two weeks after the screening.

Best practices for community diabetes screening

The best practice for community diabetes screening describes the best methods for:

- Preparing for community diabetes screening.
- Educating community members about diabetes.
- Raising awareness of the risk factors for diabetes.
- Identifying people at risk of developing diabetes.
- Identifying people with abnormal fingerstick levels and referring them for appropriate blood sugar testing and follow-up.

Table 1 summarizes the best practices for community diabetes screening.

Table 1. Best practices for community diabetes screening.

Provider Recommendations	Best Practices
<p>1. Prepare for community diabetes screening</p>	<p>Why?</p> <p>Coordinating community diabetes screening activities with community leaders and health care services, as well as careful planning, are critical components of a community diabetes screening program.</p> <p>How?</p> <ul style="list-style-type: none"> – Consider the following questions: <ul style="list-style-type: none"> • Are local resources available to screen for diabetes? • Are local resources available to treat diabetes that is detected through the screening program? • Are qualified staff and personnel available to perform testing? • Do tribal leaders, clinic staff, and other community stakeholders support community diabetes screening activities? – Establish a clinical referral system to evaluate individuals at high risk or with abnormal screening results and ensure that appropriate follow-up is received. – Choose a screening method: <ul style="list-style-type: none"> • ADA diabetes paper and pencil risk assessment, which can help identify people who are at high risk for diabetes. You can download the test for free at: www.diabetes.org/risk-test.jsp. • Capillary glucose (fingerstick). • Plasma glucose (fasting or random).

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Table 1. Best practices for community diabetes screening. (continued)

Provider Recommendations	Best Practices
<p>2. Educate the community about diabetes</p>	<p>Why?</p> <p>Education about diabetes provides a way to enhance the public’s understanding of the seriousness of diabetes and its complications (ADA, 2004).</p> <p>How?</p> <p>The content of a community diabetes education program should include:</p> <ul style="list-style-type: none"> – Definition of diabetes. – Definition of people who are at risk of developing diabetes, including: <ul style="list-style-type: none"> • American Indians and Alaska Natives. • People with blood pressure at or above 130/80. • People who have one or more family members with diabetes. • Women who had diabetes during pregnancy. • Women who had a baby weighing more than nine pounds at birth. • People exposed to mothers who had diabetes during pregnancy. – Signs and symptoms of diabetes, including: <ul style="list-style-type: none"> • Intense thirst. • Frequent urination. • Weight loss without trying. – Explanation that some people will have no signs or symptoms, but will still have diabetes. – Options of what people can do to prevent diabetes, including: <ul style="list-style-type: none"> • Keeping weight at normal limits. Define normal limits by using height, weight, and body mass index (BMI) charts. • Eating meals that are low in fat and calories. • Staying active most days of the week (e.g., at least 30 minutes, 5 days a week). (Please refer to the Indian Health Diabetes Best Practice for adult weight management and for nutrition and physical activity.) • Description of what to do if a person thinks he or she has diabetes, such as making an appointment to see a health care provider right away. Explain that the person should not wait to see a health provider because the eyes, nerves, and kidneys could be harmed.

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Table 1. Best practices for community diabetes screening. (continued)

Provider Recommendations	Best Practices
<p>2. Educate the community about diabetes (continued)</p>	<ul style="list-style-type: none"> - Educational materials including, the Diabetes Prevention Program (DPP) lifestyle curriculum, DPP video titled “Am I at Risk?”, and other patient education materials. - Resources on where patients can go for more information, such as their health care providers, written materials, and websites.
<p>3. Conduct community activities to raise awareness of diabetes</p>	<p>Why? Diabetes awareness programs may provide an opportunity to increase public awareness of diabetes and the seriousness of diabetes and its complications (ADA, 2004).</p> <p>How? Examples include:</p> <ul style="list-style-type: none"> - Work with the media (e.g., TV, newspapers, radio, movie theatres, billboards) to provide community outreach. - Conduct mass mailings. - Offer diabetes support groups. - Conduct diabetes education. - Conduct community health fairs that focus on diabetes. - Offer counseling on ways to be more physically active. - Create walking trails for safe exercise.
<p>4. Identify people at risk of developing diabetes</p>	<p>Why? Early identification and intervention of prediabetes and diabetes can prevent or delay the onset of diabetes and reduce the incidence of diabetes-related complications (UKPDS, 1998; DPP, 2002).</p> <p>How?</p> <ul style="list-style-type: none"> - Use the ADA diabetes paper and pencil risk assessment to identify people who are at high risk for diabetes. You can download the test for free at: www.diabetes.org/risk-test.jsp. - Risk factors include: <ul style="list-style-type: none"> • Being more than 20% above ideal body weight. • Having a mother, father, brother, or sister with diabetes. • Giving birth to a baby weighing more than nine pounds. • Having diabetes during pregnancy.

