*Healthy People 2020 Spotlight on Health presents*

# Empowering People to Manage Their Diabetes

Healthy People 2020

Office of Disease Prevention and Health Promotion

# Don Wright, MD, MPH

## Deputy Assistant Secretary for Health
## Director, Office of Disease Prevention and Health Promotion
## U.S. Department of Health and Human Services

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# Today's Webinar Hosts

- Diabetes Advocacy Alliance

- The U.S. Department of Health and Human Services' Office of Disease Prevention and Health Promotion

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# Healthy People 2020 Diabetes Objectives

| | |
|---|---|
| D-1 | Reduce the annual number of new cases of diagnosed diabetes in the population |
| D-5 | Improve glycemic control among persons with diabetes |
| D-15 | Increase the proportion of persons with diabetes whose condition has been diagnosed |
| D-16 | Increase prevention behaviors in persons at high risk for diabetes with prediabetes |

**This webinar also supports Healthy People 2020 Diabetes Objective D-14**

| | |
|---|---|
| D-14 | Increase the proportion of persons with diagnosed diabetes who receive formal diabetes education |

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# Agenda

## I. Overview of Healthy People 2020 Diabetes Objectives and Introduction of Topic

*Don Wright, MD, MPH, Deputy Assistant Secretary for Health, Office of Disease Prevention and Health Promotion (ODPHP), U.S. Department of Health and Human Services (HHS)*

## II. Diabetes Self-Management Education (DSME) Overview

*Deborah Greenwood, PhD, RN, BC-ADM, CDE, FAADE, Sutter Health Integrated Diabetes Education Network; Program Director and Research Scientist, Office of Patient Experience, Sutter Health; President, American Association of Diabetes Educators*

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# Agenda

## III. Review of the Evidence Supporting the Community Preventive Services Task Force Recommendations on Diabetes Self-Management

*Randy Elder, MEd, PhD, Systematic Review Science Team Lead, Community Guide, Centers for Disease Control and Prevention, HHS*

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# Agenda

## IV. Challenges and Opportunities for Delivering DSME In Communities

- ***Lessons Learned: North Carolina's Approach***

  *Mary Bea Kolbe, MPH, RD, LDN, Diabetes Education Recognition Program Coordinator, North Carolina Department of Health and Human Services*

- **Lessons Learned: Mississippi 's Approach**

  *Dietrich T. Taylor, RN, CDE, Chief Nurse, Director, Diabetes Prevention and Control, Mississippi State Department of Health*

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# Agenda

## V. Live Question and Answer Session

*Moderated by Carter Blakey, Deputy Director and Community Strategies Division Director, ODPHP, HHS*

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# What Is Healthy People?

- Provides **science-based, 10-year national objectives** for improving the health of the Nation
- A **national agenda** that communicates a vision for improving health and achieving health equity
- Identifies **measurable objectives** with **targets** to be achieved by the year 2020
- Requires tracking of **data-driven outcomes** to monitor progress and to motivate, guide, and focus action

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# Uses of Healthy People

- **Data tool** for measuring program performance
- Framework for **program planning and development**
- **Goal setting** and **agenda building**
- **Teaching** public health courses
- Benchmarks to **compare** State and local data
- Way to develop nontraditional **partnerships**
- **Model** for other countries

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# Healthy People Remains Relevant

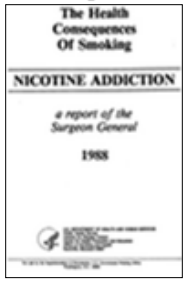
1979

1990

2000

2010

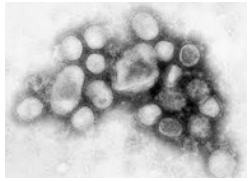
1979 Small Pox Eradicated




1988 SG Declares Nicotine Addictive

1990 Human Genome Project Begins

2000s Obesity and Chronic Disease



2009 H1N1 Flu

1970 Clean Air Act

1982 AIDS is infectious

1990s Drinking Water Fluoridation

September 11, 2001

2005 Hurricane Katrina

# Topic Areas

- Access to Health Services
- Adolescent Health
- Arthritis, Osteoporosis, and Chronic Back Conditions
- Blood Disorders and Blood Safety
- Cancer
- Chronic Kidney Disease
- Dementias, including Alzheimer's Disease
- Diabetes
- Disability and Health
- Educational and Community-Based Programs
- Early and Middle Childhood
- Environmental Health
- Family Planning
- Food Safety
- Genomics
- Global Health
- Health-related Quality of Life and Well-being
- Healthcare Associated Infections
- Lesbian, Gay, Bisexual, Transgender Health
- Nutrition and Weight Status
- Occupational Safety and Health
- Older Adults
- Oral Health
- Physical Activity
- Public Health Infrastructure
- Preparedness
- HIV
- Immunization and Infectious Diseases
- Injury and Violence Prevention
- Maternal, Infant, and Child Health
- Medical Product Safety
- Mental Health and Mental Disorders
- Health Communication and Health Information Technology
- Hearing and Other Sensory or Communication Disorders
- Heart Disease and Stroke
- Respiratory Diseases
- Sexually Transmitted Diseases
- Sleep Health
- Social Determinants of Health
- Substance Abuse
- Tobacco Use
- Vision

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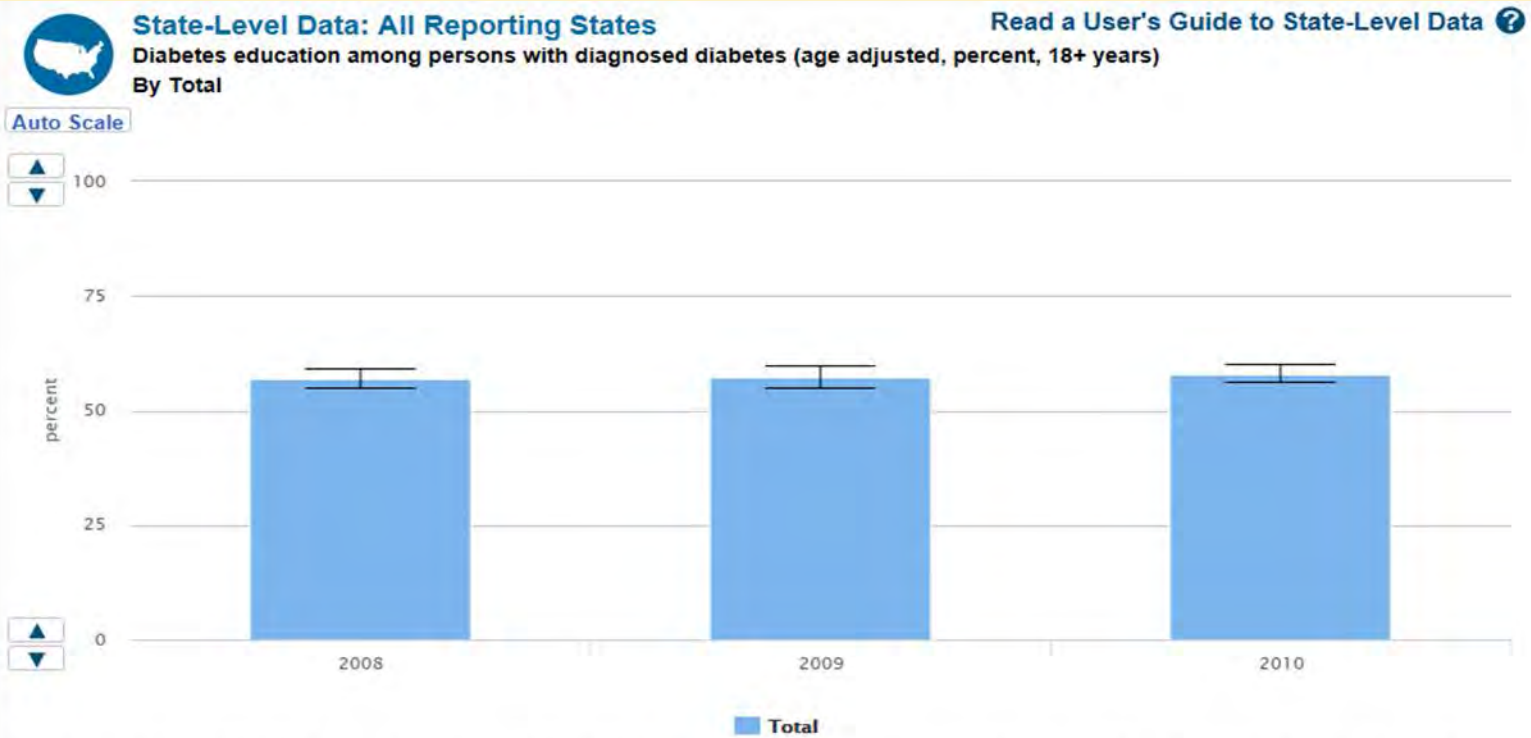
# Diabetes education among persons with diagnosed diabetes




**Data Source:** Behavioral Risk Factor Surveillance System (BRFSS); Centers for Disease Control and Prevention, Public Health Surveillance and Informatics Program Office (CDC/PHSIPO)
**Error Bar (I)** represents the 95% confidence interval
Additional footnotes may apply to these data. Please refer to footnotes below the data table for further information.

