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Monthly Campaign Webinar

September 17, 2020

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Today's Webinar

- Together 2 Goal® Updates
  - Webinar Reminders
  - *T2G Talk & Taste*
  - Final T2G Fall Survey
  - The Know Diabetes by Heart™ Professional Education Podcast Series
  - Bonus Janssen Webinar: CAD & PAD
- Addressing Social Determinants of Health: Community Partnerships and Health Equity Strategies
  - Kristen M. Kopski, M.D., Ph.D. of HealthPartners Care Group
- Q&A
  - Use Q&A or chat feature

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Webinar Reminders

- Webinar will be recorded today and available the week of September 21st
  - www.Together2Goal.org

- Participants are encouraged to ask questions using the “Chat” and “Q&A” functions on the right side of your screen

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T2G Talk & Taste

November 5, 2020

- Gather your team – in-person or virtually – for our final T2G Talk & Taste
- Download our Talk & Taste kit and watch the T2G Highlights video
- RSVP at together2goal.org/ndoa

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Final T2G Fall Survey

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The Know Diabetes by Heart™ Professional Education Podcast Series

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Bonus Janssen Webinar: CAD & PAD

Webinar

Understanding High Risk Coronary and Peripheral Artery Disease Patient Populations

Full recording and presentation coming soon from Janssen!

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Today's Featured Presenter

Kristen Kopski, M.D., Ph.D.

Primary Care Regional Medical Director
Park Nicollet Health Services

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Social Determinants of Health in the Care of Type 2 Diabetes:

Together 2 Goal

Kristen Kopski MD, PhD

Regional Medical Director

Park Nicollet/Health Partners

Sept 17, 2020

Who we are

- Consumer-governed, non-profit
- Integrated health care delivery and financing
  - 55 Clinics and 8 hospitals
  - Health plan
  - 1.8 M Members
  - 1.2 M Patients
- Twin Cities & surrounding communities (MN and Western WI)

Mission

To improve health and well-being in partnership with our members, patients and community.

Vision

Health as it could be, affordability as it must be, through relationships built on trust.

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Figure 1

Social Determinants of Health

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	Quality of care
Medical bills	Playgrounds	Higher education		Stress	
Support	Walkability				
	Zip code / geography				

Health Outcomes

Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Limitations

KFF
HENRY J KAISER FAMILY FOUNDATION

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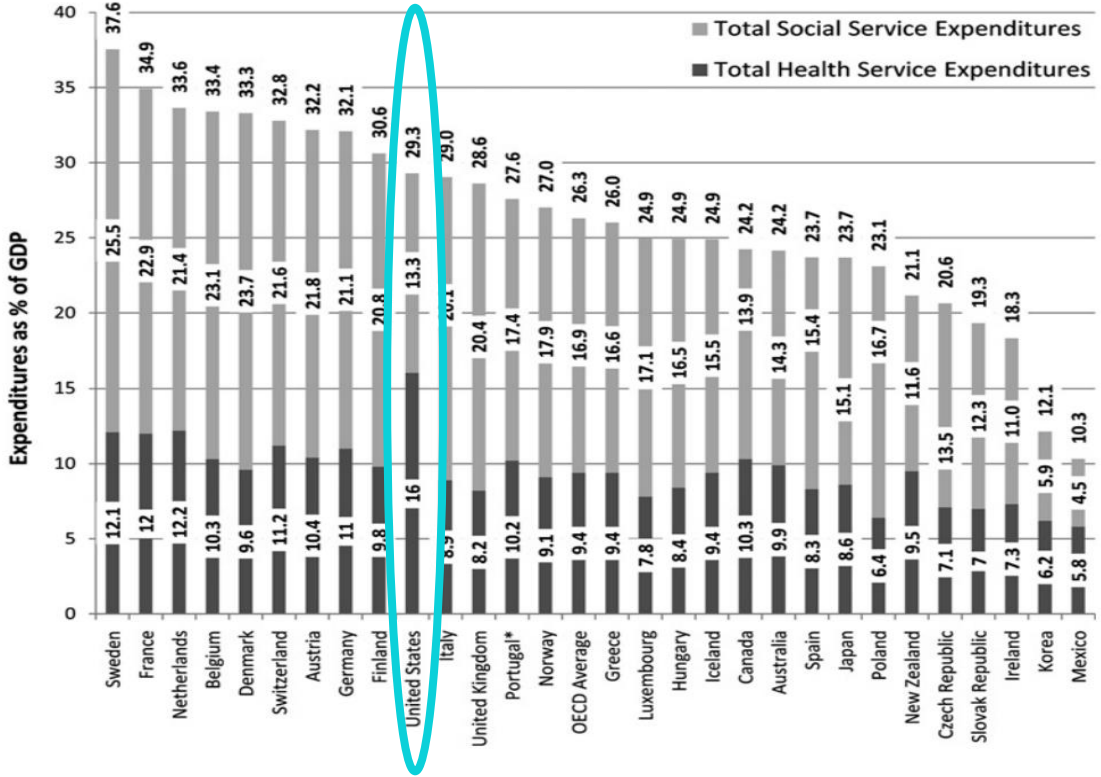
The case for equity

The right thing to do

Business case on many levels

- Return on investment to society
- Better care/outcomes lead to lower cost of care
- Improving overall quality results
- Attracting patients in changing demographic

Comparison of Medical and Social Care Costs



Health and social services expenditures: associations with health outcomes – BMJ Journal, Elizabeth Bradley

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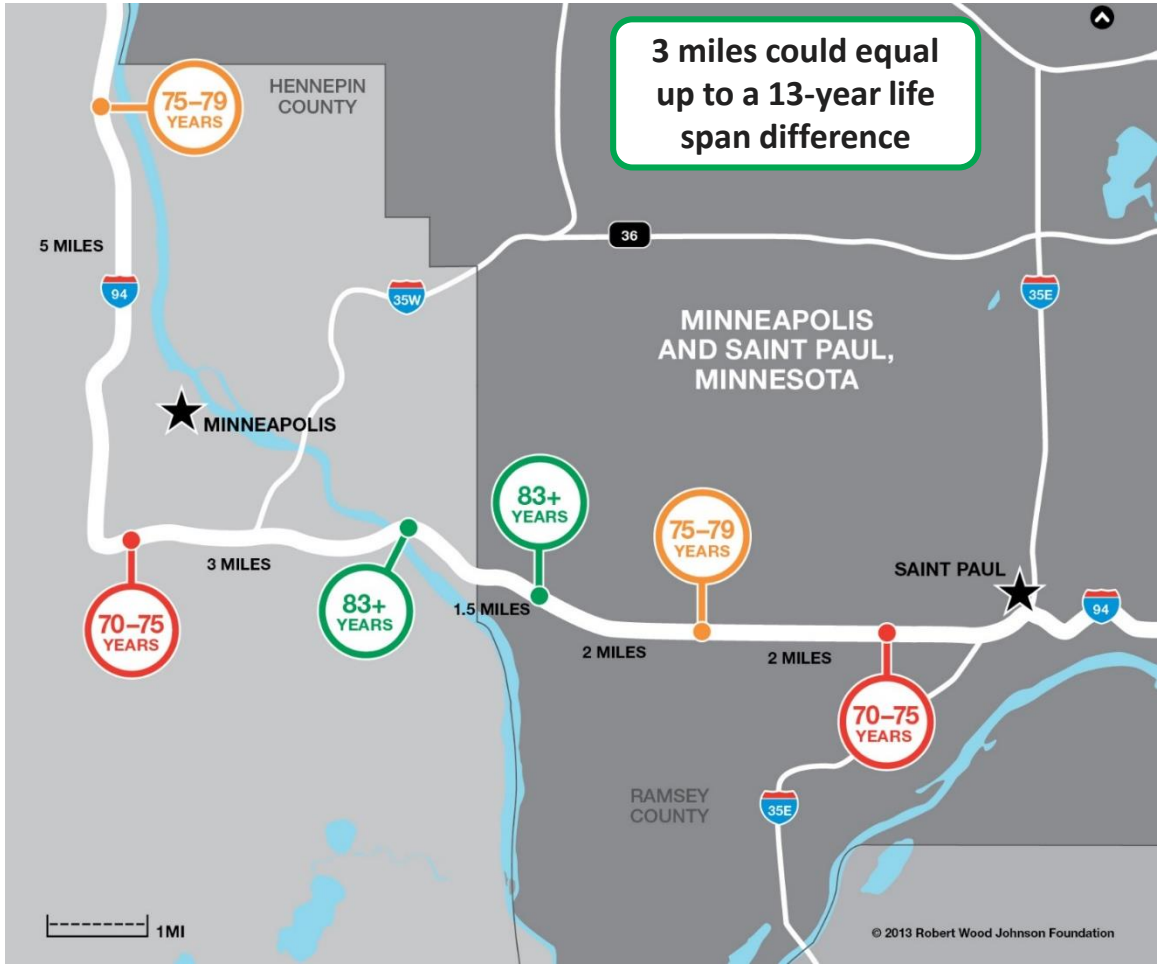

