HEALTH CENTER PROFESSIONAL DEVELOPMENT PROGRAM

PERSON-CENTERED CARE FOR INDIVIDUALS WITH HIGHER WEIGHT

POWERED BY ADCES Association of Diabetes Care & Education Specialists

OFFICE HOURS
JUNE 18, 2024
12:00 – 12:45 PM ET

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.

NATIONAL ASSOCIATION OF
Community Health Centers®

You are part of a national community of health center staff who are working to provide care and resources to the health center patients who need it most.

An exciting opportunity to learn, share, and grow in your role.

8 health center staff participants strong!

Welcome Spring 2024 Participants

- Deyanelle Timmons (CareSouth Carolina)
- Jaquetta Graham (CareSouth Carolina)
- Katilyn Jones (Coastal Family Health Center)
- Cristina Hewes (Community Health Center LLC)
- David Papcin (Moses Weitzman Health System)
- Sarah Santoni (Neighborhood Health Centers of Lehigh)
- Amanda Johnson (Northwest Community Health Center)
- Mary Vekaryasz (Thunder Bay Community Health Service)

This Professional Development Course is a NEW offering through NACHC's Elevate National Learning Forum

800+ health centers
80+ PCAs/HCCNs
15+ million patients

Higher Weight vs. National DPP

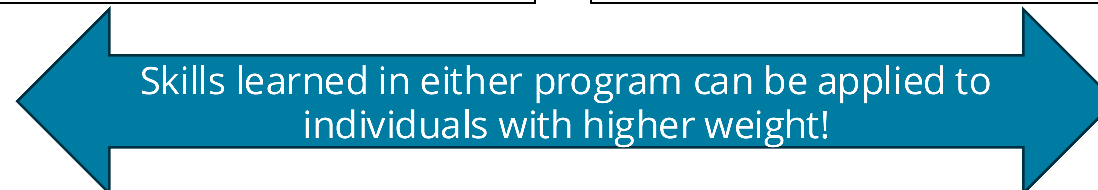
Person-Centered Care for Individuals who have Higher Weight

Diabetes care and education specialists interact with people with **type 2 diabetes** and related health complications where in some cases the disease and complications have manifested as a result of the individual having a higher weight. Although many diabetes care and education specialists have deep knowledge in caring for people with higher weight bodies, **there are simply not enough of them to provide care to the number who need it**. The entire care team should be educated to a validated level of understanding.

National Diabetes Prevention Program (NDPP)

The National DPP works to make it easier for people with **prediabetes** or **at risk of type 2 diabetes** to participate in an affordable, high-quality lifestyle change program. This includes:

- Deliver the lifestyle change program nationwide
- Ensure quality and adherence to proven standards
- **Train community organizations** that can run the lifestyle change program effectively
- Increase referrals to and participation in the lifestyle change program
- Prevent or delay type 2 diabetes
- Lasting Lifestyle Changes (e.g., healthy eating, physical activity)



Office Hours Agenda

- NDPP Lifestyle Change Program
- Coaching Quality Improvement
- 2024 Proposed Standards Changes
- NACHC Resources
- Evaluation Questions

Higher Weight Office Hours: National DPP Tools for FQHCs

18 June 2024

Quick Updates and Helpful Tools

- Pathways to sustainability for your health center or CHC/FQHC network
- Tools for your coaches
  - *Lifestyle Coach Assessment Tool*
  - *Rewire Health Videos*
- Diabetes Prevention Recognition Program Standards and Operating Procedures—policy updates for 2024!
- Questions?

Finding Your Pathway to Sustainability

WHAT'S THE RIGHT ROAD TO

Activating the National DPP Lifestyle Change Program?

Thinking about offering the National Diabetes Prevention Program (DPP) lifestyle change program, at your health center but don't know where to start? Take our quiz and figure out which roadmap is right for you.

1 First off, how many employees do you have?

- (A) 500-1,000+
- (B) 50-500
- (C) Under 50

2 What kind of staff do you have available to support your diabetes prevention and care services?

- (A) We've got mostly clinical staff like nurses, dieticians and diabetes care and education specialists (DCES).
- (B) It's a mix of clinical staff and community health workers like health educators, outreach workers, patient navigators and promotores de salud.
- (C) Our staff is composed primarily of community health workers and public health workers like health educators, program specialists and others.

