National LAN Event –
Engaging Physicians & Care Teams to Prevent & Manage Diabetes

Wednesday, November 8, 2017
3:00 – 4:30 PM ET

Welcome and Reminders

Lindsay Kaatz
Telligen
Event Lead

Karen Ten Cate
Qsource
Chat Manager

- Please be prepared for sharing and open discussion
- Slides and a recording from today's session can be found on: http://qioprogram.org/national-learning-action-network-series-november-2017

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Sharing Knowledge. Improving Health Care.
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Agenda

- Continuing Education Details
- Speaker Presentations
  - Susan Fleck, Centers for Medicare & Medicaid Services
  - Kate Kirley & Kenneth Henriksen, American Medical Association
  - Joan Bardsley, MedStar Health Research Institute
- Facilitated Discussion
- Wrap-up

Purpose of the Series

Audience: Patients, community and healthcare providers, local partners, federal partners, and Quality Improvement Organization (QIO) Program partners (*registration required)

Purpose: Offer virtual training events focused on healthcare quality improvement and hot topics in healthcare delivery transformation, and connect these national themes with related local services, resources, and support available through the QIO Program

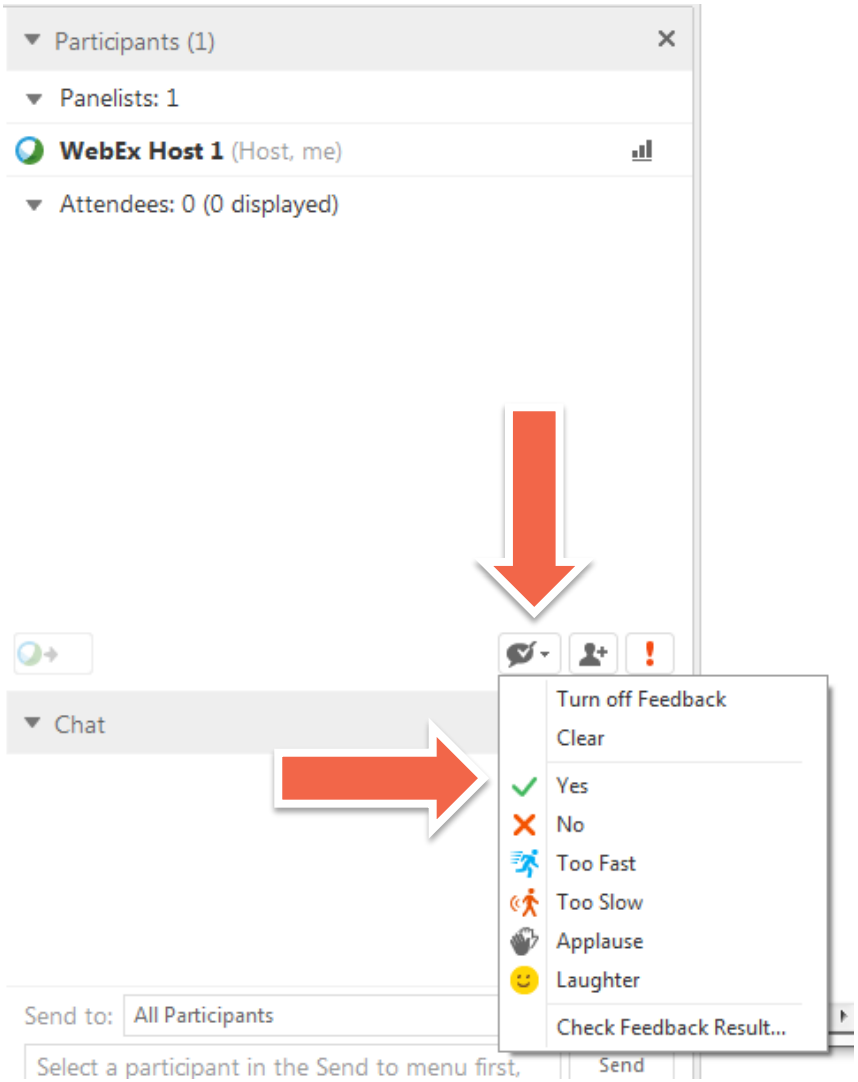
Expectations: Participants will gain knowledge that is directly applicable to their work in healthcare quality improvement and acquire information that can be easily shared among their own community, organization, or team

Topics: Topics have been aligned with the CMS Quality Strateg

Learning Outcome

- The purpose of this session is to prepare healthcare quality improvement professionals to identify and implement effective healthcare strategies by exploring promising practices to engage physicians and care teams and prevent and manage diabetes.
- We expect that this experience will help participants demonstrate and promote successful delivery of care practices and identify opportunities for improvement, all of which may promote advances in care that impact the Medicare beneficiaries served by the work of the QIO Program.

Things to Think About



Will you commit to being…

- Attentive
- Active participant
- Actionable

Show your commitment by clicking the green checkmark!

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Continuing education credit is available for:

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- Registered Nurses & Nurse Practitioners
- Dietitians
- Pharmacists & Pharmacy Technicians
- Certificate of Attendance

Instructions for Obtaining CE

- Attend the entire event
- Complete the post-event assessment that will pop up at the conclusion of the event
- There is a separate evaluation required for CE that is accessible through the post-event assessment
- Once you submit your CE evaluation, you will be provided with a certificate to retain for your records
- For technical assistance, please email Nikki Racelis (nikki.racelis@qinncc.hcqis.org)

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AKH Inc., Advancing Knowledge in Healthcare approves this knowledge-based activity for 1.5 contact hours (0.15 CEUs). UAN 0077-9999-17-037-L04-P; 0077-9999-17-037-L04-T.
Initial Release Date 11/8/2017

CE Information, Continued

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This activity is accredited for 1.5 contact hour(s) which includes 0 hour(s) of pharmacology. Activity ID #21718-8

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Disclosure of Unlabeled Use and Investigational Product
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- If you have questions about this CME/CE activity, please contact AKH Inc. at service@akhcme.com.

Who's in the room?

What entity or type of organization do you represent?

- CMS
- Home Health Agency
- Hospital
- Nursing Home/Skilled Nursing Facility
- Patient, Family, or Caregiver Representative
- Pharmacy/Pharmacist
- Provider/Practice
- QIN-QIO
- Other (please specify in chat)

Session Goals

By the end of today's call you will be able to…

- Articulate the American Medical Association's (AMA) strategy to prevent type 2 diabetes by working directly with physicians and care teams to identify patients with prediabetes and referring patients to a diabetes prevention program.
- Identify the services and resources available through the AMA to implement a screening, testing, and referral process in healthcare organizations.
- Highlight key considerations relevant to upcoming coverage through Medicare for eligible beneficiaries who participate in a diabetes prevention program.
- Describe the four critical times to assess, provide, adjust, and refer for self-management education and support.
- List three tools available to support the dissemination of the recommendations stated in the Joint Position Statement.

Engaging Physicians and Care Teams for Diabetes Prevention and Management

November 8, 2017

Susan Fleck, RN, MMHS
Subject Matter Expert
Lead, Everyone with Diabetes Counts (EDC)

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CMS Equity Plan for Medicare
Six Priorities

- Expand the collection, reporting and analysis of standardized data
- Evaluate disparities impacts and integrate equity solutions across CMS programs
- Develop and disseminate promising approaches to reduce health disparities
- Increase the ability of the healthcare workforce to meet the needs of vulnerable populations
- Improve communication and language access for individuals with limited English proficiency and persons with disabilities
- Increase physical accessibility of healthcare facilities

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Diabetes Prevalence/Medicare Expenditures Attributed to Diabetes

- 60% of Medicare beneficiaries have multiple chronic conditions
- 15% of Medicare beneficiaries have 6 or more chronic conditions; the top 6 are: HTN, High Cholesterol, Arthritis, Diabetes, Ischemic Heart Disease, and Chronic Kidney Disease, which account for 51% of Medicare spending
- 24% of Medicare-Medicaid (dually eligible) beneficiaries have 6 or more chronic conditions (Source for all of the above: CMS Chronic Conditions Among Medicare Beneficiaries Chartbook, 2015)
- 26.9% of Medicare beneficiaries age 65 and older (10.9 million Americans) have diabetes; they account for approximately 32% of Medicare spending (Source: 2013 testimony by the Congressional Diabetes Caucus in the US House of Representatives and the American Diabetes Association)

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Diabetes Statistics – Over 65/Diverse Populations

Diabetes Rates from the CDC National Diabetes Statistics Report 2017 (https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf):

- The percentage of adults with diabetes increased with age, reaching a high of 25.2% among those aged 65 years or older
- Type 2 accounts for 90 – 95% of all diabetes cases
- American Indian/Alaska Natives had the highest prevalence of diagnosed diabetes for both men (14.9%) and women (15.3%)
- Among non-Hispanic Blacks, the prevalence was: 12.7%
- Among Hispanic adults, the prevalence was: 12.1%
- Among Asian American adults, Asian Indians had the highest prevalence: 11.2%

Rural statistics:

- Diabetes is more common among beneficiaries who live in rural counties (16.7%), than among those who live in urban areas (13.5%). Source: The Rural Health Research & Policy Centers, funded by the Federal Office of Rural Health Policy

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Everyone with Diabetes Counts (EDC)

- Started as a one-state pilot 10 years ago (FL)
- Then expanded to 9 states/territories (NY, GA, LA, WV, TX, MS, MD, DC, US VI)
- **National expansion** (50 states, as well as Washington DC, Puerto Rico, and US Virgin Islands) as of **August 1, 2014.** Contract ends July 31, 2019.
- **Largest national** Medicare diabetes self-management education (DSME) program focused on **Medicare beneficiaries** in underserved minority/diverse, and rural populations

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EDC Goals

- Improve health equity by improving health literacy and quality of care among Medicare and Medicare-Medicaid (dually eligible) beneficiaries with pre-diabetes and diabetes through knowledge empowerment, enabling them to become active participants in their care **(person/patient engagement)**
- EDC is a **disparity reduction program**; target populations are minority underserved/diverse and rural
- Engage both beneficiaries and health care providers to: Decrease the disparity in diabetes testing by improving testing/measures for: **HbA1c, Lipids, Eye Exams, Foot Exams, Improve Blood Pressure control and Weight control**
- Improve actual clinical outcomes of the above measures
- **Facilitate sustainable diabetes education resources** by engaging public/private agency/organization partnerships at the community, state, and national levels

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Challenge of Literacy/Health Literacy

The current literacy rate in the US has not changed in 10 years.

- **14% of US adults cannot read (defined as being below a basic level)***
- 19% of high school graduates can't read

Reading Levels - demographics of adults who read below a basic level*

- Hispanic 41%
- African American 24%
- White 9%
- Other 13%

- * Basic level - reading at a 4th grade level, and the person should be able to make simple inferences, and interpret the meaning of a word as it is used in the text.