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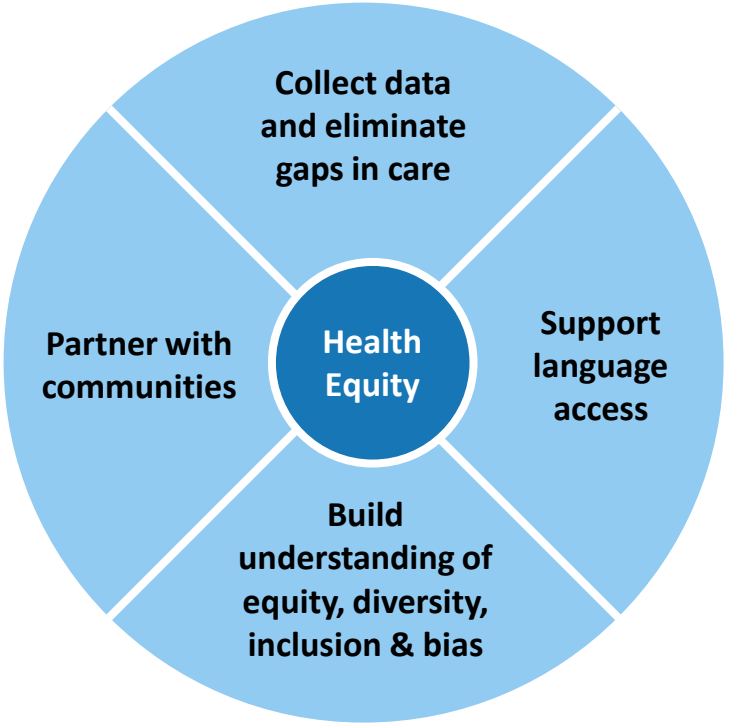
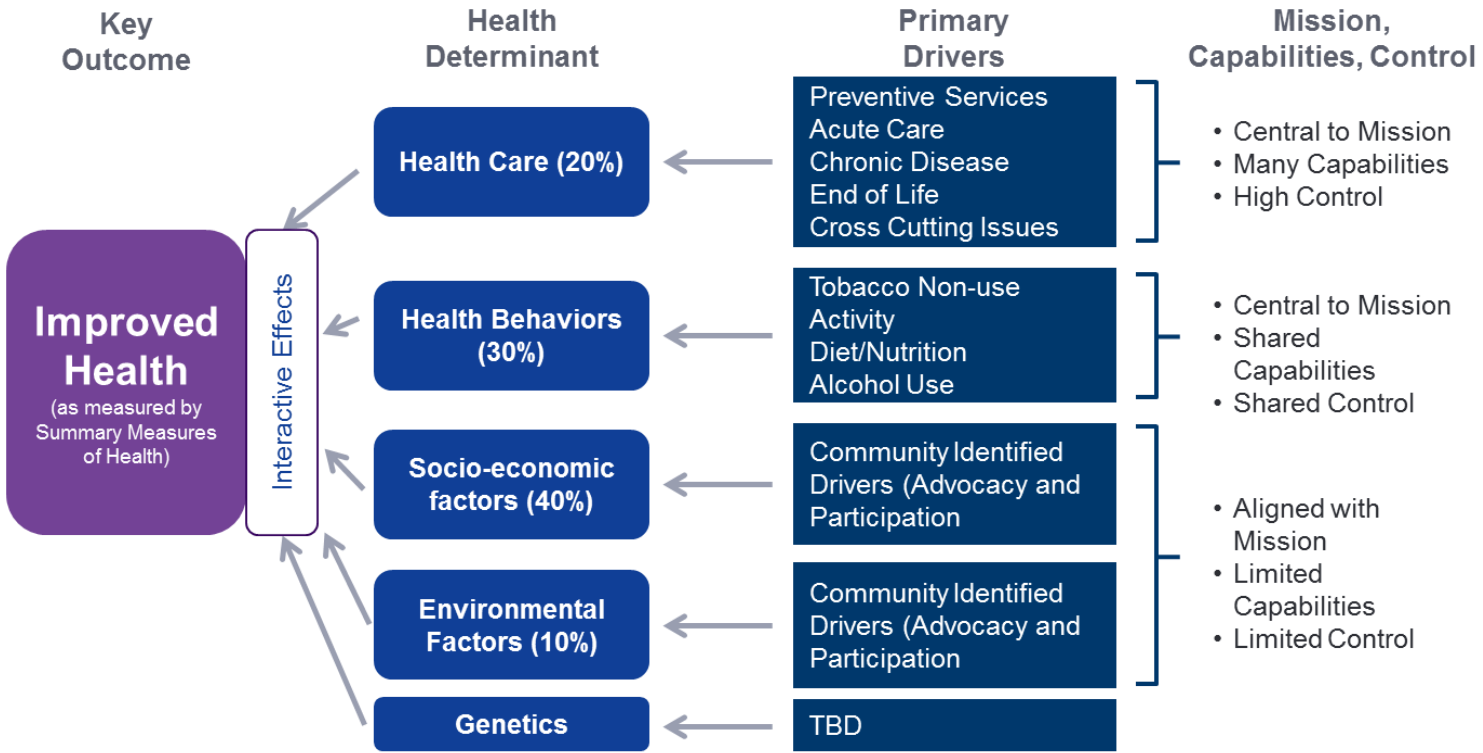
Our Approach to Health Equity

Race/ Ethnicity	Language
Income	Sexual orientation
Gender	Age
Physical ability	Religion



Social Determinants Driver Diagram



Modified from David Kindig, MD, PhD, University of WI-Madison School of Medicine and Population Health

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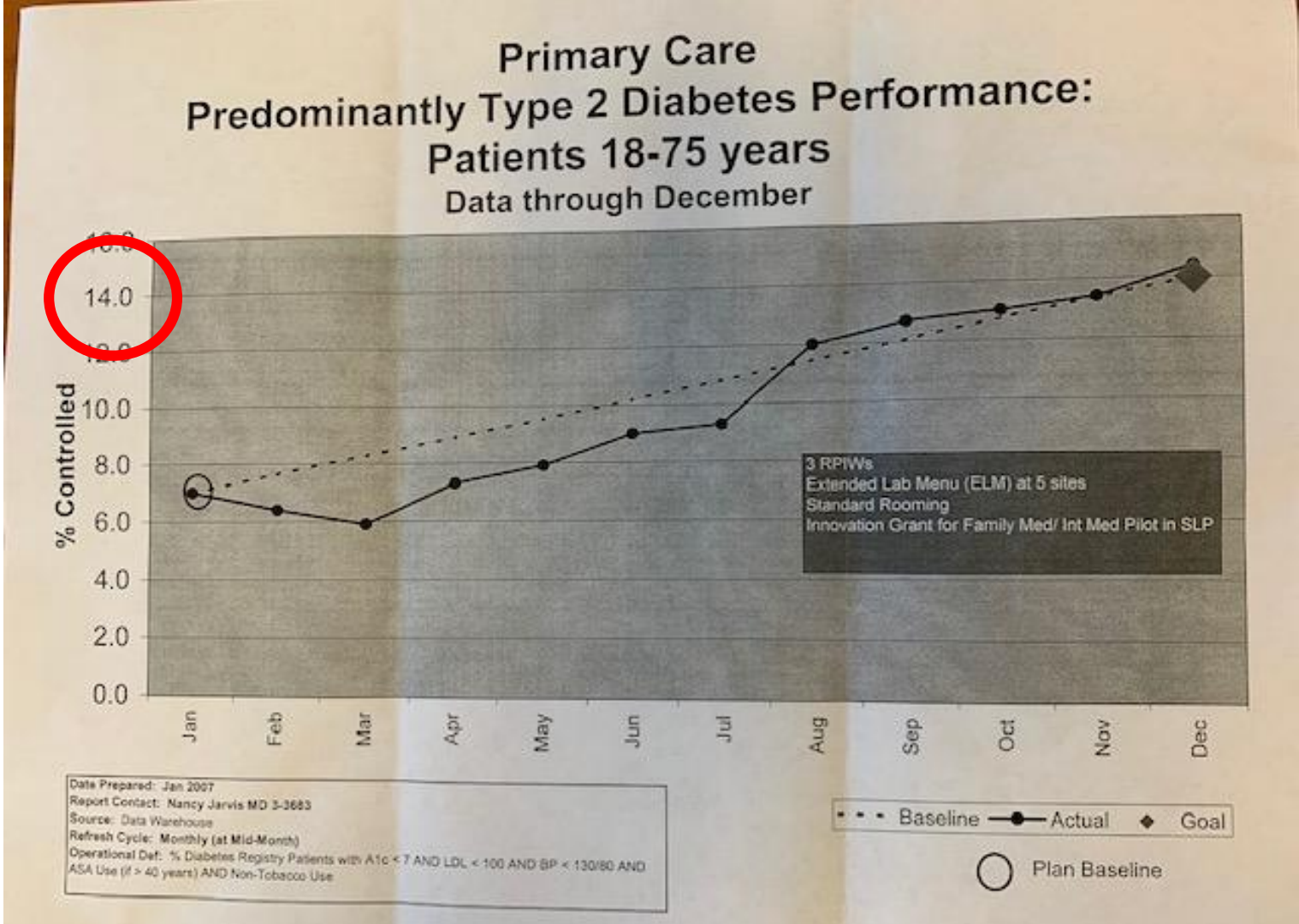
Data Collection

- **2003:** Began measuring economic disparities
- **2005:** Began asking patients to share their race, country of origin, and language

- **Identify gaps:**
  - No gaps in process measures
  - Largest gaps where additional visits or preparation required or self management
  - Cultural beliefs about preventive medicine

2007

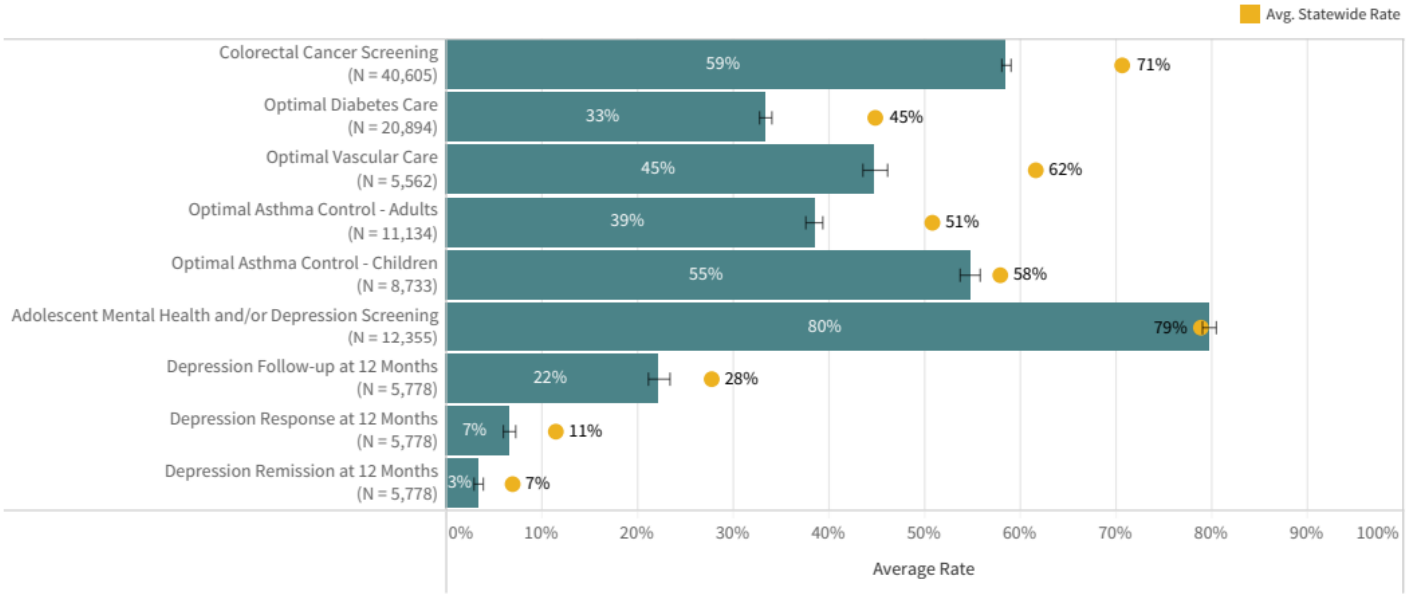
(different criteria)



