Setting Up Successful Diabetes Education Programs and Medicare Reimbursement 2023

DiabetesEd.net

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Coach Bev has no conflict of interest

- Not on any speaker's bureau
- Does not invest in pharmaceutical or device companies
- Gathers information from reading package inserts, research and standards

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- We acknowledge and are mindful that Diabetes Education Services stands on lands that were originally occupied by the first people of this area, the Mechoopda, and we recognize their distinctive spiritual relationship with this land, the flora, the fauna, and the waters that run through this area.

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Bryanna is here to Help!

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Main Articles

- 2022 National Standards for Diabetes Self-Management Education and Support – ADA & ADCES
- ADCES 7
- Diabetes Self-management Education and Support in Type 2 Diabetes 2020 – joint position statement –AADE, ADA, Academy of Nutrition and Dietetics
- Medicare Reimbursement Resources
- Posted in your resource tab

2022 National Standards for Diabetes Self-Management Education and Support

Diabetes Care 2022;45:484–494 | https://doi.org/10.2337/dc21-2396

Diabetes Self-management Education and Support in Adults With Type 2 Diabetes: A Consensus Report of the American Diabetes Association, the Association of Diabetes Care & Education Specialists, the Academy of Nutrition and Dietetics, the American Academy of Family Physicians, the American Academy of PAs, the American Association of Nurse Practitioners, and the American Pharmacists Association

Diabetes Care 2020;43:1636–1649 | https://doi.org/10.2337/dci20-0023

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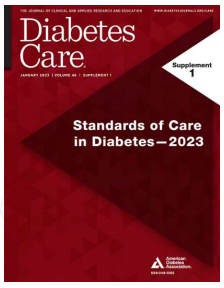


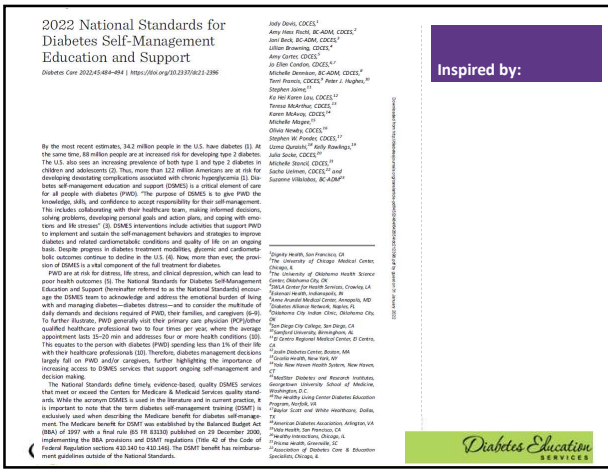
5. Facilitating Positive Health Behaviors and Well-being to Improve Health Outcomes: *Standards of Care in Diabetes—2023*

Plus other articles as sited on slides

Successful Diabetes Programs & Reimbursement

Objectives

- Describe the most recent National Standards for Diabetes Self-Management Education and Support (DSMES) Programs
- List the six standards for creating a successful DSME program
- Describe Medicare Reimbursement for diabetes care.



2022 National Standards for Diabetes Self-Management Education and Support

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By the most recent estimates, 34.2 million people in the U.S. have diabetes (1). At the same time, 88 million people are at increased risk for developing type 2 diabetes. The U.S. also sees an increasing prevalence of both type 1 and type 2 diabetes in children and adolescents (2). Thus, more than 122 million Americans are at risk for developing devastating complications associated with chronic hyperglycemia (1). Diabetes self-management education and support (DSMES) is a critical element of care for all people with diabetes (PWD). "The purpose of DSMES is to give PWD the knowledge, skills, and confidence to accept responsibility for their self-management. This includes collaborating with their healthcare team, making informed decisions, solving problems, developing personal goals and action plans, and coping with emotions and life stresses" (3). DSMES interventions include activities that support PWD to implement and sustain the self-management behaviors and strategies to improve diabetes and related cardiometabolic conditions and quality of life on an ongoing basis. Despite progress in diabetes treatment modalities, glycemic and cardiometabolic outcomes continue to decline in the U.S. (4). Now, more than ever, the provision of DSMES is a vital component of the full treatment for diabetes.

PWD are at risk for distress, life stress, and clinical depression, which can lead to poor health outcomes (5). The National Standards for Diabetes Self-Management Education and Support (hereinafter referred to as the National Standards) encourage the DSMES team to acknowledge and address the emotional burden of living with and managing diabetes—diabetes distress—and to consider the multitude of daily demands and decisions required of PWD, their families, and caregivers (6–8). To further illustrate, PWD generally visit their primary care physician (PCP)/other qualified healthcare professional two to four times per year, where the average appointment lasts 15–20 min and addresses four or more health conditions (10). This equates to the person with diabetes (PWD) spending less than 1% of their life with their healthcare professionals (10). Therefore, diabetes management decisions largely fall on PWD and/or caregivers, further highlighting the importance of increasing access to DSMES services that support ongoing self-management and decision making.

