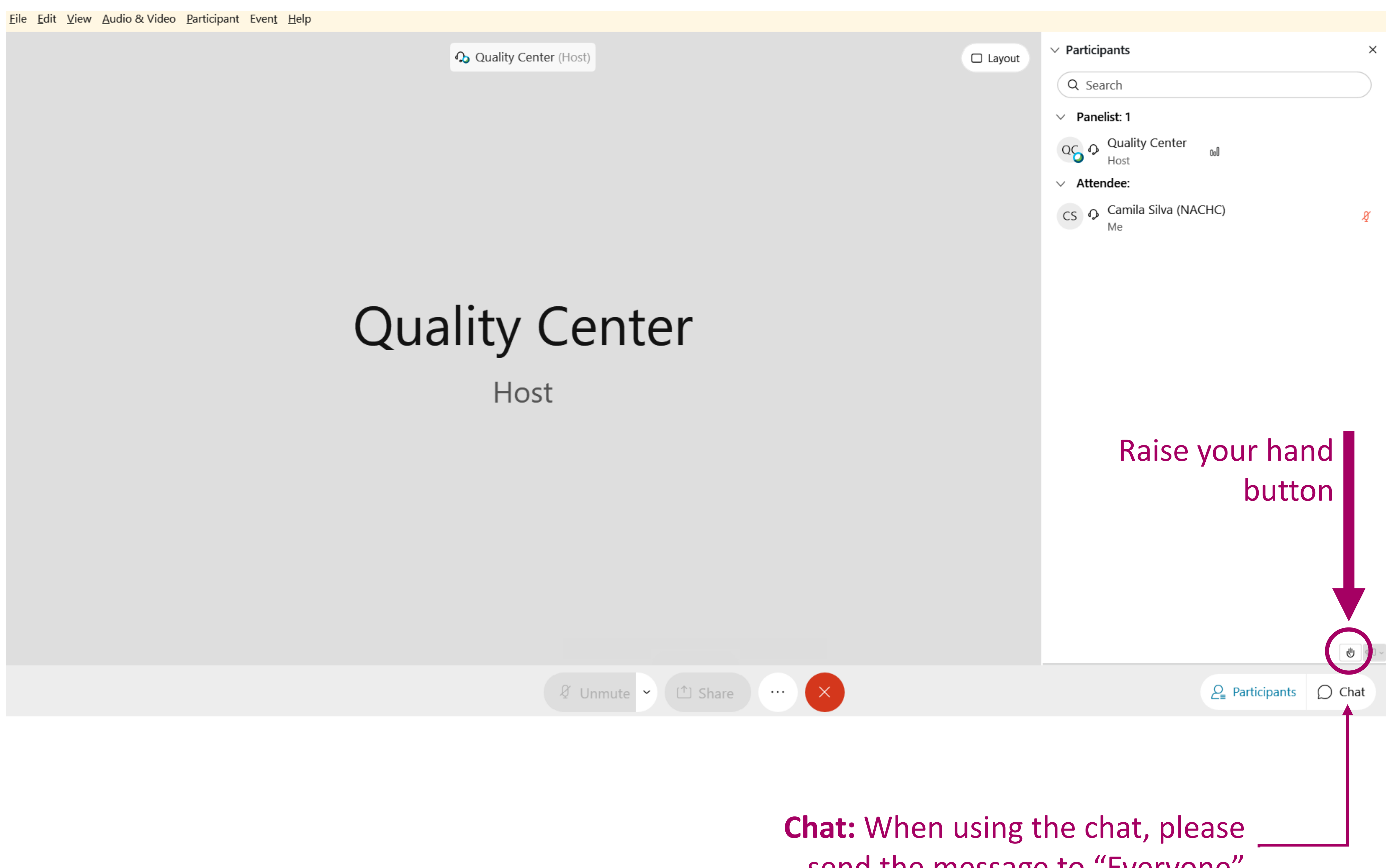
Evidence-Based Care

DIABETES CONTROL

Deep Dive

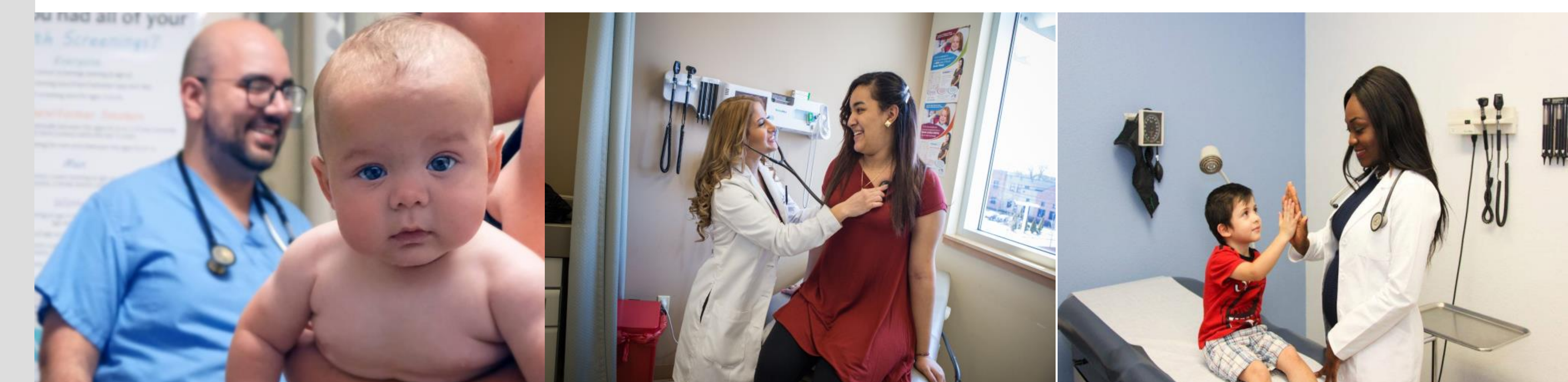
06.30.21


File Edit View Audio & Video Participant Event Help
Quality Center (Host)
Layout
Participants
Search
Panelist: 1
Quality Center
Host
Attendee:
Camila Silva (NACHC)
Me
Quality Center
Host
Raise your hand button
Unmute
Share
Participants
Chat
Chat: When using the chat, please send the message to "Everyone"

