Evidence-Based Care

DIABETES CONTROL

Deep Dive
06.30.21
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
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
Participants over 60 reduced risk by 71%

Metformin was most effective with younger participants, women with a history of GDM, and those with higher BMI.
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
Screening for Prediabetes and Type 2 Diabetes Mellitus

An Update for This Topic is In Progress

LAST UPDATED: Mar 10, 2021

Recommendation Summary

<table>
<thead>
<tr>
<th>Population</th>
<th>Recommendation</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asymptomatic adults ages 35 to 70 years who are overweight or obese</td>
<td>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.</td>
<td>B</td>
</tr>
</tbody>
</table>
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
Summary of DSMES benefits to discuss with people with diabetes

- 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

If DSMES were a pill, would you prescribe it?

### Comparing the benefits of DSMES/MNT vs metformin therapy

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>DSMES/MNT</th>
<th>METFORMIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>Efficacy</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>Hypoglycemia risk</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Weight</td>
<td>Neutral/Loss</td>
<td>Neutral/Loss</td>
</tr>
<tr>
<td>Side effects</td>
<td>None</td>
<td>Gastrointestinal</td>
</tr>
<tr>
<td>Cost</td>
<td>Low/Savings</td>
<td>Low</td>
</tr>
<tr>
<td>Psychosocial benefits*</td>
<td>High</td>
<td>N/A</td>
</tr>
</tbody>
</table>

*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).*
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!

Contact us! We’re here to help!

DPP@adces.org
DEAP@adces.org

www.adces.org
Connectus Health

Katie Fogarty, RD, LDN
Director of Operations
Infrastructure Efforts

- 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**

- **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

www.nachc.org
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
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Luke Ertle
Manager, Quality Center

Camila Silva
Manager, Quality Center Training & Curriculum

Lizzie Utset
Specialist, Quality Center
Evidence-Based Action Guide

**Action Guide**

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
- Diabetes Control Action Guide
- HTN Screening & Control Action Guide

http://bit.ly/VTF_EvidenceBasedCare
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
New NACHC Infographic

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

<table>
<thead>
<tr>
<th>USPSTF RECOMMENDATIONS: GRADE B³</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adults age 40-70</strong></td>
</tr>
<tr>
<td>• Screen for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese.</td>
</tr>
<tr>
<td>• Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.</td>
</tr>
<tr>
<td><strong>Patients &lt;40</strong></td>
</tr>
<tr>
<td>• Consider screening earlier than age 40 in persons with 1 or more of the following characteristics (regardless of body mass):</td>
</tr>
<tr>
<td>✓ Family history of diabetes,</td>
</tr>
<tr>
<td>✓ History of gestational diabetes or polycystic ovarian syndrome,</td>
</tr>
<tr>
<td>✓ Members of certain racial/ethnic groups (African Americans, American Indians or Alaskan Natives, Asian Americans, Hispanics or Latinos, or Native Hawaiians or Pacific Islanders)</td>
</tr>
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</table>

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

📅 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:
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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
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