The National Standards define timely, evidence-based, quality DSMES services that meet or exceed the Centers for Medicare & Medicaid Services quality standards. While the acronym DSMES is used in the literature and in current practice, it is important to note that the term diabetes self-management training (DSMT) is exclusively used when describing the Medicare benefit for diabetes self-management. The Medicare benefit for DSMT was established by the Balanced Budget Act (BBA) of 1997 with a final rule (65 FR 83130) published on 29 December 2000, implementing the BBA provisions and DSMT regulations (Title 42 of the Code of Federal Regulation sections 410.140 to 410.146). The DSMT benefit has reimbursement guidelines outside of the National Standards.

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Inspired by:

Diabetes Education SERVICES

Diabetes Care and Education Specialist (CDCES) Definition

"A compassionate teacher and expert who, as an integral member of the care team, provides collaborative, comprehensive, and person-centered care and education for people with diabetes"

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A Call to Action for Diabetes Specialists

- PARTICIPATE IN POPULATION HEALTH
- EMBRACE AND LEVERAGE TECHNOLOGY
- IMPLEMENT STANDARDIZED STRATEGIES
- LEAD WORKFORCE TRAINING
- REDUCE FRAGMENTATION
- DEVELOP ROBUST INTERVENTIONS FOR PREVENTING COMPLICATIONS
- MEASURE OUTCOMES
- ADVOCATE FOR NEEDED RESOURCES THAT AFFECT SDOH

Purpose of Diabetes Self-Management Education and Support (DSMES)

- To provide the knowledge, skills, and confidence for people with diabetes to accept responsibility for their self-management.
- Includes:
  - collaborating with their healthcare team,
  - making informed decisions,
  - solving problems,
  - developing personal goals and action plans,
  - and coping with emotions and life stresses"

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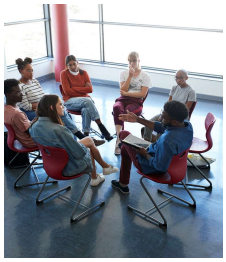
DSME Interventions includes:

- *Activities* that support ability to implement and sustain the self-management behaviors and
- *Strategies* to improve diabetes and related cardiometabolic conditions and quality of life
- …. on an ongoing basis.
- Side note
  - Center for Medicare and Medicaid Services (CMS) refers to DSME as DSMT Diabetes Self Management Training



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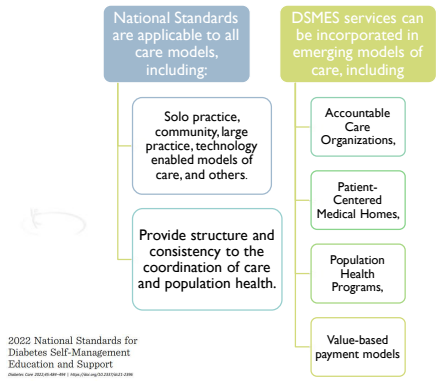
What care models can use National Standards for DSME



2022 National Standards for Diabetes Self-Management Education and Support

Care models

- Chronic Care Model – PRO-active management of diabetes.
- Minimally Disruptive Medicine (MDM)
  - person-centered approach to healthcare that prioritizes the PWD's self-determined and self-chosen goals for life and health while minimizing the healthcare disruption on their lives.
  - The goal of MDM is to maximize outcomes for the PWD without additional burden.

2022 National Standards for Diabetes Self-Management Education and Support

Poll Question 1

- What percent of the people with type diabetes enroll in a structured diabetes education program?
  - A. Less than 10%
  - B. About a quarter
  - C. More than 50%
  - D. Majority of people with type 2

Only a small percentage utilize DSMES

- 6.8% of individuals with new Type 2 and private health insurance enrolled in DSMES within a year of diagnosis.
- Less than 5% of Medicare enrollees received DSME/S or MNT
- Work is needed to decrease barriers that are limiting provision of this vital service.

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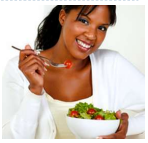
DSMES Makes a Difference

- Improves A1c by 0.6% in people with diabetes
  - Greater A1c reductions with DSMES of 10 hours +
- Positive effect on clinical, psychosocial and behavioral aspects
- Improves quality of life
  - Enhanced self-efficacy and increases healthy coping
  - Decreases diabetes distress and depression
- Increases behavior change
  - Eating healthfully
  - Regular exercise



DSMES vs Medications

Table 3—Comparing the benefits of DSMES/MNT vs. metformin therapy (17)

	Benefits rating	
Criteria	DSMES/MNT	Metformin
Efficacy	High	High
Hypoglycemia risk	Low	Low
Weight	Neutral/loss	Neutral/loss
Side effects	None	Gastrointestinal
Cost	Low/savings	Low
Psychosocial benefits*	High	N/A

N/A, not applicable. *Psychosocial benefits include *improvements to* quality of life, self-efficacy, empowerment, healthy coping, knowledge, self-care behaviors, meal planning, healthier food choices, more activity, use of glucose monitoring, lower blood pressure and lipids and *reductions in* problems in managing diabetes, diabetes distress, and the risk of long-term complications (and prevention of acute complications).