- Source for all of above: U.S. Dept. of Education, National Institute of Literacy, Illiteracy Statistics Dec. 2015

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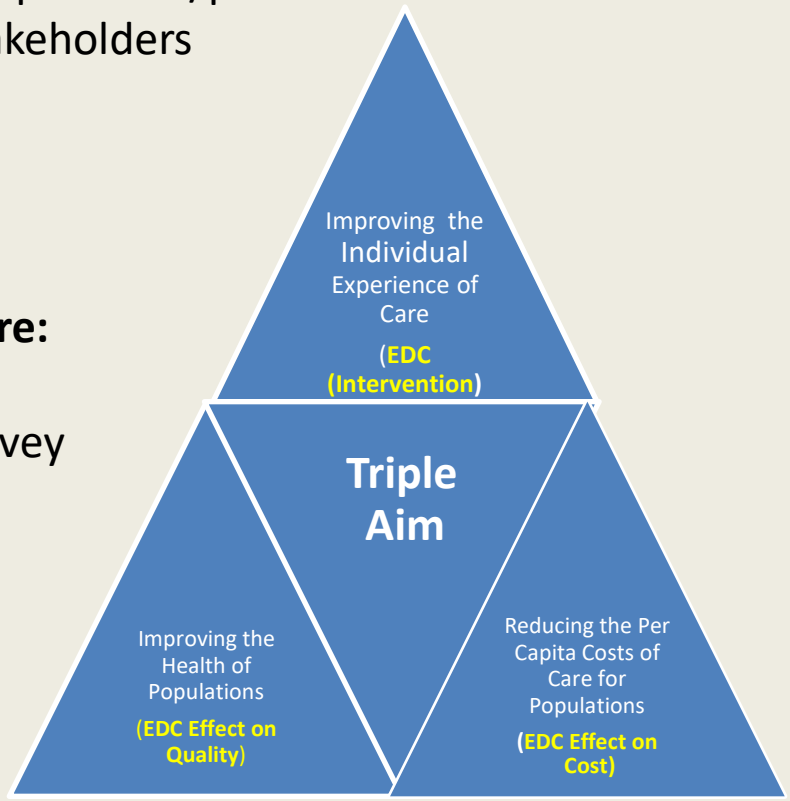
EDC Components/Triple Aim

EDC has 5 components:

- 1.) Recruitment and education of beneficiaries in diabetes self-management (DSME) classes
- 2.) Recruitment and education of physician practices/providers and staff
- 3.) Recruitment of community partners/stakeholders
- 4.) Data collection and analysis
- 5.) Sustainability planning/implementation

- **Improving the Individual Experience of Care:** Beneficiary DSME Classes and Provider Technical Assistance; Patient Activation Survey
- **EDC Effect on Health/Quality:** Clinical Data Results
- **EDC Effect on Cost:** Medicare Claims Data



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How to Accomplish EDC

- **Recruit,** enroll, and teach **beneficiaries** utilizing evidence-based DSME curricula; Stanford, or DEEP (diabetes education empowerment program from UIC (University of Illinois, Chicago)). **Classes teach/promote**: healthy lifestyles/behavioral changes, basic anatomy, nutrition, medication adherence, medical monitoring (physician appts., labs, foot and eye exams, etc.), and self-goal setting to achieve favorable outcomes.
- DSME classes: 6 consecutive weeks, 2 ½ hours each class (12-15 hours total); **community-based sites; invite guest lecturers** (i.e., pharmacists, dieticians); includes **cultural competency component**; many classes taught by community health workers **(CHWs)** who reside in the targeted community, or are members of that population group. Classes taught in the **preferred language** of the targeted population as much as possible; taught for **low literacy** populations; **family member or care-giver encouraged to attend** – person and family engagement; "meet people where they are" **Not one size fits all**
- **Recruit physician practices, clinics, Medicare Advantage (MA) Plans, Federally Qualified Health Centers (FQHCs)** to improve their adherence to standards of care for people with diabetes**; improve their data collection and data analysis skills; improve their knowledge of Medicare diabetes prevention benefits, educate provider staff**

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How to Accomplish EDC continued

- **Recruit community partners/stakeholders** - "spread the word," by attending community-based activities , i.e., health fairs, to market DSME classes; **partner/stakeholder venues to host classes (i.e., area agency on aging (AAA) sites, senior centers, grocery stores, pharmacies, libraries, faith-based organizations, police stations**); endorsement by trusted sources in the community (i.e., local "celebrity" endorsement, church Pastor endorsement); local TV and radio coverage, i.e., public service announcements (PSAs); partner with **state depts. of health**, with local politicians for endorsement (Mayor, Senator, Governor); with **state medical societies**; with **academic institutions** (schools of Nursing, Pharmacy, Medicine, Programs in Dietetics)
- **Data** – QIN-QIO will obtain **clinical results** of diabetes measures for 10% of beneficiaries who complete DSME, and match to **Medicare claims data**, following beneficiaries longitudinally over time; pre and post DSME **Patient Activation Survey (PAS)** data

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How to Accomplish EDC continued

Sustainability Planning/Implementation

- Each QIN-QIO develops and implements a **Sustainability Plan** that includes increasing the numbers of certified diabetes educators (CDEs) in their state; increasing the numbers of lay diabetes educators in their state (by training them in DSME curriculum); developing train-the-trainer programs; working to facilitate the use of CHWs in their state; providing **technical assistance** to existing ADA/AADE recognized/accredited programs; and increasing the numbers of new ADA/AADE recognized/accredited ** diabetes education programs in each state.

** Achieving this recognition/accreditation enables the program to bill for the Medicare diabetes self-management training (DSMT) benefit, as well as potentially billing to other insurers/payers for diabetes education.

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EDC Data

- Numbers of Beneficiaries who Completed diabetes self-management education (DSME) classes: 38,388 (from Aug. 1, 2014 – July 31, 2017)
- Participating Providers: Over 500 FQHCs, over 100 RHCs, over 7,000 individual physicians
- Self-attested beneficiaries' responses: One Year of patient activation surveys (PAS): 10,291 beneficiaries from underserved minority, and rural populations. Statistically significant improvement results from pre to post DSME for all 14 questions www.qioprogram.org/edc/progress-to-date Scroll down to, "Click here for more information about PAS results"
- 37% of respondents (the largest %) were recruited to classes from senior centers
- 53% respondents had diabetes for 4 or more years
- 61% respondents had never received diabetes education previously
- 19% had 8th grade education or less
- 70% reported eye disease (the highest %) as a co-morbid condition

In the process of analyzing 2nd year's PAS results

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EDC Data Continued

- Through EDC, DSME classes have been taught in 13 languages
- Train-the-Trainer Program Numbers (from Aug. 1, 2014 – July 31, 2017): 4,582, includes CHWs, lay leaders, RNs, RDs, CDEs, PharmD's, and EMTs
- Types of Technical Assistance Provided by QINs: Diabetes Measures/Guidelines/Standards of Care education; Using Practice Population Data to Identify People with Diabetes; Disparities Awareness/Cultural Competency
- Sustainability Planning/Implementation: Technical Assistance with Process to Become AADE/ADA Accredited/Recognized. Examples of provider types to whom QINs provide this assistance: community partners, physician practices, hospitals, clinics, pharmacies, FQHCs, Medicare Advantage Plans, and AAA sites

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Resources

http://qioprogram.org/EDC For information about EDC, Success Stories, Photos, Aggregated Data Results

http://qioprogram.org/edc/faq For FAQ's about EDC

http://qioprogram.org/edc/progress-to-date For survey (PAS) results, Scroll down to, "Click here for more information about PAS results"

http://qioprogram.org/diabetes-prediabetes-and-cardiovascular-preventive-services For summaries of 7 Medicare Preventive Benefits, scroll down to "Tip Sheets"

http://www.qioprogram.org/contact To locate the QIN QIO in your state, and for general information about QIN QIOs

https://www.cms.gov/About-CMS/Agency-Information/OMH/equity-initiatives/equity-plan.html For information about CMS' Health Equity Plan

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EDC CMS Contact:
Susan.Fleck@CMS.HHS.GOV

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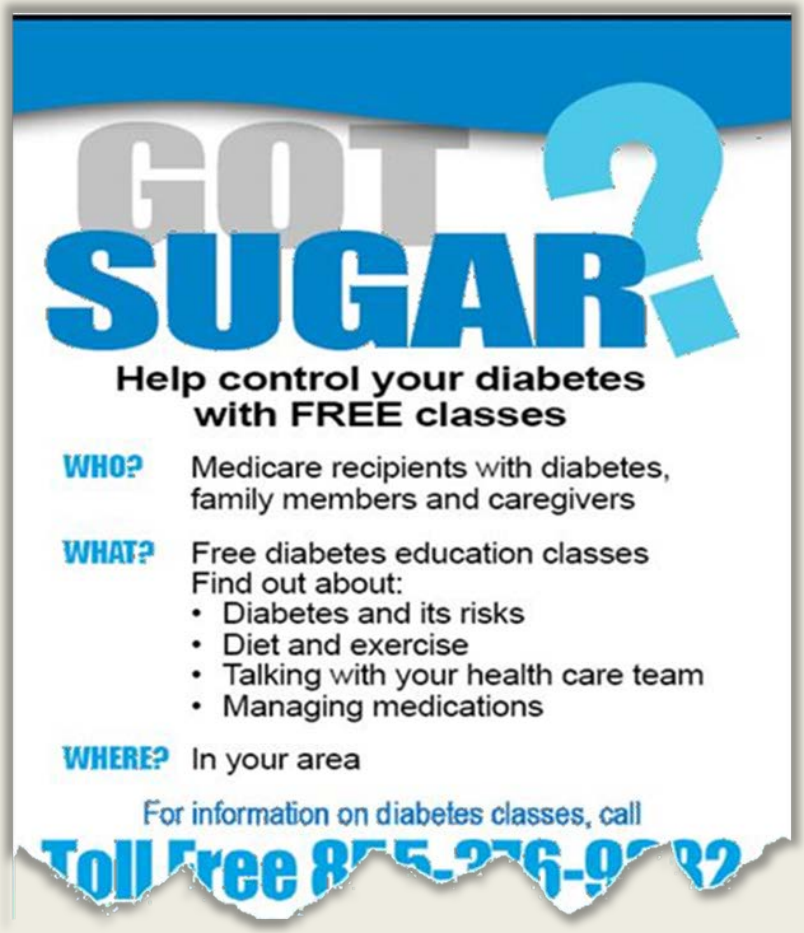
EDC Pictures

Marketing Flyer for EDC Classes



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EDC Master Trainers Class Graduates, Texas

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EDC Medicare Beneficiaries Graduation Ceremony, Bronx, NY

