

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>

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 Strategy

Learning Outcome

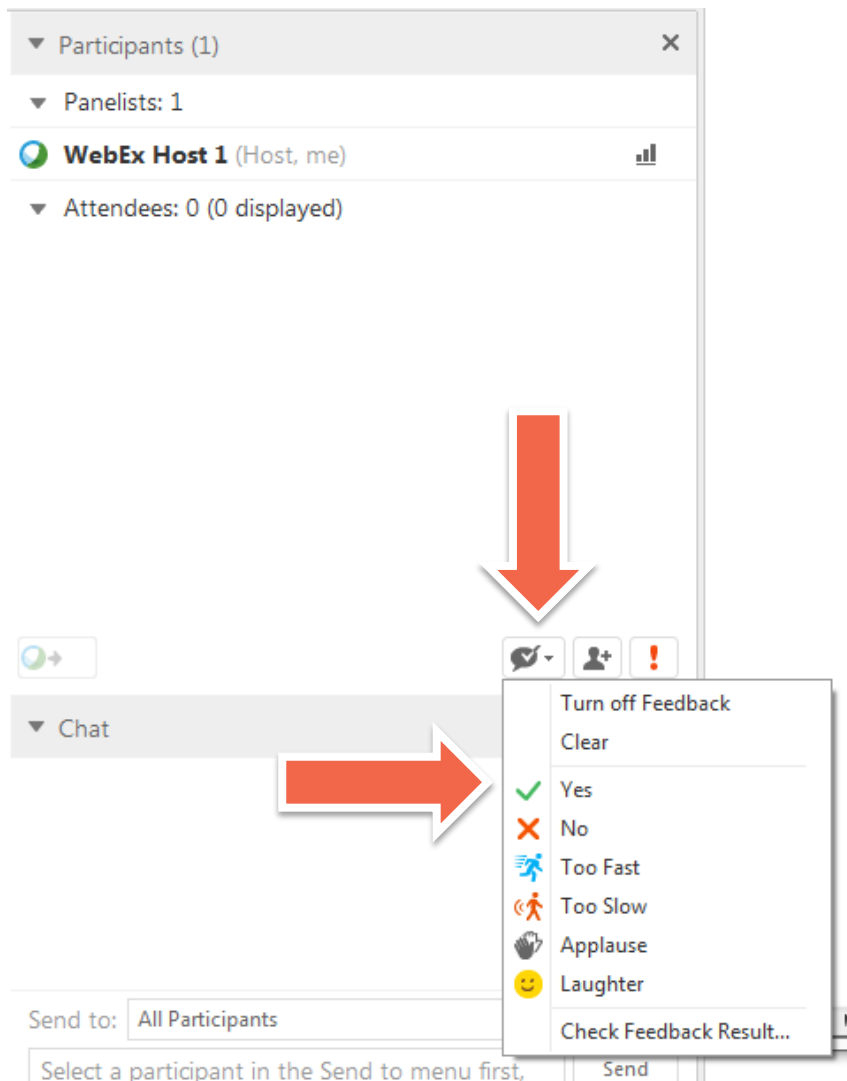
- The purpose of this session is to prepare healthcare quality improvement professionals to identify and implement effective healthcare strategies by exploring promising practices to engage physicians and care teams and prevent and manage diabetes.
- We expect that this experience will help participants 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!



Now Offering Continuing Education Credit

Continuing education credit is available for:

- Physicians & Physician Assistants
- 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)

CE Information

Physicians:

This activity has been planned and implemented in accordance with the Essential Areas and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of AKH Inc., Advancing Knowledge in Healthcare, CRW & Associates and Telligen. AKH Inc., Advancing Knowledge in Healthcare is accredited by the ACCME to provide continuing medical education for physicians.

AKH Inc., Advancing Knowledge in Healthcare designates this live activity for a maximum of 1.5 *AMA PRA Category 1 Credit(s)*[™]. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Physician Assistants:

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AKH Inc., Advancing Knowledge in Healthcare is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education.

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

Registered Nurses:

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American Association of
NURSE PRACTITIONERS™

Nurse Practitioners:

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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

Dietitians: AKH Inc., Advancing Knowledge in Healthcare is a Continuing Professional Education (CPE) Accredited Provider with the Commission on Dietetic Registration (CDR). Registered dietitians (RDs) and dietetic technicians, registered (DTRs) will receive 1.5 continuing professional education units (CPEUs) for completion of this program/material. CDR Accredited Provider #AN008. The focus of this activity is rated Level 2. Learners may submit evaluations of program/materials quality to the CDR at www.cdrnet.org.



Disclosure of Financial Relationships & Commercial Support

- The planners and faculty do not have any relevant financial relationships to disclose.
- AKH Inc., CRW & Associates, and Telligen do not have any relevant financial relationships to disclose.
- No commercial support was received for this activity.

Disclosure of Financial Relationships & Commercial Support

Disclosures

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Disclosure of Unlabeled Use and Investigational Product

This educational activity may include discussion of uses of agents that are investigational and/or unapproved by the FDA. Please refer to the official prescribing information for each product for discussion of approved indications, contraindications, and warnings.

Disclaimer

This course is designed solely to provide the healthcare professional with information to assist in his/her practice and professional development and is not to be considered a diagnostic tool to replace professional advice or treatment. The course serves as a general guide to the healthcare professional, and therefore, cannot be considered as giving legal, nursing, medical, or other professional advice in specific cases. AKH Inc. specifically disclaim responsibility for any adverse consequences resulting directly or indirectly from information in the course, for undetected error, or through participant's misunderstanding of the content.

Method of Participation

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- A statement of credit will be available upon completion of an online evaluation/claimed credit form.
- The link to the online evaluation will be provided after completion of the activity (within the post-event assessment).
- 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)



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



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)