Diabetes Self-management Education and Support in Type 2 Diabetes 2020 – joint position statement –AADE, ADA, Academy of Nutrition and Dietetics

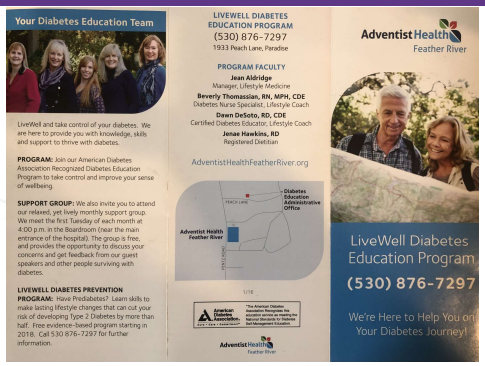
Diabetes Self Management Programs

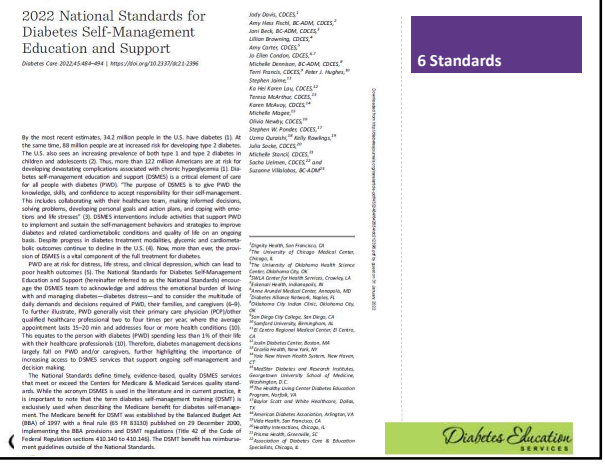
Where do I start?

- Get buy in from organization and stakeholders
- Find out community needs and barriers
- Social determinants of health
- Put a team together
- Where and how will we deliver program?
- Person centered
- Measure success
- Ongoing support
- Quality Improvement

Live Well Diabetes Program Example

Live Well Team, Support Group, & Prevention Program

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6 Standards

Diabetes Education SERVICES

National Standards – 6 Steps

1. Support for DSMES Services
2. Population and Service Assessment
3. DSMES Team
4. Delivery and Design of DSMES Services
5. Person-Centered DSMES
6. Measuring and Demonstrating Outcomes of DSMES Services

Standard 1 – Support for DSME

The DSMES team will seek leadership support for implementation and sustainability of DSMES services.

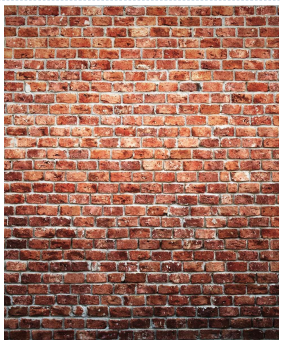
The sponsor organization will:

- *recognize and support quality DSMES services as an integral component of diabetes care.*
- *provide guidance and support for DSMES services to facilitate alignment with organizational resources and the needs of the community being served.*

Support is

To overcome low utilization of DSME due to barriers that impede access:

- Payer
- Healthcare system
- Transportation
- Cultural sensitivity
- Environment etc.



Poll Question 2

- LS wants to set up an ADA Recognized Diabetes Self-Management Education and Support (DSMES) program for her community. Based on the guidelines for setting up a Recognized DSMES program, which of the following is accurate?
  - A. At least one of the instructors needs to be a CDCES or BC-ADM
  - B. Under Medicare guidelines, participants can only attend DSMES group classes once every 5 years.
  - C. Participants must have an A1C greater than 7% to participate
  - D. A community member is considered a stakeholder and important team member.

Build Inclusive DSME Teams

- Diabetes Specialist
- People with diabetes
- Stakeholders
- Providers
- Social Services
- Health workers
- Community based groups
- And groups that support DSMES
  - Fitness clubs
  - Social media network
  - Community gardens

Benefit of External Input

- Seek input from stakeholders to better serve the "community"
- Foster ideas that will enhance the quality of the program and build sustainability.
- Social determinants related to the population served
  - Guide stakeholder selection.
  - Facilitate connection between DSMES services, the participant population, the health care providers, and the community

Standard 2 – Population and Service Assessment

- *The DSMES service will evaluate their chosen target population to determine, develop, and enhance the resources, design, and delivery methods that align with the target populations' needs and preferences.*

Community Needs Assessment

- Understand:
  - Social determinants of health
  - Demographics (from local, state orgs)
    - Race, ethnicity, cultural background, sex, age, geographic location, tech access, literacy.
  - Perceptions of risk associated with diabetes
  - ID Barriers
    - Socioeconomics, cultural factors, misaligned schedules, health insurance shortfalls, perceived lack of need, limited encouragement form health care professionals to engage in DSMES.
    - Special attention to those who do not usually attend clinic appointments

After Assessment is Done

- Anticipated volume
- Timing of Classes
- How often
  - Per month/ year
- Structure
- Location
- Strategies to overcome barriers
- Staffing needs
  - Instructors
  - Secretarial support
  - IT Support
  - Who will bill?

Standard 3 – DSMES Team

All members of a DSMES team will uphold the National Standards and implement collaborative DSMES services, including evidence-based service design, delivery, evaluation, and continuous quality improvement.
At least one team member will be identified as the ***DSMES quality coordinator*** *and will oversee effective implementation, evaluation, tracking, and reporting of DSMES service outcomes.*

DSMES Team Members

- Evidence suggests team may include an RN, RD or Pharmacist or other professionals with training and experience pertinent to DSME, or holding certification as a diabetes educator, CDCES or BC-ADM.