## D-14 Increase the proportion of persons with diagnosed diabetes who receive formal diabetes education

Diabetes education among persons with diagnosed diabetes (age adjusted, percent, 18+ years)

Display Years ▼

| POPULATIONS | 2008 | 2009 [1] | 2010 [2] |
|---|---|---|---|
| TOTAL | 56.8 | 57.3 | 58.0 |

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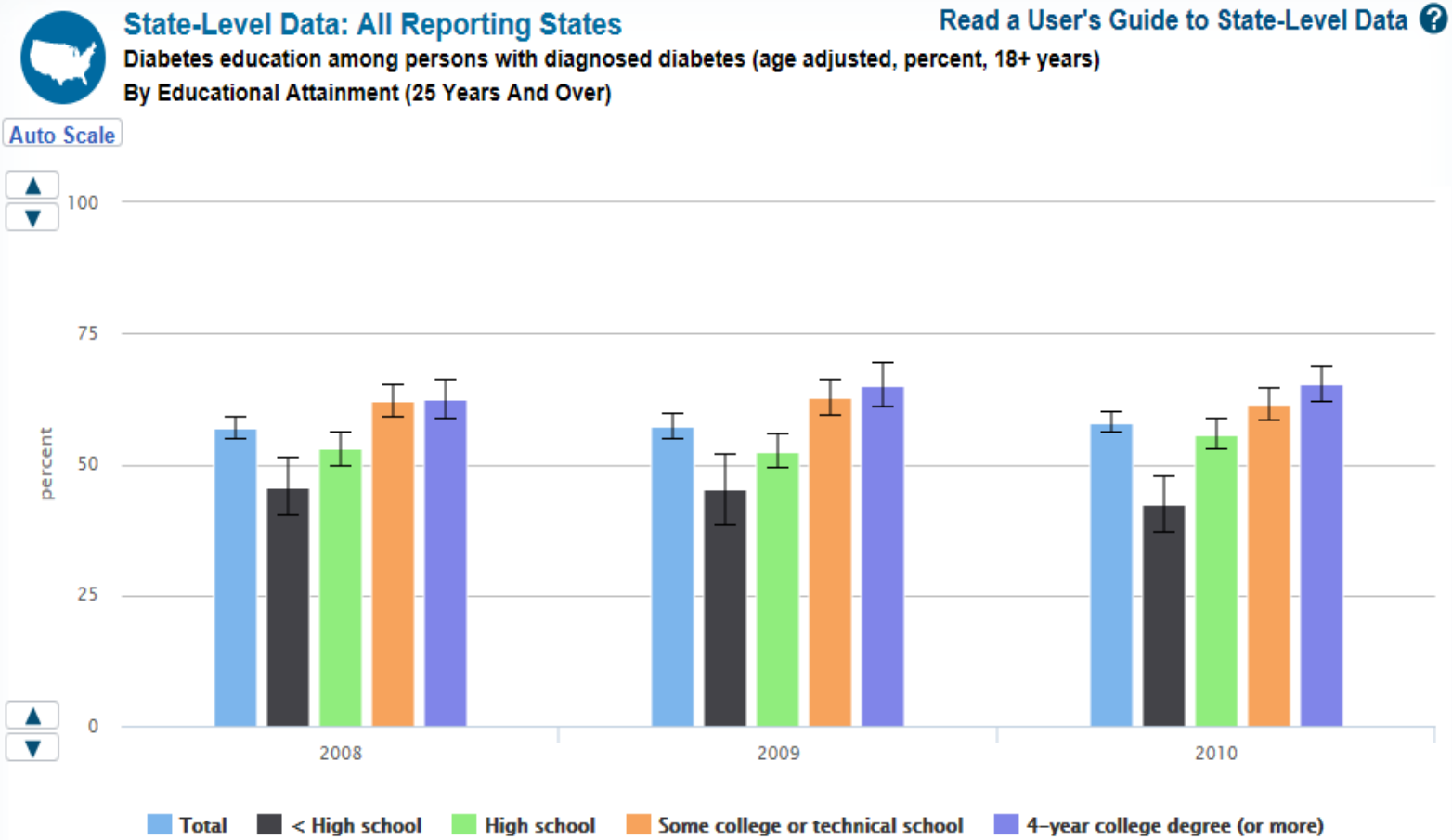
# Diabetes Education by Educational Attainment




**Data Source:** Behavioral Risk Factor Surveillance System (BRFSS); Centers for Disease Control and Prevention, Public Health Surveillance and Informatics Program Office (CDC/PHSIPO)
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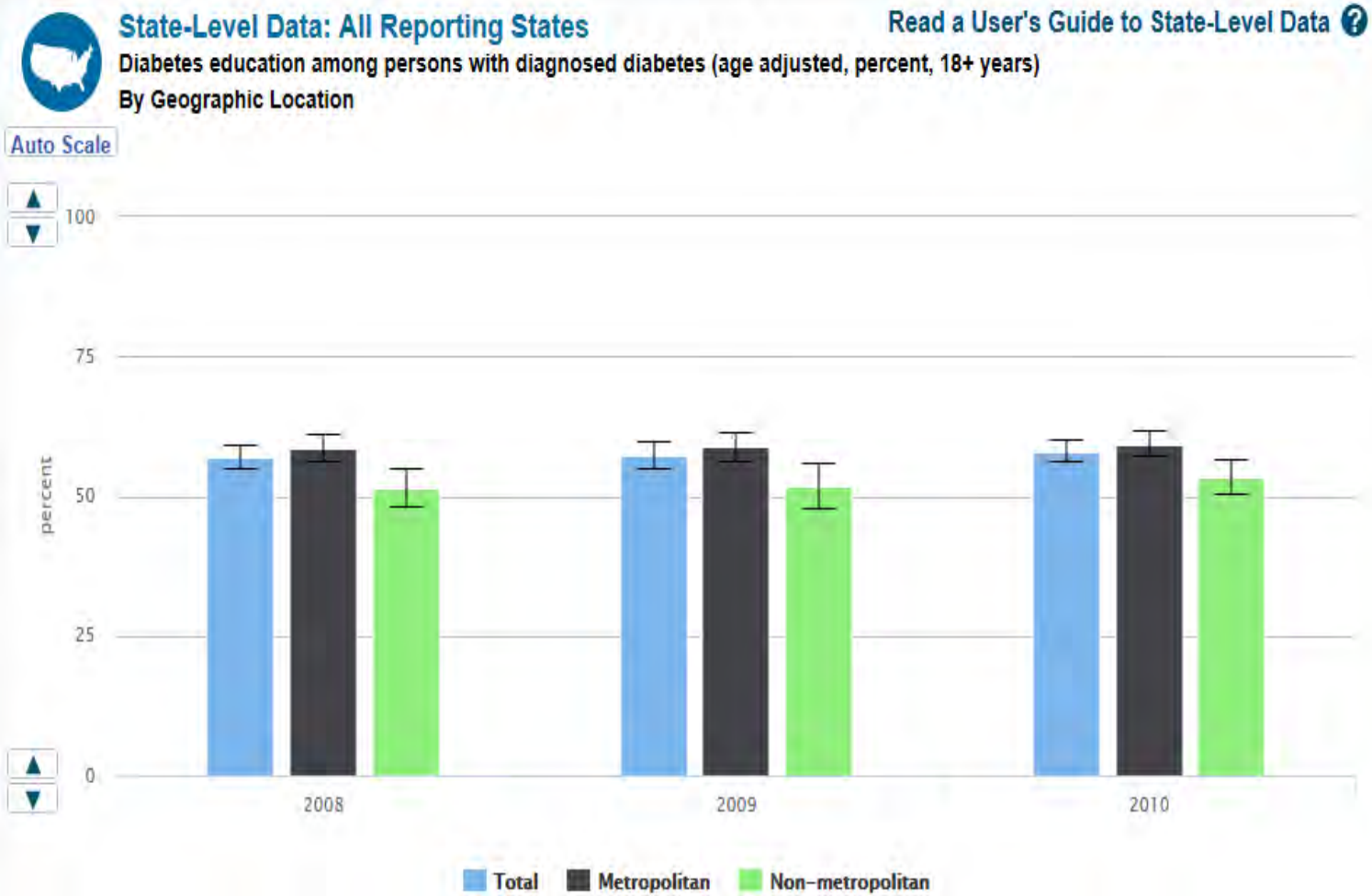
# Diabetes Education By Geographic Area




**Data Source:** Behavioral Risk Factor Surveillance System (BRFSS); Centers for Disease Control and Prevention, Public Health Surveillance and Informatics Program Office (CDC/PHSIPO)

**Error Bar (I)** represents the 95% confidence interval

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# Questions?