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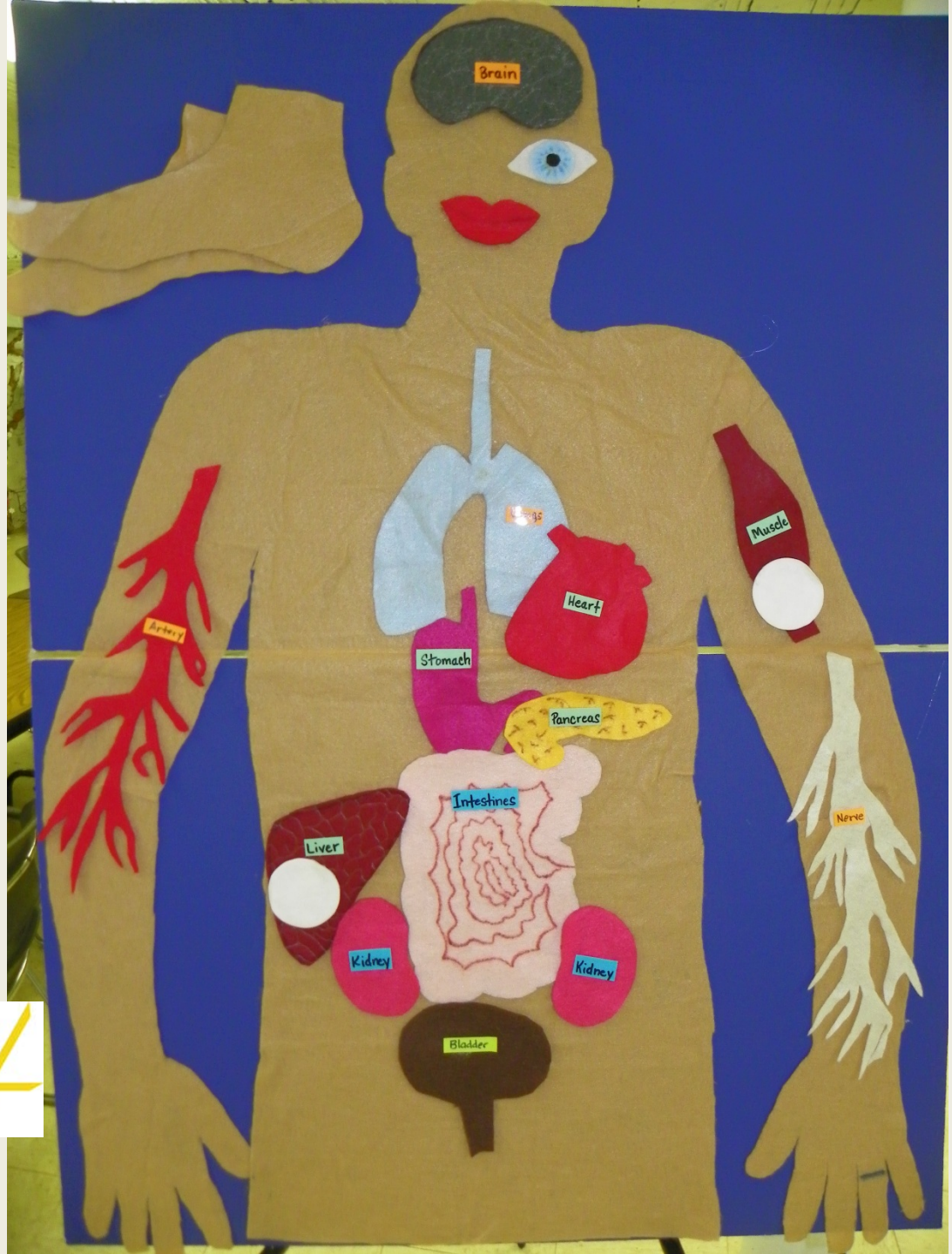

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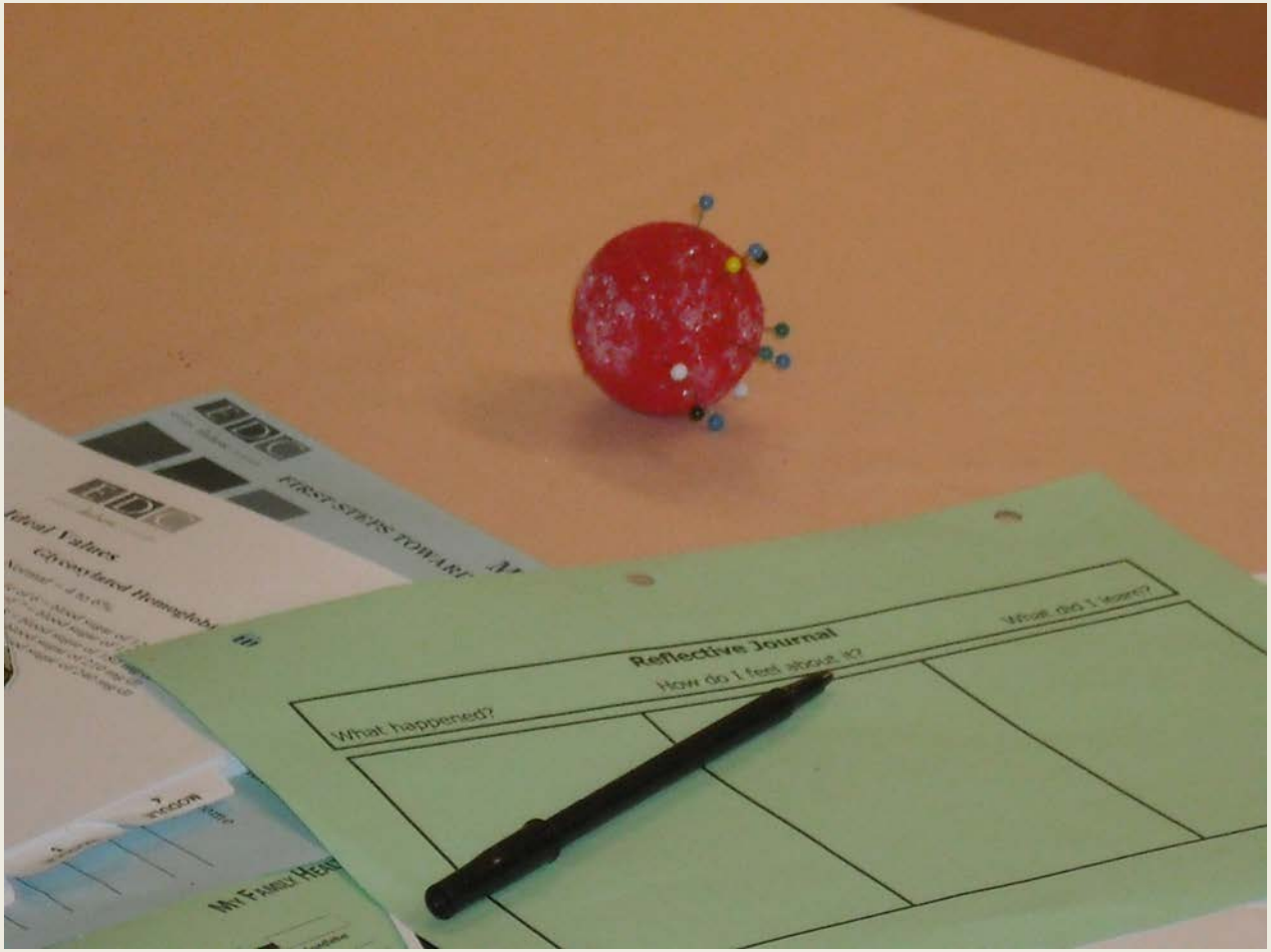
HbA1c Molecule



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How to Check Your Blood Sugar

1 Wash your hands with soap and warm water. Rinse well.

2 Gently rub your hands to warm them.

3 Put the test strip into your meter.

4 Prick the side of your finger.

5 Touch your blood drop to the test strip.

6 Write the results in your book.

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Phone: 1-800-725-2633 • Fax: 1-877-889-1870
www.DiabetesHealthForLife.org

This material was prepared by TMF Health Quality Institute, the Medicare Quality Improvement Organization for Texas, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. 10SOM-TX-EDC-12-36

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Cuidando Sus Pies

Mantenga sus pies protegidos y saludables para evitar heridas en los pies y llagas abiertas.

Mantenga los pies limpios y secos.

No sumerja sus pies durante mucho tiempo.

Use calcetines limpios todos los dias y siempre use zapatos con punta y talón cerrados.

Revise sus pies diariamente por ampollas, enrojecimiento o llagas. Consulte a su médico de inmediato si tiene cualquier llaga.

Acostúmbrese a utilizar una lima para afilarse las uñas. Nunca use una navaja o cuchillo.

Mantenga los pisos y rutas de acceso libres de objetos para evitar tropiezos con la punta de sus pies.

Examine sus zapatos todos los dias.

Nunca camine descalzo(a) o use chanclas.

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Thank You!

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American Medical Association

Kate Kirley, MD, MS
Director, Chronic Disease Prevention

Kenneth Henriksen, MBA
Director, Physician and Health System Engagement

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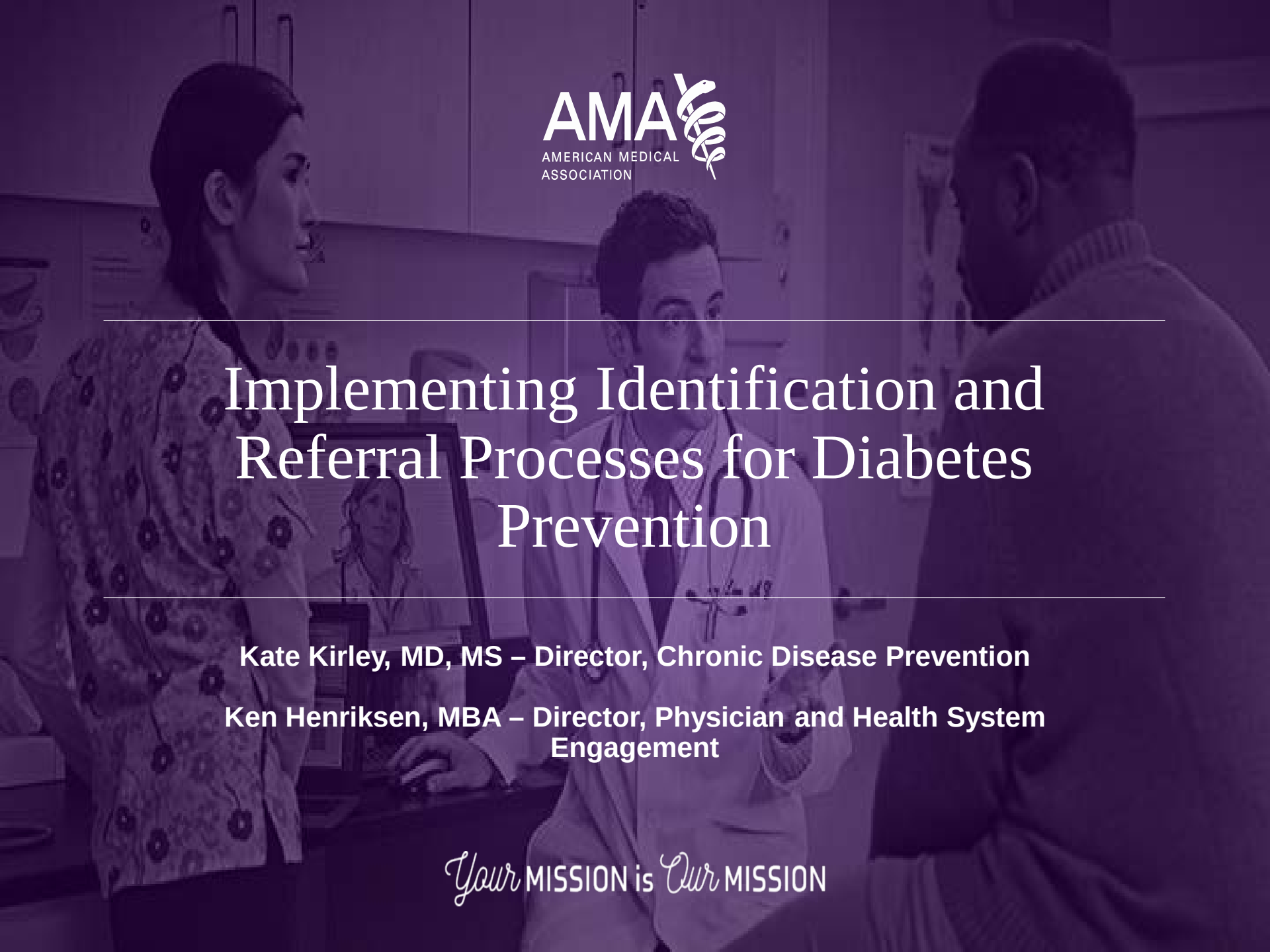