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

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



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



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

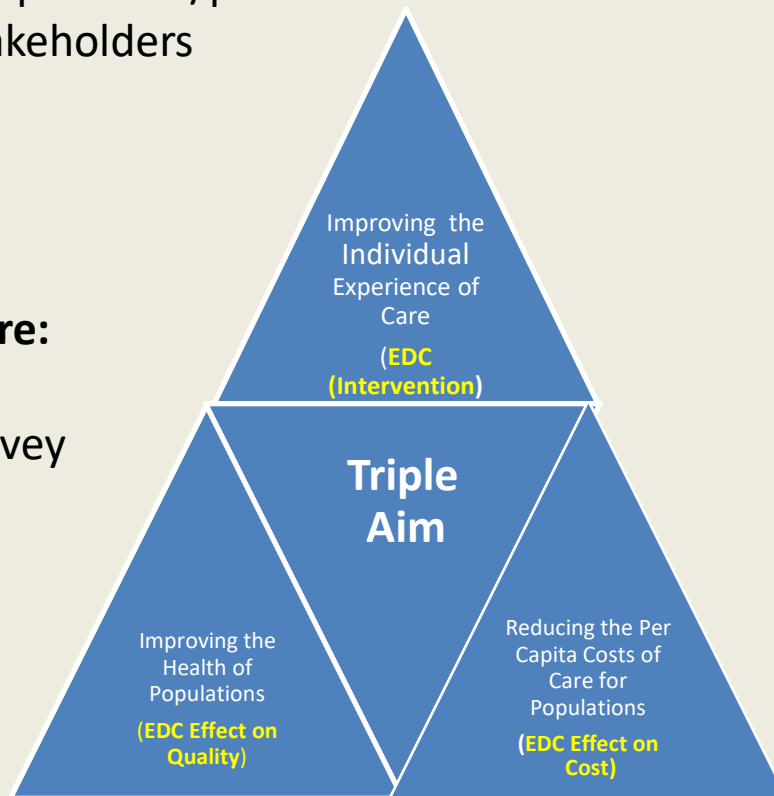
Reading Levels - demographics of adults who read below a basic level*

- 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

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



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**

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

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.

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**

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

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

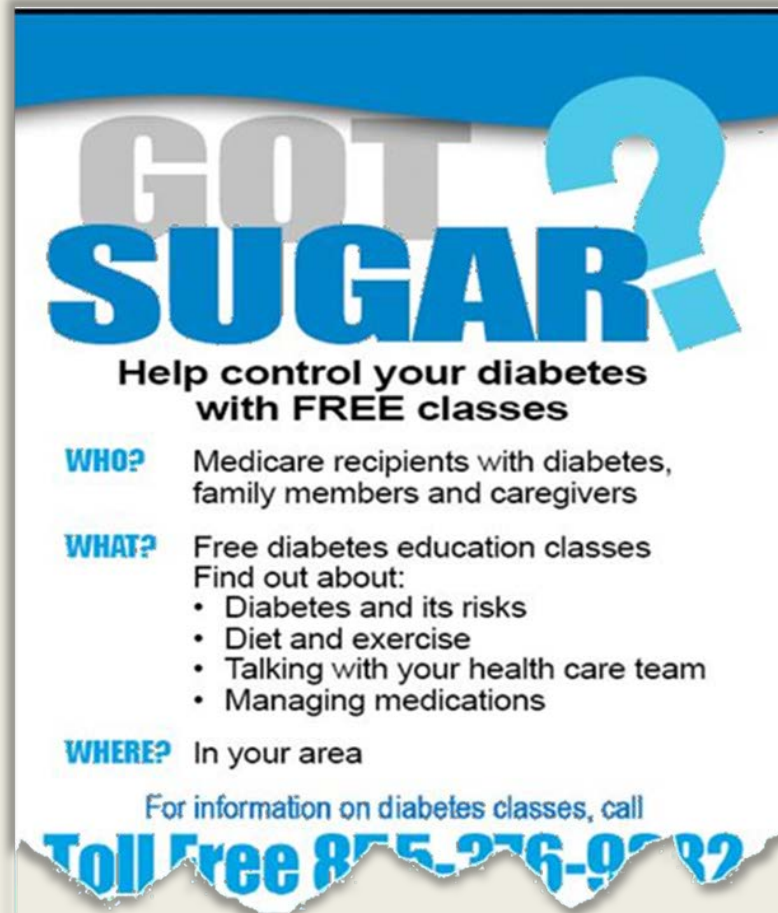


EDC CMS Contact:
Susan.Fleck@CMS.HHS.GOV



EDC Pictures

Marketing Flyer for EDC Classes



EDC Master Trainers Class Graduates, Texas



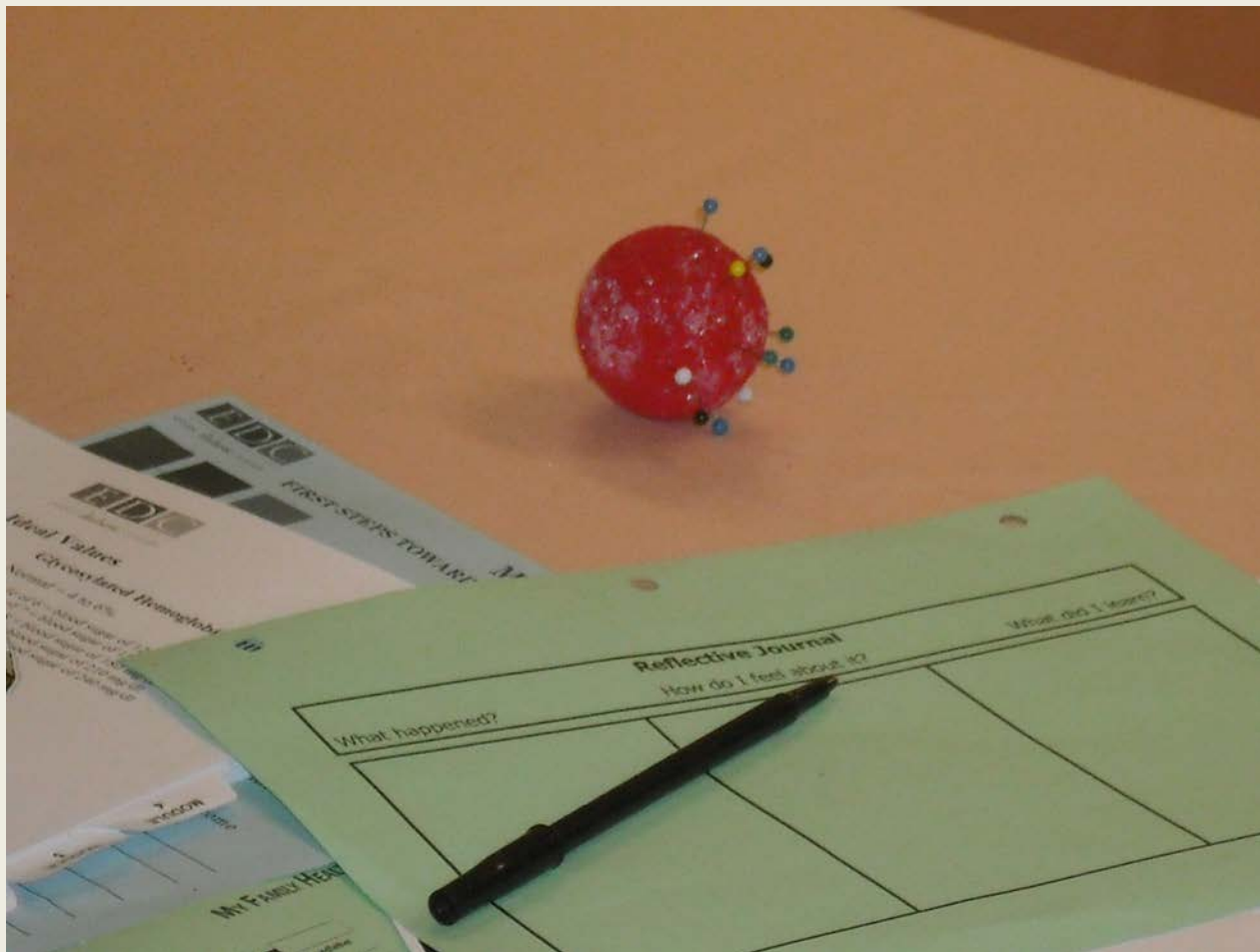
EDC Medicare Beneficiaries Graduation Ceremony, Bronx, NY