**Submit your questions using the Q & A feature on the right of your screen.**
**Presenters will respond following all the presentations**

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# Diabetes Self-Management Education Overview

*Deborah Greenwood, PhD, RN, BC-ADM, CDE, FAADE*

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# Diabetes Self-Management Education Webinar:

## What is DSME?

**DEBORAH GREENWOOD, PHD, RN, BC-ADM, CDE, FAADE**
***PRESIDENT***
***AMERICAN ASSOCIATION OF DIABETES EDUCATORS***

*"There is no one 'best' education program or approach; however,* ***programs incorporating behavioral and psychosocial strategies demonstrate improved outcomes."***

National Standards for Diabetes Self Management Education and Support. Diabetes Care. 2012 38:619

# Diabetes Self-Management Education (DSME)

- Interchangeably used with Diabetes Self-Management Training (DSMT)
- An ongoing, collaborative process of facilitating knowledge, skills, & abilities necessary for people with prediabetes/diabetes that results in behavior modification to self-manage the disease and its related conditions.
- The process of DSME/T is rooted in a set of desired outcomes to improve clinical outcomes, health status, and quality of life.

# Desired Outcomes

- Informed decision making
- Self-care behaviors
- Problem solving
- Active collaboration
- Improve clinical outcomes
- Improve health status
- Improve quality of life

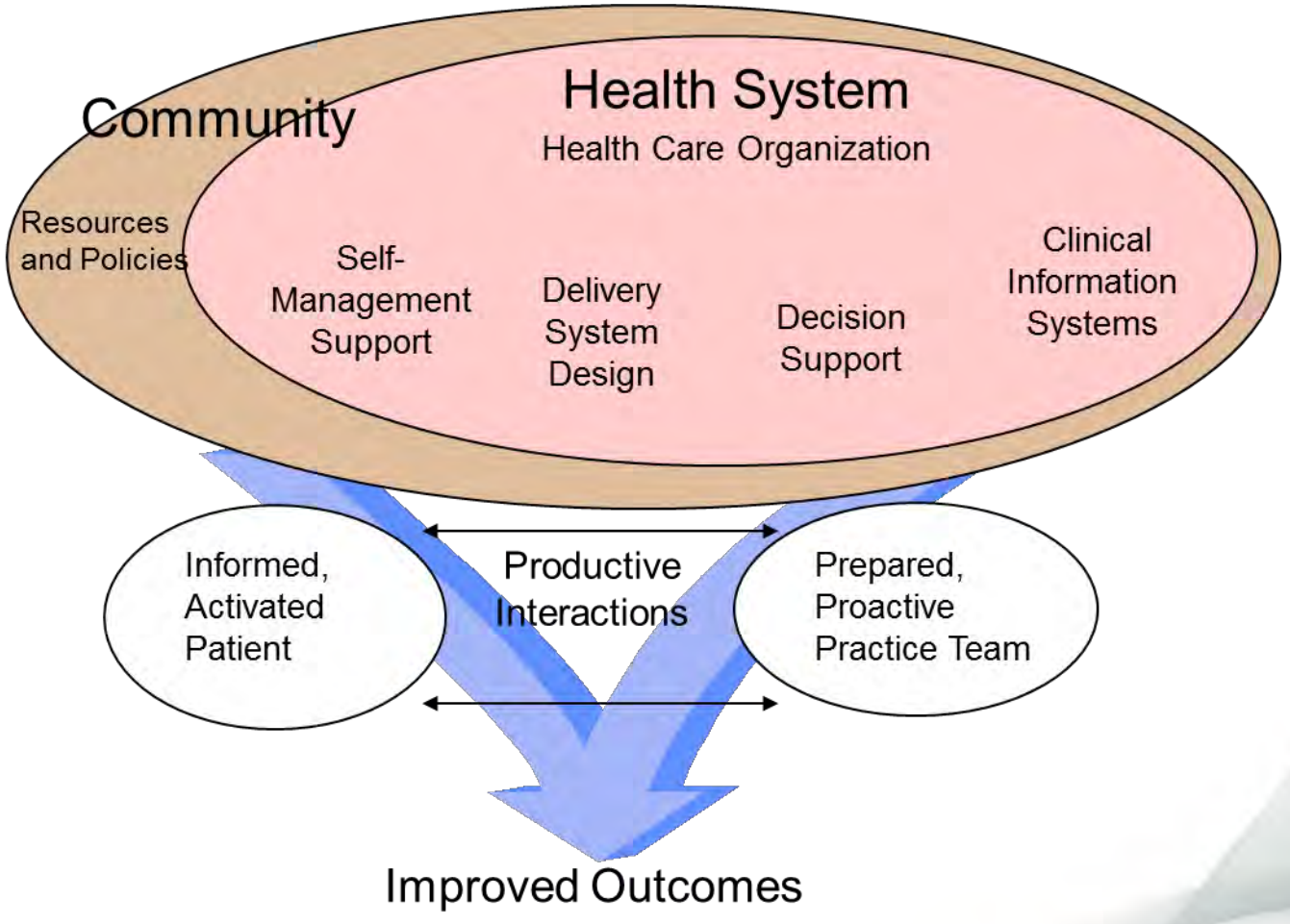
# Desired Outcomes

- Informed decision making
- **Self-care behaviors**
- Problem solving
- Active collaboration
- Facilitated positive self-care
- Improve clinical outcomes
- Improve health status
- Improve quality of life

Seven specific self-care behaviors developed by the ***American Association of Diabetes Educators***, known collectively as the AADE7™, have been defined to guide the process of DSME/T and help patients achieve behavior change.

## AADE7 Self-Care Behaviors™

# *The Chronic Care Model and DSME/T*




http://www.betterdiabetescare.nih.gov

www.improvingchroniccare.org

# Components of DSME

- **Chronic Care Model**
  - Population-based
  - Identifies essential elements of the healthcare system that foster chronic disease care
- **The Informed Activated Patient**
  - Knowledgeable about disease
  - Understands role as “self manager”
  - Family caregivers engaged
  - Team seen as knowledgeable guide and support
- **The Prepared Practice Team**
  - Ready for visit with patient information
  - People and equipment at hand
  - Time to deliver evidence-based clinical management and self-management support

# DSME is Cost Effective

- Reducing hospital admissions and readmissions
  - Patients with poorly managed diabetes ($A1_C$ >9%) and who receive formal diabetes education are associated with a lower frequency of all-cause hospital readmission within 30 days.
  - Direct patient education associated with 9.18 fewer hospitalizations per 100 person-years (95% CI 5.02-13.33)
  - $11,571 ($6,377 to $16,765) less in hospital charges per person.

Chrvala CA, Sherr D, Lipman R. Diabetes Self-management Education for Adults with Type 2 Diabetes Mellitus: A Systematic Review of the Effect on Glycemic Control. Patient Education and Counseling. 2015. (in press)
Powers, M. A. et al. "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." The Diabetes Educator 41.4 (2015): 417–430.

# DSME is Cost Effective

- Reduce lifetime health care costs related to a lower risk for complications
  - Incremental cost-effectiveness ratio of DSME intervention for adults with high glycemic levels ($A1_C$ > 9%) ranged from $10,995 to $33,319 per QALY gained when compared with usual care.
- Projected to decrease national costs related to diabetes
  - Cost of diabetes care in the US (2012) was reported to be $245 billion, DSME offers an opportunity to decrease these costs.

Chrvala CA, Sherr D, Lipman R. Diabetes Self-management Education for Adults with Type 2 Diabetes Mellitus: A Systematic Review of the Effect on Glycemic Control. Patient Education and Counseling. 2015. (in press)
Powers, M. A. et al. "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." The Diabetes Educator 41.4 (2015): 417–430.

# Importance of DSME

VITALS

- Improved hemoglobin $A1_C$ by as much as 1% in T2D patients
- Absolute reduction in $A1_C$ of 0.57% between Intervention and control
- ≥ 10 hours with a diabetes educators is associated with better outcomes

IMPACT

- Provides foundation to navigate future decisions
- Lifetime engagement in their health

Chrvala CA, Sherr D, Lipman R. Diabetes Self-management Education for Adults with Type 2 Diabetes Mellitus: A Systematic Review of the Effect on Glycemic Control. Patient Education and Counseling. 2015. (in press)
Powers, M. A. et al. "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." The Diabetes Educator 41.4 (2015): 417–430.

# Criteria for DSME/T Coverage

- Newly diagnosed with diabetes using one of the following criteria:
  - A fasting blood sugar greater than or equal to 126 mg/dL on two different occasions
  - A 2 hour post-glucose challenge greater than or equal to 200 mg/dL on 2 different occasions; or
  - A random glucose test over 200 mg/dL for a person with symptoms of uncontrolled diabetes.
- Previously diagnosed with diabetes (before Medicare eligibility) have since become eligible for Medicare coverage

# Medicare Part B Payment

- Up to 10 hours of DSMT the initial 12-months after first claim
- One hour individual training the initial 12-months
- Up to 2 hours of DSMT every 12-months following the initial period.
- Can be performed in any combination of 1/2 hour increments.