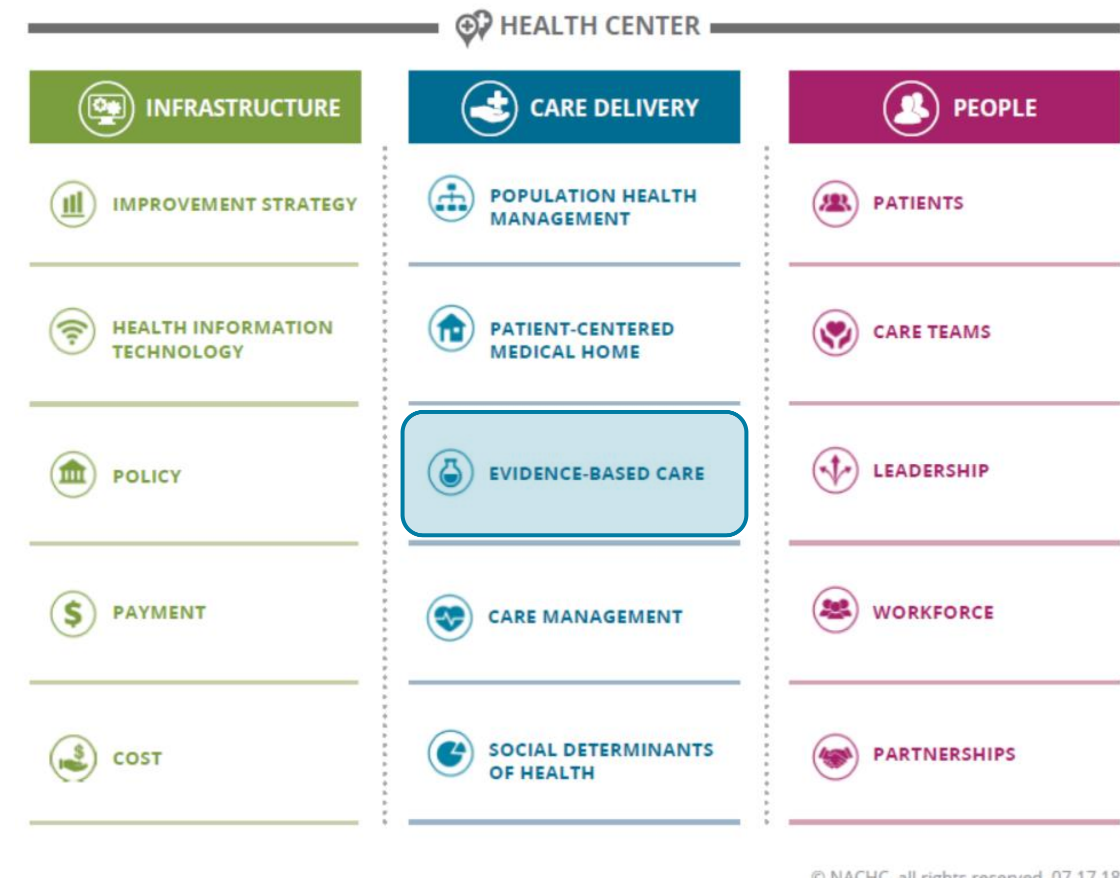
THE NACHC MISSION

America’s Voice for Community Health Care

The National Association of Community Health Centers (NACHC) was founded in 1971 to promote efficient, high quality, comprehensive health care that is accessible, culturally and linguistically competent, community directed, and patient centered for all.



Value Transformation Framework



https://www.nachc.org/clinical-matters/value-transformation-framework/

EVIDENCE-BASED CARE
DIABETES CONTROL

Make patient care decisions using a process that integrates clinical expertise and best-practice research with patient values and self-care motivators.

Evidence-Based Care Action Guide: http://bit.ly/VTF_EvidenceBasedCare

Diabetes Action Guide: https://bit.ly/VTF_EBC_Diabetes

Evidence-Based Care for Diabetes

Trainings, Technical Assistance, and Technology Support

Association of Diabetes Care & Education Specialists

Angela Forfia, MA

Senior Manager of Prevention

Who is ADCES?

- We're a multidisciplinary professional membership organization—not just DCES!
- We have more than 12,000 members across the country, organized at state/local levels
- Our members are dedicated to improving prediabetes, diabetes, and cardiometabolic care for everyone, in all communities
- Our approach lowers costs, improves experiences, and achieves better outcomes—quadruple aim!