3 How do you identify participants for wellness programs?

- (A) Mostly from clinical referrals
- (B) A mix of clinical and community referrals from local partners and health center events, such as flu shot vaccinations and benefits assistance sessions
- (C) Community events like health fairs and faith-based events

4 What other chronic care management and preventative care services do you offer?

- (A) It's robust! We offer medical nutrition therapy (MNT), diabetes self-management and education support (DSMES) programs and bariatric surgery.
- (B) We offer DSMES and chronic care management, along with some community programs like health insurance navigation and flu shots.
- (C) We tend to focus on educational programming like SNAP enrollment or application navigation, healthy childhood weight and fall prevention.

5 Where do you plan to offer your lifestyle change program?

- (A) Our hospital's community room, wellness center, or a classroom.
- (B) Our local community center or a recreation center.
- (C) We rely upon places of worship, the YMCA, a library, or set up in a neighborhood plaza.

6 How many groups or participants do you plan to have per year?

- (A) We want to go big! 6+ groups per year, with about 80 participants.
- (B) We're thinking 4+ groups per year, with about 45 participants.
- (C) We'll start small, offering 2 or so groups, with about 20 participants.

7 How do you plan to bill for diabetes prevention and care?

- (A) We'll bill Medicare, Medicaid and commercial payers.
- (B) We'll bill FQHC services, then Medicaid, and then pick up what grants we can to cover uninsured patients.
- (C) We'll most likely rely wholly upon grants.

8 Do you use electronic health records (EHR)?

- (A) Yes, and we leverage the data for improvement.
- (B) Yes, but we really need help with optimizing the data.
- (C) No, but hopefully someday!

If you got mostly A's
You're a Powerhouse!

Chances are you're a hospital, health system or a large Federally Qualified Health Center (FQHC) network. You've got a lot of resources at your organization but could use some help learning tried-and-true tips for successful National DPP delivery.

▶ **Next stop: the Powerhouse Roadmap**

If you got mostly B's
You're a POPstar!

Your community health center or FQHC focuses on population health. We've got ways to maximize results — without putting more strain on your staff.

▶ **Next stop: the POPstar Roadmap**

If you got mostly C's
You're The (Small But) MIGHTY!

Whether you're a county health department or area agency on aging, your community-based organization (CBO) could use some help getting the National DPP up and running. Fear not! We've got plenty of resources to help you every step of the way.

▶ **Next stop: The Mighty Roadmap**

This resource was supported by the cooperative agreement NU58DP006361-05-03 funded by the Centers for Disease Control and Prevention. Its contents are the sole responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention or the Department of Health and Human Services.

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What’s your pathway?

If you got mostly A’s
You’re a Powerhouse!

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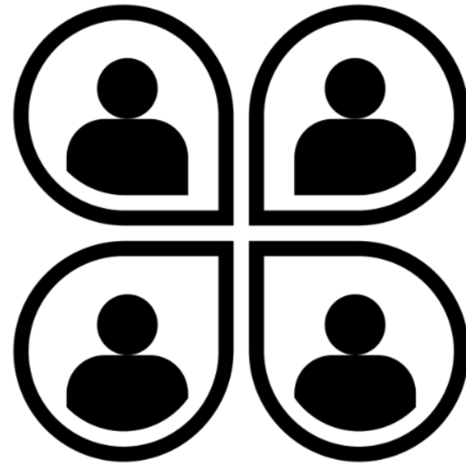
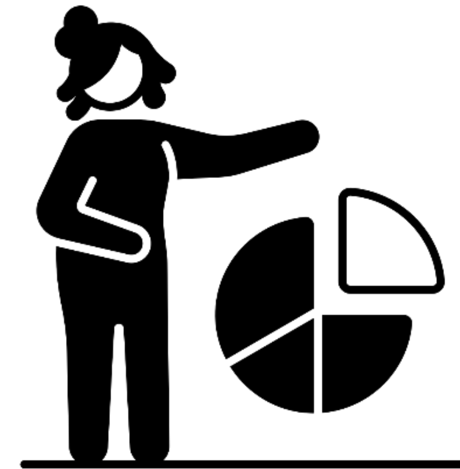
If you got mostly B’s
You’re a POPstar!