HbA1c Molecule



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.



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. 100106 TS-010C-10-00

Cuidando Sus Pies

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



Mantenga los pies limpios y secos.



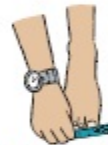
No sumerja sus pies durante mucho tiempo.



Use calcetines limpios todos los días 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 días.



Nunca camine descalzo(a) o use chanclas.



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Thank You!

EDC CMS Contact:

Susan.Fleck@CMS.HHS.GOV



American Medical Association



Kate Kirley, MD, MS
Director, Chronic Disease Prevention



Kenneth Henriksen, MBA
Director, Physician and Health System
Engagement



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

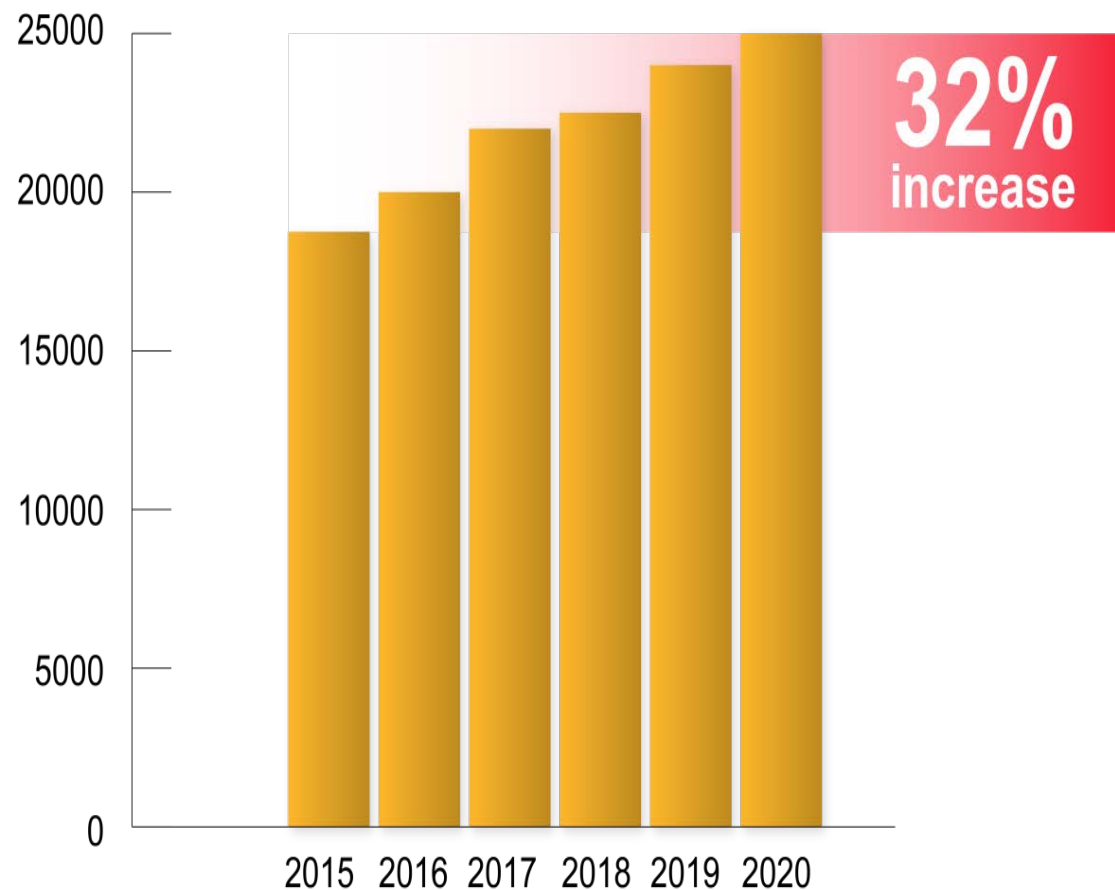
Frank



- 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

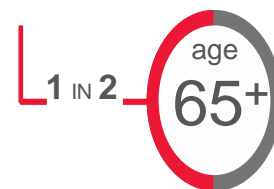
Current burden of prediabetes



84 MILLION ADULTS HAVE PREDIABETES¹

9 OF 10 DON'T KNOW THEY HAVE PREDIABETES²

1 IN 3 ADULTS HAS PREDIABETES¹



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

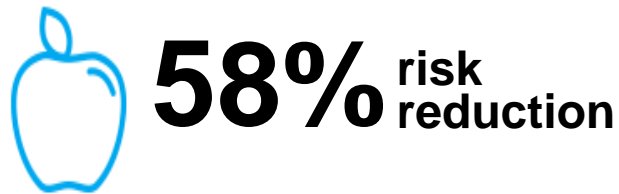
Prediabetes is a reversible condition.

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



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.