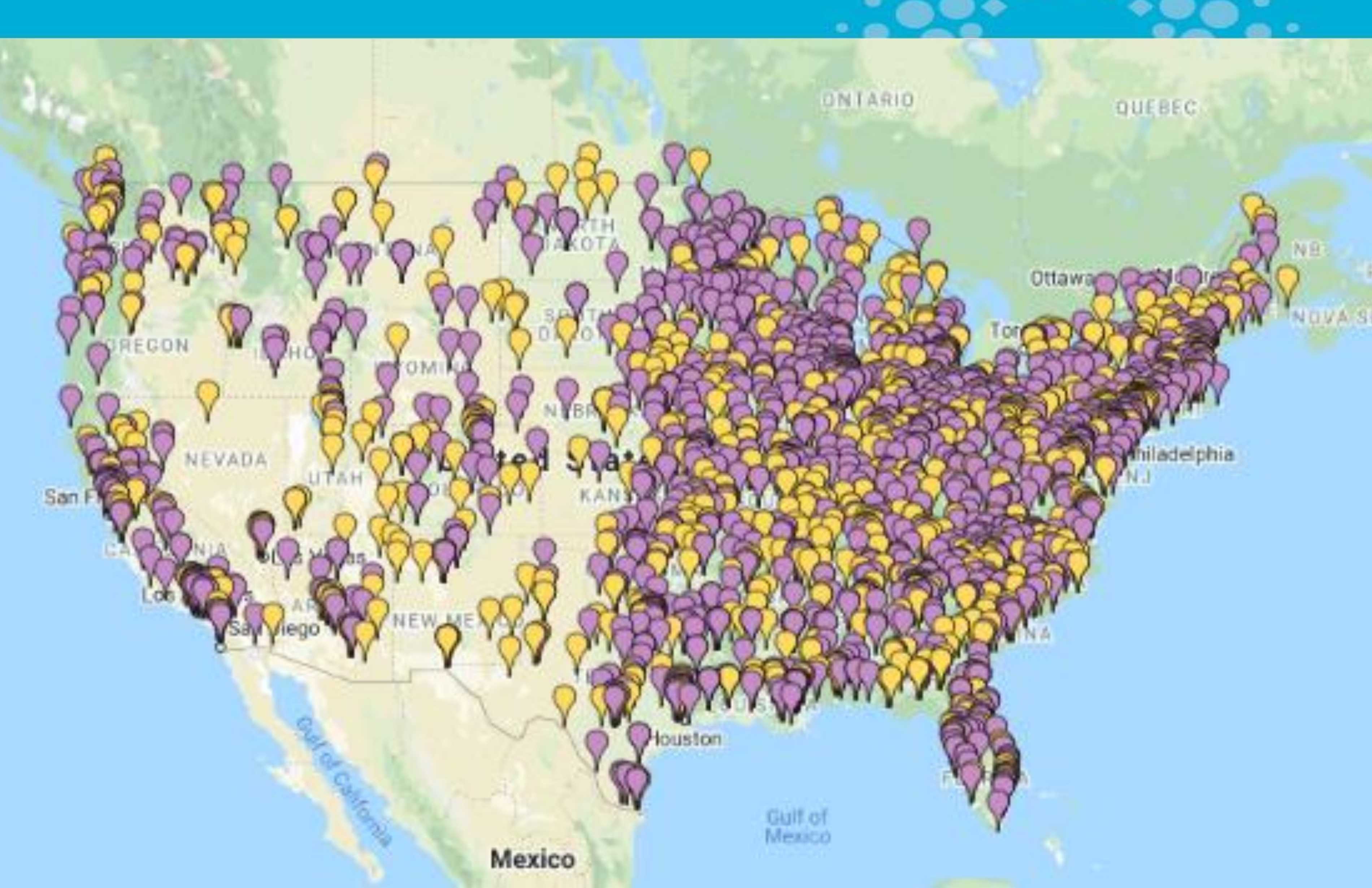
Who is ADCES?

National Accrediting Organization (NAO) for Medicare

Our Diabetes Education Accreditation Program (DEAP) certifies Diabetes Self-Management Education and Support (DSMES) programs to allow them to be eligible to bill Medicare

What that looks like today!

Engaged, experienced members + a national network of DSMES programs—a strong, connected, and powerful diabetes education infrastructure!