AMA
AMERICAN MEDICAL ASSOCIATION

Implementing Identification and Referral Processes for Diabetes Prevention

Kate Kirley, MD, MS – Director, Chronic Disease Prevention

Ken Henriksen, MBA – Director, Physician and Health System Engagement

Your MISSION is Our MISSION

Disclosure

We have no relevant financial relationships with commercial interests to disclose.

Objectives

- Articulate the American Medical Association's (AMA) strategy to prevent type 2 diabetes by working directly with physicians and care teams to identify patients with prediabetes and refer patients to a diabetes prevention program
- Identify the services and resources available through the AMA to implement a screening, testing and referral process in health care organizations
- Highlight key considerations relevant to upcoming coverage through Medicare for eligible beneficiaries who participate in a diabetes prevention program

Clinical context for diabetes prevention

Frank

Frank

- 2003 Prediabetes age 55

Frank

- 2003 Prediabetes age 55
- 2006 Type 2 Diabetes

Frank

- 2003 Prediabetes age 55
- 2006 Type 2 Diabetes

Glucometer
Lancets
Test Strips
Diabetes Education
Metformin
Statin
Aspirin?
ACE-I?
Referral Ophthalmology
Referral Podiatry
Office Visit q 3 months
Labs and Urine

Frank

- 2003 Prediabetes age 55
- 2006 Type 2 Diabetes
- 2010 Retinopathy

Frank

- 2003 Prediabetes age 55
- 2006 Type 2 Diabetes
- 2010 Retinopathy
- 2012 CKD

Frank

- 2003 Prediabetes age 55
- 2006 Type 2 Diabetes
- 2010 Retinopathy
- 2012 CKD

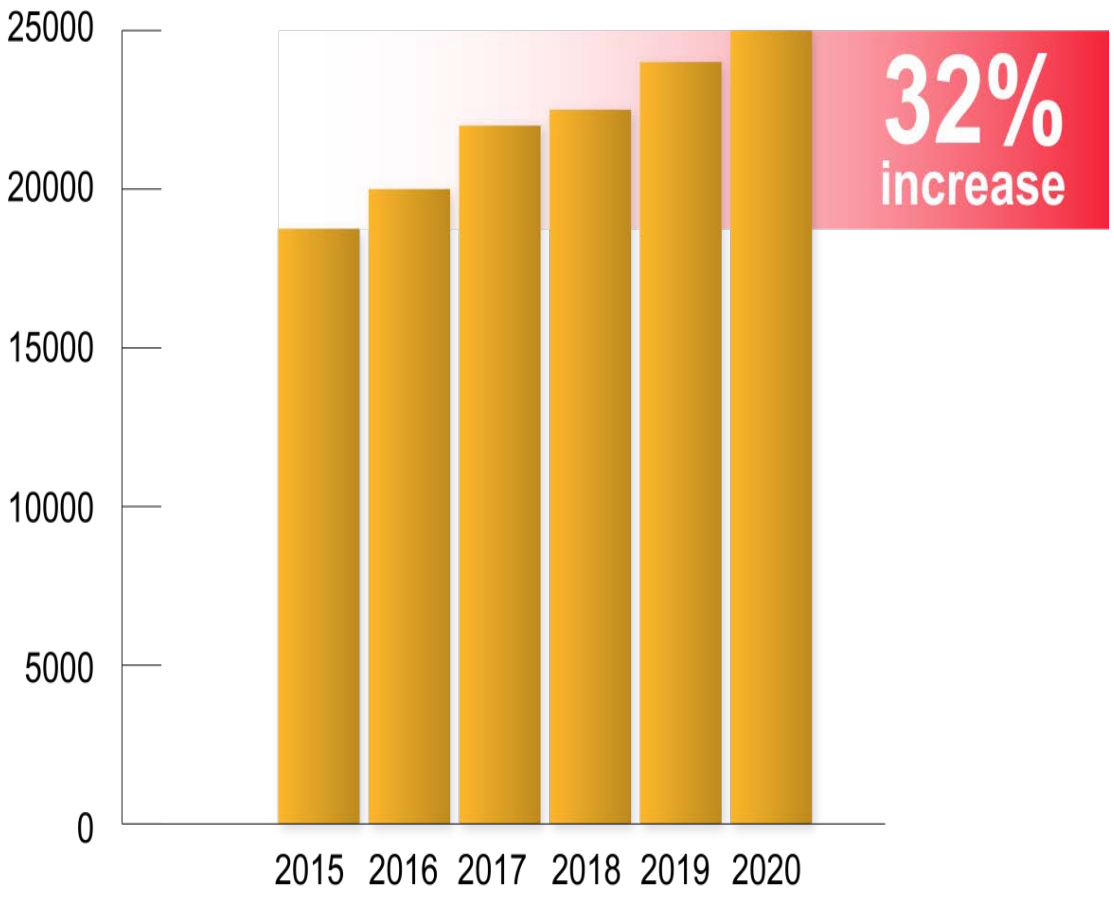
Referral Nephrology
Prior authorizations
Ongoing refills
Ongoing labs
Medical complications
Anemia
Osteoporosis
Edema

Frank

- 2003 Prediabetes age 55
- 2006 Type 2 Diabetes
- 2010 Retinopathy
- 2012 CKD
- 2016 MI and Death

Future impact on clinical practice

Over the next 5 years, a typical large clinical practice could experience a **32% increase** in the number of patients with diabetes.



Prediabetes definition

A reversible condition in which plasma glucose levels are higher than normal but not high enough to diagnose type 2 diabetes

Current burden of prediabetes

84 MILLION ADULTS HAVE PREDIABETES[1]

9 OF **10** DON'T KNOW THEY HAVE PREDIABETES[2]

1 IN **3** ADULTS HAS PREDIABETES[1]

1 IN **2** age **65+**

1. Centers for Disease Control and Prevention. National Diabetes Statistics Report: *Estimates of Diabetes and Its Burden in the United States*, 2014. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2014.

2. Centers for Disease Control and Prevention (CDC). Awareness of prediabetes--United States, 2005-2010. *MMWR Morb Mortal Wkly Rep*. 2013 Mar 22;62(11):209-12.

One solution: National Diabetes Prevention Program

Prediabetes is a reversible condition.

The National DPP can help patients lower their risk of developing type 2 diabetes and reduce the likelihood of:

ILLNESS 

MEDICATION 

EXPENSE 

Effectiveness of the National Diabetes Prevention Program

DPP Research Study: People with prediabetes who took part in a structured lifestyle change program reduced their risk of developing type 2 diabetes (at average follow-up of 3 years) compared to placebo. And the lifestyle change program was nearly twice as effective as metformin.

58% risk reduction

DPP

Intensive Lifestyle Change Program
(71% reduction for patients over age 60)

31% risk reduction

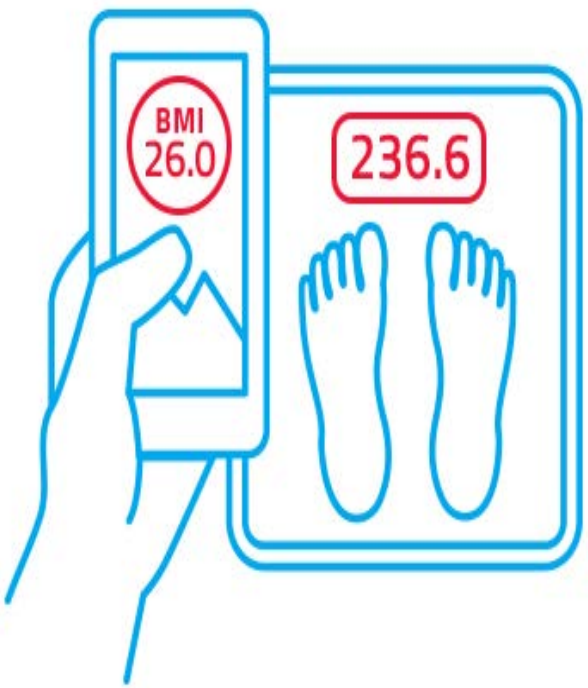
METFORMIN

Glucose Lowering Drug
(Currently, there is no FDA approval for metformin for the indication of diabetes prevention)

Knowler et al. *N Engl J Med* 2002;346:393-403.

USPSTF abnormal glucose screening recommendation

USPSTF standards suggest testing patients every 3 years.