Quality Coordinator

- Ensures person-centered approach
- Analyzes and shares data
- Familiar with marketing, healthcare admin, business management helpful
- May be part of instructional team

Diabetes Community Care Coordinators

- Includes community health workers, health promotores, dietetic technicians, medical assistants, peer educators and leaders.
- Can instruct, reinforce self-management skills, support behavior change, facilitate group discussion and provide social support.

Disciplines that can be involved as Instructors include (but are not limited to)

- Physicians, psychologists & other mental health specialists,
- Physical activity specialists , optometrists, & podiatrists.
- Health educators (Certified Health Education Specialists [CHES])
- All team members need ongoing training in diabetes management, teaching self-management skills, group facilitation, and support

Standard 4 – Delivery and Design of DSMES Services

DSMES services will utilize a curriculum to guide evidence-based content and delivery

- to ensure consistency of teaching concepts, methods, and strategies within the team and
- to serve as a resource for the team.

- DSMES teams will have knowledge of and be responsive to:
  - emerging evidence, advances in education strategies, pharmacotherapeutics, technology-enabled treatment, local and online peer support, psychosocial resources, and delivery strategies
  - relevant to the population they serve.

Developing the Curriculum

- Required Content Areas – (ADCES 7)
  - Diabetes Pathophysiology, treatment options
  - Healthy eating
  - Healthy coping
  - Being active
  - Taking medication
  - Monitoring
  - Reducing risk (treating acute and chronic complications)
  - Problem solving and behavior change strategies

ADCES 7 – Critical Topics to Address

NEW! AADE7 TIP SHEETS

ADCES Diabetes Care and Education Curriculum, 3rd edition

A curriculum for diabetes care and educations specialists and healthcare providers to use when working with people with diabetes and prediabetes. The curriculum is based upon the ADCES7 Self-Care behaviors. Whether teaching one-on-one or in groups, AADE's Diabetes Education Curriculum includes the evidence-based clinical information and teaching and patient resources you need to individualize your diabetes education and support program.

https://www.diabeteseducator.org/store/publications/detail/adces-diabetes-education-and-care-curriculum

Curriculum – Keep it Dynamic and Practical

Keep it **dynamic** & flexible & reflect **current evidence & practice guidelines**

- Research endorses inclusion of:
  - **practical**, problem-solving approaches
  - collaborative care, psychosocial issues, behavior change
  - strategies to **sustain self-management efforts**
  - Supplemented with resources and supporting materials
  - Includes effective teaching strategies
  - Helps navigate health care system, promotes self-advocacy and is relative to individuals

Focus on Person Centered Needs

Go beyond the mere acquisition of knowledge

- Use creative, person centered, experience-based delivery methods
- Effective approaches to support informed decision-making & meaningful behavior change
- Include practical problem solving and self-advocacy approaches,
- Collaborative care, including family and peer support, addressing psychosocial issues, behavior change, diabetes devices, and
- Strategies to sustain self management efforts.

Follow-up and ongoing support

- Initial improvements diminish 6 months after conclusion of the intervention
- Include family members and caregivers during initial interventions, to provide ongoing support
- Connect individuals to technology enabled solutions
  - such as mobile apps, digital therapeutics, online programs, and peer groups, within the local or online community

Ongoing Support Ideas

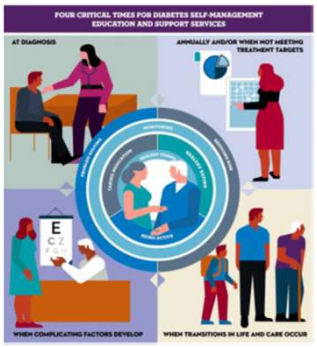
- Case management
- Diabetes support group or community program (ie Weight Watchers, or YMCA)
- Physical activity programs
- Smoking cessation
- Visiting health workers
- Apps and phone calling
- Agree to return for medical/education visits
- Subscribe to a diabetes magazine
- Diabetes chat rooms
- Ongoing education and MNT appts
- Peer support through networking and online Communities

Standard 5 – Person-Centered DSMES

- *Person-centered DSMES is a recurring process over the life span for PWD.*
- *Each person's DSMES plan is unique and based on the person's concerns, needs, and priorities collaboratively determined as part of a DSMES assessment.*
- *The DSMES team monitors, communicates outcomes of the DSMES services to diabetes care team and/or referring physician/other qualified healthcare professional.*

4 Critical Times to Provide Diabetes Support

- To address current concerns, needs, and priorities of the PWD, there are 4 critical times for DSMES referral or follow-up:
- At diagnosis.
- Annually and/or when not meeting treatment targets.
- When complicating factors develop.
- When transitions in life or care occur.



DSME Delivery Philosophy

- Ensure DSMES is addressing current concerns, needs and priorities of individual.
- DSMES plan is implemented through a series of sessions, utilizing a variety of methods.
- Team tracks related outcomes to identify trends and reinforce effective self-management behaviors.
- Communication with providers and other team members to overcome clinical inertia.