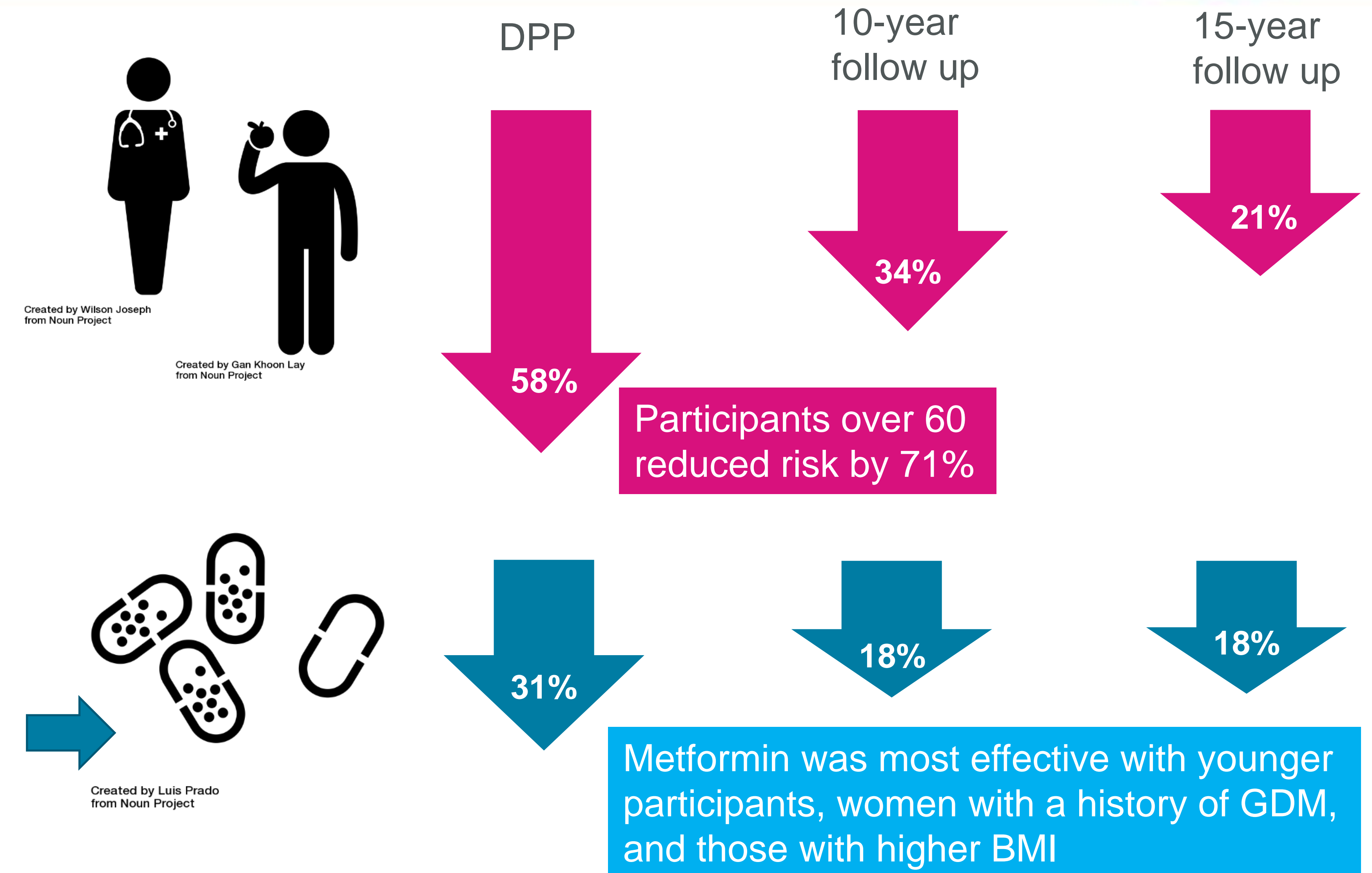


Diabetes Prevention Program

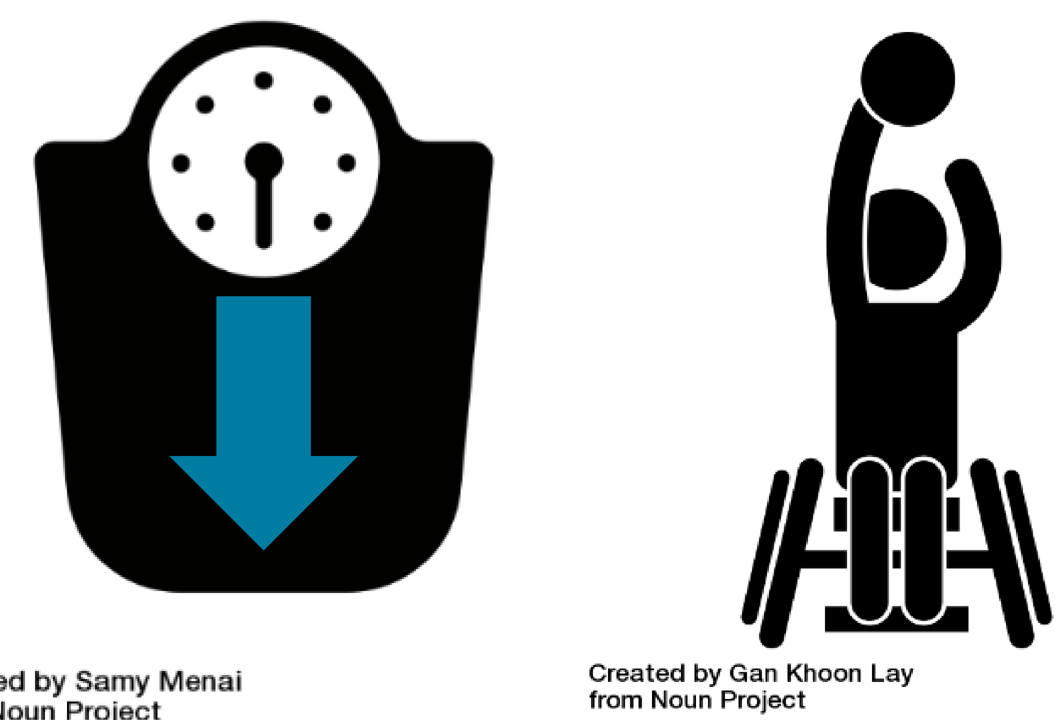
Diabetes Prevention Program (DPP)

- An intensive 12-month lifestyle change program focused on healthy eating, being active, self-monitoring, and healthy coping
- Intended for people with prediabetes + overweight/obesity at greatest risk of developing type 2 diabetes
- Group programs led by community health workers and other trained lifestyle coaches in clinical, community, and faith-based settings
- Reimbursement available from Medicare, some state Medicaid programs, and private payers

Evidence Base: DPP Study



Weight loss and physical activity



For every **2.2 pounds** (1 kg) of weight lost, risk of Type 2 diabetes decreased by **16%**

Among participants who **did not** meet the weight loss goal, those who met the activity goal had a **44% reduction** in diabetes incidence, independent of weight loss

USPSTF Guidance

Screening for Prediabetes and Type 2 Diabetes Mellitus

An Update for This Topic is In Progress

LAST UPDATED: Mar 10, 2021

Recommendation Summary

Population	Recommendation	Grade
Asymptomatic adults ages 35 to 70 years who are overweight or obese	The USPSTF recommends screening for prediabetes and type 2 diabetes in adults ages 35 to 70 years who are overweight or obese. Clinicians should offer or refer patients with prediabetes to effective preventive interventions.	B

Feeding three birds with one (healthy) scone

Diabetes Self-Management
Education and Support (DSMES)

Diabetes Self-Management Education and Support (DSMES)

- A collaborative, individualized, ongoing process that helps people with diabetes develop the knowledge, skills, and behaviors to make decisions to manage their diabetes and stay healthy
- Intended for people diagnosed with type 1 or type 2 diabetes
- One-on-one and group programs led by diabetes care & education specialists, health professionals and paraprofessionals, and community health workers
- Reimbursement available from Medicare, some state Medicaid programs, and private payers

DSMES Benefits

- Provides critical education and support for implementing treatment plans.
- Reduces emergency department visits, hospital admissions and hospital readmissions.
- Reduces hypoglycemia.
- Reduces all-cause mortality.
- Lowers A1C.
- Promotes lifestyle behaviors including healthful meal planning and engagement in regular physical activity.
- Addresses weight maintenance or loss.
- Enhances self-efficacy and empowerment.
- Increases healthy coping.
- Decreases diabetes-related distress.
- Improves quality of life.

No negative side effects | Medicare and most insurers cover the costs

Powers MA, Bardsley JK, et al. DSMES Consensus Report, The Diabetes Educator, 2020

If DSMES were a pill, would you prescribe it?

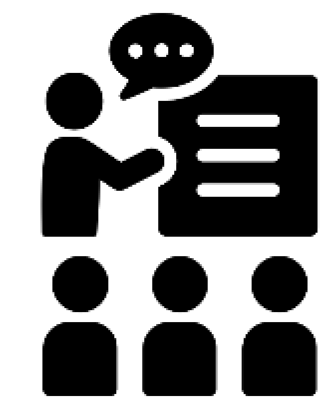
Comparing the benefits of DSMES/MNT vs metformin therapy

	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).