# Three important conditions of Part B DSME/T

- Referral from a physician or other qualified medical provider including a nurse practitioner or physician assistant.
- Reimbursement only to accredited programs by AADE or ADA.
- Medicare must officially recognize program
  - Provider must submit a copy of the accreditation certificate with the Medicare provider status and National Provider Identification Number

# Medicare Part B Payment

- Must be in group setting unless prescribing provider identifies specific needs for 1:1
  - No group session is available within 2 months
  - Special needs prohibiting group setting

# Medicare DSME Benefit: Patients

- Medicare beneficiary pays co-pay
  - Medicare covers 80% of the allowed adjusted rate,
  - Beneficiary pays 20%

Billed by G codes- 2015 Medicare Fee Schedule reimbursement varies by geographic region & carrier

- **G0108** – Individual session face-to-face, each 30 min. of training $46.46-$71.06
- **G0109** – Group session (2 or more patients) each 30 min. of training $12.57-$19.20

# Telehealth Providers of DSME

- Effective January 2011, DSME is included on the list of reimbursable Medicare telehealth services, with several requirements.

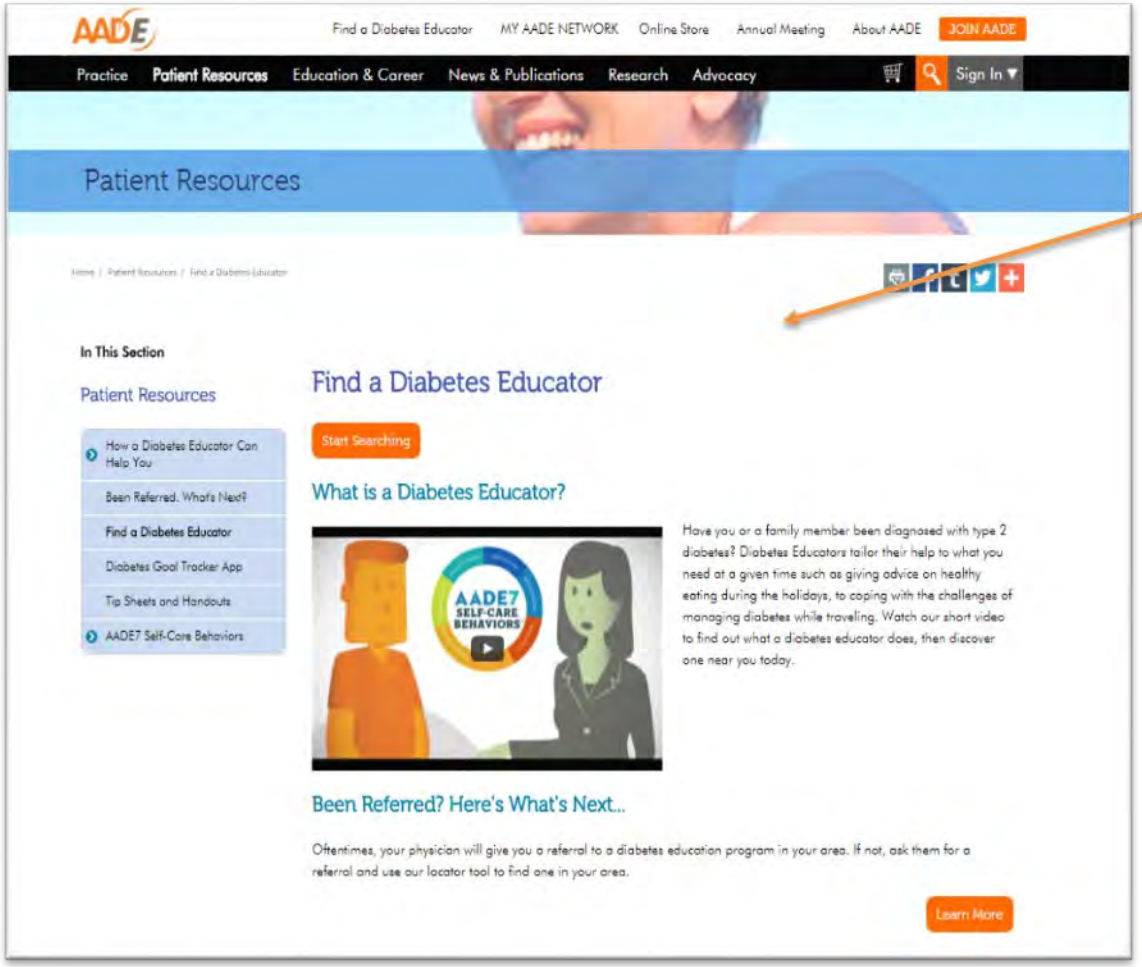
- Medicare telehealth services can only be furnished to an eligible telehealth beneficiary in an originating site – which must be located in a rural health professional shortage areas (HPSAs) or in a county outside of a metropolitan statistically area (MSA).

  - Offices of a physician or practitioner
  - Hospitals
  - CAHs
  - RHCs
  - FQHCs
  - Hospital-Based or Critical Access Hospital-Based Renal Dialysis Centers (including Satellites)
  - SNFs
  - CMHCs

# Telehealth Providers of DSME

- Providers approved by CMS to provider telehealth services (including DSMT telehealth services):
  - Physician
  - Physician assistant (PA)
  - Nurse practitioner (NP)
  - Clinical nurse specialist (CNS)
  - Nurse midwife
  - Clinical psychologist
  - Clinical social worker
  - Registered dietitian
  - Nutrition professional

# Finding a Diabetes Educator




- Visit AADE's website diabeteseducator.org to find a diabetes educator in your area.
- Share this video about diabetes educators

# Thank You!

- greenwd@sutterhealth.org
- @DebGreenwood

# Questions?

**Submit your questions using the Q & A feature on the right of your screen.**
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# Review of the Evidence Supporting the Community Preventive Services Task Force Recommendations on Diabetes Self-Management

*Randy Elder, MEd, PhD*

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# Review of the Evidence Supporting the Community Preventive Services Task Force Recommendations on Diabetes Self-Management

Randy Elder, MEd, PhD
Systematic Review Science Team Lead
Community Guide Branch

Empowering People to Manage Their Diabetes:
A Healthy People 2020 Spotlight on Health Webinar

December 10, 2015

# Disclaimer

The findings and conclusions in this presentation do not necessarily represent the official position of the Centers for Disease Control and Prevention.

The Community Preventive Services Task Force's evidence-based recommendations are not mandates for compliance or spending. Instead, they provide information and options for decision makers and stakeholders to consider when determining which programs, services, and policies best meet the needs, preferences, available resources, and constraints of their constituents.

The Centers for Disease Control and Prevention "provides administrative, research, and technical support for the Community Preventive Services Task Force."
[PHS Act §399U[c]

# Review Coordination Team

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Sanford Garfield

David McCulloch

# The Community Guide

## Systematic reviews

- Evaluate and analyze all available evidence on the effectiveness of community-based programs, services, and policies in public health
- Assess the economic benefit of effective programs, services, policies
- Highlight evidence gaps

## Evidence-based findings and recommendations

- About the effectiveness of these programs, services, and policies
- Help inform decision-making
- Developed by independent Community Preventive Services Task Force (Task Force)