Assessment Process

- Identify needs and agree on ind's preferred educational, coping, and behavioral interventions to develop needed problem-solving, decision-making, and self-management skills and strategies:
- Include assessment of:
  - Health status, housing, physical limitations
  - Learning level, diabetes knowledge
  - Lifestyle practices, self-management skills, behaviors
  - Psychosocial adjustment: Emotional response to diabetes and level of distress.

Needs and priorities change over a lifetime

Person Centered Assessment

- After initial assessment, the ind and DSMES team member(s) develop a person-centered DSMES plan.
- DSMES team uses nonjudgmental, non-stigmatizing, and gender-inclusive, jargon free language
- Includes goal setting, action planning, empowerment-based principles and strategies, motivational interviewing, shared decision making, cognitive behavioral therapy, problem solving, self-efficacy enhancement, teach-back method, and relapse prevention strategies.

- How is diabetes affecting your daily life and that of your family?
- What questions do you have?
- What is the hardest part right now about your diabetes, causing you the most concern or most worrisome to YOU about your diabetes?
- How can we best help you?

Person Centered Coaching

Diabetes Education SERVICES 25

How to Succeed with Person-Centered Coaching

By Beverly Thomassian, RN, MPH, CDCES BC-ADM

A diagnosis of diabetes often carries a significant emotional response. A person with diabetes might report shame, fear, and guilt as they come to terms with their diagnosis and anticipate their future. As diabetes healthcare providers, we can learn to address these feelings while helping people move forward!

This cheat sheet provides a dozen simple coaching strategies for providers to help people believe in their ability to self-manage their diabetes successfully.

Using a person-centered approach, we can identify the individual's strengths and expertise and then leverage this information to open a door of possibilities. Our choice of communication techniques can spark behavior change in people living with diabetes.

Adopting this style of communication can be a dramatic shift for some providers. Think of it this way: In usual care, the diabetes healthcare provider steers the boat, brings the fuel, and charts the course. Using the person-centered approach, the provider is simply the rudder, serving as a guide, and the individual steers.

DO: Mindfully Listen to the individuals' problems and fears.
The first strategy is carefully listening to the person's fears and concerns. If someone struggles with nutrition, meds, or behavioral changes, listen to the struggle, and try not to push, advise, or fix it. Listen and reflect on what you think is happening for the first few minutes.
For example, reflecting back could go something like this: "Taking medications is hard for you because you are not sure if they are really working." Or, "It's hard to eat more vegetables because you are a long-haul truck driver." Or, "It sounds like you blame yourself for having diabetes."

How to Succeed with Person-Centered Coaching

This cheat sheet provides a dozen simple coaching strategies for providers to help people believe in their ability to self-manage their diabetes successfully.

https://diabetesed.net/coach-bevs-diabetes-cheat-sheets/

Evidence Based Communications Strategies

- Collaborative goal setting
- Action planning
- Motivational interviewing
- Shared decision making
- Cognitive behavioral therapy
- Problem solving
- Relapse prevention strategies

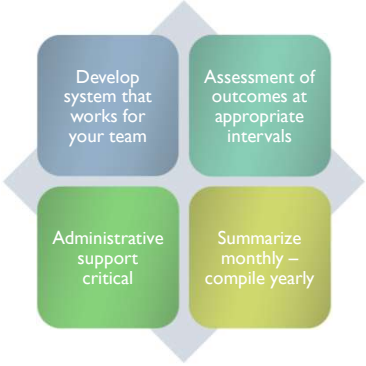
Supporting and Tracking Person-Centered Self-Management Outcomes

Clinical outcomes reflect impact of DSME	Tracking outcomes imperative.	Collaborate with individual to develop:
	• Clinical outcomes • Participant reported outcomes • Psychosocial outcomes • Behavioral outcomes	• action oriented behavior plans to reach their personal behavioral goals, • coping strategies, • and treatment (or clinical) targets

SMART Behavioral Goal

- Identify program goals and set individual behavioral goals
  - SMART
    - specific
    - measurable
    - attainable
    - realistic
    - timely

Tracking Participant Data



Standard 6: Measuring and Demonstrating Outcomes of DSMES Services

DSMES services will have ongoing continuous quality improvement (CQI) strategies in place that measure the impact of the DSMES services.

Systematic evaluation of process and outcome data will be conducted to identify areas for improvement and to guide services optimization and/or redesign.

Tracking Process and Outcome Data

Quality improvement initiatives may target DSMES services at an individual practice, multicenter system, or larger DSMES effort level.

- Individual outcomes are aggregated to report practice level population outcomes.
- Behavior change a key outcome, and the ADCES7 Self-Care Behaviors provide a useful framework for assessment, documentation, and evaluation

Quality Improvement Strategy

- The Institute for Healthcare Improvement Model consists of three fundamental questions:
- 1) "What are we trying to accomplish?"
- 2) "How will we know a change is an improvement?" and
- 3) "What changes can we make that will result in an improvement?"