Powers MA, Bardsley JK, et al. DSMES Consensus Report, The Diabetes Educator, 2020

What ADCES provides (Prevention)



- Lifestyle Coach Training
- Advanced trainings
- Webinars on key topics like 5% weight loss

- Data Analysis of Participants System (DAPS)

- Formal learning collaboratives
- Informal "Phone a Friend!"

What ADCES provides (DSMES)

- Webinars on key topics like tele-health!
- ADCES7 materials and curriculum

- A7S system for Diabetes Education and Accreditation Program (DEAP) data

- Formal learning collaboratives
- Informal "Phone a Friend!"

THANK YOU!

DPP@adces.org

DEAP@adces.org

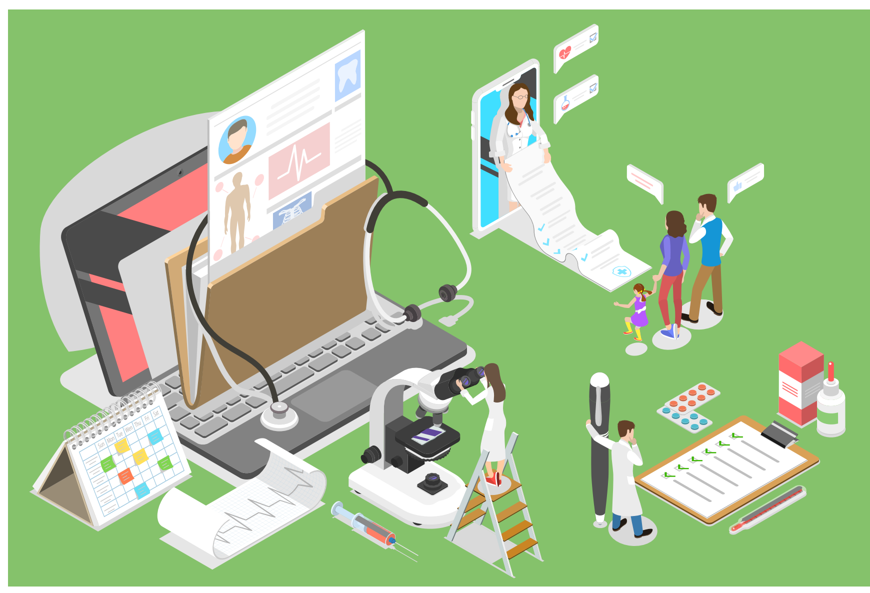
www.adces.org

Connectus Health

Katie Fogarty, RD, LDN
Director of Operations

Infrastructure Efforts

Workforce



- Quarterly run of all UDS and Insurance Quality Program metrics; track metrics to identify where action and follow-up is needed
- Daily scrub of charts
  - Identify prevention/chronic care needs; gaps in care
  - Flag chart
- EHR configured so staff follow-up on measures is ‘simple’ and requires minimal clicks

EHR= Allscripts Professional

Care Delivery Efforts

Population Health Management

Patient Centered Medical Home

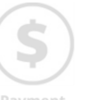
Evidence-Based Care

Care Coordination & Management

Social Determinants of Health

- Director of Information & Quality
  - Provides education to care team so they understand importance from an organizational perspective
- Care Coordinator role pivotal to success
  - Patient reminders, engagement, and education
  - Lays the groundwork for the patient care team
  - 1 FTE. Initially an MA. Currently an RN.
- PSR Manager
  - Works with Director of Information & Quality and Care Coordinator to optimize PSR processes

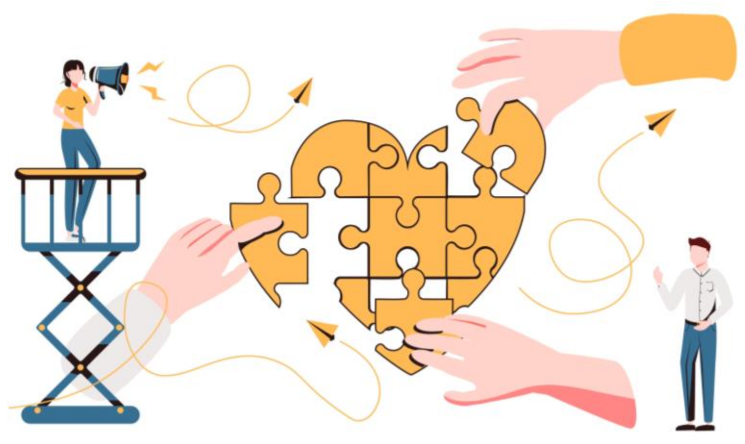
People Efforts



- **Broad job roles**
  - Director of Information & Quality
    - Q1-4: Runs report and discusses with PSR Manager and Care Coordinator
    - Team creates customized call log template for PSRs
  - Patient Service Representatives (PSR)
    - Q1: Receives customized call log template; schedules diabetic patients who haven't been seen in over 3 months
    - Q2-4: Schedules patients whose metrics are not met or haven't been seen in the current measurement year (attempt contact 3 times; document follow-up in the report)
  - Care Coordinator
    - Q1-3: Scrubs charts daily; add/remove prompts
      - Prompts - note date last completed and value (A1c, BP, microalbumin, retinal eye screening)
      - Prompts - added as a reminder to EHR
    - Q4: Reaches out to every patient with open gaps in care to provide education and schedule as a nurse or provider visit

Lessons Learned:

Tips to Share with Other Health Centers



- Utilize/maximize the resources you have.
- Ensure billing claims match documentation from progress note
- Update patient contact information at EVERY visit
- Consider patient resources – language barriers, transportation, and availability to be seen
- Build rapport with patients

East Jordan Family Health Center

Laurence Yung, DO, MBA, FAAFP
Chief Medical Officer

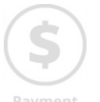
Infrastructure Efforts

- **Point of Care A1c testing implementation**
  - Allowed for more timely capture of patients who would otherwise skip the lab work when due (16 percent v 8 percent)
- **Developed internal process to enter external A1c results into the EMR**
  - Internal process that reduced our outstanding A1c numbers (20 percent v 7 percent)
- **Continuous glucose monitoring**
  - Helped develop more precise management of lifestyle changes and medication treatment
- **Reimagining the patient experience**
  - All staff encouraged to identify patients who need additional health center support and refer without LIP orders