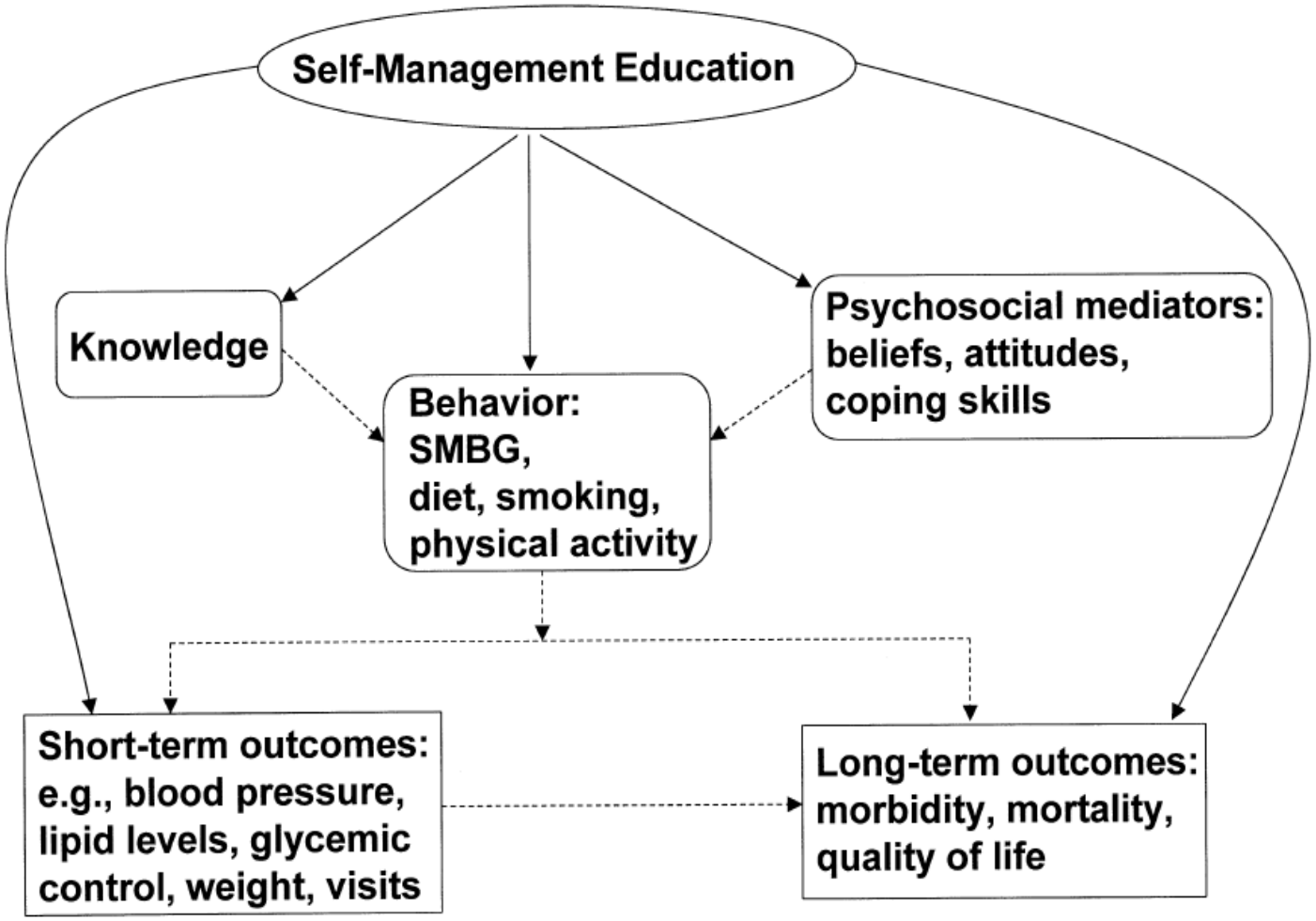
**www.thecommunityguide.org**

# Community Guide
# Diabetes Self-Management Education (DSME) Reviews

- Focus: Effectiveness of DSME delivered outside of traditional clinical settings
- Separate reviews for five settings:
  - Community gathering places
  - The home
  - Recreational camps
  - Worksites
  - Schools
- Population:
  - People with diabetes
  - Adults and children
  - Type 1 and 2

Norris SL, Nichols PJ, Caspersen CJ, et al. Increasing diabetes self-management education in community settings. A systematic review. American journal of preventive medicine. May 2002;22(4 Suppl):39-66.

# Analytic Framework for DSME



# Short-Term Recommendation Outcomes

- Glycemic control
  - Glycated Hemoglobin
  - Blood Glucose
- Physiologic Outcomes
  - Weight
  - Lipid levels
  - Foot lesions
  - Blood pressure
  - Microalbuminurea
  - Retinopathy
- Behavioral Outcomes
  - Physical Activity
  - Diet
  - Smoking
- Mental Health Outcomes
  - Depression
  - Anxiety

# Long-Term Recommendation Outcomes

- Macrovascular complications
  - Peripheral vascular disease
  - Coronary heart disease
  - Cerebrovascular disease
- Microvascular complications
  - Decreased vision
  - Peripheral neuropathy
  - Renal disease
  - Periodontal disease
  - Foot lesions, amputations
- Quality of life
  - Disability/function
- Mortality

# In General, a Conclusion on Effectiveness Requires….

**A Body of Evidence** + **A Demonstration of Effectiveness**

Multiple studies

Fewer if high quality

More if lower quality

**Consistency of Effect** + **Sufficient Magnitude of Effect**

"Most" studies demonstrated an effect in the favorable direction

The effect demonstrated across the body of evidence is "meaningful"

# DSME in Community Gathering Places

- Recommended for adults with Type 2 diabetes (8 studies; Sufficient Evidence)
  - Glycated hemoglobin (HbA1c) levels: mean decrease of 1.9 percentage points (95% CI:-2.4, -1.4; 4 studies)
  - Fasting blood glucose (mmol/L): median decrease of 2.0 (range: -1.3 to -4.0; 4 studies)
  - Weight: median decrease of 5.2 lbs (range: -9.0 to 1.6; 6 studies)
  - Blood pressure (mmHg): decreases in favor of the intervention (2 studies)
  - Cholesterol: inconsistent findings (3 studies)
  - All of the included studies involved adults with Type 2 diabetes
- Emphasis on need for coordination with clinical care

# DSME in the Home

- Recommended for adolescents with Type 1 diabetes (10 Studies; Sufficient Evidence)
  - Glycated hemoglobin (HbA1c) levels: mean decrease of 1.1 percentage points among adolescents with Type 1 diabetes (95% CI: -1.6, -0.6; 4 studies)
- Insufficient Evidence to determine whether or not home-based DSME works for people with Type 2 diabetes because only two studies were available.

# DSME in Other Settings

- Insufficient evidence to determine effectiveness of DSME in
  - Recreational Camps
  - Worksites
  - Schools
- Results generally favorable, but too few studies with recommendation outcomes to draw clear conclusions

# Next Steps: Planned Review Update

- Reconceptualize to include **all settings**
- Stratify on setting and other potentially important factors
- Definition revised to include diabetes self-management **support:**
  - Consistent with 2015 national standards from ADA, AADE, and AND.*
  - Reflects importance of ongoing support for behavior change/maintenance and psychosocial concerns.

* Powers et al. (2015). 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.. Diabetes Care, 38(7), 1372-82.

# Thank You

Randy Elder

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www.thecommunityguide.org

# Poll Question

**To allow us to better serve you, please respond to the poll question on the right hand portion of your screen.**

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# Lessons Learned: North Carolina's Approach

Mary Bea Kolbe, MPH, RD, LDN

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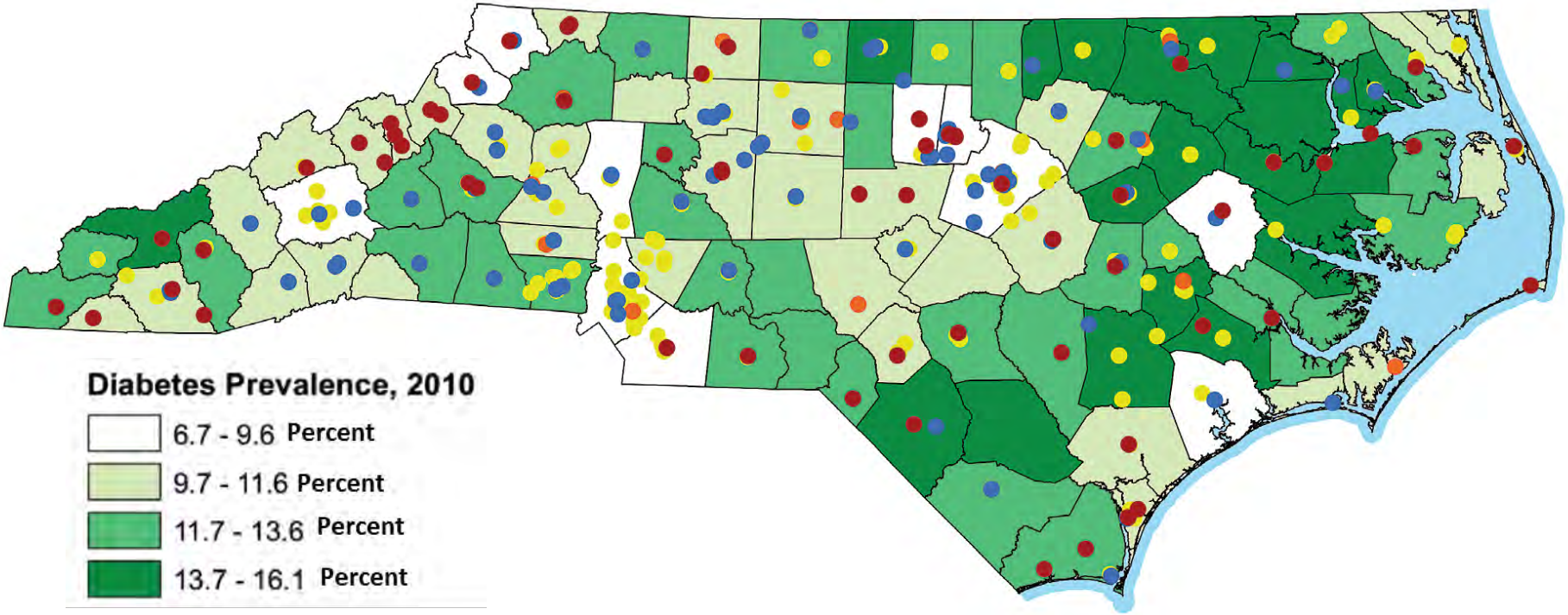
Nothing Compares