We traveled the U.S to check in with colleagues and their Diabetes Programs

Next Stop - Northern Vermont

Diabetes Prevention Program (DPP) via Zoom

- Esther Seibold provides care to a rural, economically challenged population in Northern Vermont.
- Due to COVID, moved over to Zoom to provide DPP
- 3 cohorts since Jan 2020
  - 15-20 in group
- Sends learning modules by email
- Food logs by email
- Biggest barriers:
  - Tech issues time consuming
  - Difficult to collect weight and activity data

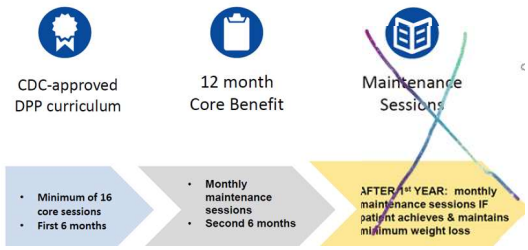
Esther Seibold, RN, DNSc, Care Coordinator (rt) and Alicia Armstrong RD, CDCES, DM and Nutrition Program Coordinator at St. Johnsbury Community Health Center

Diabetes Prevention Program

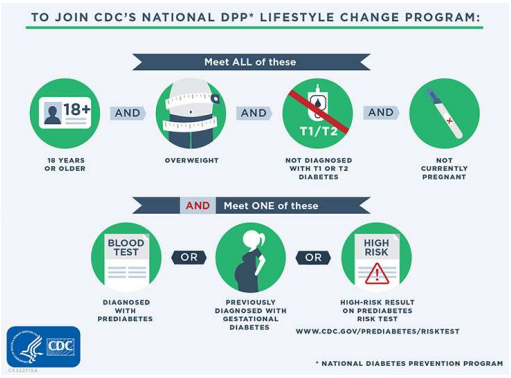
Eat Smart | Move More
Prevent Diabetes

CDC National Diabetes Prevention Program

- For population with pre-diabetes
- Medicare and some MediCaid programs are now funding (MDDP)
- Most often community based for free or low cost cash pay
- Medicare Reimbursement based on attendance and goal achievement



Requirements to Join



Diabetes Prevention Program Recognition

Standards for CDC recognition include:

- Use of a CDC-approved curriculum.
- Offer lifestyle program within 6 mo's of receiving pending approval from CDC.
- Capacity and commitment to deliver program over 1 year, including at least 16 sessions during the first 6 mo's and at least 6 sessions during the last 6 mo's.
- Ability to regularly submit data on participants' progress—including attendance, weight loss, and physical activity
- Trained lifestyle coaches by approved CDC 2 day training program who can help build participants' skills and confidence to make lasting lifestyle changes.
  - Possess the skills, knowledge, and qualities to provide content. Lifestyle coaches may have credentials (e.g., RD, RN), but credentials not required.
- Designated individual(s) to serve as diabetes prevention program coordinator.

(DPP) via Zoom in Northern Vermont

- How did you achieve success?
  - Identified people with prediabetes and sent invitation letter to join
  - Posted classes on state website
  - Classes available in evening and daytime so more accessible
- Why do you think so successful?
  - No drive time required
  - Group interaction
  - Positive feedback
  - Repetition of key points

Dr. Seibold says, "we will continue virtual delivery of DPP, even after COVID".

Insurance and Reimbursement

To bill insurance and Medicare for your program, it will first need to be recognized by either:
ADCES - DEAP
ADA - ERP
CDC for DPP Diabetes Prevention Program

National Standards Program Recognition - Options

- American Diabetes Association (ERP)
- Association of Diabetes Care and Education Specialists (Diabetes Education Accreditation Program)
- CDC for Diabetes Prevent Program

ADCES DEAP DIABETES EDUCATION ACCREDITATION PROGRAM

Different Work Settings - Locations

- Hospital based – see only inpatient
- Hospital based – see inpatient and outpatient
- HMO/ Clinic based – see only outpatients
- Private practice
- Other
  - Medicare
  - Private Payor
  - Rural health care
  - Medicaid
  - Indian Health Services, VA
  - Cash pay

Billing Practices

- Insurance companies provide a variety of payment schedules and degrees of coverage
  - Inform participant of out-of-pocket expenses for program
    - Deductible (worse at beginning of year)
    - Co-pay
- Financial agreement with clients
- Can't charge less for program than Medicare rates
- If bill Medicare for services, other participants not allowed to attend for free

Medicaid Insurance Coverage

- Medicaid – partially federally funded, but administered by states
  - Establishes its own eligibility standards
  - Determines the type, amount, duration and scope of service
  - Sets the rate of payment for services
  - Administers its own program
  - Moving many participants to HMOs
  - Does not reimburse for DSME/S

Poll Question 3

Which of the following is accurate regarding Medicare Coverage?

A. Medicare Part A covers Diabetes Prevention Programs
B. Medicare Part B covers durable medical equipment and diabetes medications
C. Medicare Part D covers DSMES
D. Medicare Part A covers hospitalization

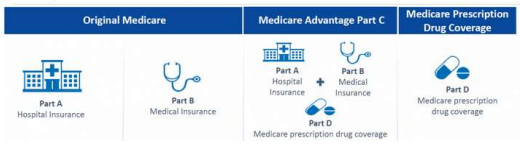
Medicare Parts

A = Hospital Insurance Program

B = Supplemental Medical Insurance
- Elective program (95% participate)
- Covers 80% - Outpt services, durable medical equipment, pumps, CGM and DSMT, MNT

C = Medicare Advantage

D = Prescription Drug Coverage



Poll Question 4

- Which of the following are covered by Medicare Part B?
- A. DSME group classes once a year
- B. CDC Recognized Diabetes Prevention Program
- C. Medications
- D. Hospitalization

Medicare Part B

- Glucose Monitors and testing supplies (100 strips for 3 months if on oral meds).
  - More strips for people on insulin
- Annual Wellness Visit
- Influenza vaccine and Pneumococcal vaccination
- Outpatient DSME and DPP training, MNT therapy
- Foot exam every 6 months
- Annual glaucoma exam
- Some insulin pumps and CGMs
- Therapeutic shoes or inserts with a prescription

Devices & Technology

New Medicare Coverage Requirements Make CGMs More Accessible

The diabetes community is celebrating a huge win! Beginning on July 10, 2021, Medicare will permanently eliminate the requirement of the four-time-daily fingerstick in order to qualify for coverage of a continuous glucose monitor (CGM).