Transparency

FIGURE 3: Summary by Race: Black/African American

(2018 report year)



[2018 MNCM Healthcare Disparities Report]

MN Community Measurement
Measure Up To Better Health

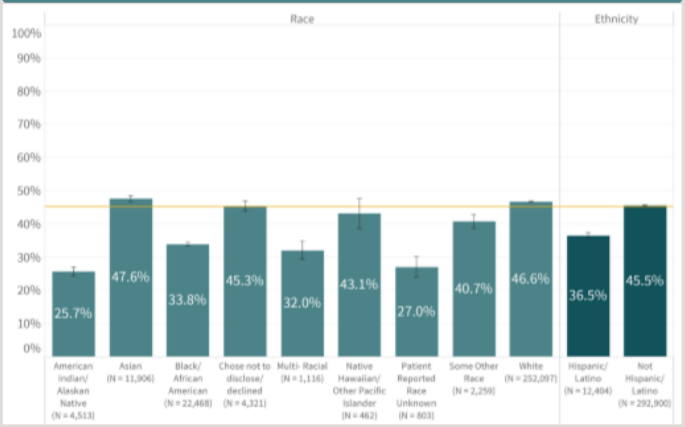
OPTIMAL DIABETES CARE

Race/Ethnicity Summary

2019 Report Year (2018 dates of service)

Optimal Diabetes Care

By Race/Ethnicity



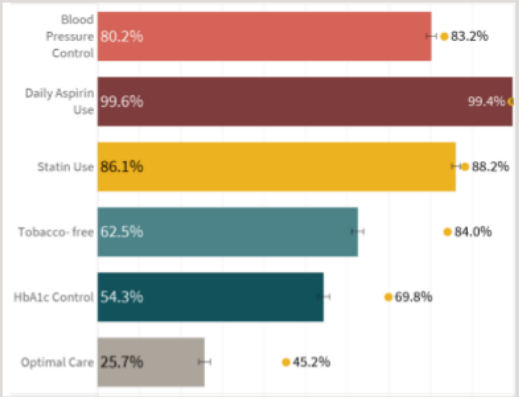
Statewide average for patients with race/ethnicity information available
Race average = 45.2% **Ethnicity average = 45.2%**

American Indian/Alaskan Native, Black/African American, Multi-Race and Hispanic/Latino patients have **significantly lower** rates of optimal diabetes care compared to the race/ethnicity average.

Black/African American female and White female patients have **significantly higher** rates of optimal diabetes care compared to Black/African American males and White males, respectively.

American Indian/Alaskan Native

By Optimal Diabetes Component

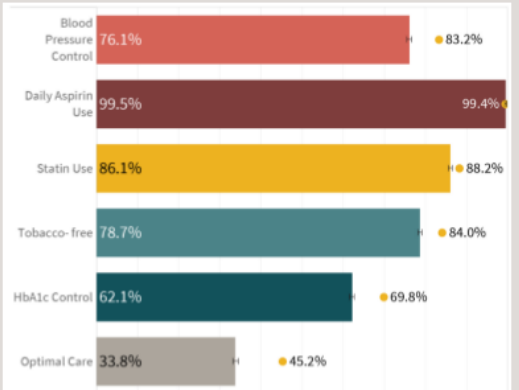


62.5% of American Indian patients are tobacco-free, the lowest of any race group.

54.3% of American Indian patients have a controlled HbA1c (< 8.0), the lowest of any race group.

Black/African American

By Optimal Diabetes Component



62.1% of Black/ African American patients have a controlled HbA1c (< 8.0), the second lowest of any race group

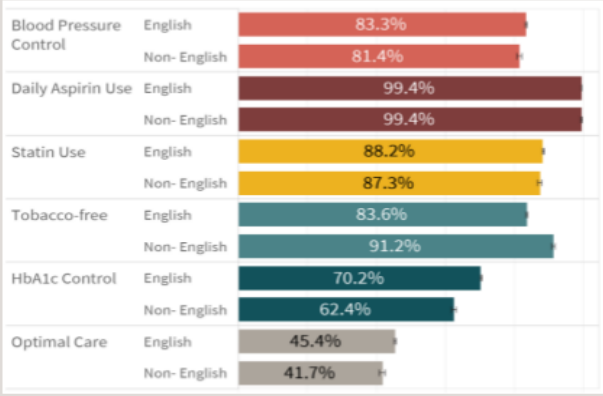
OPTIMAL DIABETES CARE

Preferred Language Summary

2019 Report Year (2018 dates of service)

English-speaking vs. Non-English-speaking

By Optimal Diabetes Component

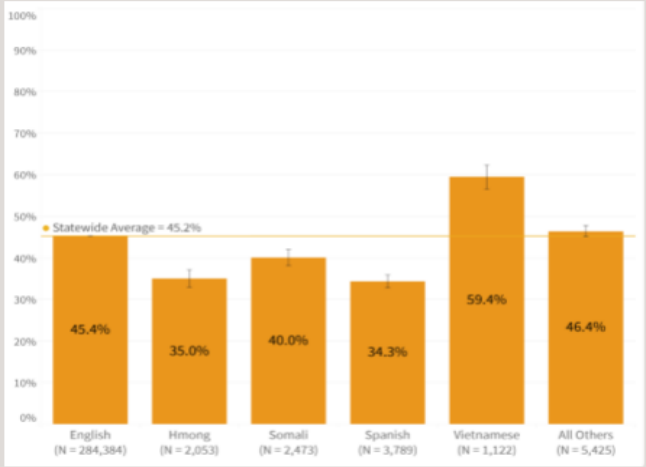


Non-English-speaking patients have **significantly lower rates of HbA1c control** compared to English-speaking patients.

English-speaking patients have **significantly lower rates of being tobacco-free** compared to Non-English-speaking patients.

Optimal Diabetes Care

By Preferred Language



Patients who speak **English, Hmong, Somali, Spanish or Vietnamese** make up the largest portion of the eligible population.

Patients who speak **Hmong, Somali or Spanish** have **significantly lower** rates of optimal diabetes care compared to the statewide average.

49.2% English-speaking Asian patients

45.8% Non-English-speaking Asian patients

English-speaking Asian patients have **significantly higher** rates of optimal diabetes care compared to non-English-speaking Asian patients.

32.5% English-speaking Black/African American patients

41.2% Non-English-speaking Black/African American patients

Non-English-speaking Black/African American patients have **significantly higher** rates of optimal diabetes care compared to English-speaking Black/African American patients.

● Statewide average for patients with preferred language information available

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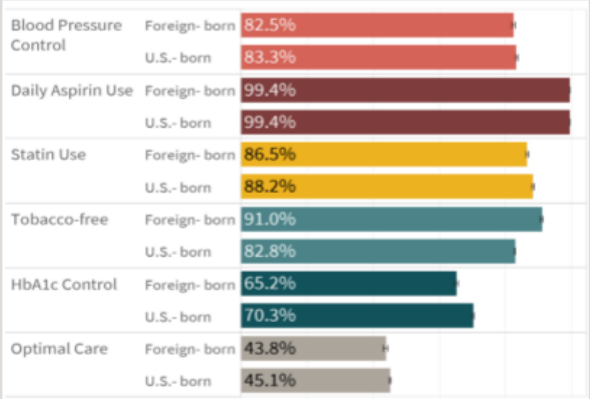
OPTIMAL DIABETES CARE

Country of Origin Summary

2019 Report Year (2018 dates of service)

Born in the U.S. vs. Born Outside the U.S.

By Optimal Diabetes Component

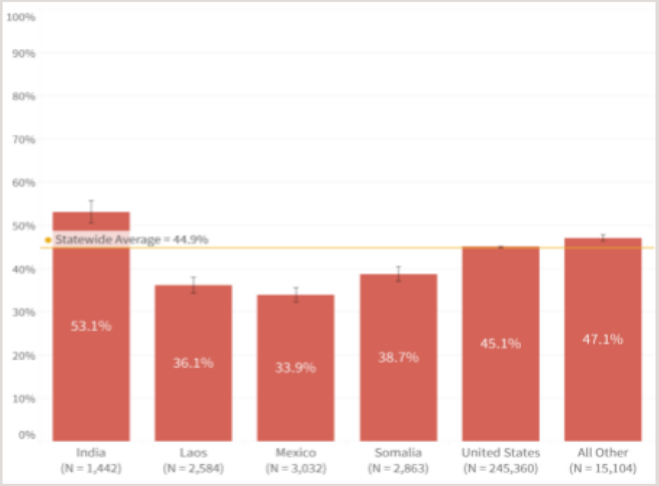


Patients born outside the United States have **significantly lower rates of HbA1c control** compared to patients born in the United States.

Patients born in the United States have **significantly lower rates of being tobacco- free** compared to patients born outside the United States.

Optimal Diabetes Care

By Country of Origin



Patients from India, Laos, Mexico, Somalia and United States make up the largest portion of the eligible population.

Among these patients, those from **Laos, Mexico and Somalia** with diabetes have the **lowest rates of optimal care.**

25.3% American Indian/ Alaskan Native patients born in U.S.

37.6% American Indian/ Alaskan Native patients born outside U.S.

29.0% Black/ African American patients born in U.S.

41.0% Black/ African American patients born outside U.S.

American Indian/Alaskan Native patients born in the United States have **significantly lower** rates of optimal diabetes care compared to American Indian/Alaskan Native patients born outside the United States.

Black/African American patients born in the United States have **significantly lower** rates of optimal diabetes care compared to Black/African American patients born outside of the United States.