Your community health center or FQHC focuses on population health. We’ve got ways to maximize results — without putting more strain on your staff.

Four key signposts





Pop Star Signposts

- **A “quiver” of trained health educators who can be cross-trained to support the DPP, DSMES, and other programs**
- **Ability to invest in your workforce over time—lifestyle coach trainings, advanced trainings, professional advancement**
- **Electronic Health Records systems to facilitate screening, testing and referral**
- **Integration with other chronic care management services**

Pop Star Signposts

- **Potential to reach at least 45 participants annually through strategic cohort planning (e.g. 2 at main site, one each at satellite sites)**
- **Able to bill Medicaid**
- **Integration with other Medicaid, Medicare, and other services (e.g. FQHC services)**
- **Covering the DPP for your own employees**
- **Grant funding or Community Benefit support for uninsured**

Pop Star Examples

POP STAR!

Team
- Pharmacists
- Technicians/CHWs
- Lifestyle coaches (2)
- Interns
- Management

Awareness
- get in front of PCPs
  - Smaller clinics
  - Senior health clinic/center
  - long-term care facilities
- Promotional Materials

cohorts
- 2 cohorts/yr
  ~ 10 per group

Payer mix/$
- get private payers on board
- working towards medical billing

IHS ☆ POP STARS ☆

Team
Health Promotion Disease Prevention (HPDP Team) → Food awareness, Chapter houses, Employee wellness
→ Lifestyle coaches
traditional healer
Group clinic → optometrists eyedoctors providers
mental health
Public Health Nurses / Nurse educators, NPs, MDs → DSMES (19)
RPs
CHRs
pharmacists
pharmacy interns

Awareness
clinical
→ pre-DM clinic
data reviews
→ self referrals
→ Icare
→ optometrists
podiatrists
dentists
→ pharmacy residents/interns

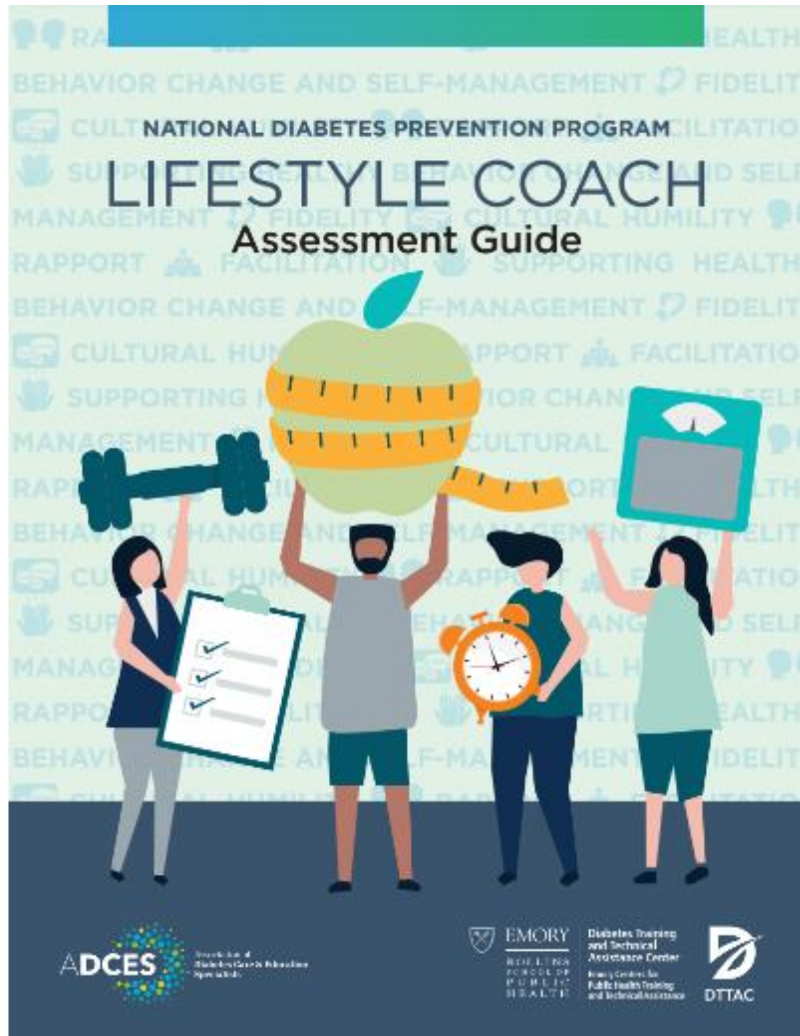
comm
- recruitment outside hosp
- "brown bag" events
- schools → sbhc, parents, staff, BMI outreach
- tribal utilities
"wellness on wheels"