DPP

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



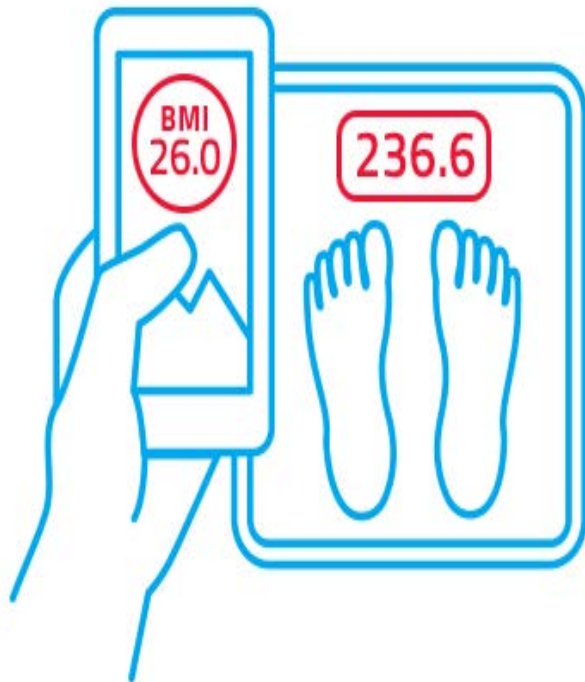
METFORMIN

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

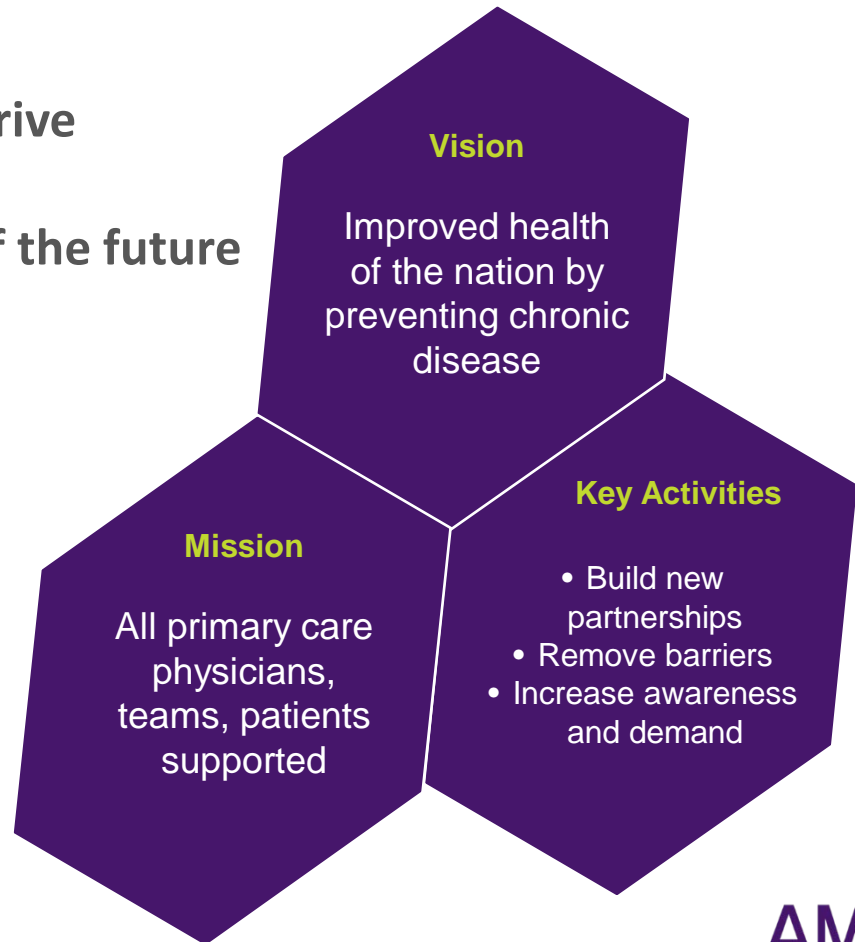
Siu AL. US Preventive Services Task Force. Screening for Abnormal Blood Glucose and Type 2 Diabetes Mellitus: US Preventive Services Task Force Recommendation Statement. *Ann Intern Med.* 2015;163(11):861-8.



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



Prevent Diabetes **STAT**

Screen / Test / Act Today™

84 MILLION AMERICAN ADULTS HAVE PREDIABETES

9 OUT OF **10** PEOPLE WITH PREDIABETES DON'T KNOW THEY HAVE IT.*

PATIENTS AND PARTNERS

HEALTH CARE PROFESSIONALS

EMPLOYERS AND INSURERS

THE AMA AND CDC URGE YOU TO:



www.preventdiabetesstat.org

A photograph of a female doctor with dark hair, wearing a white lab coat and a stethoscope, smiling at an elderly male patient. The patient is wearing a plaid shirt and is seated at a desk. The doctor is also seated, holding a pen and a clipboard. The background shows a typical medical office setting with a window and some medical equipment. The entire image has a purple tint.

Services and resources available from AMA

AMA diabetes prevention offerings

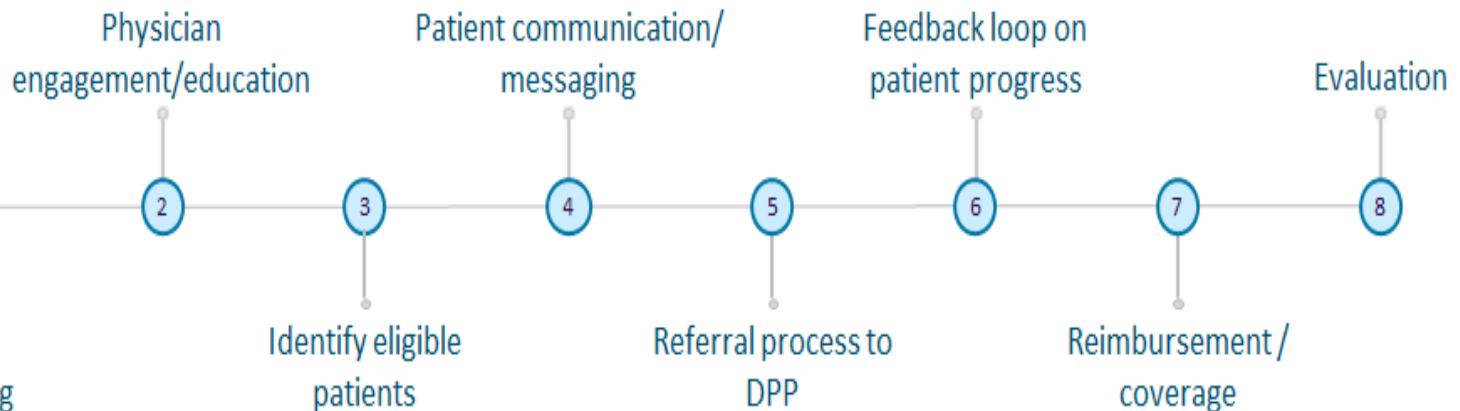
The AMA offers a comprehensive program to guide implementation of clinical practice change in order to prevent type 2 diabetes.