This requirement was an unnecessary barrier for Medicare beneficiaries, delaying access to this effective technology for individuals with diabetes.

Medicare Advantage Part C:

- Medicare Advantage are offered by private insurance companies
- Combine Medicare A+B, plus offers additional benefits
- More expensive than original Medicare, but add more benefits
- To find out what is offered in your region medicare.gov/find-a-plan

Medicare Part D –Prescription Drug Program

- Under Part D, beneficiaries choose a Prescription Drug Plan run by a private insurance company approved by Medicare.
- Most Medicare Advantage plans offer prescription drug coverage
- Each Medicare Prescription Drug Plan has its own list of covered drugs (formulary).
- Drugs in each tier have a different cost.
- Insulin and injection supplies are usually covered

Medicare Criteria for Referral to DSMT

- Fasting BG 126 or greater x 2 *or*
- Random BG 200 or greater w/ symptoms *or*
- 2 hr post glucose challenge 200 or > x 2

Medicare - Final Regulation for DSMT

Have one year to complete:

- 9 hours group = 18 (½) hrs
- 1 hour individual = 2 (½) hrs

After 12 months, can offer participant:

- 2 hours follow-up DSMT annually
- Need Provider order
- Use group codes even though individual app

- Must be ADA or ADCES Recognized DSMT
- Participant must meet criteria

Final Regulation for DSMT / MNT

- 3 hours initial benefit in first calendar year
- 2 hours follow-up annually
- Must be ADA or Recognized DSMT
- If DSMT and MNT services are provided on same date, only one service can be billed.

Marketing

Build it and they will come?

A. True
B. False

Increase Provider Referrals

- Direct mail
- Cold calls
- Networking
- Advertising
- Lunches
- CE activities
- Hallway conference
- Welcome packet for new MDs
- Participant Testimonials
- Other

Increase Self Referrals

- Publish articles
- Press releases
- Events - health fairs
- Community presentations
- Direct mail
- Special events
- Word of mouth
- Internet
- Advertising
- Other?

Other High Profile Events

- Reception/ press release each time your program gets Recognition

- Diabetes Special Events
  - November – National Diabetes Month
  - November 14, World Diabetes Day
- Hold a Walk for Diabetes

Thank You

Questions:
info@diabetesed.net
www.DiabetesEd.net
Bryanna at 530-893-8635

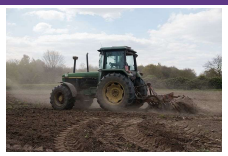
Diabetes Education SERVICES

Bonus Content on Diabetes Self Management Programs

We traveled the U.S to check in with colleagues and their Diabetes Programs

Case Study from Indian Health Services Clinic – Northern California

- RJ works in the fields driving a tractor 6 days a week from 5am to 6pm. RJ can't leave work for a diabetes education appointment. A1c is 8.9%, checks BG a few times a week.
- Speaks Spanish only



Majority of the people we serve:

- Medicaid / Medicare
- Lower income
- Seasonal work
- Mental health considerations
- About half speak Spanish

We Expanded our Curiosity and Connection

- Assessment
  - How are you managing?
  - Food availability.
  - Medication affordability.
  - Acknowledging the emotional impact of the pandemic.
- Resources
  - Food banks
  - Providing trauma informed care
  - Mental health counseling
  - Growing our team
    - Psychiatrist
    - Mental health counselor

Closer Attention to Missed Appts

- If no show, we call during their scheduled time slot
- If answer, provide instant phone appt.
- No answer, leave message to schedule next appt
- Wonder – Why did person miss appointment?
  - Structural barrier?
  - Emotional barrier?
  - Other?

In vulnerable populations, reaching out to those who don't show for appointments Is Important

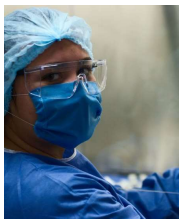
Next Stop - Texas

Safety Net Teaching Hospital in Texas

- Lindsey, RN, MSN, CDCES
- 200 bed hospital
- Low income and high-risk population
- 30% Spanish Speaking
  - Language line, iPad
  - Personalized handouts
- Lower extremity issues

Diabetes Nurse in Texas Hospital Faces plenty of Barriers During Pandemic

- With COVID, Lindsey keeps providing care and education in hospital.
- Call inpt by phone or put on protective gear and enter hospital room
- Encouraged use of TV based education videos
- Providing education during pandemic, much more time consuming



Texas – Train the Trainer to Empower Staff

- Providing training program to floor nurses to empower diabetes bedside teaching
- Partnering with case management to assist with transition to follow-up care and safety net clinics
- Trying to phone follow-up with those discharged who are high risk.
- Limited time and resources biggest barrier.