Grade B recommendation

- Screen age 40-70 AND BMI ≥ 25*
- Screen with a fasting glucose, hemoglobin A1C or oral glucose tolerance test.
- Refer patients with abnormal glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity

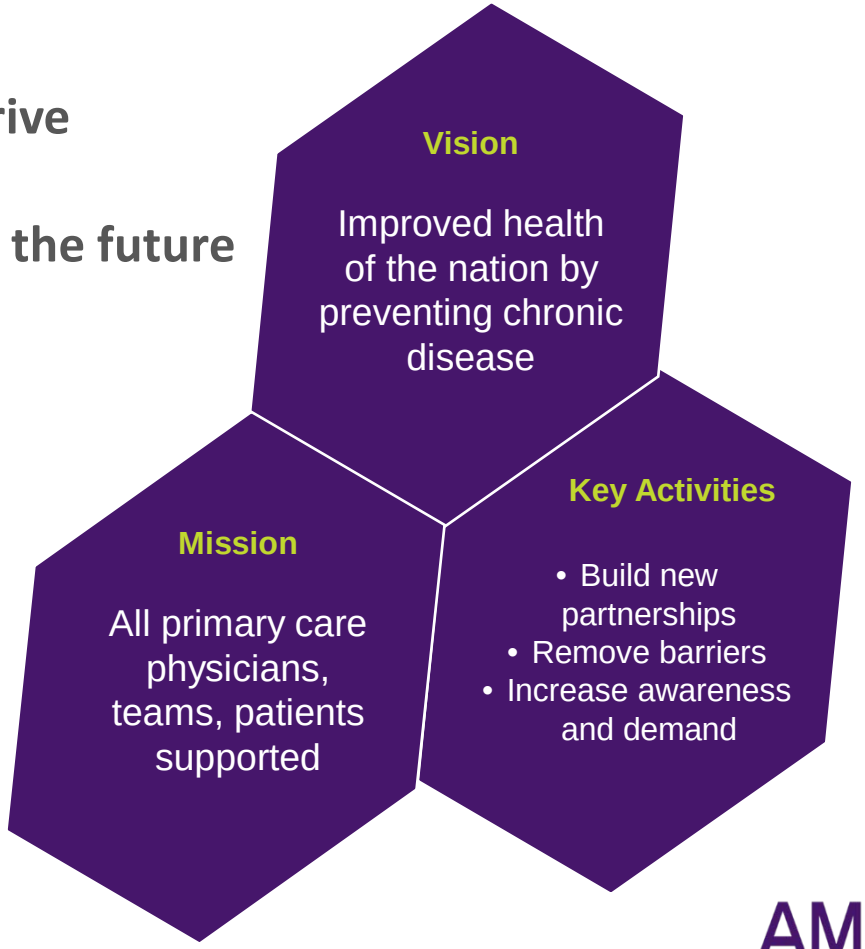
* The American Diabetes Association encourages screening for diabetes at a BMI of ≥ 23 for Asian Americans

Siu AL. U.S Preventive Services Task Force. Screening for Abnormal Blood Glucose and Type 2 Diabetes Mellitus: U.S. Preventive Services Task Force Recommendation Statement. *Ann Intern Med.* 2015;163(11):861-8.

AMA strategy to prevent type 2 diabetes

AMA strategic focus to improve health outcomes

- **Helping physician practices thrive**
- **Creating the medical school of the future**
- **Improving patient health**



AMA-CDC national collaboration to prevent diabetes

THE AMA AND CDC URGE YOU TO:

SCREEN → TEST → ACT TODAY

www.preventdiabetesstat.org


Services and resources available from AMA

AMA diabetes prevention offerings

The AMA offers a comprehensive program to guide implementation of clinical practice change in order to prevent type 2 diabetes.

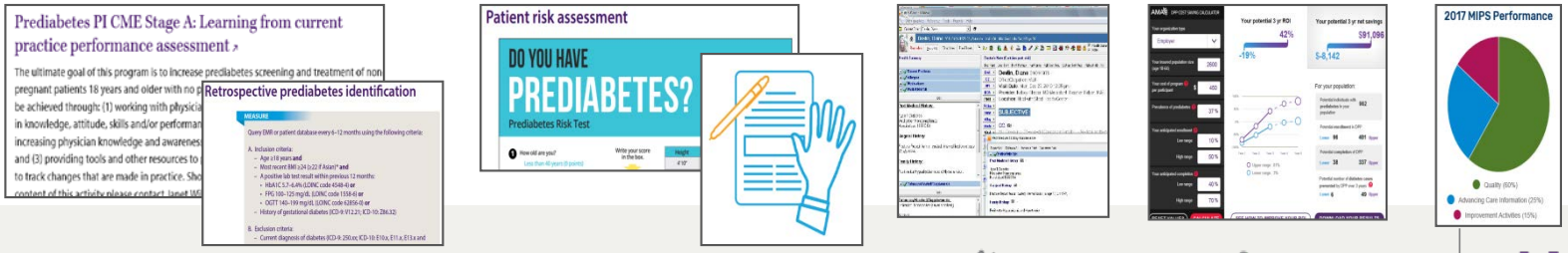
Services

Engagement | Consulting | Implementation support (admin)

Walk through core decisions

1. DPP Offering
2. Physician engagement/education
3. Identify eligible patients
4. Patient communication/ messaging
5. Referral process to DPP
6. Feedback loop on patient progress
7. Reimbursement / coverage
8. Evaluation

Tools and solutions *(examples, not comprehensive)*



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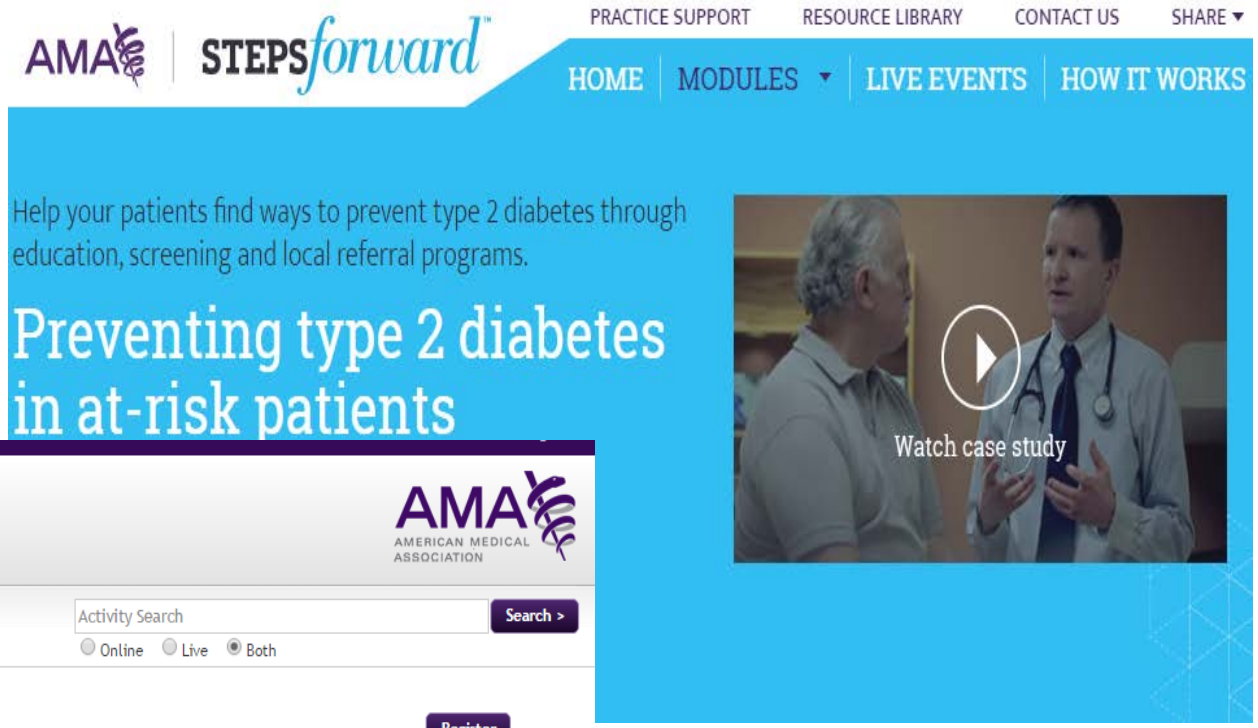
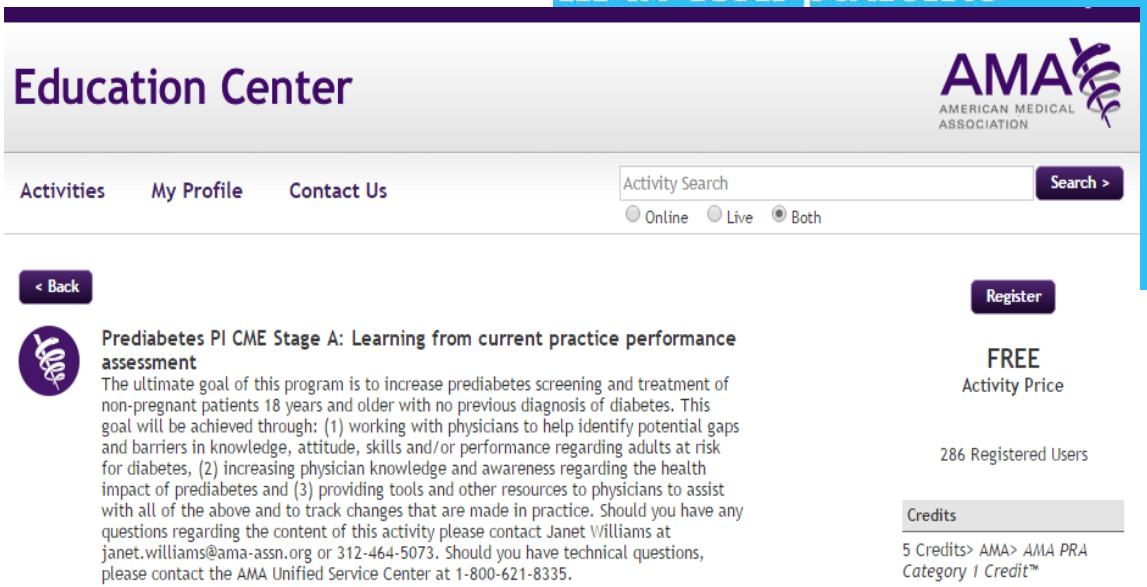
Engaging physicians and care teams