cohorts
2
lots of barriers to participate
employee wellness 5-7 people
wellness sessions
senior centers

support/sustainability
Staff turnover
→ cross trained "quiver"
→ HIV tech → LSC
DPP
Space
→ conference room
budget for healthy snacks

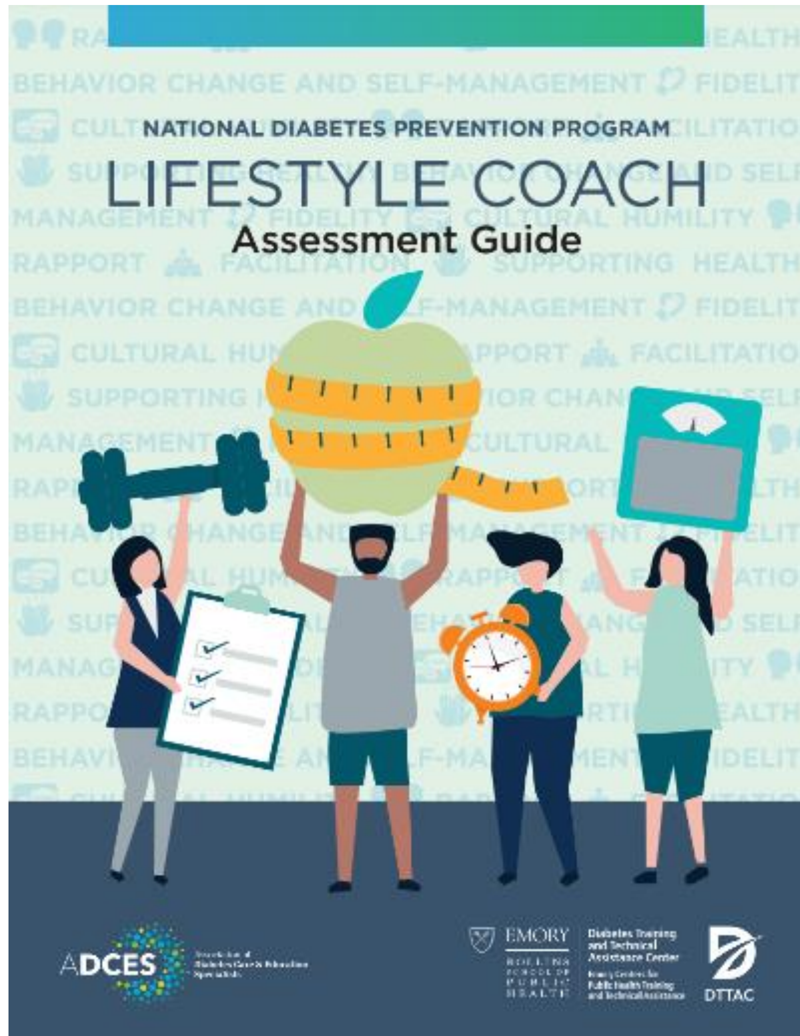
Tools for Diabetes Prevention Lifestyle Coaches and Health Educators

Coaching quality improvement



- Coach self-assessment
- Lifestyle Coach Observation assessment
  - Program Coordinator
  - Mentor
- Focused on key competencies for lifestyle coaches
  - Rapport
  - Facilitation
  - Supporting healthy behavior change and self-management
  - Fidelity
  - Cultural humility

Coaching quality improvement



- Positive, strengths-based, and focused on enhancing coaching skills through co-facilitation, advanced training, peer support and problem solving
- No cost, easy to add to your team capacity building
- Available in Spanish and English!