Next Stop - New Orleans, Louisiana

New Orleans FQHC Clinic

- Carole Pindaro, FNP-BC, MPH, MSN, CDCES, serving community for 13 years
- **Population served**
  - Low income, many who are without housing
  - High rates of elevated BMIs and substance use
  - 40-50% of population are black and a small Vietnamese community
  - High risk of food insecurity

Carole Pindaro, FNP-BC, MPH, MSN, CDCES

Clinic in New Orleans

- No shows a big issue
  - Often associated with drug use
- How overcome
  - Telehealth and video health
  - Call no shows and let them know that we missed seeing you
  - Take a harm reduction approach
  - Offer incentives and freebies when show up

Carole Recognized for Achieving Success

- Her clinic measures provider outcomes.
- Recognized for her excellence achieving A1c target (<9%) over 80% of the time
- **Carole Quotes**
  - "Keep trying, every person is unique"
  - "We won't judge or yell at you"

- Focus on:
  - Compassionate care
  - Nutrition
  - CV Risk reduction
  - Check-in every 3 months

Harm Reduction Principles

- Humanism
  - Providers value, care for, respect and dignify patients as individuals
  - Recognize that people do things for a reason
  - Judging individuals' actions, does not provide positive health outcomes
  - Providers accept individuals' choices

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5655864/

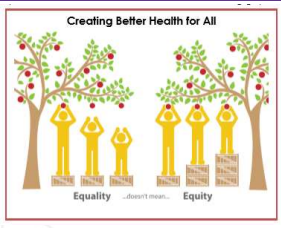
- Pragmatism
  - None of us will ever achieve perfect health behaviors
  - Health behaviors and ability to change are influenced by social and community norms
- Individualism
  - Every person presents with their own needs and strengths
  - Providers tailor messages and maximize treatment options

Harm Reduct J. 2017; 14: 70.
Published online 2017 Oct 24. doi: 10.1186/s12954-017-0195-4
PMCID: PMC5655864
PMID: 29065890

Harm reduction principles for healthcare settings

Marc Hawk,[1] Robert W. S. Coulter,[2] James E. Egan,[3] Stuart Fox,[4] R. Raquel Friedman,[5] Monique Tula,[6] and Suzanne Kerns[7]

Striving for Equity in Health Care



"Equitable care does not mean treating every patient exactly the same".

"Equitable care ensures optimal outcomes for all patients regardless of their background or circumstances."

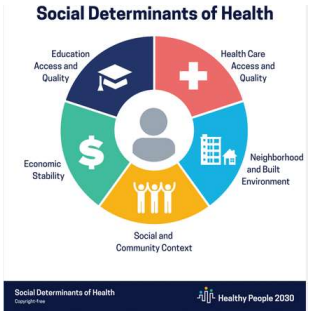
Equality SOUNDS fair.
Equity IS fair.

Source: The Roadmap to Reduce Disparities, Robert Wood Johnson Foundation (2014)

http://www.communityview.ca/index.html

Social Determinants of Health and Equity

- Recognize the need to provide person-centered services that embrace
  - cultural differences
  - social determinants of health (SDOH)
  - ever-increasing technological engagement platforms and systems.
- Goal is to increase health equity through access to this critical service while focusing *more* on person-centered care and decreasing administrative complexities.

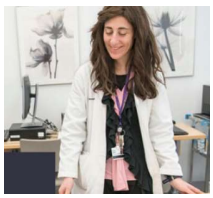


Last Stop - Cleveland, Ohio

Cleveland Clinic Endocrinology and Metabolism Institute

Conversation with Dr. Diana Isaacs

- Provide diabetes care to all regardless of insurance
- Provide care to specialized populations especially transplant, pregnancy and other high-risk individuals.
- Usually sees about 10 clients a day
- During COVID Pandemic
  - Saw ½ in person
  - Other half by virtual visit or phone
  - CGM/Pump Downloads remotely



Diana Isaacs, PharmD, BCPS, BCACP, BC-ADM, CDCES, FADCES, FCCP
Endocrine Clinical Pharmacy Specialist
CGM and Remote Monitoring Program Coordinator
Co-Director Center of Excellence for Endocrine Disorders in Pregnancy
ADCES Educator of the Year in 2020

Cleveland Clinic Diabetes Program

- **How measure success?**
  - Measure outcomes based on individual improvement, not specifically by how many people reach A1c target.
  - Students use computer data to analyze care outcomes
  - Computerized charting templates so students can help document care provided.
- **Team Approach**
  - Entire diabetes team works under one roof
  - Adding new members to the team including cardiology, ophthalmology, podiatry.
  - Team huddle or quick meeting every day.
  - Planning more case management in future.

Hopes for the Future?

- Ongoing virtual appointments
- Integrated team approach
- Significant increase in REAL accessibility among ALL groups

What I Have Learned from my Colleagues

- Offering virtual options for DPP programs and DSMES has improved access for many.
- Engaging students to provide diabetes care can expand our reach.
- Train the trainer programs empower staff to extend our services.
- Taking a harm reduction approach, keeps us person centered.
- Connection with our most vulnerable community members makes a difference.