- Clinic Awareness
- Grand Rounds
- Online Modules
- PICME – Part

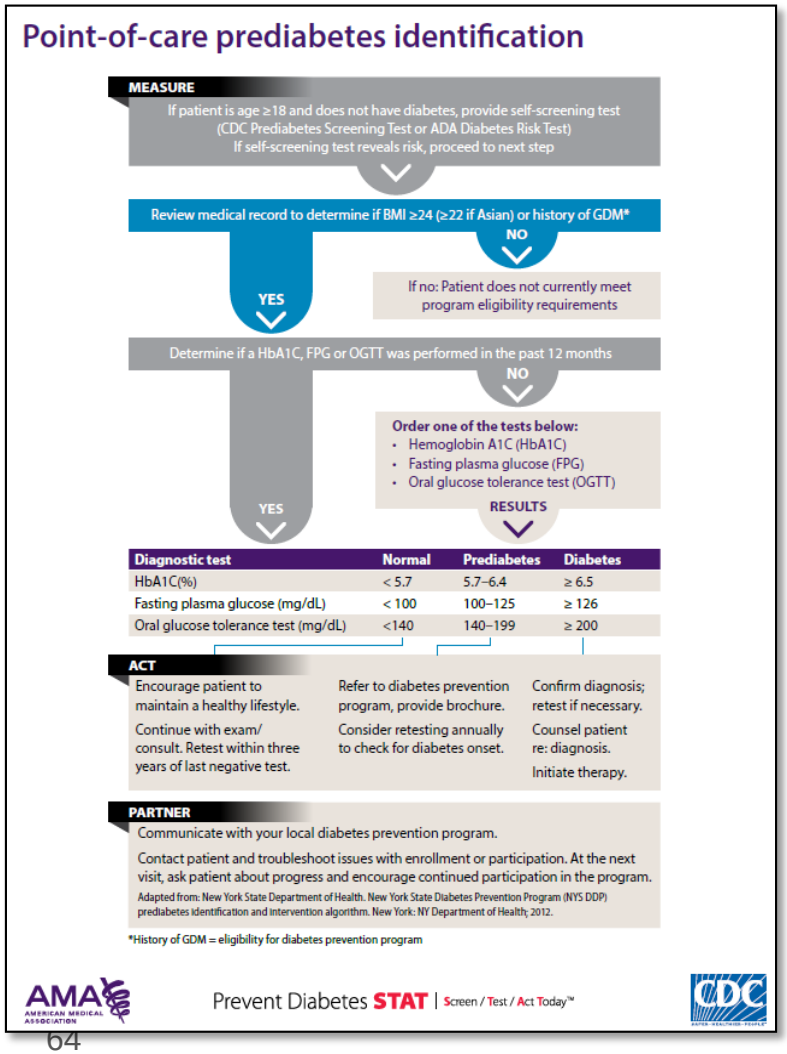


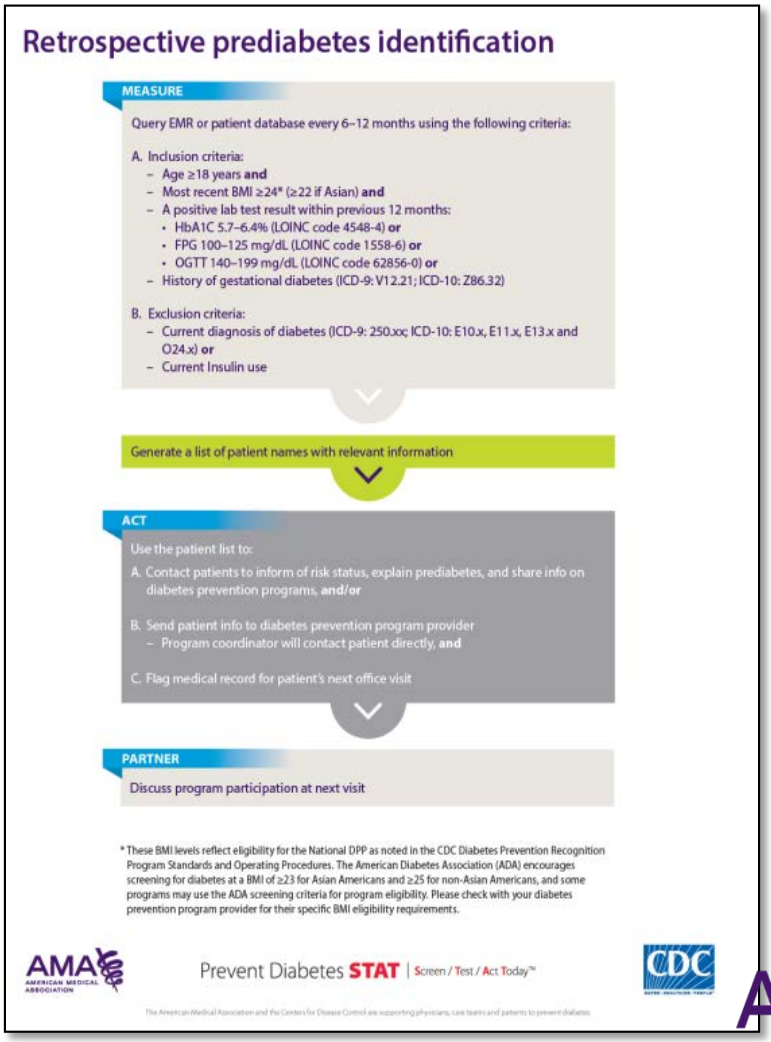


https://www.stepsforward.org/

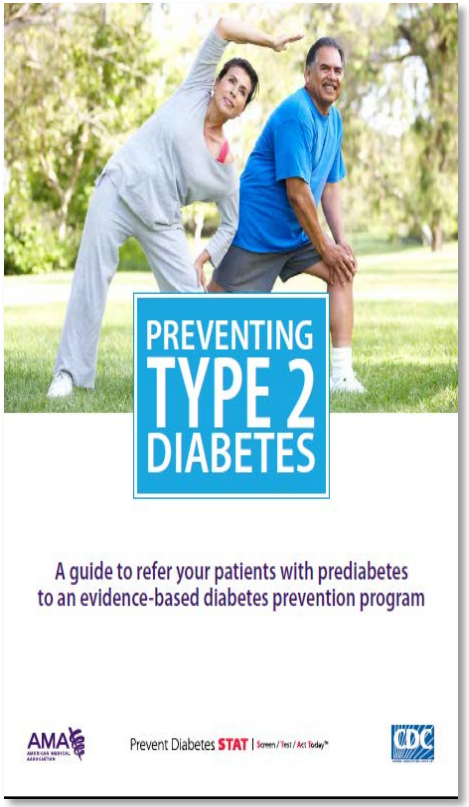
https://www.ama- assn.org/education/

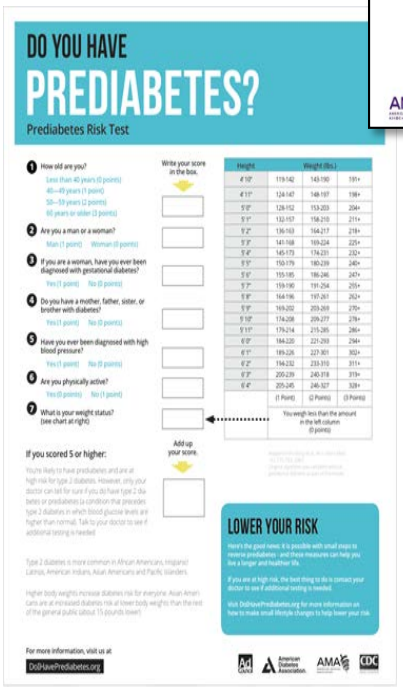
Identifying eligible patients

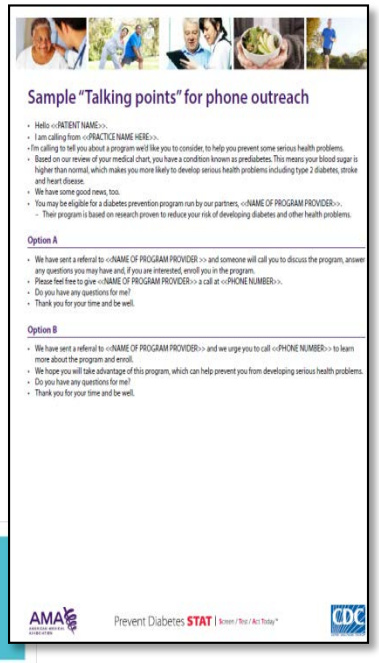


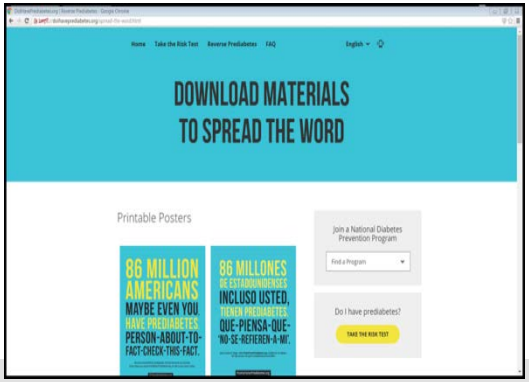


Patient communications









www.doihaveprediabetes.org
Your MISSION is Our MISSION
AMA

Medicare Diabetes Prevention Program

Building a case for prevention:
CMS expansion of Medicare benefits to include DPP

Deploying the National DPP
savings of $2,650
per participant for Medicare

Office of the Actuary, Centers for Medicare and Medicaid Services. "Certification of Medicare Diabetes Prevention Program". March 23, 2016.

Considerations for Medicare DPP

- Coverage begins April 1, 2018
- Beneficiary Eligibility
  - BMI ≥ 25 (≥23 if Asian) AND
  - Lab value in prediabetes range (HbA1C 5.7-6.4%, fasting glucose 100-125mg/dL) AND
  - No previous diagnosis of type 1 or type 2 diabetes AND
  - No current diagnosis of end-stage renal disease
- Medicare DPP set of services
  - At least 16 core sessions during months 1-6
  - At least 6 core maintenance sessions during months 7-12
  - For those achieving 5% weight loss in year 1, up to 12 additional months of maintenance sessions

Your MISSION is *Our* MISSION

Facilitated Discussion

Chat in your questions and comments.

Press *1 on your telephone key pad to enter the teleconference queue.

MedStar Health Research Institute

Joan Bardsley, MBA, RN, CDE, FAADE
Assistant Vice President

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Utilizing the Diabetes Self - Management Education and Support Joint Position Paper and Algorithm in the Care of Those with Type 2 DM

Joan Bardsley MBA, BS, RN, CDE, FAADE

AVP MedStar Health Research Institute

Past President American Association of Diabetes Education

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
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Collaboration

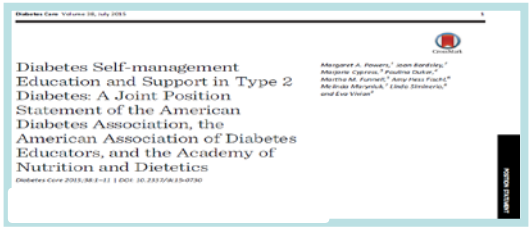
American Diabetes Association.

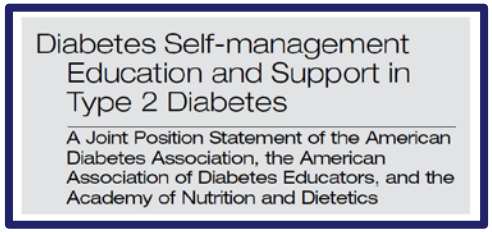
AADE American Association of Diabetes Educators

eat right. Academy of Nutrition and Dietetics

NDEP National Diabetes Education Program

- Margaret A. Powers (Chair)
- Joan Bardsley
- Marjorie Cypress
- Paulina Duker
- Martha M. Funnell
- Amy Hess Fischl
- Melinda Maryniuk
- Linda Siminerio
- Eva Vivian


Diabetes Self-management Education and Support in Type 2 Diabetes: A Joint Position Statement of the American Diabetes Association, the American Association of Diabetes Educators, and the Academy of Nutrition and Dietetics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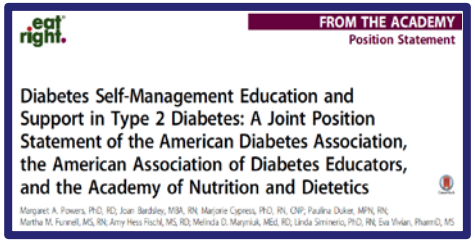

eat right.

FROM THE ACADEMY

Position Statement

Diabetes Self-Management Education and Support in Type 2 Diabetes: A Joint Position Statement of the American Diabetes Association, the American Association of Diabetes Educators, and the Academy of Nutrition and Dietetics

Powers MA et al. DSME/S Position Statement 2015, *Diabetes Care, The Diabetes Educator, Journal of Academy of Nutrition and Dietetics.*

Definitions

Diabetes Self Management Education and Support - DSMES

The ongoing process of facilitating the knowledge, skills, and ability necessary for prediabetes and diabetes self-care, as well as the activities that assist the person with diabetes or prediabetes in implementing and sustaining the behaviors needed to manage his or her condition on an ongoing basis, beyond or outside of formal self-management training.