Services

Engagement

Consulting

Implementation support (admin)



Walk through core decisions

Tools and solutions
(examples, not comprehensive)

Prediabetes PI CME Stage A: Learning from current practice performance assessment

The ultimate goal of this program is to increase prediabetes screening and treatment of non-pregnant patients 18 years and older with no history of diabetes. This program is designed to be achieved through: (1) working with physicians in knowledge, attitude, skills and/or performance; (2) increasing physician knowledge and awareness; and (3) providing tools and other resources to track changes that are made in practice. See content of this article please contact Janet W.

Retrospective prediabetes identification

Query EHR or patient database every 6-12 months using the following criteria:

A. Inclusion criteria:

- Age 18 years and older
- Not pregnant (ICD-9-CM 630-634)
- A positive lab test result within previous 12 months
- HbA1C 5.7-6.4% (ICD-9-CM 250.91)
- FPG 100-125 mg/dL (ICD-9-CM 250.91)
- OGTT 140-199 mg/dL (ICD-9-CM 250.91)
- History of gestational diabetes (ICD-9-CM 648.01, 648.02, 648.03)

B. Exclusion criteria:

- Current diagnosis of diabetes (ICD-9-CM 250.00, 250.01, 250.02, 250.03, 250.04, 250.05, 250.06, 250.07, 250.08, 250.09, 250.10, 250.11, 250.12, 250.13, 250.14, 250.15, 250.16, 250.17, 250.18, 250.19, 250.20, 250.21, 250.22, 250.23, 250.24, 250.25, 250.26, 250.27, 250.28, 250.29, 250.30, 250.31, 250.32, 250.33, 250.34, 250.35, 250.36, 250.37, 250.38, 250.39, 250.40, 250.41, 250.42, 250.43, 250.44, 250.45, 250.46, 250.47, 250.48, 250.49, 250.50, 250.51, 250.52, 250.53, 250.54, 250.55, 250.56, 250.57, 250.58, 250.59, 250.60, 250.61, 250.62, 250.63, 250.64, 250.65, 250.66, 250.67, 250.68, 250.69, 250.70, 250.71, 250.72, 250.73, 250.74, 250.75, 250.76, 250.77, 250.78, 250.79, 250.80, 250.81, 250.82, 250.83, 250.84, 250.85, 250.86, 250.87, 250.88, 250.89, 250.90, 250.91, 250.92, 250.93, 250.94, 250.95, 250.96, 250.97, 250.98, 250.99, 250.00)

Patient risk assessment

DO YOU HAVE PREDIABETES?

Prediabetes Risk Test

How old are you? Write your score

100% 0% 100%

Electronic medical record interface showing patient data and clinical notes.

Dashboard showing patient progress, risk scores, and performance metrics.



Engaging physicians and care teams

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



PRACTICE SUPPORT

RESOURCE LIBRARY

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HOME

MODULES ▼

LIVE EVENTS

HOW IT WORKS

Help your patients find ways to prevent type 2 diabetes through education, screening and local referral programs.

Preventing type 2 diabetes in at-risk patients



Watch case study

Education Center



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< Back

Register



Prediabetes PI CME Stage A: Learning from current practice performance assessment

The ultimate goal of this program is to increase prediabetes screening and treatment of non-pregnant patients 18 years and older with no previous diagnosis of diabetes. This goal will be achieved through: (1) working with physicians to help identify potential gaps and barriers in knowledge, attitude, skills and/or performance regarding adults at risk for diabetes, (2) increasing physician knowledge and awareness regarding the health impact of prediabetes and (3) providing tools and other resources to physicians to assist with all of the above and to track changes that are made in practice. Should you have any questions regarding the content of this activity please contact Janet Williams at janet.williams@ama-assn.org or 312-464-5073. Should you have technical questions, please contact the AMA Unified Service Center at 1-800-621-8335.

FREE

Activity Price

286 Registered Users

Credits

5 Credits> AMA> AMA PRA
Category 1 Credit™

<https://www.stepsforward.org/>

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

Identifying eligible patients

Point-of-care prediabetes identification

MEASURE

If patient is age ≥ 18 and does not have diabetes, provide self-screening test (CDC Prediabetes Screening Test or ADA Diabetes Risk Test)
If self-screening test reveals risk, proceed to next step

Review medical record to determine if BMI ≥ 24 (≥ 22 if Asian) or history of GDM*

YES

If no: Patient does not currently meet program eligibility requirements

Determine if a HbA1C, FPG or OGTT was performed in the past 12 months

YES

RESULTS

Order one of the tests below:

- Hemoglobin A1C (HbA1C)
- Fasting plasma glucose (FPG)
- Oral glucose tolerance test (OGTT)

Diagnostic test	Normal	Prediabetes	Diabetes
HbA1C(%)	< 5.7	$5.7-6.4$	≥ 6.5
Fasting plasma glucose (mg/dL)	< 100	$100-125$	≥ 126
Oral glucose tolerance test (mg/dL)	< 140	$140-199$	≥ 200

ACT

Encourage patient to maintain a healthy lifestyle.	Refer to diabetes prevention program, provide brochure.	Confirm diagnosis; retest if necessary.
Continue with exam/consult. Retest within three years of last negative test.	Consider retesting annually to check for diabetes onset.	Counsel patient re: diagnosis.
		Initiate therapy.

PARTNER

Communicate with your local diabetes prevention program.

Contact patient and troubleshoot issues with enrollment or participation. At the next visit, ask patient about progress and encourage continued participation in the program.

Adapted from: New York State Department of Health. New York State Diabetes Prevention Program (NYS DPP) prediabetes identification and intervention algorithm. New York: NY Department of Health; 2012.

*History of GDM = eligibility for diabetes prevention program



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Retrospective prediabetes identification

MEASURE

Query EMR or patient database every 6–12 months using the following criteria:

A. Inclusion criteria:

- Age ≥ 18 years and
- Most recent BMI $\geq 24^*$ (≥ 22 if Asian) and
- A positive lab test result within previous 12 months:
 - HbA1C $5.7-6.4\%$ (LOINC code 4548-4) or
 - FPG $100-125$ mg/dL (LOINC code 1558-6) or
 - OGTT $140-199$ mg/dL (LOINC code 62856-0) or
- History of gestational diabetes (ICD-9: V12.21; ICD-10: Z86.32)

B. Exclusion criteria:

- Current diagnosis of diabetes (ICD-9: 250.xx; ICD-10: E10.x, E11.x, E13.x and O24.x) or
- Current Insulin use

Generate a list of patient names with relevant information

ACT

Use the patient list to:

- Contact patients to inform of risk status, explain prediabetes, and share info on diabetes prevention programs, and/or
- Send patient info to diabetes prevention program provider
 - Program coordinator will contact patient directly, and
- Flag medical record for patient's next office visit

PARTNER

Discuss program participation at next visit

* These BMI levels reflect eligibility for the National DPP as noted in the CDC Diabetes Prevention Recognition Program Standards and Operating Procedures. The American Diabetes Association (ADA) encourages screening for diabetes at a BMI of ≥ 23 for Asian Americans and ≥ 25 for non-Asian Americans, and some programs may use the ADA screening criteria for program eligibility. Please check with your diabetes prevention program provider for their specific BMI eligibility requirements.