NORTH CAROLINA

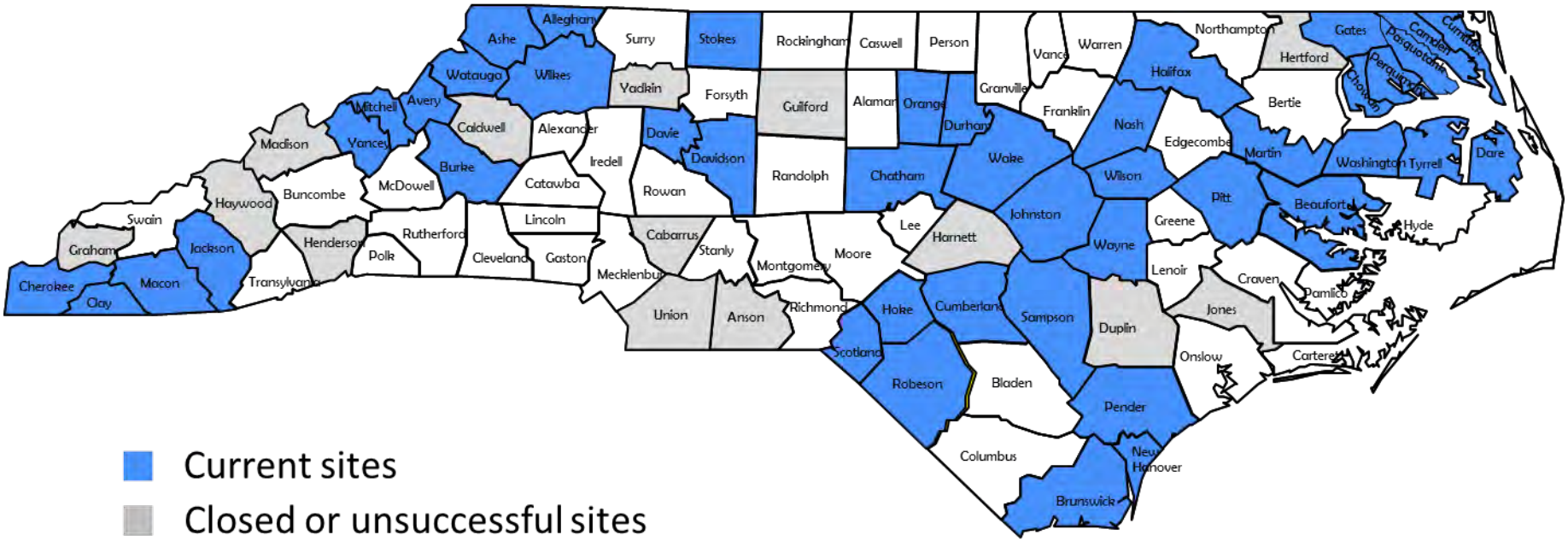



**Diabetes Self-Management Program Sites**

- Diabetes Education Recognition Program (63)
- American Association of Diabetes Educators (AADE) (17)
- American Diabetes Association (ADA) (117)
- Stanford Diabetes Self-Management Program (151)

Community & Clinical CONNECTIONS for Prevention & Health Branch NORTH CAROLINA DIVISION OF PUBLIC HEALTH

# NC Diabetes Education Recognition Program




Current sites

Closed or unsuccessful sites

Community & Clinical CONNECTIONS for Prevention & Health Branch NORTH CAROLINA DIVISION OF PUBLIC HEALTH

# Participant Demographics

| | All years | Past year |
|---|---|---|
| Total number of participants seen | 11860 | 1239 |
| Race, ethnicity | | |
| • American Indian | 1% | 0% |
| • African American | 25% | 26% |
| • Hispanic | 11% | 10% |
| • White/Caucasian | 52% | 56% |
| Insurance | | |
| • Medicare | 15% | 24% |
| • Medicaid | 10% | 14% |
| • BCBS | 10% | 12% |
| • Other | 3% | 0% |
| • Self-pay or uninsured | 60% | 45% |

# DSME Readiness Assessment

*For local health departments considering an application to NC-DERP*

## Assessment: Is Our Health Department Ready to Offer DSME?

*For each item below, check the box next to a statement if it is true of your health department at this time.*

| Category | Statements | Notes |
|---|---|---|
| A. Leadership and Goals | ☐ 1. Our health director has endorsed offering DSME at our health department<br>☐ 2. Our health director is actively involved in the DSME program development and application process<br>☐ 3. Other key leaders at the health department are supportive of and involved in the DSME program<br>☐ 4. We have defined our goals and what success means to us | *Leadership support is crucial for DSME program success. Consider who in the management team could be an asset or a barrier, and how you might improve these relationships, engage management in the development process, and address potential concerns of leaders. What do you consider success? It may be financial stability, serving all of the uninsured, improving specific health outcomes in the community, achieving patient satisfaction, or something else.* |
| B. Staff | ☐ 5. We have identified a sufficient number of interested staff members who are qualified to instruct DSME<br>☐ 6. Potential instructors have Continuing Education in diabetes from last 12 months<br>☐ 7. We have the necessary administrative staff for the DSME program | *DSME Instructional staff must hold appropriate credentials and receive continuing education. Remember that It is easy to underestimate the administrative support needed. Consider whether existing staff can take on these additional tasks. Could the health department hire more staff if needed?* |
| C. Finances | ☐ 8. We have projected expenses for running a DSME program, including administration, staff, rent/utilities, office supplies, program supplies, training, and travel<br>☐ 9. We have estimated potential revenue from participants and 3rd party reimbursement, considering the payer mix of target participants<br>☐ 10. We have researched other sources of revenue, including health department funds, outside grants, and in-kind donations<br>☐ 11. Based on our projections, we anticipate that revenue will equal or exceed expenses | *Funding is often the biggest challenge in running a DSME program. Consider how long it may be before the program is self-sustaining, as well as length of grants and possibilities for other funding. What will happen if you have a budget shortfall? Approach existing NC DERP programs for estimates of expenses and ideas for funding.* |

| | | |
|---|---|---|
| **D. Referrals and Recruitment** | ☐ 12. Our health department currently receives referrals from local providers for diabetes care<br>☐ 13. We have contacted local health care providers to discuss the possibility of referring patients for DSME<br>☐ 14. We have a marketing/recruitment plan to attract participants in the DSME program | *Health care providers must be willing to refer patients to your DSME program in order to maintain patient load and insurance reimbursement. Talk with physicians directly to understand what it would take for them to refer patients to your DSME program.* |
| **E. Understanding the community and its needs** | ☐ 15. We have identified our target audience to whom we will offer DSME, including approximate size and demographics<br>☐ 16. We have considered and described specific needs or considerations for serving our target audience<br>☐ 17. We have knowledge of all existing local DSME programs, and can demonstrate a need for additional DSME in this community | *Consider which segments of your community are most affected by diabetes, as well as where the greatest potential for impact lies. What needs are not being met for diabetes care in your community? What will you do differently to meet these needs? How will you address patient barriers such as limited time and/or transportation?* |
| **F. Engagement with target audience** | ☐ 18. Our health department has active channels of communication with our target audience, including solicitation of how to serve their needs<br>☐ 19. Our health department has active and positive relationships with our target audience<br>☐ 20. We have considered how potential stigma of visiting the health department may be a barrier to individuals attending DSME, and we have a plan for how to address this challenge | *Take the time—before applying to DERP—to understand the needs of and potential barriers for these individuals, particularly why they are not receiving diabetes education now. Focus groups and community organizations can be great resources.* |

| | | |
|---|---|---|
| G. External Partnerships | ☐ 21. Our health department has strong relationships with one or more health-focused organizations in our community<br>☐ 22. Our health department has strong relationships with one or more healthcare providers in our community<br>☐ 23. Our health department has strong relationships with other relevant partners such as local government, media outlets, or cooperative extension<br>☐ 24. Our health department has strong relationships with community support services to which we may need to refer DSME participants | *Partnerships are crucial for sustainability and providing complete care. Consider what you would do if a patient needed other support services, such as financial or mental. If your relationships with these other organizations are not strong and positive, reach out to them to build awareness and teamwork in serving your community. Note: "strong relationships" may include collaboration on projects or events; frequent or formal patient referral; staff of one organization serving as board members for another organization; and/or contracts and memorandums of understanding between the organizations.* |
| H. Implementation and Sustainability | ☐ 25. Our identified program staff and administration have program implementation experience and/or expertise<br>☐ 26. We have planned or identified a specific course of appointments and DSME curriculum for program participants<br>☐ 27. Our staff has plans for and knowledge of using electronic health records to record patient data<br>☐ 28. We have a plan to collect aggregate data, including identifying who and how, for analysis of both behavioral and clinical outcomes<br>☐ 29. We have considered how to review the program and perform continuous quality improvement | *Who in your team has experience providing DSME, using electronic health records, collecting data, and performing quality improvement (QI)? Look for available resources to increase your capacity, through education, training, and additional staff.* |

# Program Successes: Lessons Learned

- External Partnerships (Toe River and M-T-W)
- Engagement with the target audience (statewide marketing campaign, focus groups)
- Finances (Wilkes)

*Ultimately there is no such thing as failure.*
*There are lessons learned in different ways.*
~ Twyla Tharp

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# External Partnerships

- Referrals
- Resources

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# M-T-W & Toe River District Health Departments

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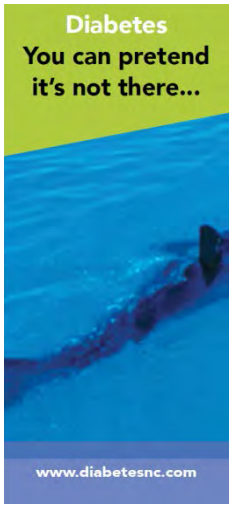
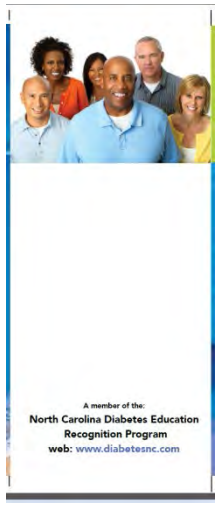
# Engagement with Target Audience

- Active communication






- Acknowledgement of Barriers

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# Focus Group Results

- What influences a participant's readiness for the program
  - Reaction to diagnosis
  - Co-morbid events
  - Uncertainty
- Barriers to participation
  - System
  - Program

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# Finances

- Funding
- Billing

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# Wilkes County Health Department

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# The road to success starts here…..