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Table 1. Best practices for community diabetes screening. (continued)

Provider Recommendations	Best Practices
<p>4. Identify people at risk of developing diabetes (continued)</p>	<ul style="list-style-type: none"> • Having high blood pressure. • Having abnormal blood lipid levels. • Having abnormal glucose tolerance in an earlier diabetes test.
<p>5. Identify people with abnormal fingerstick levels and refer for appropriate blood sugar testing and follow-up</p>	<p>Why?</p> <p>As noted above, some American Indian and Alaska Native communities feel that random screening is an important or useful strategy in their community-based diabetes programs. However, the ADA does not recommend random blood sugar screening even in high-risk populations (ADA, 2004). The ADA is concerned that people with a positive diabetes screening test may not seek and obtain the appropriate follow-up testing and care, or that people who have a negative diabetes screening test may not obtain appropriate repeat testing. Therefore, it is important to refer and follow people who have abnormal fingerstick levels for appropriate testing and follow-up care.</p> <p>How?</p> <p>If your program has decided to perform community screening, remember that screening results are not diagnostic for diabetes. All abnormal results should be referred to clinical care services for reassessment and further evaluation.</p> <ul style="list-style-type: none"> – Refer any individual with a blood sugar level over 200 mg/dl to a health care provider immediately. – Refer any high-risk individual with a fasting blood sugar over 100 mg/dl or random blood sugar over 120 mg/dl to a health care provider and follow them to ensure they are seen within two weeks after the screening. – Maintain a registry and tickler system to track referred patients: <ul style="list-style-type: none"> • Offer lifestyle education programs to patients with prediabetes or patients who had a negative diabetes screen but are still at high risk. • Ensure that people with a positive diabetes screen receive appropriate diabetes care and education.

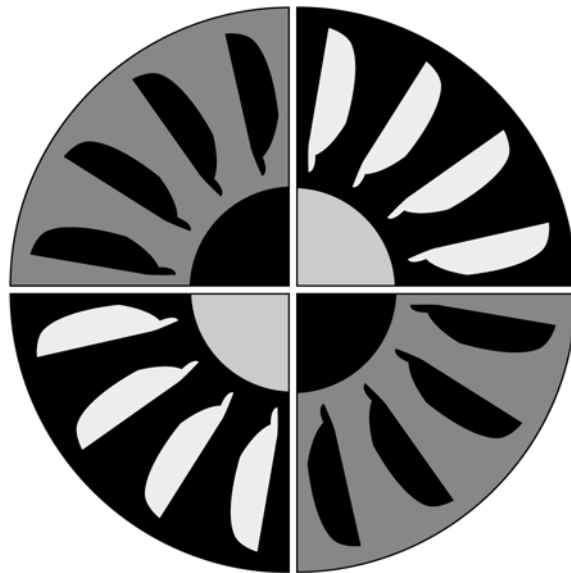
Best practices for health care organizations

A health care organization that wants to improve community diabetes screening must be motivated and prepared for change throughout the entire organization. The organization’s leadership must identify community diabetes screening as important work. They must also develop clear improvement goals, policies, and effective improvement strategies. This will help encourage the entire organization to make changes that will help improve community diabetes screening programs.

Table 2 describes the best practices for health care organizations.

Table 2. Best practices for health care organizations.

Organization Recommendations	Best Practices
<p>System and programmatic changes</p>	<p><i>Why?</i></p> <p>Community screening may provide a way to increase awareness of diabetes and its complications (ADA, 2004).</p> <p><i>How?</i></p> <p>The following activities may help reduce the burden of diabetes:</p> <ul style="list-style-type: none"> - Provide formal commitment to community diabetes screening programs. - Establish structured policies and procedures for community screening.



Essential elements of best practice community diabetes screening programs

High quality community diabetes screening programs involve implementing six essential elements* in your health care organization. These elements are:

- Community resources and policies.
- Health care organization leadership.
- Patient self-management support.
- Delivery system design: Services, programs, systems, and procedures.
- Decision support: Information and training for providers.
- Clinical information systems: Collecting and tracking information.

Table 3 summarizes how these elements apply to basic, intermediate, and comprehensive community diabetes screening programs.

* Adapted from the Chronic Care Model, which was developed by the MacColl Institute for Healthcare Innovation at the Group Health Cooperative. For more information on the Chronic Care Model, visit their website at www.improvingchroniccare.org.