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The American Medical Association and the Centers for Disease Control are supporting physicians, care teams and patients to prevent diabetes.



Patient communications



PREVENTING TYPE 2 DIABETES

Ask me
about
prediabetes

A guide to refer your patients with prediabetes
to an evidence-based diabetes prevention program



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DO YOU HAVE PREDIABETES?

Prediabetes Risk Test

1 How old are you?

- Less than 40 years (0 points)
- 40–49 years (1 point)
- 50–59 years (2 points)
- 60 years or older (3 points)

2 Are you a man or a woman?

- Man (0 points)
- Woman (0 points)

3 If you are a woman, have you ever been diagnosed with gestational diabetes?

- Yes (3 points)
- No (0 points)

4 Do you have a mother, father, sister, or brother with diabetes?

- Yes (3 points)
- No (0 points)

5 Have you ever been diagnosed with high blood pressure?

- Yes (3 points)
- No (0 points)

6 Are you physically active?

- Yes (3 points)
- No (0 points)

7 What is your weight status?

- Underweight (0 points)
- Normal weight (0 points)
- Overweight (3 points)
- Obese (3 points)

Write your score on the box.

0 1 2 3

4 5 6 7

8 9 10 11

12 13 14 15

16 17 18 19

20 21 22 23

24 25 26 27

28 29 30 31

32 33 34 35

36 37 38 39

40 41 42 43

44 45 46 47

48 49 50 51

52 53 54 55

56 57 58 59

60 61 62 63

64 65 66 67

68 69 70 71

72 73 74 75

76 77 78 79

80 81 82 83

84 85 86 87

88 89 90 91

92 93 94 95

96 97 98 99

100 101 102 103

104 105 106 107

108 109 110 111

112 113 114 115

116 117 118 119

120 121 122 123

124 125 126 127

128 129 130 131

132 133 134 135

136 137 138 139

140 141 142 143

144 145 146 147

148 149 150 151

Height	Weight (lb)	Weight (kg)
4' 0"	110-140	50-63
4' 1"	124-152	56-69
4' 2"	138-166	62-75
4' 3"	152-180	68-81
4' 4"	166-194	75-88
4' 5"	180-208	81-94
4' 6"	194-222	88-100
4' 7"	208-236	94-107
4' 8"	222-250	100-113
4' 9"	236-264	107-120
4' 10"	250-278	113-126
4' 11"	264-292	120-132
5' 0"	278-302	126-138
5' 1"	292-316	132-144
5' 2"	306-330	138-150
5' 3"	320-344	144-156
5' 4"	334-358	150-162
5' 5"	348-372	156-169
5' 6"	362-386	162-175
5' 7"	376-400	169-182
5' 8"	390-414	175-188
5' 9"	404-428	182-194
5' 10"	418-442	188-200
5' 11"	432-456	194-207
6' 0"	446-470	200-214
6' 1"	460-484	207-220
6' 2"	474-498	214-227
6' 3"	488-512	220-233
6' 4"	502-526	227-239
6' 5"	516-540	233-246
6' 6"	530-554	239-252
6' 7"	544-568	246-258
6' 8"	558-582	252-265
6' 9"	572-596	258-271
6' 10"	586-610	265-277
6' 11"	600-624	271-283
7' 0"	614-638	277-289
7' 1"	628-652	283-296
7' 2"	642-666	290-302
7' 3"	656-680	296-309
7' 4"	670-694	302-315
7' 5"	684-708	309-321
7' 6"	698-722	315-327
7' 7"	712-736	321-334
7' 8"	726-750	327-340
7' 9"	740-764	334-346
7' 10"	754-778	340-353
7' 11"	768-792	346-359
8' 0"	782-806	353-365
8' 1"	796-820	359-372
8' 2"	810-834	365-378
8' 3"	824-848	372-384
8' 4"	838-862	378-391
8' 5"	852-876	384-397
8' 6"	866-890	391-403
8' 7"	880-904	397-409
8' 8"	894-918	403-416
8' 9"	908-932	409-422
8' 10"	922-946	416-428
8' 11"	936-960	422-435
9' 0"	950-974	428-440
9' 1"	964-988	435-447
9' 2"	978-1002	440-454
9' 3"	992-1016	447-460
9' 4"	1006-1030	454-467
9' 5"	1020-1044	460-473
9' 6"	1034-1058	467-479
9' 7"	1048-1072	473-486
9' 8"	1062-1086	479-492
9' 9"	1076-1100	486-498
9' 10"	1090-1114	492-505
9' 11"	1104-1128	498-511
10' 0"	1118-1142	505-517
10' 1"	1132-1156	511-524
10' 2"	1146-1170	517-529
10' 3"	1160-1184	524-536
10' 4"	1174-1198	530-543
10' 5"	1188-1212	536-549
10' 6"	1202-1226	543-556
10' 7"	1216-1240	549-562
10' 8"	1230-1254	556-568
10' 9"	1244-1268	562-574
10' 10"	1258-1282	568-581
10' 11"	1272-1296	574-587
11' 0"	1286-1310	581-594
11' 1"	1300-1324	587-600
11' 2"	1314-1338	594-606
11' 3"	1328-1352	600-612
11' 4"	1342-1366	606-619
11' 5"	1356-1380	612-625
11' 6"	1370-1394	619-631
11' 7"	1384-1408	625-638
11' 8"	1398-1422	631-644
11' 9"	1412-1436	638-650
11' 10"	1426-1450	644-656
11' 11"	1440-1464	650-663
12' 0"	1454-1478	656-669

You weigh less than the amount in the left column (0 points).
You weigh more than the amount in the right column (3 points).

LOWER YOUR RISK

Reach the goal scores. 5 or higher with small steps to reverse prediabetes, and these measures can help you live a longer and healthier life.
If you are at high risk, the best thing to do is consult your doctor to see if additional testing is needed.

Visit doihaveprediabetes.org for more information on how to make small lifestyle changes to help lower your risk.