Essential components:

- External Partnerships
- Engage the Target Audience
- Finances

Our successes:

- # of Multi-sites ≥ 6 years
- # of educators, # of CDEs
- Average decrease in HgbA1c

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Mary Bea Kolbe, RD LDN

Diabetes Education Recognition Program Coordinator

North Carolina Division of Public Health

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# Questions?

**Submit your questions using the Q & A feature on the right of your screen.**
**Presenters will respond following all the presentations**

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# Lessons Learned: Mississippi ‘s Approach

Dietrich T. Taylor, RN, CDE

Healthy People 2020

Office of Disease Prevention and Health Promotion

# Increasing Access to Diabetes Self-Management Education in Rural and Underserved Populations

Dietrich T. Taylor, Chief Nurse, CDE, Director Diabetes Prevention and Control Program
Mississippi State Department of Health

# Background

- Mississippi is a predominantly rural state with a population of approximately 3 million people
- 51 of 82 counties are considered medically underserved
- 3nd highest rates in U.S. for diabetes (12.9%) compared to the national average (9.7%) and obesity ( 34.6%) compared to the national average (27 %)

# The Cost of Treating Diabetes

**Nationally**

- Diabetes cost the nation $245 billion (CDC, 2012)
  - $176 billion in direct costs
  - $69 billion in indirect costs (reduced productivity, disability, work loss, premature death)

**Mississippi**

- Diabetes cost Mississippi $2.74 billion (ADA,2012)
  - $28,819,497 for 13,892 state covered beneficiaries with a Diagnosis of diabetes
  - $2,075 per person with diabetes

*(Mississippi Department of Finance September 2013 and August 2014)*

# The Cost of Treating Diabetes in MS

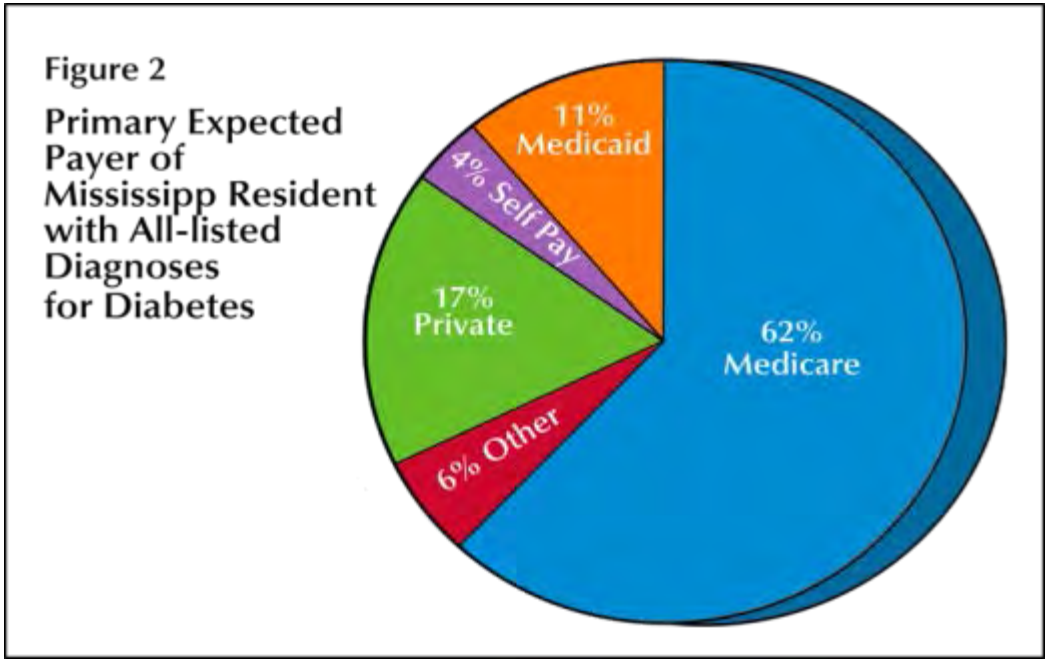
## Hospital Admissions

- 27% of all hospitalization charges were attributed to diabetes and to diabetes associated complications (Hospital Discharge Data, 2011)
- $191 million, cost of primary diagnosis of diabetes alone
- Nearly $3 billion, ($2,854,658,69) cost of primary and secondary diagnosis of diabetes