Statewide average for patients with country of origin information available

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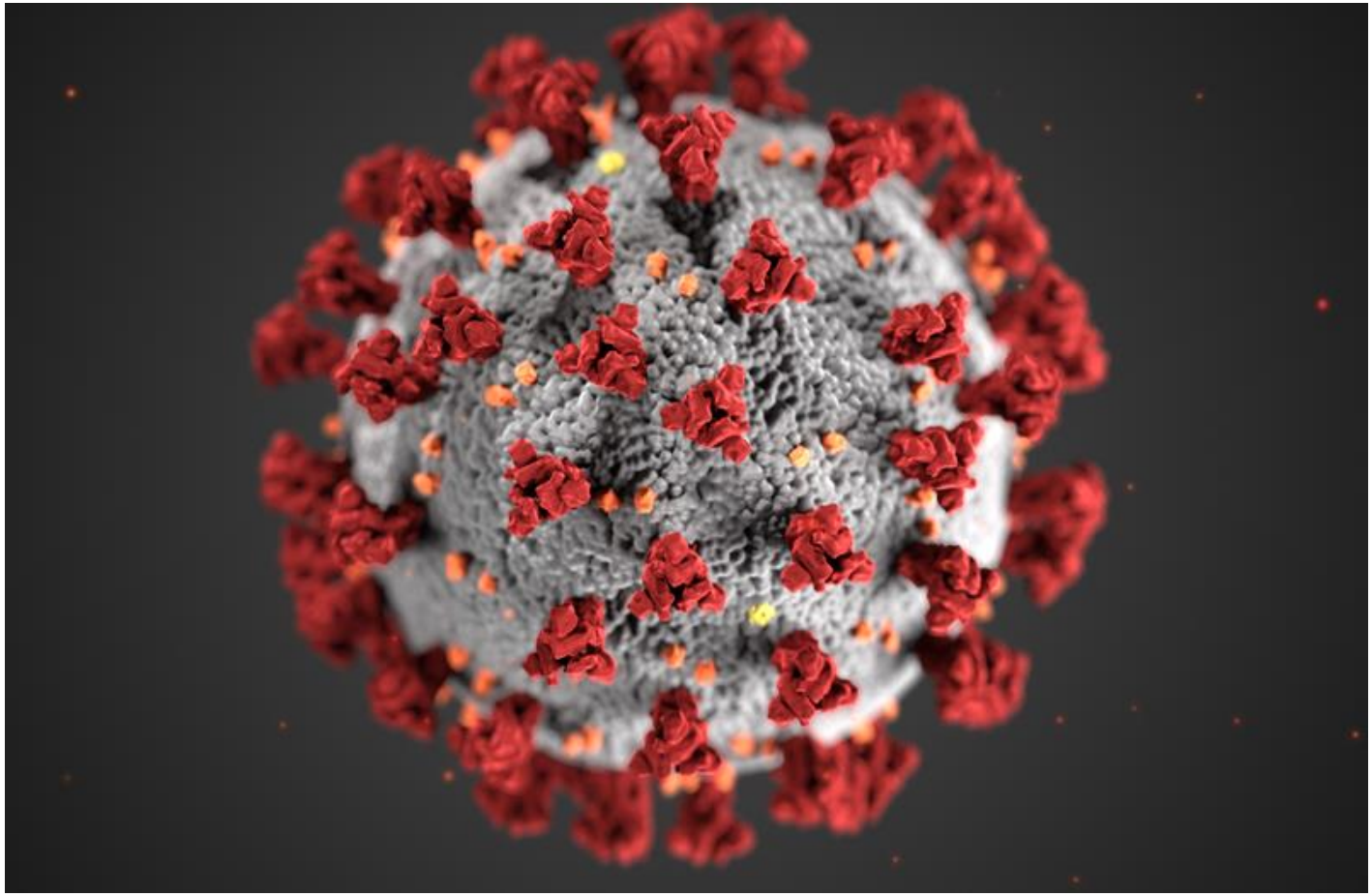
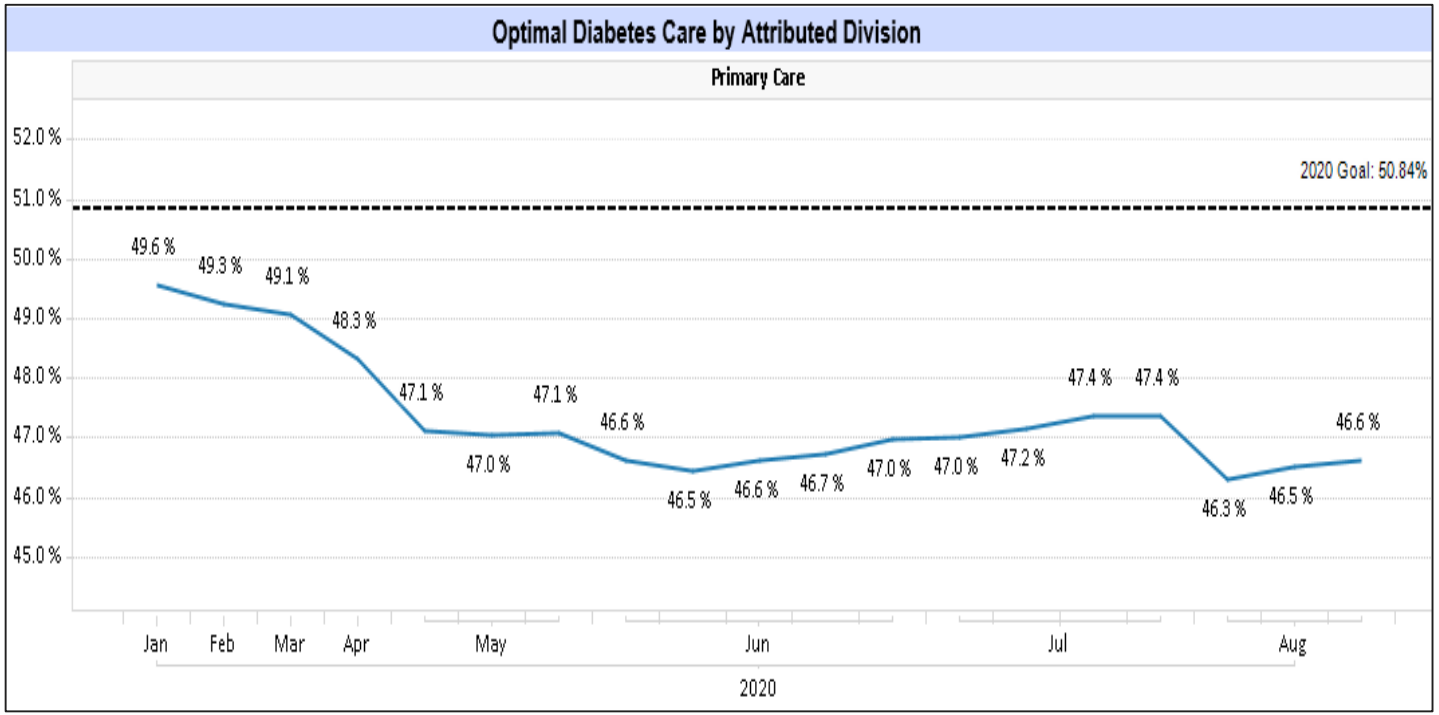


Care Group Diabetes Primary Care

GOAL: 50.8%



Measure: Percentage of patients with diabetes, ages 18 through 75 years, who meet all five Optimal Diabetes Care components:

1. HbA1c <8.0 mg/dL: Most recent A1c test in the last 12 mo.
2. Statin Medication: If most recent LDL not at clinical goal, patient is prescribed a statin medication or has documented contraindication in the last 12 mo.
3. Blood Pressure <140/90 mm/Hg: Most recent blood pressure in the last 12 mo.
4. Non-Tobacco User: Most recent status indicating non-tobacco user in the last two years.
5. Daily Aspirin (IVD Patients Only): Patient is prescribed daily aspirin or anti-platelet medication or has documented contraindication in the last 12 mo.

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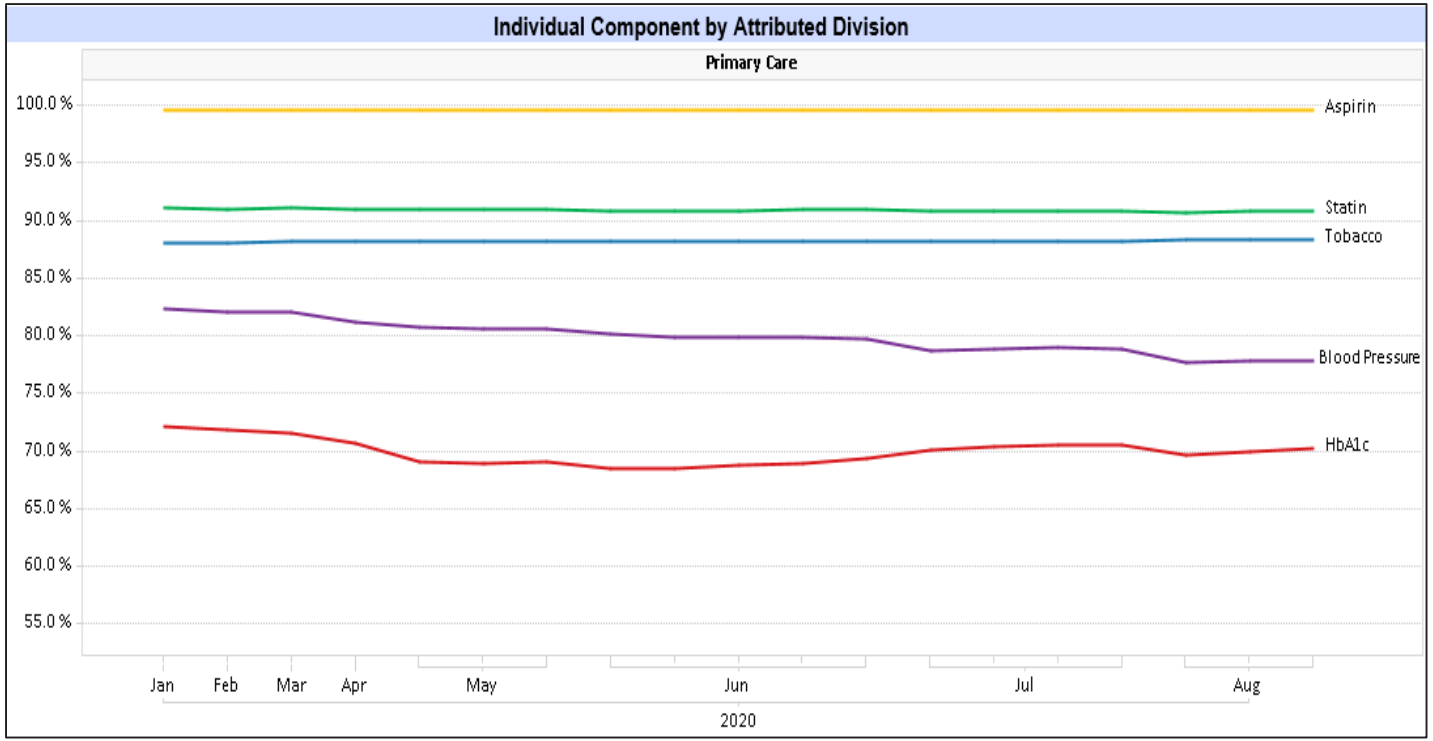
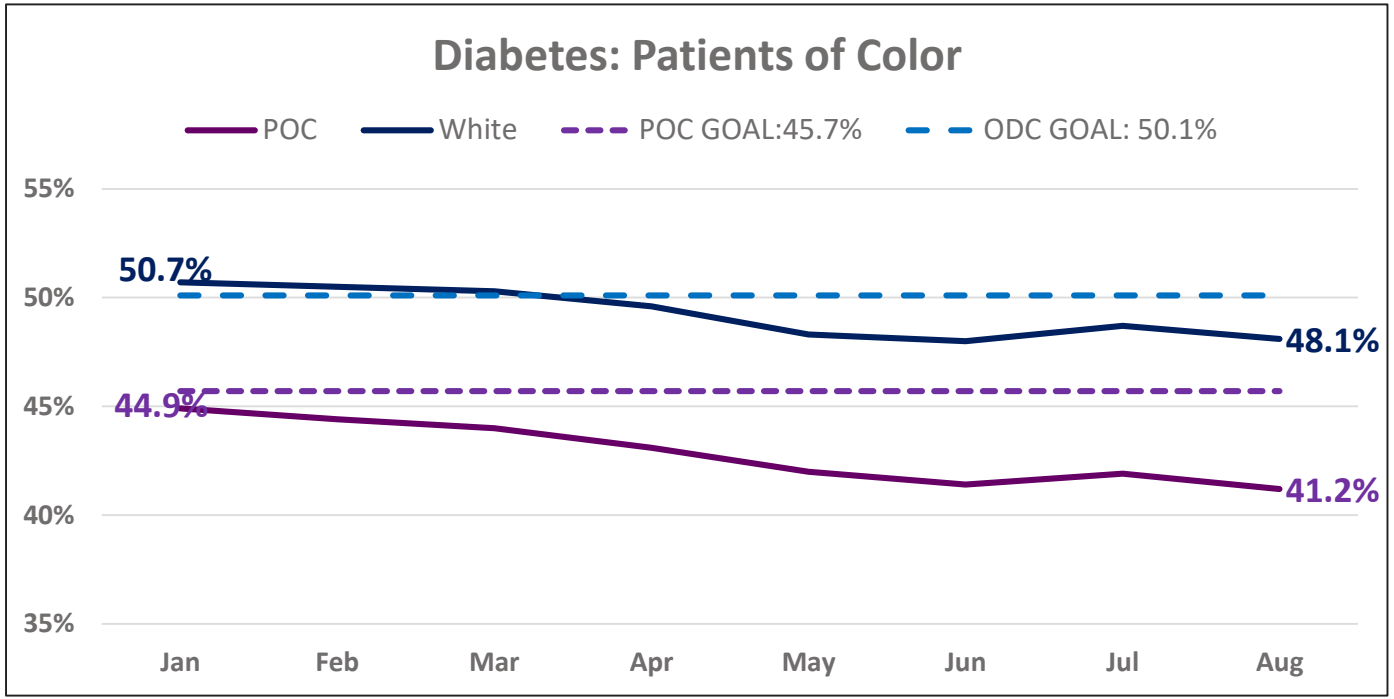
Individual Component
Primary Care



