Healthy People 2020 Spotlight on Health presents
Empowering People to Manage Their Diabetes
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
Today’s Webinar Hosts

- Diabetes Advocacy Alliance

- The U.S. Department of Health and Human Services’ Office of Disease Prevention and Health Promotion
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
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
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*
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
V. Live Question and Answer Session

*Moderated by Carter Blakey, Deputy Director and Community Strategies Division Director, ODPHP, HHS*
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
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
Health-related Quality of Life and Well-being
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/PHSIFO)
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)

<table>
<thead>
<tr>
<th>POPULATIONS</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
</tr>
</thead>
<tbody>
<tr>
<td>TOTAL</td>
<td>56.8</td>
<td>57.3</td>
<td>58.0</td>
</tr>
</tbody>
</table>
Diabetes Education by Educational Attainment

State-Level Data: All Reporting States
Diabetes education among persons with diagnosed diabetes (age adjusted, percent, 18+ years)
By Educational Attainment (25 Years And Over)

Data Source: Behavioral Risk Factor Surveillance System (BRFSS), Centers for Disease Control and Prevention, Public Health Surveillance and Informatics Program Office (CDC/PHSIP0)
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.
Diabetes Education By Geographic Area

State-Level Data: All Reporting States
Diabetes education among persons with diagnosed diabetes (age adjusted, percent, 18+ years)
By Geographic Location

Auto Scale

Data Source: Behavioral Risk Factor Surveillance System (BRFSS); Centers for Disease Control and Prevention, Public Health Surveillance and Informatics Program Office (CDC/PHS IPO)
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.
Questions?
Submit your questions using the Q & A feature on the right of your screen. Presenters will respond following all the presentations.
Diabetes Self-Management Education Overview

Deborah Greenwood, PhD, RN, BC-ADM, CDE, FAADE
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.”

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

AADE7 Self-Care Behaviors™

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.
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 (A1C >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.

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 ($A1C > 9\%$) 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.

Importance of DSME

VITALS
- Improved hemoglobin A1C by as much as 1% in T2D patients
- Absolute reduction in A1C 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

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](http://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. Presenters will respond following all the presentations.
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

**CDC Staff**
- Susan L. Norris
- Phyllis J. Nichols
- Carl J. Caspersen
- Michael M. Engelgau
- Leonard Jack Jr
- Susan R. Snyder
- Vilma G. Carande-Kulis
- Peter Briss

**External SMEs**
- Russell E. Glasgow
- George Isham
- 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
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

Analytic Framework for DSME

Self-Management Education

Knowledge

Psychosocial mediators: beliefs, attitudes, coping skills

Behavior: SMBG, diet, smoking, physical activity

Short-term outcomes: e.g., blood pressure, lipid levels, glycemic control, weight, visits

Long-term outcomes: morbidity, mortality, quality of life
# Short-Term Recommendation Outcomes

<table>
<thead>
<tr>
<th>Glycemic control</th>
<th>Behavioral Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Glycated Hemoglobin</td>
<td>• Physical Activity</td>
</tr>
<tr>
<td>• Blood Glucose</td>
<td>• Diet</td>
</tr>
<tr>
<td></td>
<td>• Smoking</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physiologic Outcomes</th>
<th>Mental Health Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Weight</td>
<td>• Depression</td>
</tr>
<tr>
<td>• Lipid levels</td>
<td>• Anxiety</td>
</tr>
<tr>
<td>• Foot lesions</td>
<td></td>
</tr>
<tr>
<td>• Blood pressure</td>
<td></td>
</tr>
<tr>
<td>• Microalbuminurea</td>
<td></td>
</tr>
<tr>
<td>• Retinopathy</td>
<td></td>
</tr>
</tbody>
</table>
## Long-Term Recommendation Outcomes

<table>
<thead>
<tr>
<th>Macrovascular complications</th>
<th>Microvascular complications</th>
<th>Quality of life</th>
</tr>
</thead>
<tbody>
<tr>
<td>Peripheral vascular disease</td>
<td>Decreased vision</td>
<td>Disability/function</td>
</tr>
<tr>
<td>Coronary heart disease</td>
<td>Peripheral neuropathy</td>
<td></td>
</tr>
<tr>
<td>Cerebrovascular disease</td>
<td>Renal disease</td>
<td>Mortality</td>
</tr>
<tr>
<td></td>
<td>Periodontal disease</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Foot lesions, amputations</td>
<td></td>
</tr>
</tbody>
</table>
In General, a Conclusion on Effectiveness Requires....

A Body of Evidence

- Multiple studies
- Fewer if high quality
- More if lower quality

A Demonstration of Effectiveness

- Consistency of Effect
  - “Most” studies demonstrated an effect in the favorable direction
- Sufficient Magnitude of Effect
  - 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.