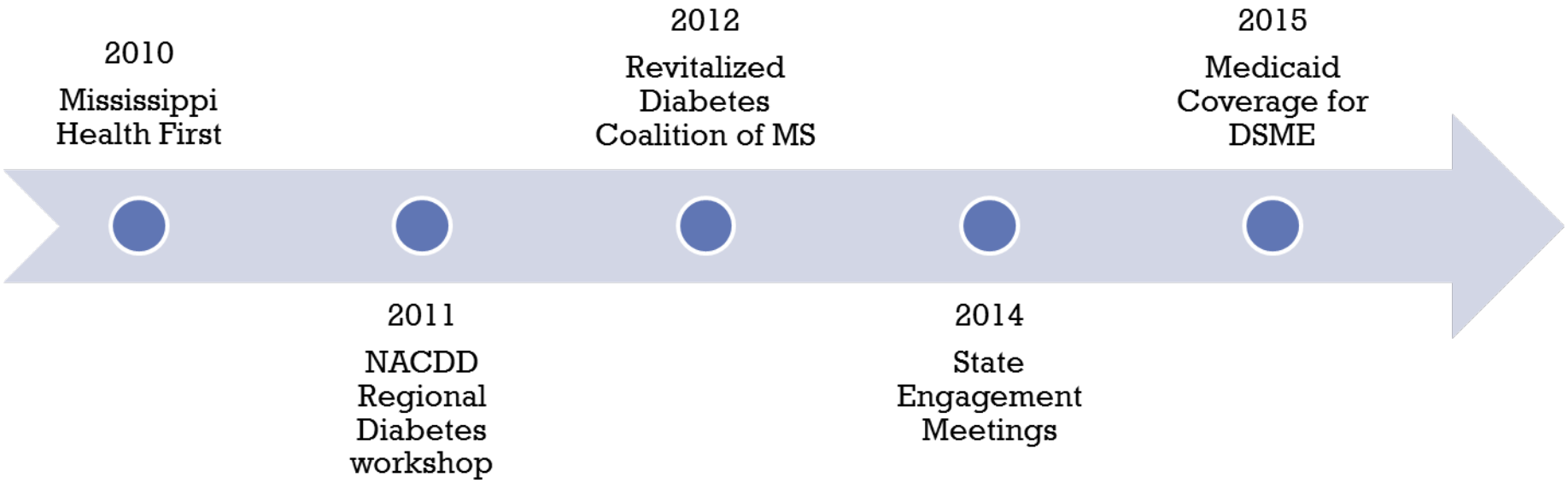
# The Cost of Treating Diabetes in MS

## Mississippi Medicaid

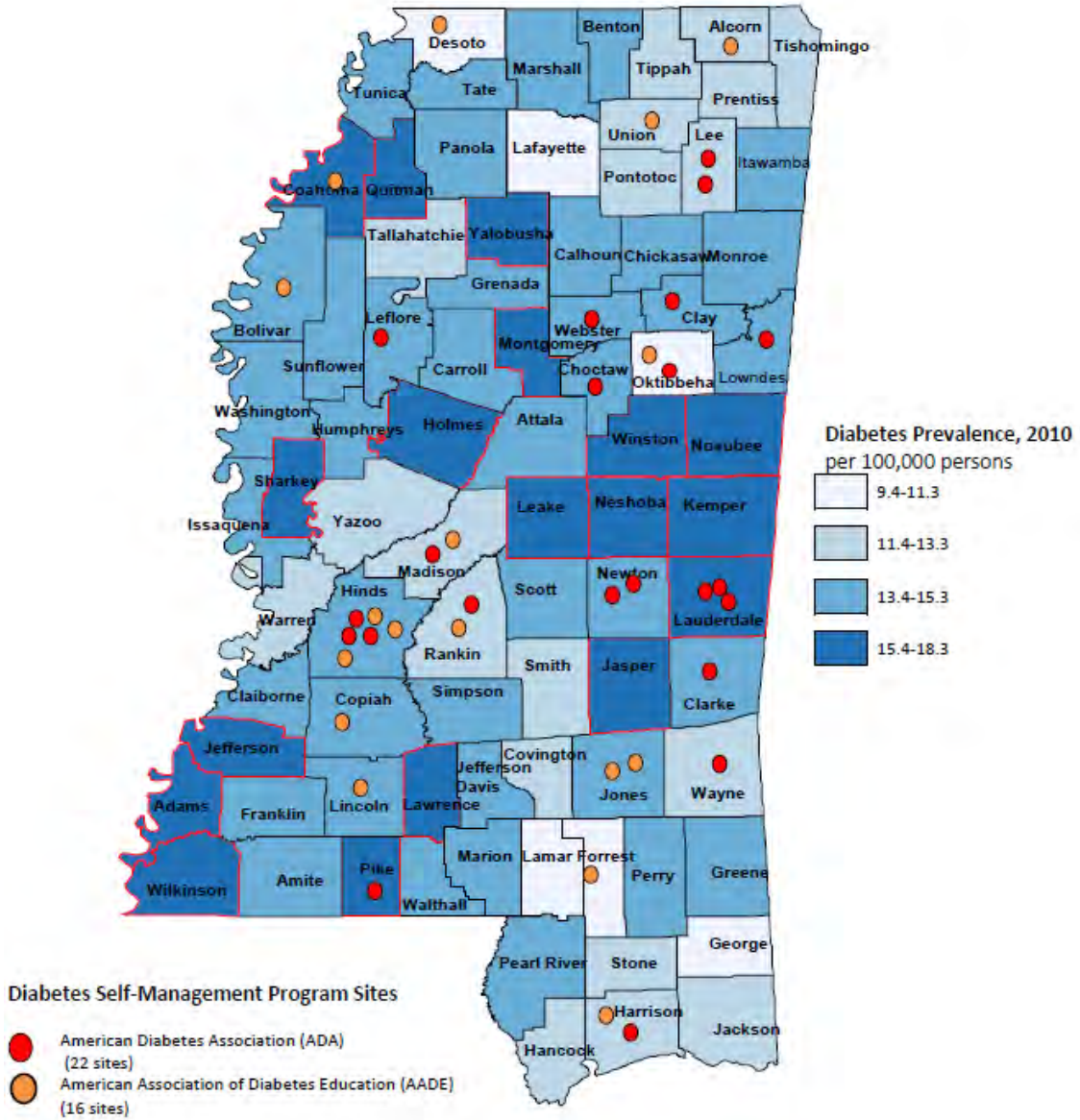
- In 2013, total charges to the Mississippi Division of Medicaid for diabetes and diabetes associated complications totaled almost 1 billion dollars ($964,428,604).



# Increasing Access to Diabetes Self Management Education (DSME)



# Diabetes Self Management Program Sites



# DSME Recognition and Accreditation

- Mississippi State Department of Health (MSDH) is the fourth state health department in the nation to become a recognized provider of Diabetes Self Management Education.

November 2014

# Increasing Access to DSME in the Appalachian Regional Commission (ARC)

- Offering DSME at local MSDH health departments.
- Assisting three hospital systems and one private physician with the Education Recognition Process.
- Building diabetes coalitions and sustainability

# State and National Partners

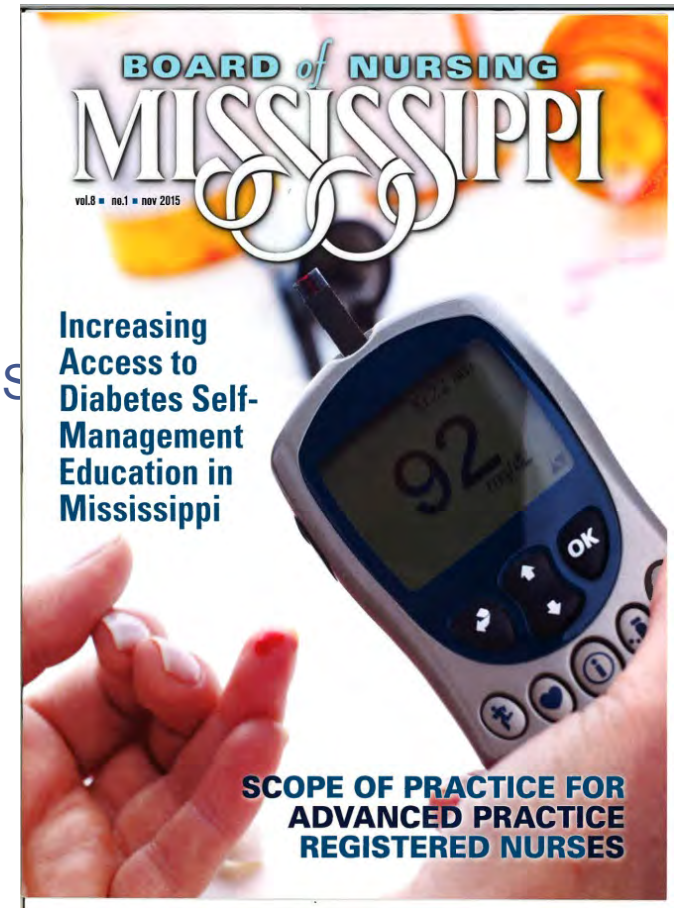
**National Association of Chronic Disease Directors (NACDD)**

# Partnership Development

- Diabetes Coalition of Mississippi
  - A group of 90 individuals representing 60 organizations
  - Work Streams
    - Management
    - Prevention
    - Policy (Worked to get Medicaid reimbursement for DSME)

- State Partners: MS Board of Nursing, Jackson State University, University of MS Medical Center, Delta State University, MS Division of Medicaid, MS Department of Finance and Administration, Information and Quality Healthcare, MS Business Group on Health, and Faith-Based Organizations

- National Partners: AADE, ADA, NACDD, Appalachian Regional Commission (Marshall University), Emory University, and Pharmaceutical Companies



# Leading Mississippi Towards a Diabetes Free Tomorrow

Revitalized the Diabetes Coalition of Mississippi (DCM) to create synergy among stakeholders that will help Mississippians live more healthful lives

# Success Stories

- Nine newly accredited DSME programs added over the last 3 years
- The DCM coalition has received training on the policy planning process from NACDD. Used that training to facilitate a change in Medicaid reimbursement for DSME
- Collaborating with ADA to help professionals pass the Certified Diabetes Educators Exam
- Scaling DSME to 4 more MSDH Public Health Districts starting in February 2016

# Moving Forward with Partners

- Work with Medicare Quality Improvement Network to increase beneficiaries' participation in Diabetes Self Management Education
- Work with Diabetes Self Management Education providers to increase clinician referrals
- Work with the Mississippi State Employee Wellness Program to offer Diabetes Self Management Education as a covered benefit to state employees and their beneficiaries at MSDH clinics

# Acknowledgements


- Mississippi State Department of Health
  - Office of Health Promotion/Equity
    - Evelyn Walker, MD, MPH
  - OPH Leadership
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    - Frances Moody, RN, BSN
    - Latonya Lott, MS, MPH
- University of Mississippi Medical Center
  - Office of the Vice Chancellor
    - Michael Jones, RN, MSN, MBA

# Questions?

**If you have any questions you would like to pose to the presenters, please type it into the Q&A window to the right. We will address as many questions as we can in the time allotted.**

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# Stay Connected

## Join the Healthy People Listserv & Consortium

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| YouTube | ODPHP<br>[search “healthy people”] |

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## Spotlight on Health Webinar

Join us on November 13 for a Spotlight on Health webinar highlighting free evidence-based and emerging mobile technologies designed to improve glycemic control and the health of persons with diabetes.

**Register today!**

## DATA2020 Search

This interactive data tool allows users to explore the data and technical information related to the HealthyPeople 2020 objectives. **Search Healthy People data!**

New

## Leading Health Indicators: Progress Update

**Read the report** to learn about progress that's been made in each of the 26 Leading Health Indicators.

# *Who's Leading the Leading Health Indicators?* webinar

***Register in January 2016, by visiting: www.healthypeople.gov***

Join us on **January 21, 2016 12:00pm-1:00pm ET** for the *Who's Leading the Leading Health Indicators* (LHI) Webinar series on the LHI topic Injury and Violence Prevention

Who's Leading the Leading Health Indicators?

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# Addressing the Social Determinants of Health

Health starts in our homes, schools, workplaces, neighborhoods, and communities. Explore resources related to the social determinants of health and see what communities are doing across the country to address the social determinants of health.

***Visit www.healthypeople.gov to get started!***

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# Healthy People 2020 Progress Reviews

**Webinars will resume in June 2016!**

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# Community Preventive Services Task Force Findings on Diabetes Interventions

| | |
|---|---|
| Combined Diet and Physical Activity Promotion Programs to Prevent Type 2 Diabetes Among People at Increased Risk | Recommended |
| Case Management Interventions to Improve Glycemic Control | Recommended |
| Disease Management Programs | Recommended |

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# Community Preventive Services Task Force Findings on Diabetes Interventions

| **Self-Management Education** | |
|---|---|
| In Community Gathering Places - Adults with Type 2 Diabetes | Recommended |
| In the Home - Children and Adolescents with Type 1 Diabetes | Recommended |
| In the Home – People with Type 2 Diabetes | Insufficient Evidence |
| In Recreational Camps | Insufficient Evidence |
| In Worksites | Insufficient Evidence |
| In School Settings | Insufficient Evidence |

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