Diabetes – Patients of Color

GOAL: 45.7%



Race Group	# Eligible	% Met ODC	HbA1c	Blood Pressure	Statin	Aspirin	Tobacco
Of Color	13,369	41.21 %	63.98 %	75.76 %	90.14 %	99.70 %	87.61 %
Unknown	601	40.93 %	63.89 %	73.04 %	87.02 %	99.83 %	88.35 %
White	38,015	48.07 %	71.41 %	78.45 %	91.13 %	99.47 %	88.62 %
	51,985	**46.23 %**	**69.42 %**	**77.70 %**	**90.83 %**	**99.53 %**	**88.35 %**

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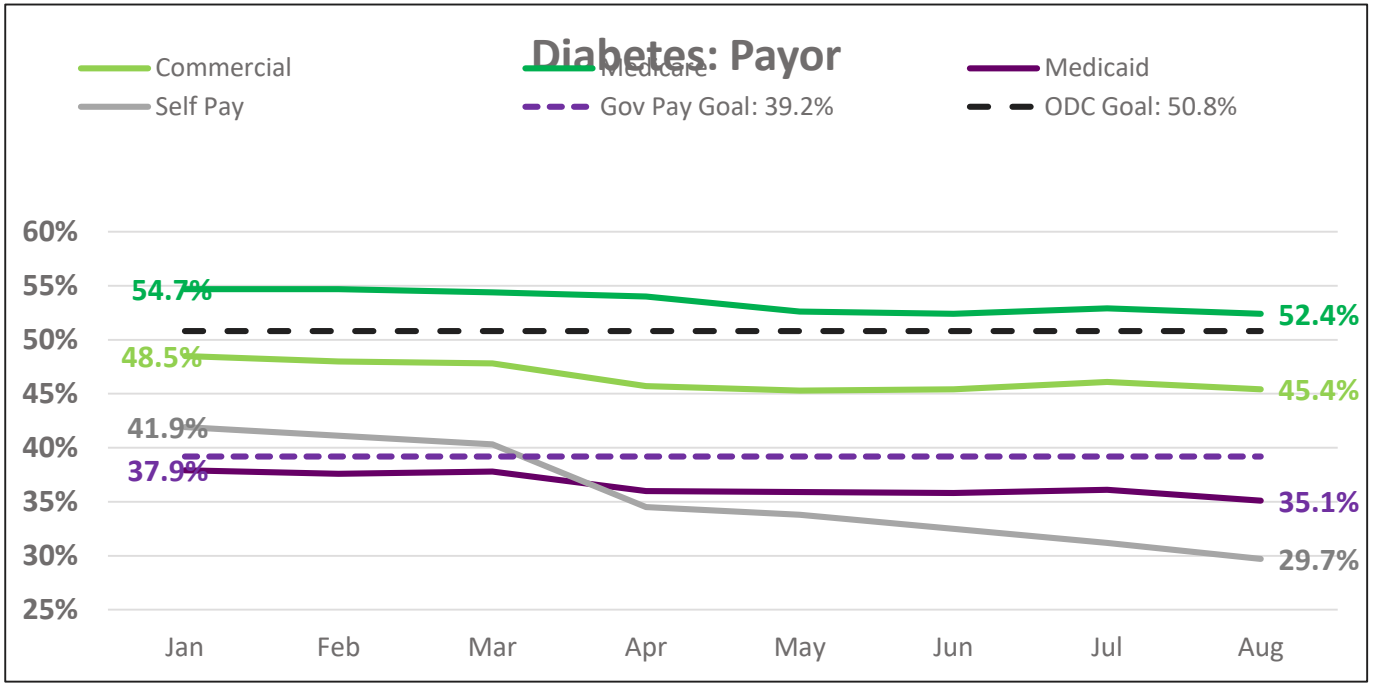
Diabetes: Payor

GOAL: 39.2%



Payor Group	# Eligible	% Met ODC	HbA1c	Blood Pressure	Statin	Aspirin	Tobacco
Commercial	26,647	45.36 %	67.70 %	77.16 %	89.48 %	99.67 %	90.67 %
Medicaid	6,709	35.06 %	59.44 %	76.18 %	90.21 %	99.64 %	77.85 %
Medicare	17,777	52.53 %	76.69 %	79.52 %	93.35 %	99.29 %	89.13 %
Self-pay	852	29.69 %	49.77 %	68.54 %	85.09 %	99.41 %	82.51 %
	51,985	46.23 %	69.42 %	77.70 %	90.83 %	99.53 %	88.35 %

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Process

Rapid A1C Expansion

Current Rapid A1C Sites

HP ARDEN HILLS CLINIC
HP BLOOMINGTON CLINIC
HP HEALTH CENTER FOR WOMEN
HP MIDWAY CLINIC
HP ST PAUL CLINIC
PNC 3800 ST LOUIS PARK CLINIC
PNC 3850 ST LOUIS PARK CLINIC
PNC BLOOMINGTON CLINIC
PNC BROOKDALE CLINIC
PNC BURNSVILLE CLINIC
PNC CREEKSIDE CLINIC
PNC MAPLE GROVE REGIONAL CENTER
PNC MINNEAPOLIS CLINIC
PNC SHAKOPEE CLINIC
HUT HUTCHINSON HEALTH CL
RW CLINICS - ANOKA
SMG CURVE CREST
SMG SOMERSET
WESTFIELDS HOSPITAL

Next sites:

Criteria:

- Number of diabetes patients at clinic site
- Number of clinicians
- Patients of color with diabetes
- Diabetes patients of color with government Payor
- Non-English speaking diabetes patients

The sites to be added in 2020 are:

1. PN Chanhassen
2. HP Maplewood
3. PN Eagan

Quality by Location "Friendly Competition"

Quality Metrics by Location

	Aug Rank															
	July Rank	13	3	14	7	5	9	15	4	2	16	9	9	12	8	1	6
	June Rank	9	3	12	5	6	8	14		6	13	10	4	2	11	1	
	Goal	18484 Lakeville	Bloom	Brook	Burns	Carlson	Chan	Creek	Eagan	Maple Grove	Mpls	Plymouth	Shak	SmartCare	SLP Fam Med	SLP Int Med	Wayz
Adult Asthma	69.2%	67.2%	69.9%	56.6%	65.0%	67.7%	59.4%	59.0%	68.4%	61.5%	49.6%	62.8%	67.8%	69.1%	64.6%	71.3%	67.2%
ODC	50.8%	38.4%	45.8%	47.4%	49.2%	53.6%	43.1%	35.7%	50.4%	51.2%	35.8%	43.9%	48.0%	46.2%	41.1%	52.0%	47.9%
Hypertension	80.5%	61.8%	72.4%	69.6%	70.4%	75.5%	65.1%	66.0%	75.7%	71.2%	62.9%	68.3%					
Adult Depression 6 mos	17.1%	12.6%	13.0%	12.3%	18.0%	15.8%	13.8%	9.7%	22.9%	15.3%	12.0%	18.6%					
Adult Depression 12 mos	17.7%	12.5%	22.8%	14.3%	20.9%	13.9%	16.1%	11.1%	22.5%	14.6%	6.2%	12.6%					
BC Screening	85.9%	74.3%	85.0%	73.3%	83.3%	84.1%	84.4%	59.0%	85.5%	86.4%	65.4%	81.6%					
Cerv. Cancer Screening	85.8%	82.1%	86.7%	83.1%	84.9%	86.9%	83.0%	76.0%	85.7%	87.5%	75.7%	85.2%					
Chlamydia	65.8%	57.4%	53.7%	64.5%	54.5%	53.4%	54.9%	47.7%	56.3%	60.2%	66.0%	54.7%					
CRC Screening	75.7%	64.6%	74.5%	68.3%	76.8%	78.4%	74.6%	59.5%	77.7%	76.1%	64.7%	74.2%					
CRC POC Screening	68.3%	60.0%	73.0%	64.1%	68.1%	69.5%	63.4%	59.5%	67.6%	67.7%	51.9%	60.0%					
Adol Imms	46.7%	48.6%	51.5%	41.7%	42.9%	42.3%	49.4%	53.1%	38.7%	38.1%	35.1%	40.6%					
Child Imms	65.0%	69.6%	63.3%	57.2%	59.7%	77.2%	73.1%	60.0%	63.8%	74.3%	23.9%	71.7%					