Email dpp@adces.org for these resources!

Rewire Health "Mid-Tech" Videos

MODULE 5:
Tracking Your Food

OVERVIEW:

This video teaches you how to Track Your Food

LEARNING OBJECTIVES:

- Identify the benefits of tracking food
- Explain how to track the food you eat and the calories you take in
- Explain how to use Nutrition Facts labels

MODULE 6:
Get More Active

OVERVIEW:

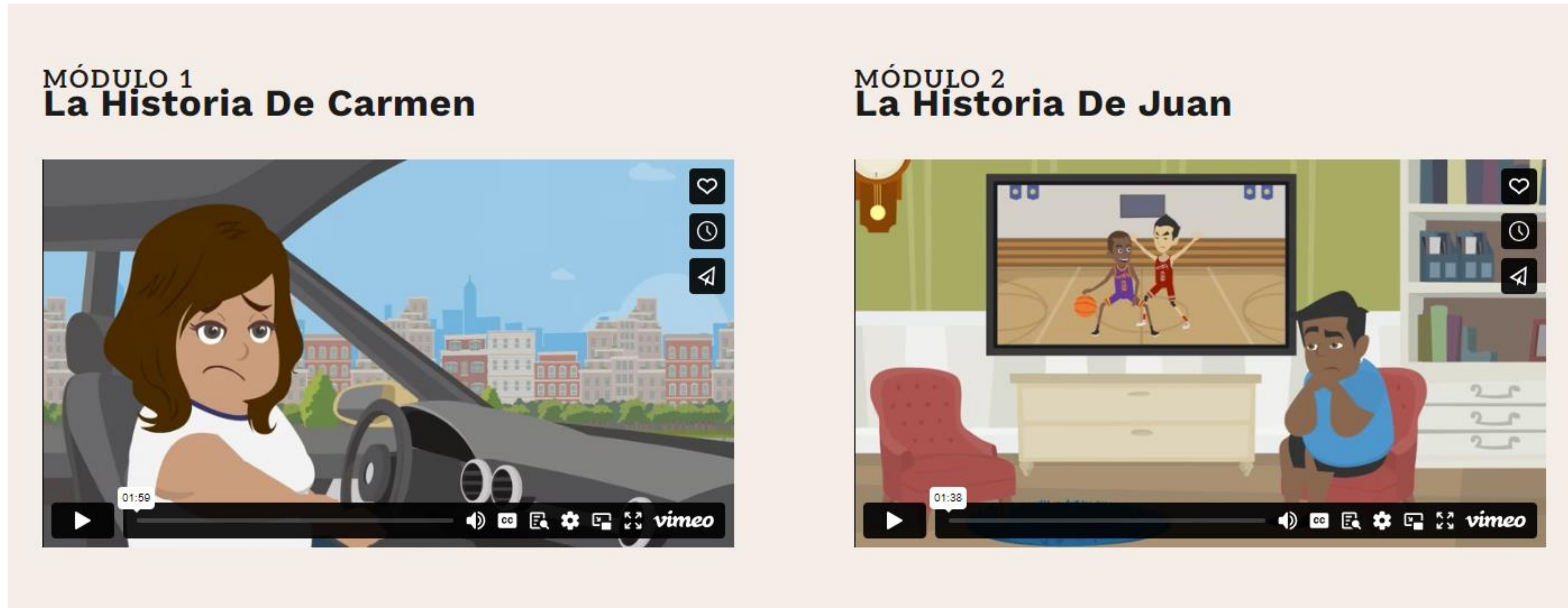
This video teaches you how to Get More Active

LEARNING OBJECTIVES:

- Explain the purpose of getting more active
- Identify some ways to get more active
- Explain how to track more details about your activity

https://rewire-dpp.com/video-library/

Rewire Health “Mid-Tech” Videos



https://rewire-dpp.com/short-clips-library-spanish/

Upcoming DPRP Standards Updates!