For more information, visit us at doihaveprediabetes.org



Sample "Talking points" for phone outreach

- Hello <PATIENT NAME>.
- I am calling from <PRACTICE NAME HERE>.
- I'm calling to tell you about a program we'd like you to consider, to help you prevent some serious health problems.
- Based on our review of your medical chart, you have a condition known as prediabetes. This means your blood sugar is higher than normal, which makes you more likely to develop serious health problems including type 2 diabetes, stroke and heart disease.
- We have some good news, too.
- You may be eligible for a diabetes prevention program run by our partners, <NAME OF PROGRAM PROVIDER>.
- This program is based on research proven to reduce your risk of developing diabetes and other health problems.

Option A

- We have sent a referral to <NAME OF PROGRAM PROVIDER> and someone will call you to discuss the program, answer any questions you may have and, if you are interested, enroll you in the program.
- Please feel free to give <NAME OF PROGRAM PROVIDER> a call at <PHONE NUMBER>.
- Do you have any questions for me?
- Thank you for your time and be well.

Option B

- We have sent a referral to <NAME OF PROGRAM PROVIDER> and we urge you to call <PHONE NUMBER> to learn more about the program and enroll.
- We hope you will take advantage of this program, which can help prevent you from developing serious health problems.
- Do you have any questions for me?
- Thank you for your time and be well.

AMA logo Prevent Diabetes **STAT** | Screen / Test / Act Today™ CDC logo

Are you at risk for prediabetes?

1 in 3 U.S. adults has prediabetes. Most don't know it. Are you at risk?

You may have prediabetes and be at risk for type 2 diabetes if you:

- Are 45 years of age or older
- Are overweight
- Have a family history of type 2 diabetes
- Have high blood pressure
- Are physically active less than three times per week
- Even had diabetes while pregnant (gestational diabetes) or gave birth to a baby that weighed more than 9 pounds

Prediabetes can lead to serious health problems:

- Having prediabetes means your blood glucose is higher than normal, but not high enough to be diagnosed as diabetes. But, nearly 90 percent of adults who have prediabetes don't know they have it.
- If you have prediabetes and don't lose weight or increase your physical activity, you could develop type 2 diabetes within five years. Type 2 diabetes is a serious condition that can lead to health issues such as heart attack, stroke, blindness, kidney failure, or loss of toes, feet or legs.

What can you do?

- Talk to your doctor about your risk of having prediabetes.

Here's the good news:

- If you have prediabetes, your doctor may refer you to a proven lifestyle change program that can help you prevent or delay getting type 2 diabetes.

The National Diabetes Prevention Program can help!

The National Diabetes Prevention Program (National DPP) uses a program that is proven to prevent or delay type 2 diabetes, and will help you lower your risk by improving your food choices and increasing physical activity.

How does it work? As part of a group in your community or online, you will work with a trained lifestyle coach to learn the skills you need to make lasting lifestyle changes. You will learn to eat healthy, add physical activity to your life, manage stress, stay motivated and solve problems that can get in the way of healthy changes.

Features:

- Trained coach to guide and encourage you
- In-person or online
- CDC approved program
- Support from others working on the same goals as you
- Skills to help you lose weight, be more physically active and manage stress
- Some insurance companies will cover

What participants are saying...

"I was having a lifestyle coach. She has given us great information, helped me stay on track and stay positive!" —Bruce

"I've needed someone to want to be the doctor that used a lot of my numbers were down and I really say no longer have prediabetes." —John

Now is the time to take charge of your health and make a change. Ask your doctor or nurse.

AMA logo Prevent Diabetes **STAT** | Screen / Test / Act Today™ CDC logo

DOWNLOAD MATERIALS TO SPREAD THE WORD

Printable Posters

86 MILLION AMERICANS MAYBE EVEN YOU HAVE PREDIABETES. PERSON-ABOUT-TO-FACT-CHECK-THIS-FACT.

88 MILLONES DE ESTADOUNIDENSES INCLUSO USTED, PUEDE TENER QUE PIENSA QUE NO SE REFEREN A MI.

Join a National Diabetes Prevention Program

Find a Program

Do I have prediabetes?

TAKE THE RISK TEST



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, FADE
Assistant Vice President

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

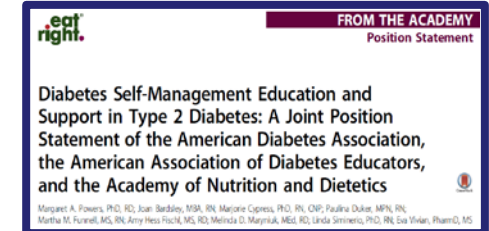
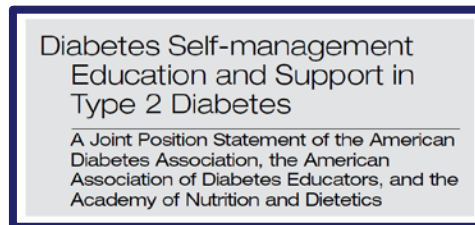
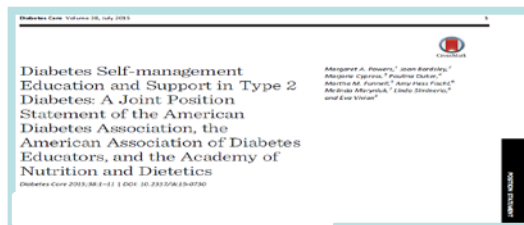
AVP MedStar Health Research Institute

Past President American Association of Diabetes Education

Collaboration



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



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

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.

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; Mami J. Armstrong, PhD, RCEP; Sonia Butalia, MD, MSc; Lois E. Donovan, MD; Ronald J. Sigal, MD, MPH; Ben Vandermeer, MSc; Pritam Chordia, BDS, MSc; Sanjaya Dhakal, MBBS, MPH; Lisa Hartling, PhD; Megan Nussli, BSc; Robin Featherstone, MLI; 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 ($\geq 0.4\%$ 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 $\geq 75\%$ 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 sub-optimal 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.

PICOS Question

	PICOS component	Study question
P	<u>P</u> atient population or problem	Adults with type 2 diabetes
I	<u>I</u> ntervention	Diabetes self-management education
C	<u>C</u> omparison group	Usual care
O	<u>O</u> utcomes	A1C
S	<u>S</u> etting	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

- 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

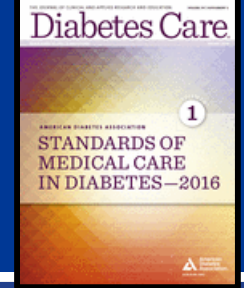
Sorry State of DSME

- 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).