% Green	% Yellow	%Red	Measure
12.5%	68.8%	18.8%	Adult Asthma
28.6%	57.1%	14.3%	Child Asthma
18.8%	62.5%	18.8%	ODC
0.0%	87.5%	12.5%	Diabetes- Nephropathy
0.0%	31.3%	68.8%	Hypertension
37.5%	62.5%	0.0%	Adult Depression 6 mos
37.5%	56.3%	6.3%	Adult Depression 12 mos
12.5%	62.5%	25.0%	BC Screening
31.3%	62.5%	6.3%	Cerv. Cancer Screening
6.3%	50.0%	43.8%	Chlamydia
43.8%	37.5%	18.8%	CRC Screening
18.8%	75.0%	6.3%	CRC POC Screening
28.6%	50.0%	21.4%	Adol Imms
58.3%	33.3%	8.3%	Child Imms

Over 50% of clinics at goal- green or yellow is highlighted

Over 20% of clinics not at goal- red is highlighted

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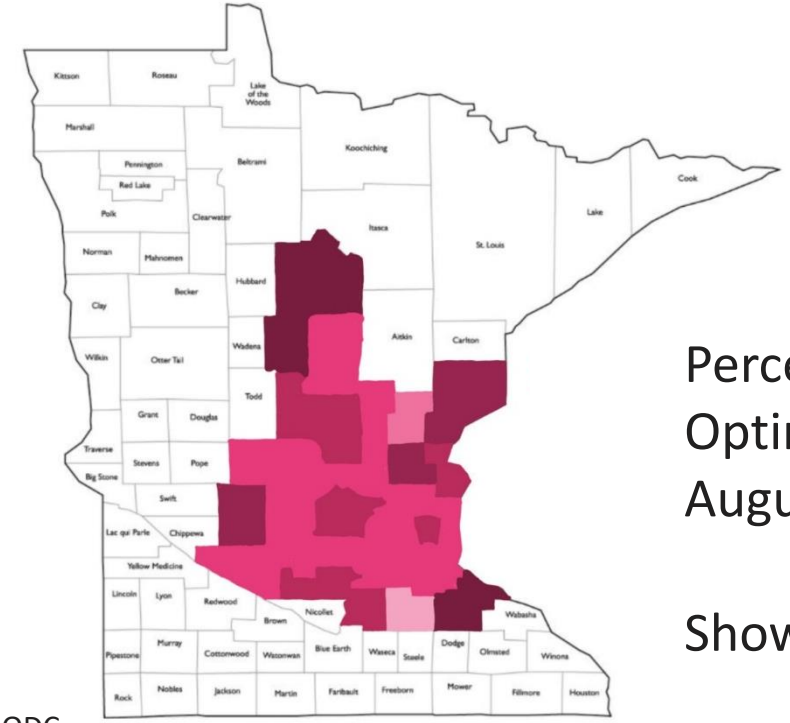
Diabetes Quality Analysis
Diabetes Patient Panel: Use for focused population efforts (list showing patient by Payor and Race)
Care team ask for lists of their patients to reach out to

Diabetes Patient Panel

Payor Group	Plan Name	Race Group	Race Detail	HbA1c Date	HbA1c Value	HbA1c Status	HbA1c Action	BP Action	BP STATUS	BP Date	BP Systolic	BP Diastolic	Statin Flag	LDL Date
Commercial	BCBS OUT O...	White	White	[redacted]20...	13.8	POOR CONT...	HbA1c >=8 - ...		MET	[redacted]020	115	70	MET	[redacted]020
Medicare	MEDICARE	White	White	[redacted]20...	14.6	POOR CONT...	HbA1c >=8 - ...	BP Due Soon	MET	[redacted]2019	114	80	MET	[redacted]2019
Commercial	HP FULLY IN...	White	White	[redacted]20...	9.2	POOR CONT...	Review for Act...		MET	[redacted]020	88	59	MET	[redacted]020
Commercial	BCBS MN	White	White	[redacted]020	9.6	POOR CONT...	HbA1c >=8 - ...	Overdue for F...	ELEVATED	[redacted]020	139	96	MET	[redacted]20
Commercial	HP FULLY IN...	White	White	[redacted]20...	11.4	POOR CONT...	Review for Act...		MET	[redacted]020	104	74	MET	[redacted]020
Commercial	HP FULLY IN...	White	White	[redacted]20...	9.8	POOR CONT...	HbA1c >=8 - ...	Overdue for F...	ELEVATED	[redacted]020	145	83	MET	[redacted]020
Commercial	HP FULLY IN...	White	White	[redacted]20...	10.7	POOR CONT...	HbA1c >=8 - ...		MET	[redacted]020	106	67	MET	[redacted]19
Self-pay		White	White	[redacted]20...	10.8	POOR CONT...	HbA1c >=8 - ...		MET	[redacted]019	138	84	MET	[redacted]019
Commercial	UHC	White	White	[redacted]20...	9.1	POOR CONT...	HbA1c >=8 - ...		MET	[redacted]20	129	70	MET	[redacted]019
Medicaid	UHC COMMU...	White	White	[redacted]20...	12.0	POOR CONT...	HbA1c >=8 - ...		MET	[redacted]020	123	85	MET	[redacted]018
Commercial	HP SELF INS...	White	White	[redacted]20...	9.6	POOR CONT...	HbA1c >=8 - ...		MET	[redacted]020	115	68	MET	[redacted]016
Commercial	BCBS OUT O...	White	White	[redacted]20...	12.1	POOR CONT...	Review for Act...		MET	[redacted]020	137	76	MET	[redacted]020
Medicare	MEDICA PRI...	White	White	[redacted]20...	9.1	POOR CONT...	Review for Act...	Overdue for F...	ELEVATED	[redacted]20	94	90	MET	[redacted]019
Commercial	BCBS OUT O...	White	White	[redacted]20...	12.8	POOR CONT...	Review for Act...		ELEVATED	[redacted]020	161	91	MET	[redacted]020
Medicaid	BCBS WI ME...	Of Color	Multiple Value...	[redacted]/2...	11.3	POOR CONT...	HbA1c >=8 - ...		MET	[redacted]019	127	83	MET	[redacted]16
Commercial	BCBS OUT O...	White	White	[redacted]20...	10.8	POOR CONT...	HbA1c >=8 - ...		MET	[redacted]020	125	85	MET	[redacted]2019
Commercial	MEDICA IFB I...	White	White	[redacted]/2...	9.2	POOR CONT...	HbA1c >=8 - ...	Overdue for F...	ELEVATED	[redacted]020	157	96	MET	[redacted]19
Medicaid	GHC OF EAU ...	White	White	[redacted]20...	13.9	POOR CONT...	HbA1c >=8 - ...	Overdue for F...	ELEVATED	[redacted]020	144	100	MET	[redacted]019
Commercial	BCBS OUT O...	White	White	[redacted]020	9.0	POOR CONT...	HbA1c >=8 - ...		MET	[redacted]20	127	88	MET	[redacted]019
Commercial	AETNA	White	White	[redacted]20...	12.4	POOR CONT...	HbA1c >=8 - ...	Overdue for F...	ELEVATED	[redacted]020	153	80	MET	[redacted]2019
Medicare	MEDICA PRI...	White	White	[redacted]020	9.0	POOR CONT...	HbA1c >=8 - ...		MET	[redacted]020	125	74	MET	[redacted]20
Medicare	MEDICA PRI...	White	White	[redacted]020	10.0	POOR CONT...	HbA1c >=8 - ...		MET	[redacted]20	133	74	MET	[redacted]20
Self-pay		White	White	[redacted]019	11.6	POOR CONT...	HbA1c >=8 - ...	BP Due Soon	MET	[redacted]19	136	84	MET	[redacted]18
Commercial	HP FULLY IN...	White	White	[redacted]20...	11.3	POOR CONT...	HbA1c >=8 - ...		MET	[redacted]020	105	64	MET	[redacted]19



Percent of patients achieving Optimal Diabetes Care August 2020

Shown by County

Percent ODC
>55%
50-55%
45-49%
40-44%
35-39%
Below 35%

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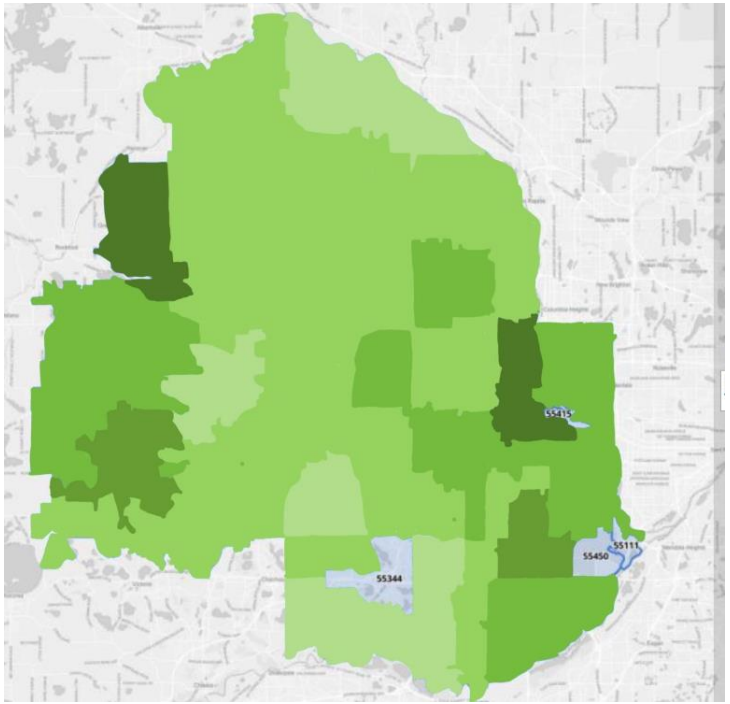
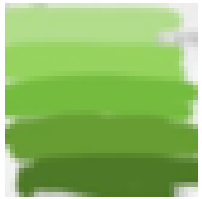
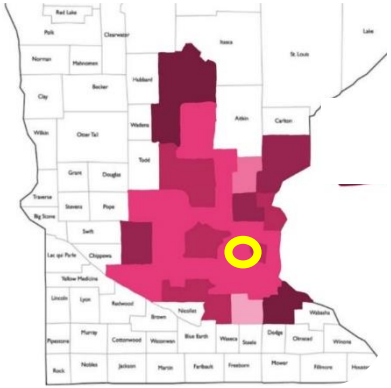