Thank You

Randy Elder

rfe3@cdc.gov

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.
Lessons Learned: North Carolina’s Approach

Mary Bea Kolbe, MPH, RD, LDN
Diabetes Self Management Education, North Carolina’s approach
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)
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

<table>
<thead>
<tr>
<th></th>
<th>All years</th>
<th>Past year</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total number of participants seen</strong></td>
<td>11860</td>
<td>1239</td>
</tr>
<tr>
<td><strong>Race, ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• American Indian</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>• African American</td>
<td>25%</td>
<td>26%</td>
</tr>
<tr>
<td>• Hispanic</td>
<td>11%</td>
<td>10%</td>
</tr>
<tr>
<td>• White/Caucasian</td>
<td>52%</td>
<td>56%</td>
</tr>
<tr>
<td><strong>Insurance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Medicare</td>
<td>15%</td>
<td>24%</td>
</tr>
<tr>
<td>• Medicaid</td>
<td>10%</td>
<td>14%</td>
</tr>
<tr>
<td>• BCBS</td>
<td>10%</td>
<td>12%</td>
</tr>
<tr>
<td>• Other</td>
<td>3%</td>
<td>0%</td>
</tr>
<tr>
<td>• Self-pay or uninsured</td>
<td>60%</td>
<td>45%</td>
</tr>
</tbody>
</table>
# 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.*

<table>
<thead>
<tr>
<th>Category</th>
<th>Statements</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Leadership and Goals</strong></td>
<td>1. Our health director has endorsed offering DSME at our health department</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>2. Our health director is actively involved in the DSME program development and application process</td>
<td></td>
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<tr>
<td></td>
<td>3. Other key leaders at the health department are supportive of and involved in the DSME program</td>
<td></td>
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<tr>
<td></td>
<td>4. We have defined our goals and what success means to us</td>
<td></td>
</tr>
<tr>
<td><strong>B. Staff</strong></td>
<td>5. We have identified a sufficient number of interested staff members who are qualified to instruct DSME</td>
<td>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?</td>
</tr>
<tr>
<td></td>
<td>6. Potential instructors have Continuing Education in diabetes from last 12 months</td>
<td></td>
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<tr>
<td></td>
<td>7. We have the necessary administrative staff for the DSME program</td>
<td></td>
</tr>
<tr>
<td><strong>C. Finances</strong></td>
<td>8. We have projected expenses for running a DSME program, including administration, staff, rent/utilities, office supplies, program supplies, training, and travel</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>9. We have estimated potential revenue from participants and 3rd party reimbursement, considering the payer mix of target participants</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10. We have researched other sources of revenue, including health department funds, outside grants, and in-kind donations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>11. Based on our projections, we anticipate that revenue will equal or exceed expenses</td>
<td></td>
</tr>
<tr>
<td>D. Referrals and Recruitment</td>
<td></td>
<td></td>
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<tr>
<td>-----------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 12. Our health department currently receives referrals from local providers for diabetes care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ 13. We have contacted local health care providers to discuss the possibility of referring patients for DSME</td>
<td></td>
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</tr>
<tr>
<td>□ 14. We have a marketing/recruitment plan to attract participants in the DSME program</td>
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</tbody>
</table>

**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.**

<table>
<thead>
<tr>
<th>E. Understanding the community and its needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 15. We have identified our target audience to whom we will offer DSME, including approximate size and demographics</td>
</tr>
<tr>
<td>□ 16. We have considered and described specific needs or considerations for serving our target audience</td>
</tr>
<tr>
<td>□ 17. We have knowledge of all existing local DSME programs, and can demonstrate a need for additional DSME in this community</td>
</tr>
</tbody>
</table>

**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?**

<table>
<thead>
<tr>
<th>F. Engagement with target audience</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ 18. Our health department has active channels of communication with our target audience, including solicitation of how to serve their needs</td>
</tr>
<tr>
<td>□ 19. Our health department has active and positive relationships with our target audience</td>
</tr>
<tr>
<td>□ 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</td>
</tr>
</tbody>
</table>

**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

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>21.</td>
<td>Our health department has strong relationships with one or more health-focused organizations in our community.</td>
</tr>
<tr>
<td>22.</td>
<td>Our health department has strong relationships with one or more healthcare providers in our community.</td>
</tr>
<tr>
<td>23.</td>
<td>Our health department has strong relationships with other relevant partners such as local government, media outlets, or cooperative extension.</td>
</tr>
<tr>
<td>24.</td>
<td>Our health department has strong relationships with community support services to which we may need to refer DSME participants.</td>
</tr>
</tbody>
</table>

**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

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>25.</td>
<td>Our identified program staff and administration have program implementation experience and/or expertise.</td>
</tr>
<tr>
<td>26.</td>
<td>We have planned or identified a specific course of appointments and DSME curriculum for program participants.</td>
</tr>
<tr>
<td>27.</td>
<td>Our staff has plans for and knowledge of using electronic health records to record patient data.</td>
</tr>
<tr>
<td>28.</td>
<td>We have a plan to collect aggregate data, including identifying who and how, for analysis of both behavioral and clinical outcomes.</td>
</tr>
<tr>
<td>29.</td>
<td>We have considered how to review the program and perform continuous quality improvement.</td>
</tr>
</tbody>
</table>

**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
External Partnerships

• Referrals
• Resources
M-T-W & Toe River District Health Departments
Engagement with Target Audience

• Active communication

• Acknowledgement of Barriers
Focus Group Results

• What influences a participant’s readiness for the program
  – Reaction to diagnosis
  – Co-morbid events
  – Uncertainty

• Barriers to participation
  – System
  – Program
Finances

• Funding
• Billing
Wilkes County Health Department
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
Thank You!

Mary Bea Kolbe, RD LDN
Diabetes Education Recognition Program Coordinator
North Carolina Division of Public Health
Questions?
Submit your questions using the Q & A feature on the right of your screen. Presenters will respond following all the presentations.