2024 Proposed Standards Changes

- Commitment to health equity
- Family members attending with participants
- New delivery modes
  - In-Person
  - Distance Learning (live)
  - In-Person with Distance Learning Component
  - Online (non-live)
  - Combination with an on-line component
- Guidelines for session delivery
  - Delivery requirements for online providers
  - Guardrails for artificial intelligence (AI)

2024 Proposed Standards Changes

- Fast Tracking for Certain Organizations
  - ***Happening now!*** Accredited/recognized DMSES programs
  - Organizations in High Social Vulnerability Index (SVI) counties
  - Organizations adding new modalities
- Slight changes to the recognition level criteria
  - Easier to reach preliminary recognition—10 attendees, 3 completers
  - Adding 4% + attendance/retention goal for risk reduction

Find out more!

Title:
Transitioning to the 2024 DPRP Standards
Description:
This webinar will present major changes reflected in the 2024 DPRP Standards with respect to delivery, evaluation, and recognition.
Registration Link:
https://cdc.zoomgov.com/webinar/register/WN_kCvCfflmQk-4b_lngwAJEw#/registration
Start Time:
Jun 25, 2024 2:00 ET
End Time:
Jun 25, 2024 3:30 ET

You're not alone!

- ADCES resources https://www.diabeteseducator.org/prevention
- CDC resources https://nationaldppcsc.cdc.gov/s/
- AMA resources https://amapreventdiabetes.org/
- NACDD resources https://coveragetoolkit.org/
- CMS resources: https://www.cms.gov/priorities/innovation/innovation-models/medicare-diabetes-prevention-program

Questions?

Contact us!

We're here to help!

Angela M Forfia, MA

Director, Prevention and Public Health Initiatives

aforfia@adces.org OR DPP@adces.org

(312) 601-4802

Additional NACHC Resources

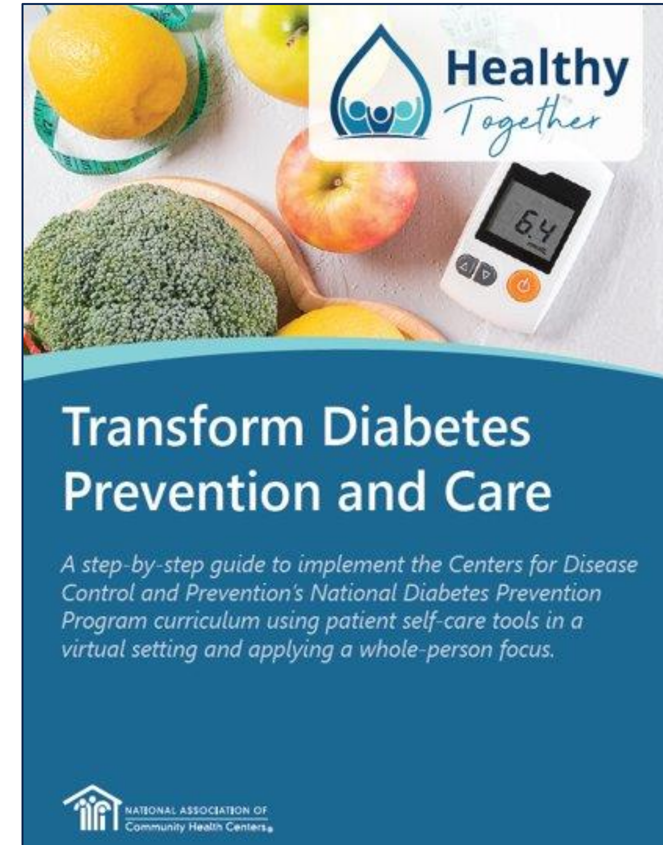
Increase the impact of **diabetes prevention and management** at health centers.