Hennepin County (includes Minneapolis) Optimal Diabetes Care By Zip Codes August 2020



Percent ODC
>52%
47-51%
42-46%
37-41%
32-36%



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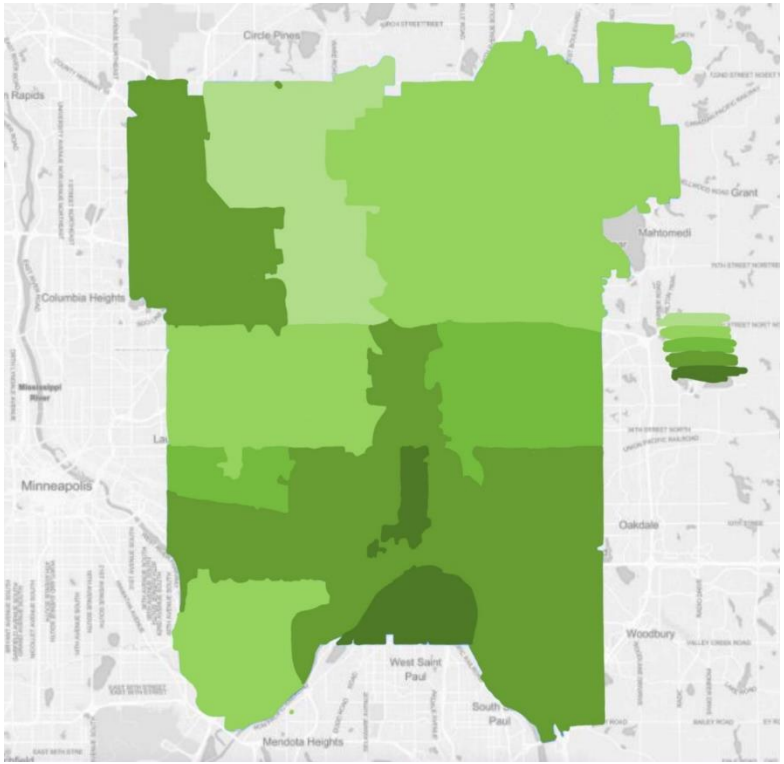
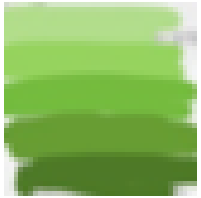
Ramsey County (includes St. Paul) Optimal Diabetes Care By Zip Codes August 2020





Percent ODC
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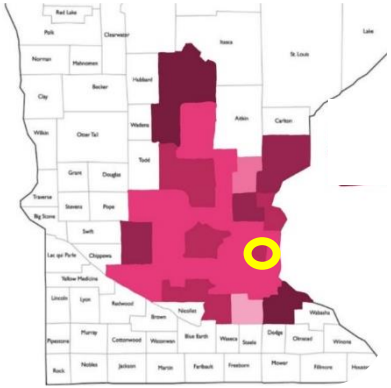

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ASIAN VEGETARIAN CUISINE
BLACK
1920 × 1080

Burch
Burch Steak
I CAN'T BREATHE
REFORM

Walgreens
CAN'T BREATH

Walgreens pharmacy

What key system resources to help support people with Diabetes?

- Primary Care
- International Diabetes Center
- RN Care Coordinators
- Diabetes Educators
- MTM Pharmacists
- Social Work Care Coordinators
- Insurance Plan Programs
  - Case Managers
  - Virtual/Digital programs
- Technology / Monitoring

Care Coordination Tips: Assessing SDOH factors with DM Patients

- Conversational assessment as you interview and educate the patient:
  - Tell me about who shops for food in your household . . .
  - Tell me about your meals . . .
  - When do you first eat in the morning?
  - Tell me about your home/kitchen . . .
  - Who helps with medications or meals in your home?
  - Who do they call when they need help?
- Further assessment – probing questions depending on responses

Common SDOH Factors & Resources for DM Patients

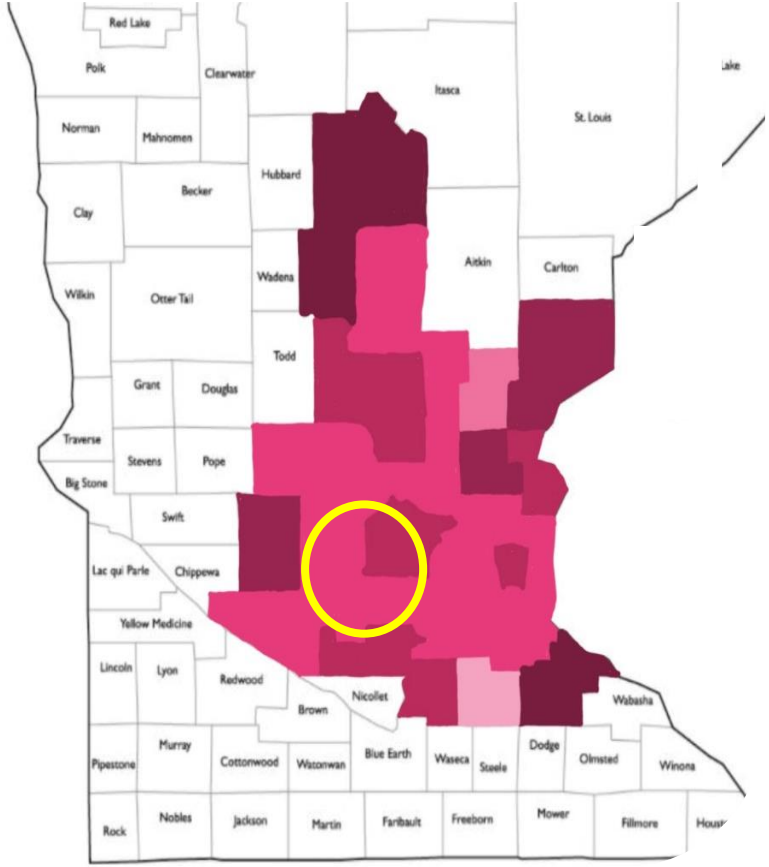
- Ability to afford testing supplies and medication
- Ability to navigate insurance benefits
- Food insecurity – compounded by need for new nutritional plan to control blood sugars
- Housing instability – often a higher priority than good nutrition or testing supplies
- Transportation barriers

- Insurance plan programs
- Pharmacy assistance programs
- Industry programs for support
- Medication charity/grant program
- Hunger Solutions – also assist with further SDOH assessment and resource finding
- MTM referral
- Care Coordination referral
- Nutrition Services referral
- General community resource referrals

Strategies that Work

- Patient Centered approach
  - Meet patient where they are at
  - Simple goal setting
- Prioritize needs of patient – not just medical needs – social often higher priority for patient
- Relationship building – trust & care
  - Respectful language: adherent vs compliant; in range or out of range vs good or bad readings
- Customized follow up
  - Frequency
  - Intensity
  - With whom
  - Accountability check in
- In Person visits
- Video visits

Hutchinson Health
McLeod County, MN



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Hutchinson

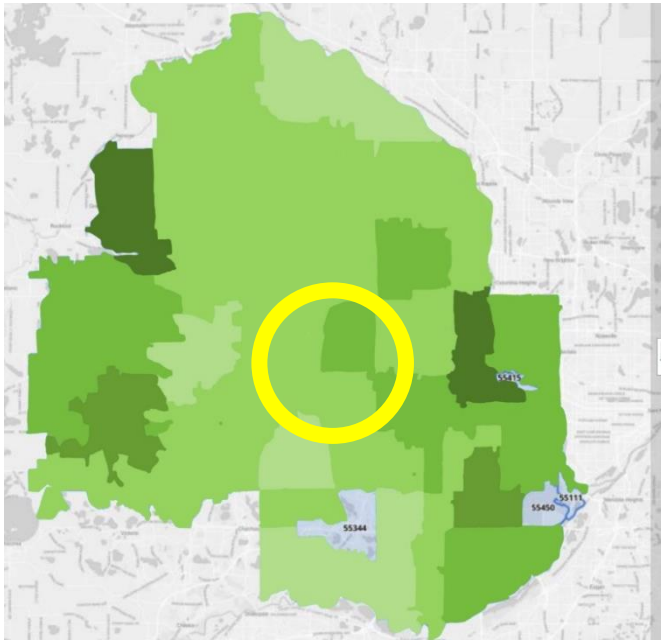
- Small town, “farm belt”
- Population generally conservative, prefer traditional care
- Farmers don’t come in for visits March-October
- Barriers to considering insulin therapy
  - Considerations for maintaining DOT licenses
- Transportation barriers
  - Geographic distance and long drives
  - Minimal other transportation options
- Unexpectedly high costs for nutritious foods
- Formal Diabetes Education often unaffordable

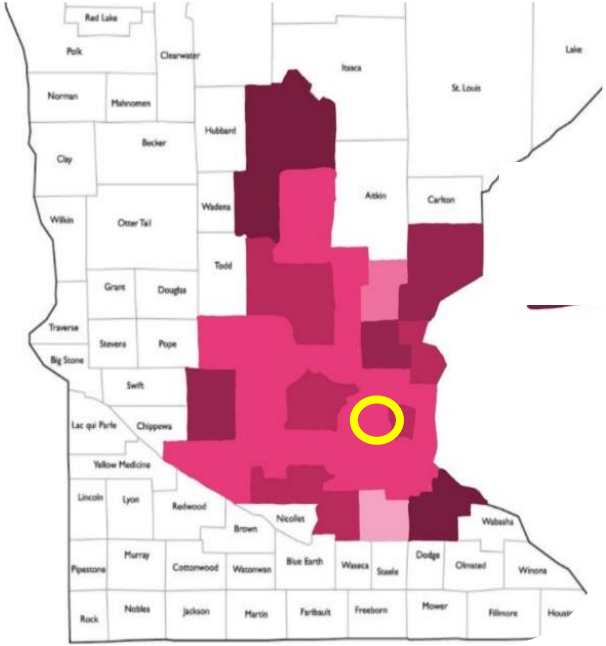
Hutchinson's tips

- Accommodate people's schedule (farm seasonality)
- "Next Visit Set up"
  - Clear expectations for patient on timing of next follow up
  - Labs ordered for next visit before patient leaves
  - Most of the time, patient leaves with their appt already scheduled
  - Also leaves ensuring all meds refilled
- Keep individual clinician performance numbers close to the provider
  - Reports and viewing of their own diabetes panel