Care Delivery Efforts

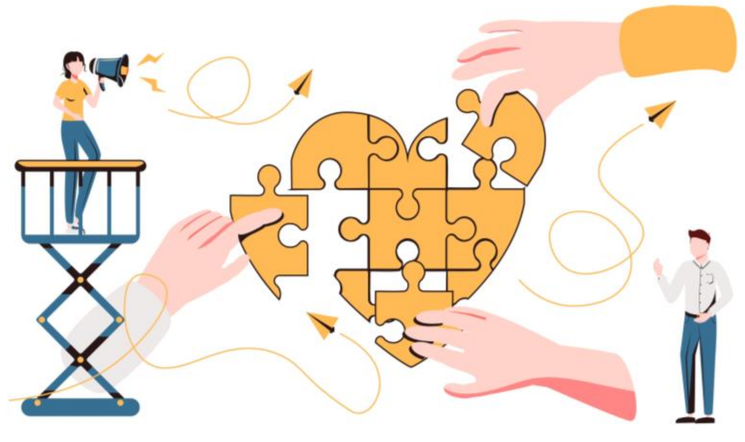
- Included PharmD’s in the co-management of patients with diabetes not at target A1c
  - Placement of Continuous Glucose Monitors (CGMs)
  - Counseling patients on results of CGMs
  - Co-management of medication plan with LIPs
  - Task Pharmacy Technicians in working out an efficient Prior Authorization process to get patients the medications they need to be most successful
- Nurse Care Managers involved in coaching patients on importance of lifestyle changes
  - Referred patients for lifestyle coaching, set up testing materials, timing of meals.

People Efforts



- **PharmD’s**
  - Involved in managing the CGM placement, review of results, and adjustments to medication plans
- **Nurse Care Managers**
  - Worked with LIPs, PharmD’s in coaching lifestyle changes after POC A1c and CGM results
- **Pharmacy Technicians**
  - Helped with timely Prior Authorizations on what health center considers essential diabetic medications based on current endocrine recommendations(e/g SGLT-2 and GLP-1 medications)
- **All Health Center Staff**
  - Empowered to refer patients who need testing, counseling, coaching without LIP approval

Lessons Learned: Tips to Share with Other Health Centers



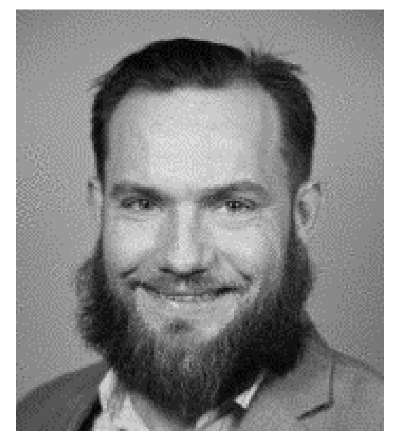
- It takes a village or community health center to raise a patient with diabetes to goal.
- Must have buy-in from all stakeholders, including the patient.
- Expect early excitement followed by a drop in performance if there is not continued support and buy-in from stakeholders.
- Reality is that there is no one particular “low hanging fruit” action. Key is to have quantifiable measures.

Packaging and implementing evidence-based transformational strategies for safety-net providers

Bringing science, knowledge, and innovation to practice

Cheryl Modica

Director,
Quality Center



Luke Ertle

Manager,
Quality Center

Camila Silva

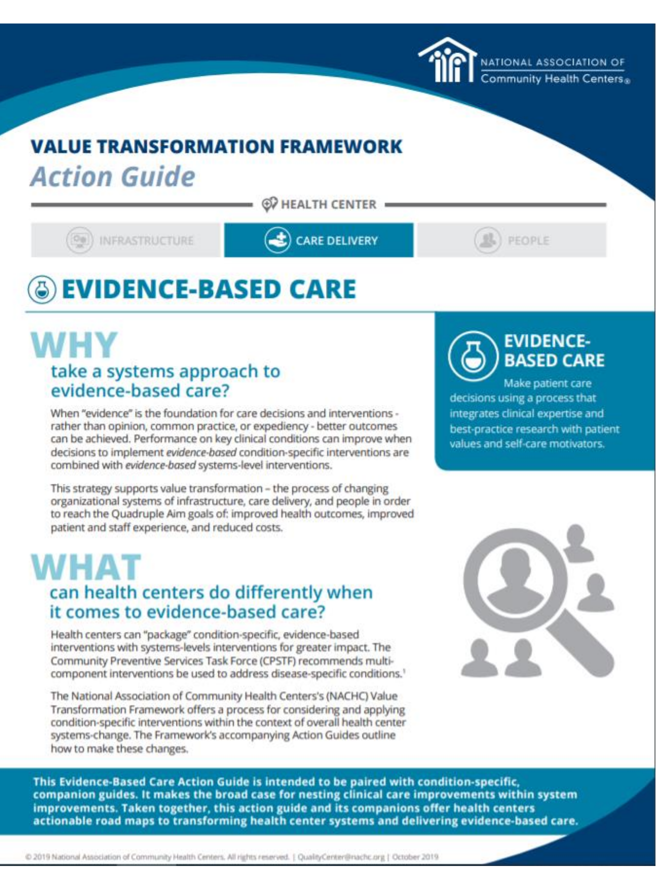
Manager, Quality Center Training & Curriculum

Lizzie Utset

Specialist, Quality Center

Evidence-Based Action Guide

Action Guide



NATIONAL ASSOCIATION OF Community Health Centers®

VALUE TRANSFORMATION FRAMEWORK
Action Guide

HEALTH CENTER

INFRASTRUCTURE | CARE DELIVERY | PEOPLE

EVIDENCE-BASED CARE

WHY take a systems approach to evidence-based care?