Barriers to DSME

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

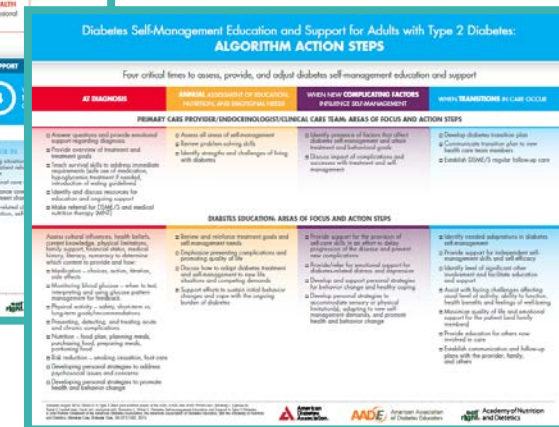
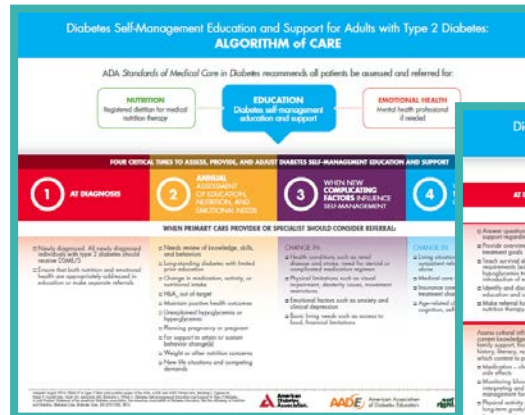
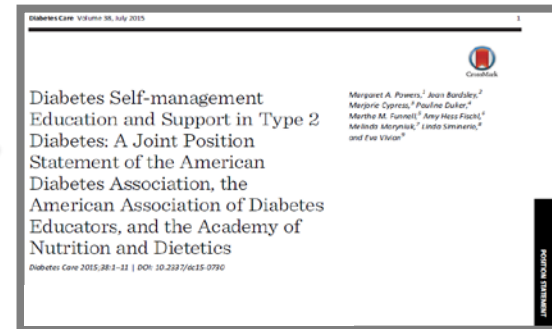
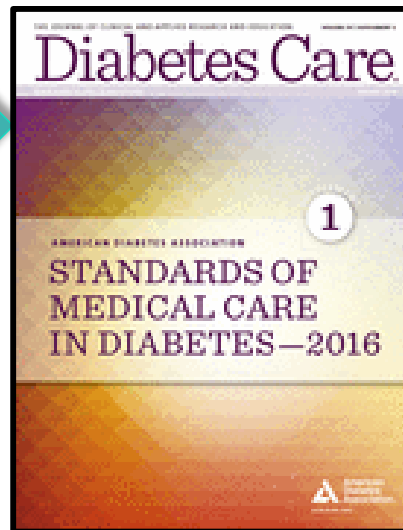
ADA Standards of Medical Care



- 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

Research/
Evidence

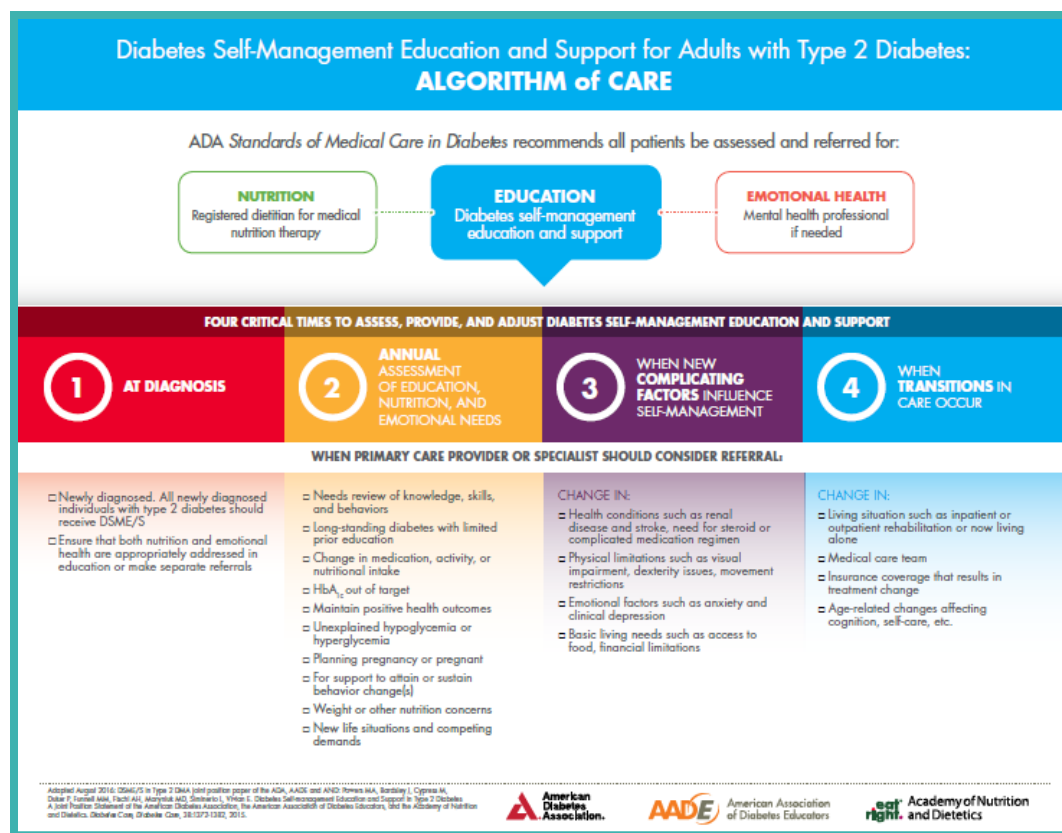


ADA. *Diabetes Care* (2016)
Powers et al. *Diabetes Care* (2015)

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

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)

DSMES Algorithm of Care: 4 Critical Times

ADA Standards of Medical Care in Diabetes recommends all patients be assessed and referred for:



FOUR CRITICAL TIMES TO ASSESS, PROVIDE, AND ADJUST DIABETES SELF-MANAGEMENT EDUCATION AND SUPPORT

1

AT DIAGNOSIS

2

ANNUAL
ASSESSMENT
OF EDUCATION,
NUTRITION, AND
EMOTIONAL NEEDS

3

WHEN NEW
COMPLICATING
FACTORS INFLUENCE
SELF-MANAGEMENT

4

WHEN
TRANSITIONS IN
CARE OCCUR

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*

**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

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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

Thank you!

This material was prepared by Telligen, the Quality Innovation Network National Coordinating Center, 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. 11SOW-QINNCC-01695-10/13/17