Special thanks to Dr. Leah Schrupp at Hutchinson Health

Park Nicollet Brookdale Clinic
Brooklyn Center, MN





Brooklyn Center

- Highest “no show” rate for appointments
- High interpreter need
- Large West African and Southeast Asian population
- “Working Class” population
- High percent of literacy/numeracy barriers to care
- Diabetes educators embedded within the clinic

Brooklyn Center tips

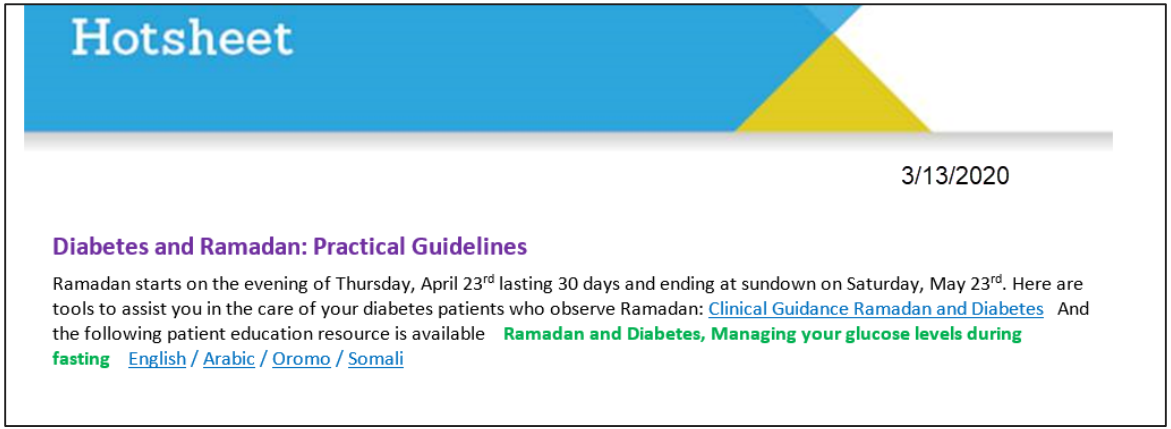
- See patient while they are there (“just in time”)
- Cultural Sensitivity
  - Talk in terms of what foods they eat
  - Cultural considerations around mealtime environment
  - What comparisons make sense related to portion
- Relationships and Trust, understand the individual
  - First visit is often “What does yoru day look like”
- Creativity

System Wide Tips

- Expert Panel
  - Brings together leaders in various disciplines to prioritize
- Robust Standing orders for DM Med titration
  - Used by CDEs (IDC, some care coordinators)
- Protocols for CDEs and clinicians alike
  - Pre-procedural, fasting, glucocorticoid use, etc

Ramadan Annual Review

- Review annually at Fall Expert Panel
- Communicate in March



Hotsheet

3/13/2020

Diabetes and Ramadan: Practical Guidelines

Ramadan starts on the evening of Thursday, April 23rd lasting 30 days and ending at sundown on Saturday, May 23rd. Here are tools to assist you in the care of your diabetes patients who observe Ramadan: Clinical Guidance Ramadan and Diabetes And the following patient education resource is available **Ramadan and Diabetes, Managing your glucose levels during fasting** English / Arabic / Oromo / Somali

A picture is worth a thousand words

- Take a picture of your food
- CGM printouts/trends have color coding- can sometimes be used when language, literacy, or numeracy barriers present
- Have patient take a picture of a certain product or recommended food to help them get it at store

Video visits: “Show me…..

- the inside of your cupboard/ refrigerator
- Your pillbox
- Your actual pills
- Your dinner (or send me a photo). Let’s carb count this together.
- How you check your BG, how you give your insulin

Books for patients

Diabetes Burnout: What to Do When You Can't Take It Anymore by William H. Polonsky, PhD, CDE

Eating Mindfully: How to End Mindless Eating and Enjoy a Balanced Relationship with Food by Susan Albers, PsyD.

Intuitive Eating: A Revolutionary Program That Works by Evelyn Tribole, MS, RD and Elyse Resch, Ms, RD, FADA

Mindless Eating: Why We Eat More Than We Think by Brian Wansink, PhD.

Nutrition and Diabetes Tools

CalorieKing

-Provides free mobile app, products and services designed to educate, motivate and inspire lifelong weight management.

Calorieking.com

GoMeals

-Offers free mobile app with features for healthy eating, staying active and tracking glucose levels.

GoMeals.com

Diabetes Goal Tracker

-Free mobile app from AADE to help set diabetes management goals.

Available in Spanish and English.

Diabeteseducator.org/patient-resources/diabetes-goal-tracker-app

MyFitnessPal

-Provides free diet and exercise journal and online calorie counter. Apps available.

Myfitnesspal.com

Glucose Buddy

-Offers free mobile app to help manage diabetes.

Glucosebuddy.com

SparkQuote

-Provides free inspiring quote of the day

Www.sparkquote.com

Helpful Resources for patients and professionals

Academy of Nutrition and Dietetics (AND)

-Offers a user friendly website that contains a wealth of science-based information and advice on eating well and optimizing health.

Https://www.eatright.org/

American Association of Diabetes Educators (AADE)

-Offers a variety of tools and resources to help make living with diabetes manageable.

Diabeteseducator.org/patient-resources

American Diabetes Association (ADA)

-Offers a wide range of information related to diabetes. Search by specific topics under ADA's search engine or through the main headings on the home page of the website. Also offers an online support community.

Diabetes.org

American Heart Association (AHA)

-Offers a wide range of information related to heart heath, including a Heart Attack Risk Calculator. Search by specific topics under AHA's search engine or through the main headings on the home page of the website.

Heart.org

Behavioral Diabetes Institute (BDI)

-Offers tools to face the psychological demands of diabetes.

Behavioraldiabetes.org

Center for Mindful Eating

-Offers information about mindful eating and conducts classes and training for ongoing education about mindful eating.

Thecenterformindfuleating.org

International Diabetes Center (IDC) - at Park Nicollet

-A leader in diabetes innovation, education and research to improve patient care.

Internationaldiabetescenter.com

National Diabetes Education Program

-Offers resources on diabetes management and prevention for patients and health care professionals through partnerships with more than 200 public and private organizations. A federally funded program sponsored by the National Institutes of Health and the Centers of Disease Control and Prevention (CDC).

Ndep.nih.gov

United States Department of Agriculture (USDA) - MyPlate

-Offers information and tools on eating for better health, physical activity and more.

Choosemyplate.gov

Diabetes Life Website

Informs, inspires and connects millions of diabetes patients, costumers and caregivers. Recipes, nutrition tips, and expert advice.

DLife.com

HealthPartners

October Webinar

- **Date/Time**: October 15, 2020 from 2-3pm Eastern
- **Topic**: Optimizing Diabetes Care in 4 High Volume Primary Care Clinics of Henry Ford Health System
- **Presenters**: Denise White-Perkins, M.D., Ph.D.; Kate Weisberg-Zenlea, MPH, CPH; Doreen Dankerlui, MPH;

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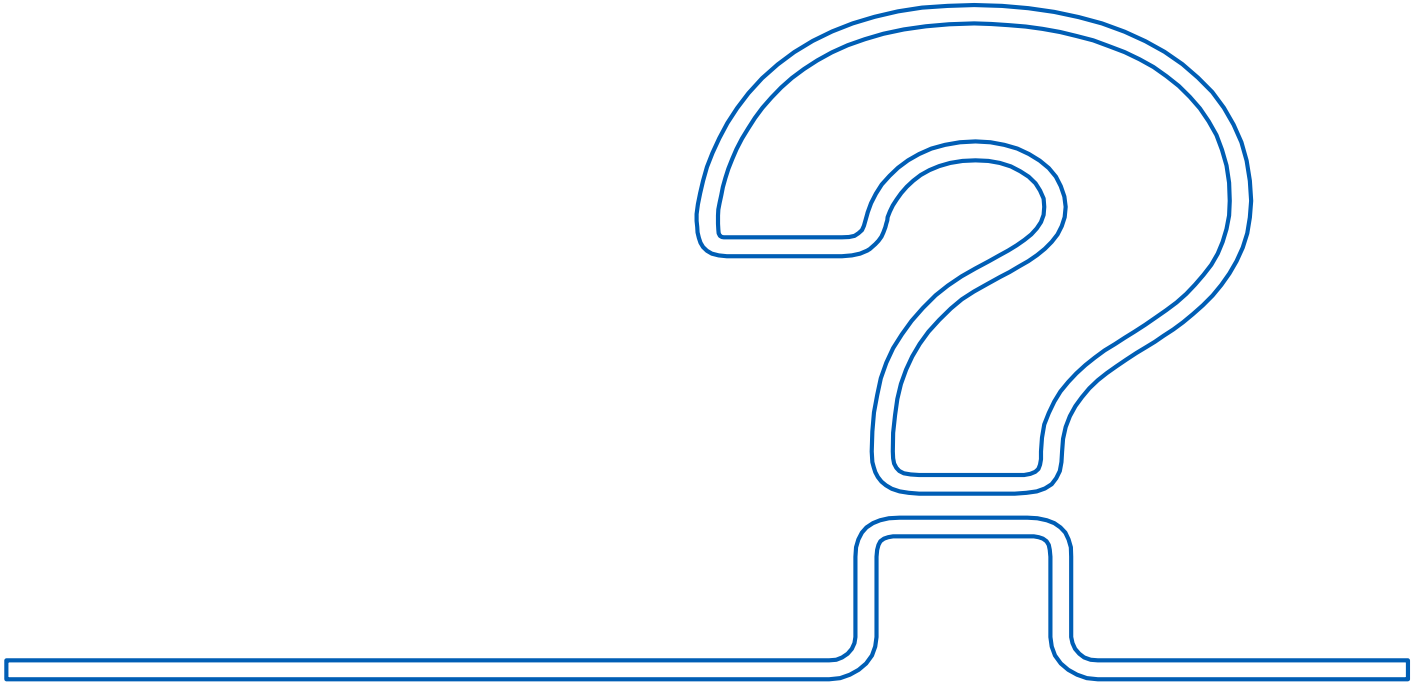
Questions



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