When "evidence" is the foundation for care decisions and interventions - rather than opinion, common practice, or expediency - better outcomes can be achieved. Performance on key clinical conditions can improve when decisions to implement *evidence-based* condition-specific interventions are combined with *evidence-based* systems-level interventions.

This strategy supports value transformation – the process of changing organizational systems of infrastructure, care delivery, and people in order to reach the Quadruple Aim goals of: improved health outcomes, improved patient and staff experience, and reduced costs.

EVIDENCE-BASED CARE

Make patient care decisions using a process that integrates clinical expertise and best-practice research with patient values and self-care motivators.

WHAT can health centers do differently when it comes to evidence-based care?

Health centers can "package" condition-specific, evidence-based interventions with systems-levels interventions for greater impact. The Community Preventive Services Task Force (CPSTF) recommends multi-component interventions be used to address disease-specific conditions.[1]

The National Association of Community Health Centers's (NACHC) Value Transformation Framework offers a process for considering and applying condition-specific interventions within the context of overall health center systems-change. The Framework's accompanying Action Guides outline how to make these changes.

This Evidence-Based Care Action Guide is intended to be paired with condition-specific, companion guides. It makes the broad case for nesting clinical care improvements within system improvements. Taken together, this action guide and its companions offer health centers actionable road maps to transforming health center systems and delivering evidence-based care.

© 2019 National Association of Community Health Centers. All rights reserved. | QualityCenter@nachc.org | October 2019

http://bit.ly/VTF_EvidenceBasedCare

Actions

Pair the Evidence-Based Action Guide with condition-specific companion guides – nesting clinical improvements within overall system improvements

Resources

Evidence-Based Care Action Guide

Cancer Screening Action Guide

HTN Screening & Control Action Guide

Action Guide:
Diabetes Control

- Synthesis of the evidence-base
- Guidelines and recommendations
- Sample clinical policies
- Sample standing orders
- Care team training resources
- Links to documentation guides for leading EHRs
- Links to patient educational resources
- Links to guides supporting community partnerships
- Reimbursement and payment strategies

NATIONAL ASSOCIATION OF Community Health Centers®

VALUE TRANSFORMATION FRAMEWORK

Companion Action Guide >> Evidence-Based Care

HEALTH CENTER

INFRASTRUCTURE | CARE DELIVERY | PEOPLE

DIABETES CONTROL

Providing diabetes care that improves health outcomes, improves patient and provider experiences, and reduces costs (the Quadruple Aim), requires health centers to couple evidence-based diabetes interventions with larger systems-level change. NACHC's Value Transformation Framework is designed to guide this systems approach to transformation.

WHY is attention to diabetes so important?

The impact of diabetes within the United States population is staggering. Diabetes directly impacts an estimated 114.4 million Americans, with 23.1 million people diagnosed, 84.1 million pre-diabetics, and 7.2 million undiagnosed diabetics.[1] Many more feel the impact of diabetes indirectly. This problem is expected to grow, with at least 15-30% of pre-diabetics developing type 2 diabetes within 5 years without weight loss or moderate physical activity.[2] The highest rates of diabetes are found among minority populations (African Americans, Mexican Americans, Puerto Ricans, and Native Americans) and older Americans.[3] The percent of community health center patients who have been told they have diabetes is 21% versus 11% in the general population.[4]

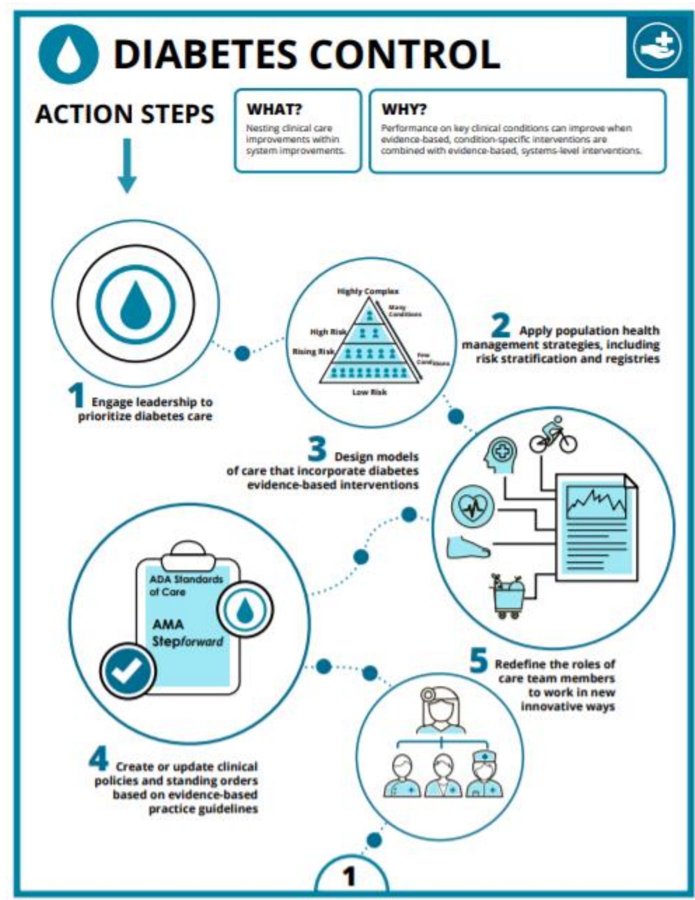
One-third or more patients with diabetes do not meet healthy target levels for blood sugar, blood pressure, or cholesterol.[5] Without control for these targets, patients with diabetes have a higher risk of serious health complications like heart disease and stroke. Diabetes can lead to kidney failure, lower limb amputations, and adult-onset blindness.[3]

The estimated cost of diabetes in the United States in 2017 was $327 billion, including $237 billion for direct medical costs and $90 billion in indirect costs for disability, time lost from work, and premature death.[6] The cost of medical care increases significantly for every 1% increase in a patient's glycemic level (for HbA1c above 7%).[7] If health center patients with uncontrolled diabetes could reduce their HbA1c by just 1.25%, the potential savings in medical costs could exceed $3.44 billion over three years.[8]

This Evidence-Based Companion Guide on diabetes care explores the evidence-based steps for managing patients with diabetes. Used alongside the Evidence-Based Care Action Guide, it offers health centers an actionable road map to track and control diabetes within the context of whole person care.