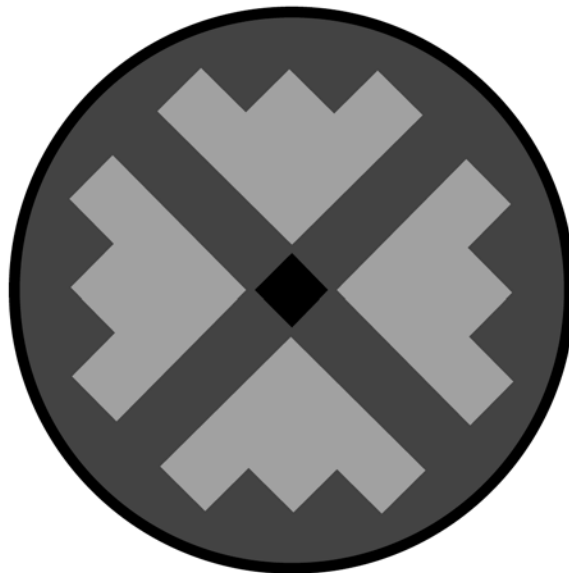


Table 3. Essential elements of basic, intermediate, and comprehensive best practice community diabetes screening programs.

Basic Community Screening Programs	Intermediate Community Screening Programs Basic program <i>plus</i> :	Comprehensive Community Screening Programs Basic and intermediate programs <i>plus</i> :	Examples
Community resources and policies			
<ul style="list-style-type: none"> - Assess community resources. - Identify key community contacts to link the community screening program with the clinic. - Develop collaborative partnerships with community groups. - Establish formal policies for community screening. 	<ul style="list-style-type: none"> - Train community health personnel in risk assessment and diabetes education. 	<ul style="list-style-type: none"> - Conduct community education programs on diabetes, risk factors, and lifestyle changes. 	<ul style="list-style-type: none"> - Work with public health nurses. - Establish memoranda of understanding and agreement with partners. - Establish contracts with providers. - Develop a community assessment tool.
Organization leadership			
<ul style="list-style-type: none"> - Provide formal commitment to community diabetes screening programs. - Establish structured policies and procedures for community screening. 	<ul style="list-style-type: none"> - Identify community screening in the clinic's annual goals. 	<ul style="list-style-type: none"> - Include community screening measures in annual performance-based objectives. 	<ul style="list-style-type: none"> - Establish contracts and memoranda of agreement that include signatures and dates. - Include community screening in vision statements and program plans. - Develop reporting tools. - Conduct advocacy and update key leadership. - Implement an evaluation plan that looks at the whole program and trends, and makes recommendations.

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Table 3. Essential elements of basic, intermediate, and comprehensive best practice community diabetes screening programs. (continued)

Basic Community Screening Programs	Intermediate Community Screening Programs Basic program <i>plus</i> :	Comprehensive Community Screening Programs Basic and intermediate programs <i>plus</i> :	Examples
Patient self-management support			
<ul style="list-style-type: none"> - Develop or adopt education materials on diabetes risk (e.g., “Am I at Risk?” handouts, media kits, and Diabetes Prevention Program videos). - Provide community education and raise awareness of diabetes risk. - Identify role models. - Inform people of community and clinic resources. 	<ul style="list-style-type: none"> - Establish referral mechanisms for blood sugar testing. - Provide follow-up education on lifestyle changes for people with prediabetes or at risk of diabetes. 	<ul style="list-style-type: none"> - Establish referral mechanisms for re-testing blood sugar levels. - Follow-up with people who have tested positive for diabetes at a clinic, and confirm that the patient is receiving diabetes care. 	<ul style="list-style-type: none"> - Provide access to web resources for diabetes prevention. - Use a tickler system for follow-up and surveillance. - Establish registries for the at-risk population. - Implement a media campaign to raise awareness. - Develop a handout that provides examples of simple things people can do to prevent diabetes. - Inform community members of local options and choices.

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Table 3. Essential elements of basic, intermediate, and comprehensive best practice community diabetes screening programs. (continued)

Basic Community Screening Programs	Intermediate Community Screening Programs Basic program <i>plus</i> :	Comprehensive Community Screening Programs Basic and intermediate programs <i>plus</i> :	Examples
Delivery system design: Services, programs, systems, and procedures			
<ul style="list-style-type: none"> - Establish a diabetes team that meets on a regular basis. - Identify team members' roles and responsibilities. - Identify a team leader. - Assess patient risk. - Use evidence-based guidelines to develop community screening protocols. - Coordinate and collaborate with the clinic to develop community-based screening activities. 	<ul style="list-style-type: none"> - Provide effective activities, interventions, and support for behavior change. 	<ul style="list-style-type: none"> - Establish a formal community screening team that is part of the diabetes team. - Develop and implement community outreach programs. 	<ul style="list-style-type: none"> - Develop position descriptions for personnel who will conduct the screening. - Base staff assignments on skill level. - Conduct regular quality assurance reviews and address problems.