Beck, J and Greenwood, D et al. National Standards for DSMES, *Diabetes Care*, 2017.

Benefits Associated with DSME

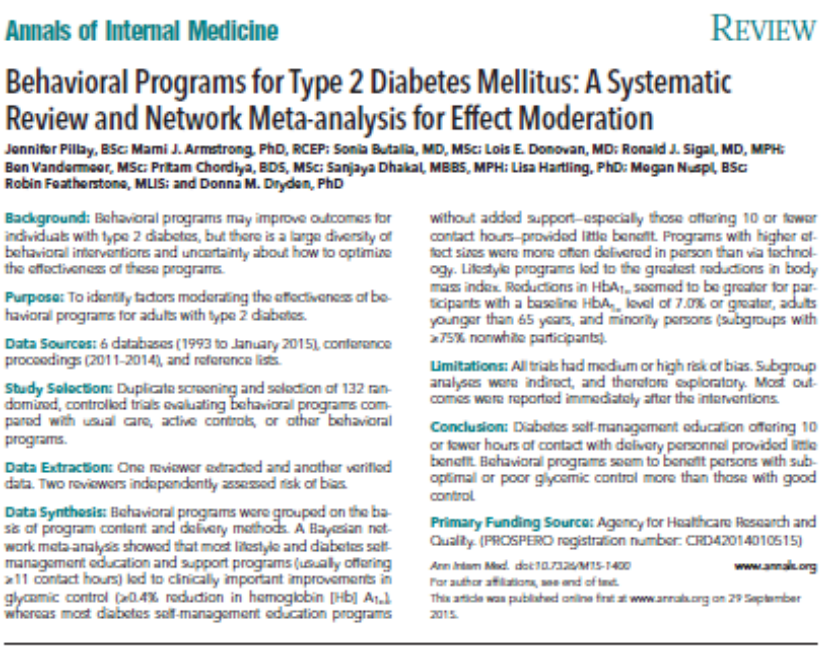
- Improved health outcomes
  - Reduced A1c by as much as .88%
  - Reduced onset and/or advancement of complications
  - Reduced hospital admissions and readmissions
  - Increased medication adherence
- More healthful eating patterns and regular activity
- Enhanced self-efficacy and empowerment
  - Increased healthy coping
  - Improved quality of life

***NOTE*: 1)** Benefits of education decrease over time, **2)** sustained improvement requires time and follow-up, and **3)** effectiveness directly correlated to amount of time spent with educator

Powers MA, et al. DSM/S Position Statement 2015, *Diabetes Care, The Diabetes Educator, Journal of Academy of Nutrition and Dietetics.*
Norris SL, et al. *Diabetes Care* 2001.

Evidence Confirmed

AADE: Systematic Review of the Impact of Diabetes Self-Management Education on Glycemic Control in Adults with Type 2 Diabetes



Annals of Internal Medicine REVIEW

Behavioral Programs for Type 2 Diabetes Mellitus: A Systematic Review and Network Meta-analysis for Effect Moderation

Jennifer Pillay, BSc; Marni J. Armstrong, PhD, RCEP; Sonia Butalia, MD, MSc; Lois E. Donovan, MD; Ronald J. Sigal, MD, MPH; Ben Vandermeer, MSc; Pritam Chordiya, BDS, MSc; Sanjaya Dhakal, MBBS, MPH; Lisa Hartling, PhD; Megan Nuspl, BSc; Robin Featherstone, MLIS; and Donna M. Dryden, PhD

Background: Behavioral programs may improve outcomes for individuals with type 2 diabetes, but there is a large diversity of behavioral interventions and uncertainty about how to optimize the effectiveness of these programs.

Purpose: To identify factors moderating the effectiveness of behavioral programs for adults with type 2 diabetes.

Data Sources: 6 databases (1993 to January 2015), conference proceedings (2011-2014), and reference lists.

Study Selection: Duplicate screening and selection of 132 randomized, controlled trials evaluating behavioral programs compared with usual care, active controls, or other behavioral programs.

Data Extraction: One reviewer extracted and another verified data. Two reviewers independently assessed risk of bias.

Data Synthesis: Behavioral programs were grouped on the basis of program content and delivery methods. A Bayesian network meta-analysis showed that most lifestyle and diabetes self-management education and support programs (usually offering ≥11 contact hours) led to clinically important improvements in glycemic control (≥0.4% reduction in hemoglobin [Hb] A_{1c}), whereas most diabetes self-management education programs without added support—especially those offering 10 or fewer contact hours—provided little benefit. Programs with higher effect sizes were more often delivered in person than via technology. Lifestyle programs led to the greatest reductions in body mass index. Reductions in HbA_{1c} seemed to be greater for participants with a baseline HbA_{1c} level of 7.0% or greater, adults younger than 65 years, and minority persons (subgroups with ≥75% nonwhite participants).

Limitations: All trials had medium or high risk of bias. Subgroup analyses were indirect, and therefore exploratory. Most outcomes were reported immediately after the interventions.

Conclusion: Diabetes self-management education offering 10 or fewer hours of contact with delivery personnel provided little benefit. Behavioral programs seem to benefit persons with suboptimal or poor glycemic control more than those with good control.

Primary Funding Source: Agency for Healthcare Research and Quality. (PROSPERO registration number: CRD42014010515)

Ann Intern Med. doi:10.7326/M15-1400 www.annals.org
For author affiliations, see end of text.
This article was published online first at www.annals.org on 29 September 2015.

AADE. Systematic Review, August 2015.
Pillay, et al. *Annals of Internal Medicine*, 2015.

PICOS Question

	PICOS component	Study question
P	Patient population or problem	Adults with type 2 diabetes
I	Intervention	Diabetes self-management education
C	Comparison group	Usual care
O	Outcomes	A1C
S	Setting	Randomized controlled trials

Change in A1c by Mode of DSME Delivery

Mode	Number of interventions	Intervention (SD)	Control (SD)	Absolute difference in A1C with addition of DSME
All Models Together	118	-0.74(0.63)	-0.17(0.5)	0.57
Combination	22	-1.0(0.6)	-0.22(0.62)	0.88
Group	33	-0.62(0.46)	-0.10(0.42)	0.52
Individual	47	-0.78(0.63)	-0.28(0.46)	0.50
Remote	12	-0.50(0.67)	-0.17(0.46)	0.33

AADE. Systematic Review, August 2015

AADE Systematic Review

- Engaging adults with type 2 diabetes in DSME results in statistically significant and clinically meaningful improvement in A1c
- DSME that involves both group and individualized engagement results in the greatest improvement in A1c
- There is a greater likelihood of DSME resulting in statistically significant improvement when a team rather than a single individual is involved in its provision
- Those receiving more than 10 hours of DSME had greater improvement in A1c

Chrvala, et al. *Pt Ed & Counseling,* 2015.

Sorry State of DSME

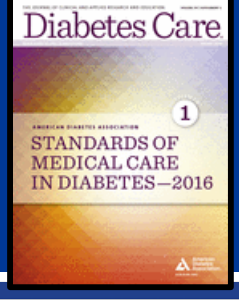
- 6.8% of individuals with newly diagnosed type 2 diabetes with private health insurance received DSME/S within 12 months of diagnosis
- 5% of Medicare participants received DSME/S and/or Medical Nutrition Therapy (MNT).

Duncan et al. Diab Educ. 2009;35:752-760.
Li et al. MMWR. 2014;63:1045-1049.

Barriers to DSME

- Time
- Location
- Referral
- Diversity
- Value confusion
- Clear expectations
- Cost, reimbursement

ADA Standards of Medical Care

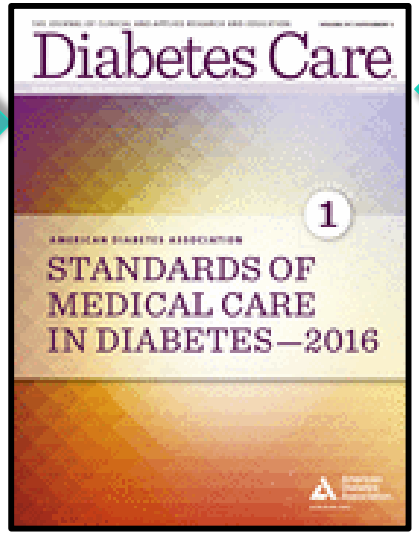


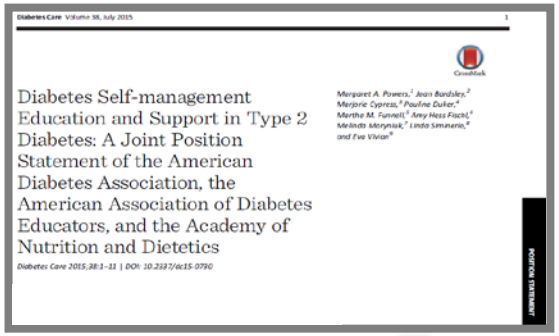
- All people with diabetes should participate in DSME/S both at diagnosis and as needed thereafter
- An individualized medical nutrition therapy program is recommended for all people with diabetes as an effective component of the overall treatment plan
- DSME/S should be patient centered, respectful and responsive to individual patient preferences, needs, and values, which should guide clinical decisions
- DSME/S and medical nutrition therapy can result in cost-savings and improved outcomes
- DSME/S and medical nutrition therapy should be adequately reimbursed by third-party payers

ADA. Standards of Medical Care. *Diabetes Care* (2015 and 2016)

ADA Standards of Medical Care

Research/ Evidence

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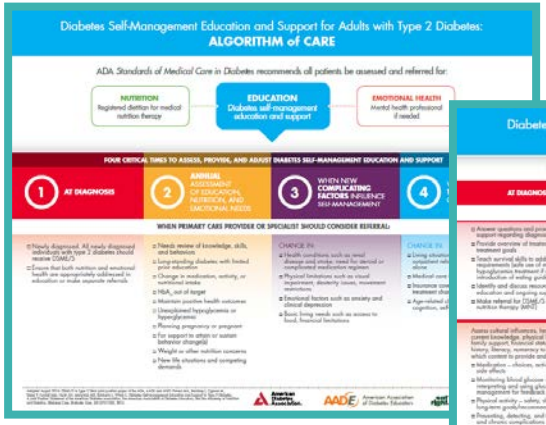
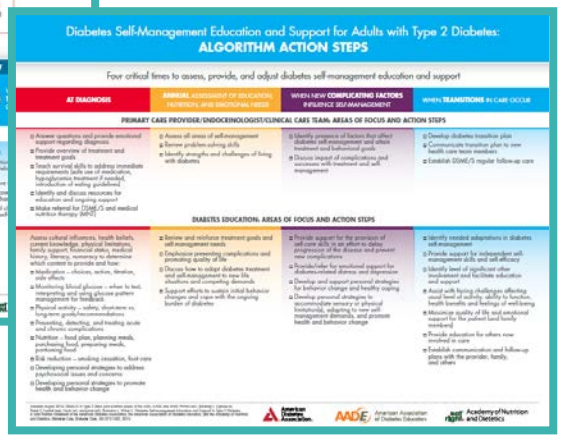