Healthy Together is a lifestyle change program that blends:

- ✓ Virtual care
- ✓ Self-care tools
- ✓ Lifestyle coaching following the CDC's National Diabetes Prevention Program curriculum

Recorded Webinar: National Diabetes Prevention Program - Basics for Health Centers

Healthy Together Project Summary



Healthy Together Action Guide

Additional NACHC Resources

[Care Management Action Guide]

[Diabetes Action Guide]

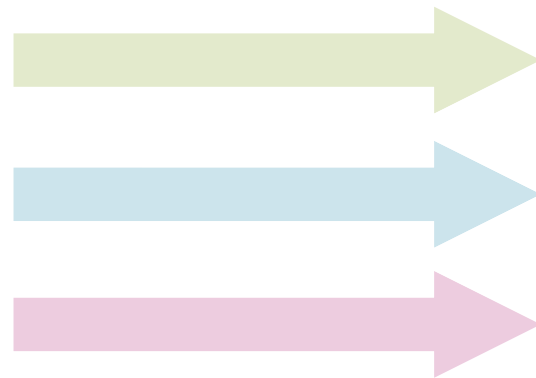
[Hypertension Action Guide]

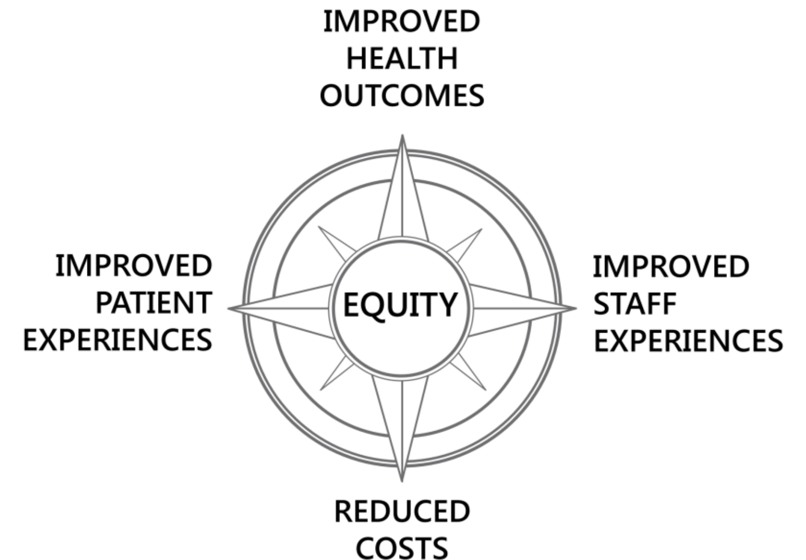
...and MORE!

Healthy Weight Course

- The NACHC Quality Center recognizes the critical importance of providing access to training opportunities for health center professionals to build skills, develop competencies, and advance careers while driving improved patient care and health outcomes.
- These trainings support health centers to achieve the Quintuple Aim

Improved Health Center Performance through **Systems Transformation**





Evaluation Questions

Contact Us!

The NACHC Quality Center team is here to help!

Questions on how to access online content? VTF Assessment?

Contact **QualityCenter@NACHC.org**

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $6,625,000 with 0 percentage financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

Course Content

ADCES Association of Diabetes Care & Education Specialists

Quality Center ▾

Profile ▼

My Learning | My Credits | Support | About ADCES Online Learning

Person-Centered Care for Individuals who have Higher Weight: A Certificate Program (2nd edition) (CPIHW004) (Incomplete)

Change View | Exit

Welcome

Welcome to ADCES' Person-Centered Care for Individuals who have Higher Weight: A Certificate Program.

Start by reading the Program Overview and Disclosures.

You must complete the pre-test, view all seven (7) modules, pass the 35-question post-test, and complete the final program evaluation in order to earn your CE/CME credit.

[CE expiration date: 8/17/2025]

Activities

- ✔ Program Overview and Disclosures
  You must read this section before moving on to the coursework.

Pre-Test

You must complete this 35-question pre-test in order to open the modules.

Activities

- ✔ Pre-Test
  Estimated Time: 15 minutes
  Attempts

Coursework

A copy of the presentation slides can be found under the Resources below.

You must view all modules for it to count as complete.

Activities

- ✔ Scope of the Problem
- ✔ Psychological Considerations
- ✔ Obesity as a Chronic Disease
- Lifestyle Treatment
- Treatment Options
- Behavior Change
- Counseling Caveats

Post-Learning Assessment

Evaluation Survey and CE Credit

Certificate of Program Completion

ADCES 'My Learning'