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Table 3. Essential elements of basic, intermediate, and comprehensive best practice community diabetes screening programs. (continued)

Basic Community Screening Programs	Intermediate Community Screening Programs Basic program <i>plus</i> :	Comprehensive Community Screening Programs Basic and intermediate programs <i>plus</i> :	Examples
Decision support: Information and training for providers			
<ul style="list-style-type: none"> - Train providers on current clinical guidelines and community screening practices. 	<ul style="list-style-type: none"> - Establish detailed guidelines on referral processes. 	<ul style="list-style-type: none"> - Train local providers in community screening. 	<ul style="list-style-type: none"> - Ensure providers have access to American College of Endocrinology (ACE), American Association of Clinical Endocrinologists (AACE), and World Health Organization (WHO) recommendations, guidelines, articles on cost effectiveness, and cut-off information. - Use the Indian Health Service (IHS) Standards of Care for Diabetes. - Ensure providers have access to tools, such as patient education media kits, patient handouts, and videos.

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Table 3. Essential elements of basic, intermediate, and comprehensive best practice community diabetes screening programs. (continued)

Basic Community Screening Programs	Intermediate Community Screening Programs Basic program <i>plus</i> :	Comprehensive Community Screening Programs Basic and intermediate programs <i>plus</i> :	Examples
Clinical information systems: Collecting and tracking information			
<ul style="list-style-type: none"> – Establish and maintain a diabetes registry for those at risk of diabetes. 	<ul style="list-style-type: none"> – Establish and maintain a diabetes registry and tickler system capable of tracking education and referrals, and listing them on the Health Summary. 	<ul style="list-style-type: none"> – Establish and maintain a diabetes registry and tickler system capable of tracking outcomes of referrals and people who need to be re-tested, and listing them on the Health Summary. 	<ul style="list-style-type: none"> – Develop a protocol for re-call and evaluation. – Establish memoranda of agreement that define access to data and outline an understanding that data will be shared with the tribes. – Use the Resource and Patient Management (RPMS) Patient Care Component (PCC) group service forms. – Have paraprofessionals document information in patient charts. – Establish performance improvement plans. – Provide regular reports at meetings, including tribal meetings.

Evaluating your community diabetes screening program

Evaluation is important because it helps you see what is working and what is not working in your community diabetes screening program. It will show you if adjustments or changes need to be made in order to improve your program. Evaluation also provides you with information that you can use to share your successes with patients, providers, tribal leaders, administrators, the community, funders, and other stakeholders.

Consider including the following when developing your program and evaluation:

- Develop a written evaluation plan and review the plan regularly.
- Evaluate the program as a whole, as well as program trends.
- Conduct exit surveys and use other methods to collect feedback from screening participants and staff.

Sustaining your community diabetes screening program

Often, for care goals to be reached, programs must be in place for more than a few years. Here are some helpful tips for sustaining your community diabetes screening program:

- Ensure the organization has written policies and procedures for community diabetes screening.
- Provide regular reports to stakeholders based on your program evaluation to demonstrate the effectiveness of the program.
- Ensure that tribal and health organization leadership and the community understand and acknowledge the magnitude and effect of the obesity epidemic.
- Maintain awareness about the importance of diabetes treatment and prevention among stakeholders.
- Secure non-grant funding to support your community screening program.

Contacting others for help

Contacting other people involved in community diabetes screening is important because they can help you get started with your program. Your peers at other health care organizations can share their expertise, materials, and ideas, and can also tell you what has worked for them and what has not worked. This can help you avoid reinventing the wheel. Here are some tips on how to connect with others:

- Ask your Area Diabetes Consultant for the names of people who may be able to help you.
- Contact the IHS Division of Diabetes Treatment and Prevention for ideas. They may be able to point you in the right direction.
- Ask the IHS Integrated Diabetes Education Recognition Program for suggested contacts. They have names and contact information for people who work with IHS-accredited diabetes education programs.

- Flip through issues of *Health for Native Life Magazine*. The magazine profiles many diabetes programs throughout Indian Country. The articles may give you ideas for activities to try and people to contact.
- Review resources from the National Diabetes Education Program (NDEP). NDEP offers materials that will help your program get started, including information specifically for American Indians and Alaska Natives. You can access these resources at the website: www.ndep.nih.gov

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