https://bit.ly/VTF_EBC_Diabetes

New NACHC Infographic



https://bit.ly/VTF_EBC_Diabetes-graph

1 Engage leadership to prioritize diabetes care

Highly Complex
Many Conditions
High Risk
Rising Risk
Few Conditions
Low Risk

2 Apply population health management strategies, including risk stratification and registries

3 Design models of care that incorporate diabetes evidence-based interventions

ADA Standards of Care
AMA Step*forward*

4 Create or update clinical policies and standing orders based on evidence-based practice guidelines

3. Design models of care that incorporate diabetes evidence-based interventions

USPSTF RECOMMENDATIONS: GRADE B[9]	
Adults age 40 - 70	• Screen for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. • Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.
Patients <40	• Consider screening earlier than age 40 in persons with 1 or more of the following characteristics (regardless of body mass): ✓ Family history of diabetes, ✓ History of gestational diabetes or polycystic ovarian syndrome, ✓ Members of certain racial/ethnic groups (African Americans, American Indians or Alaskan Natives, Asian Americans, Hispanics or Latinos, or Native Hawaiians or Pacific Islanders)

U.S. Preventive Services Task Force, Final Recommendation Statement, Abnormal Blood Glucose and Type 2 Diabetes Mellitus: Screening

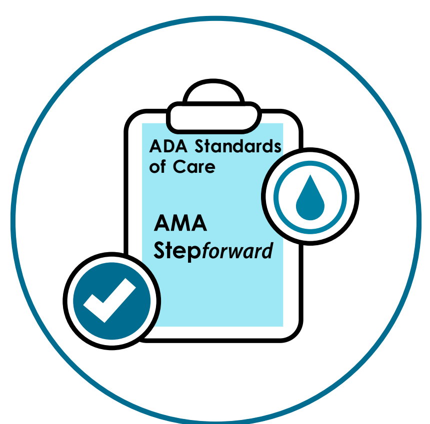
American Diabetes Association 2021 Standards of Care Guidelines

Guiding Principles for the Care of People with or at Risk for Diabetes: endorsed by more than a dozen federal agencies

3. Design models of care that incorporate diabetes evidence-based interventions

As part of a comprehensive, whole-person approach to diabetes care, include:

- Depression Screening: PHQ-2; PHQ-9
- Weight Management: USDA's MyPlate; video on MyPlate
- Exercise: Exercise Prescription Release Form
- Heart/Cardiovascular Health:
    - Blood Pressure: NACHC SMP Video; AMA SMBP video
    - Lipids/Cholesterol: Electronic Quality Measure (eCQM) for Statin Therapy
    - Tobacco Cessation: Protocol for Identifying & Treating Patients Who Use Tobacco
- Foot Care: Video: How to Complete a Diabetic Foot Exam
- Eye Care/Retinopathy: Maintain a list of ophthalmologists/optometrists for retinal exam referral
- Medication Use: ADA Antihyperglycemic Therapy flowchart; AMA Medication Adherence training



4. Create or update clinical policies and standing orders based on evidence-based practice guidelines

Diabetes Practice Guidelines include:

- ADA Standards of Medical Care
- American Academy of Family Physicians Clinical Practice Guidelines
- American College of Physicians
- Endocrine Society
- Sample Health Center Policy: Management of Diabetes Mellitus

Diabetes Control Infographic

5 Redefine the roles of care team members to work in new innovative ways

6 Create or update EHR templates to capture data on screening UDS and other measures

7 Establish systems to use patient engagement tools and support patient self-management and shared decision-making

8 Create a list of community partnerships and referral processes with them to support patient needs

9 Tailor treatment for social context

10 Collect reimbursement for all evidence-based care and services

Discussion

UPCOMING EVENTS

July 2021

SUN	MON	TUE	WED	THU	FRI	SAT
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31

August 2021

SUN	MON	TUE	WED	THU	FRI	SAT
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

13. Monthly Forum: Value Transformation & Patient Engagement

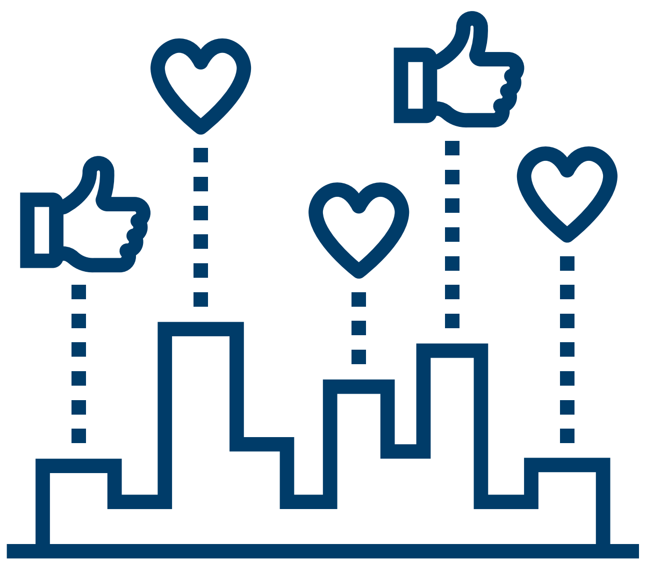
~~20.~~ **PCMH & Organizational Resiliency during the Pandemic** ***(Shifting to Sept)***

21. Dental Services, Part 1

28. Dental Services, Part 2

08. Monthly Forum: Care Management, Part 2 (Reimbursement)

Scan QR code to register



Provide Us Feedback

FOR MORE INFORMATION CONTACT:

qualitycenter@nachc.org

Cheryl Modica
Director, Quality Center
National Association of Community Health Centers
cmodica@nachc.org
301.310.2250

Next Monthly Forum Call:

July 13th, 2021
1 -2 pm ET

FEEDBACK

Don't forget! Let us know what you thought about today's session.

Together, our voices elevate all.

The Quality Center Team
Cheryl Modica, Luke Ertle, Camila Silva & Lizzie Utset
qualitycenter@nachc.org