ADA. *Diabetes Care* (2016)

Powers et al. *Diabetes Care* (2015)

Purpose of Position Statement

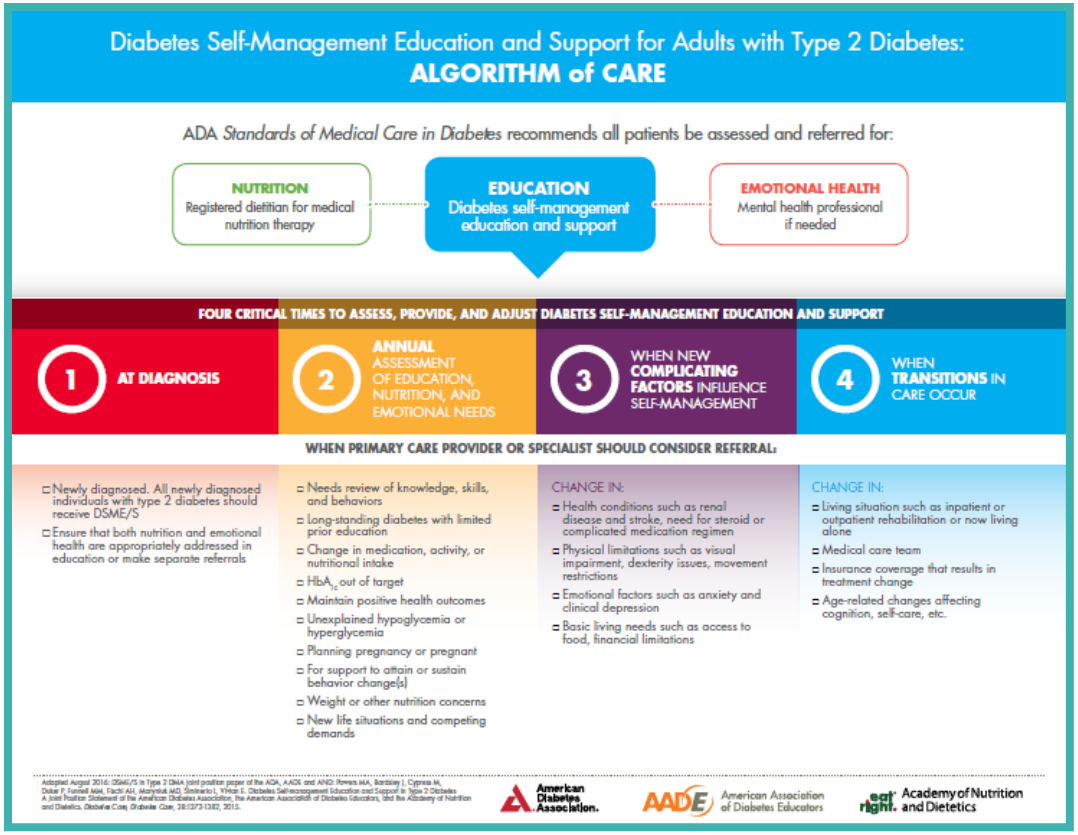
- Address triple aim - Improve patient experience of care and education, improve health of individuals and populations, reduce diabetes-associated per capita health care costs

- Provide health care teams with information required to better understand the educational process and expectations for DMS/S and their integration into routine care

- Create a diabetes education algorithm that defines when, what, and how DSME/S should be provided for adults with type 2 diabetes

Powers MA et al. DSME/S Position Statement 2015
Diabetes Care, The Diabetes Educator, Journal of the Academy of Nutrition and Dietetics

DSMES Algorithm of Care: 4 Critical Times



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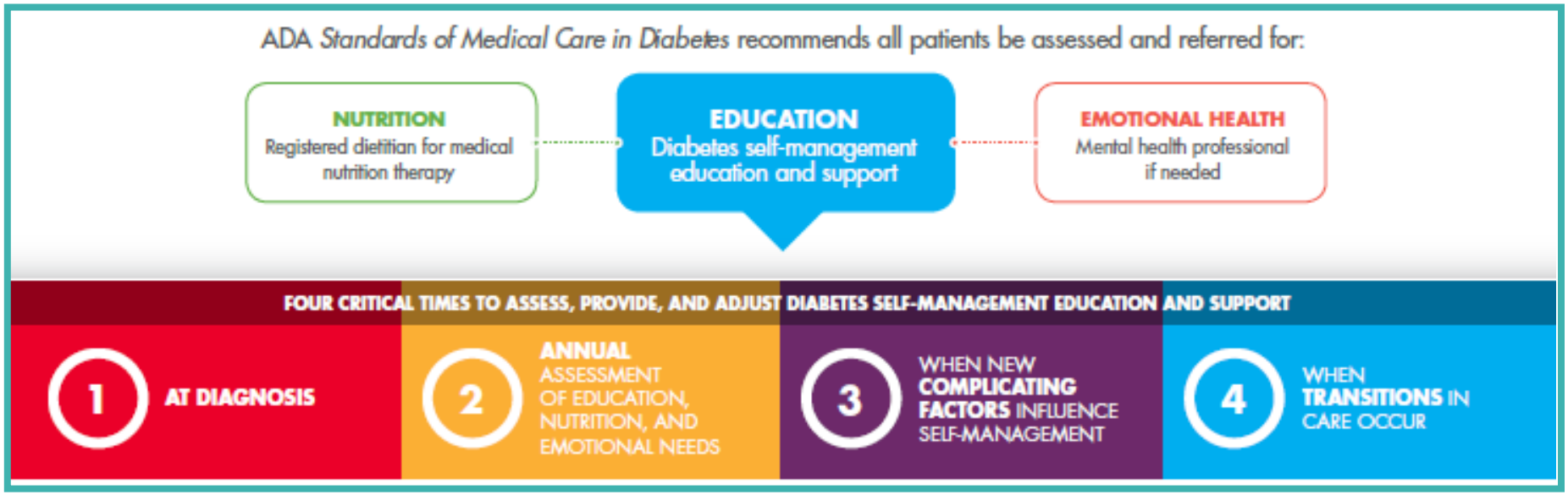
DSMES Algorithm of Care: 4 Critical Times



Powers MA et al. DSME/S Position Statement
Diabetes Care, The Diabetes Educator, Journal of the Academy of Nutrition and Dietetics (2015)

AADE Self Care Behaviors™

AADE has defined the AADE7 Self-Care Behaviors™ as a framework for patient centered diabetes self- management education and support (DSMES) and care.

- *Healthy Eating*
- *Being Active*
- *Monitoring*
- *Taking Medications*
- *Problem Solving*
- *Healthy Coping*
- *Reducing Risks*

https://www.diabeteseducator.org/patient-resources/aade7-self-care-behaviors

4 critical times to assess, provide and adjust DSME/S

1. At diagnosis
2. Annually
3. When complicating factors occur
4. When transitions in care occur

1. At diagnosis

- All individuals with type 2
- Include emotional health and nutrition

Areas of Focus and Action Steps At Diagnosis

Diabetes education

Assess cultural influences, health beliefs, current knowledge, physical limitations, family support, financial status, medical history, literacy, numeracy to determine which content to provide and how regarding:

- **Medications**
- **Monitoring blood glucose**
- **Physical activity**
- **Acute and chronic complications**
- **Psychosocial issues and concerns**
- **Health and behavior change**

2. Annually

Annual assessment of education, nutrition and emotional health needs

- No prior education
- Change in medication
- A1c out of range
- Maintain positive health outcomes
- Planning pregnancy
- Support
- Weight issues
- New life situations

Areas of Focus and Action Steps Annually

Diabetes Education

- **Review and reinforce treatment goals and self-management needs**
- **Emphasize preventing complications and promoting quality of life**
- **Discuss how to adapt diabetes treatment and self-management to new life situations and competing demands**
- **Support efforts to sustain initial behavior changes and cope with the ongoing burden of diabetes**

3. Complicating Factors

When new complicating factors influence self management

- Health conditions
- Physical conditions
- Emotional factors
- Basic living needs

Areas of Focus and Action Steps
Complicating Factors

Diabetes education

- **Provide support for the provision of self-care skills in an effort to delay progression of the disease and prevent new complications**
- **Provide/refer for emotional support for diabetes-related distress and depression**
- **Develop and support personal strategies for behavior change and healthy coping**
- **Develop personal strategies to adapt to sensory or physical limitation(s), adapting to new self-management demands, and promote health and behavior change**

4. Transitions

When transition in care occur

- Living situations
- Medical care team
- Insurance coverage
- Age related change

Areas of Focus and Action Steps Transitions

Diabetes education

- **Provide support for independent self-management skills and self-efficacy**
- **Identify level of significant other involvement and facilitate education and support**
- **Assist with facing challenges affecting usual level of activity, ability to function, health beliefs, and feelings of well-being**
- **Maximize quality of life and emotional support for the patient (and family members)**
- **Provide education for others now involved in care**
- **Identify needed adaption in diabetes self-management**
- **Establish communication and follow-up plans with the provider, family, and others**

If DMSES were a pill, would you prescribe it?

Benefits of DSME*	
Efficacy	High
Hypo Risk	Low
Weight	Neutral / Loss
Side Effects	None
Costs	Low / Savings
Psychosocial benefits	High

*Powers MA. Diabetes Spectrum (In press)

Benefits of Metformin+	
Efficacy	High
Hypo Risk	Low
Weight	Neutral / Loss
Side Effects	GI
Cost	Low
Psychosocial benefits	NA

+Inzucchi et al. Diabetes Care (2015)

Powers MA. ADA President Health Care and Education Address, ADA 2016
Powers MA, Diabetes Spectrum, In press.

THANK YOU ON BEHALF OF THE PATIENTS WE SERVE

Joan.k.bardsley@medstar.net

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
CENTERS FOR MEDICARE & MEDICAID SERVICES

Facilitated Discussion

Chat in your questions and comments.

Press *1 on your telephone key pad to enter the teleconference queue.

Individual Reflection

What are your key takeaways?

Did you hear any approaches or tactics that you could apply to your efforts in engaging physicians and care teams to prevent and manage diabetes?

Call to Action

- Identify one approach or technique to incorporate into your efforts to engage physicians and care teams to prevent and manage diabetes.
- Identify a community partner you can engage in your efforts.
- Complete the post-event assessment upon exiting WebEx:

https://www.surveymonkey.com/r/Q5X38RY

Call For Future Topics

- We want to hear from you!
- Do you have a need or desire to hear about a certain topic?
- Submit your ideas in chat or email us at:
  QINNCC@area-d.hcqis.org

Quality Improvement Organizations
Sharing Knowledge. Improving Health Care.
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Thank you!

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