TODAY’S WEBINAR

• Together 2 Goal® Updates
  – Webinar Reminders
  – Goal Post July Newsletter Highlights
  – Baseline Data Results

• Refer to Diabetes Self-Management Education & Support Programs
  – Deborah Greenwood, PhD, RN, BC-ADM, CDE, FAACE (American Association of Diabetes Educators & Sutter Health)
  – Margaret (Maggie) Powers, PhD, RD, CDE (American Diabetes Association)

• Q&A
  – Use Q&A or chat feature
WEBINAR REMINDERS

• Webinar will be recorded today and available the week of July 25th
  – Together2Goal.org Website (Improve Patient Outcomes → Webinars)
  – Email distribution

• Participants are encouraged to ask questions using the “Chat” and “Q&A” functions on the right side of your screen
GOAL POST JUNE NEWSLETTER HIGHLIGHTS

Campaign Spotlight:

Behavioral Diabetes Institute

Together 2 Goal.
Resource of the Month:

- **Topic:** Care4Today™
- **When:** Thursday, August 4 from 2-3 p.m. Eastern
- **Who:** Principal Corporate Collaborator Johnson and Johnson Family of Diabetes Companies and AMGA member Sharp Community Medical Group

Registration information will be sent next week!
Email distributed on Friday, July 15 to all campaign points of contacts

Includes:
- Unique identification code
- Link to baseline data report
- Next data reporting deadline (September 1, 2016)
Available on Together2Goal.org Website (Improve Patient Outcomes → Data Reporting)

Link at Top of Page: “Baseline (Q1 2016) data results are now available!”

Prevalence of Type 2 Diabetes Among Total Patient Population

HbA1c Control

Blood Pressure Control

Proportion of Patients with Medical Attention for Nephropathy

Proportion of Patients with Lipid Management

Proportion of Patients Compliant with All Elements of the T2G Bundle
**BASELINE DATA RESULTS**

Available on Together2Goal.org Website (Improve Patient Outcomes → Data Reporting)  
Link at Top of Page: “Baseline (Q1 2016) data results are now available!”

<table>
<thead>
<tr>
<th>Organization Code</th>
<th>Track</th>
<th>Prevalence of Type 2 Diabetes</th>
<th>HbA1c Control</th>
<th>BP Control</th>
<th>Medical Attention for Nephropathy</th>
<th>Lipid Management</th>
<th>Diabetes Care Bundle</th>
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<tr>
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<td>51.1%</td>
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<td>70.2%</td>
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<td>98.6%</td>
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<td>DV4</td>
<td>Core</td>
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<td>55.4%</td>
<td>63.5%</td>
<td>88.9%</td>
<td>68.7%</td>
<td>22.6%</td>
</tr>
<tr>
<td>FR7</td>
<td>Basic</td>
<td>10.8%</td>
<td>69.0%</td>
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</table>

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**BASELINE DATA RESULTS**

- **Measurement Period:** April 1, 2015 – March 31, 2016
- **Campaign denominator:** 1.05 million patients with Type 2 diabetes, across 95 reporting organizations

<table>
<thead>
<tr>
<th>Measure</th>
<th>Group Weighted Average</th>
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<tbody>
<tr>
<td>Prevalence Rate</td>
<td>14.0%</td>
</tr>
<tr>
<td>HbA1c Control Rate (&lt;8%)</td>
<td>66.1%</td>
</tr>
<tr>
<td>Blood Pressure Control Rate (&lt;140/90 mmHg)</td>
<td>67.2%</td>
</tr>
<tr>
<td>Lipid Management</td>
<td>65.7%</td>
</tr>
<tr>
<td>Medical Attention for Nephropathy</td>
<td>84.0%</td>
</tr>
<tr>
<td>Bundle Measure Control</td>
<td>30.2%</td>
</tr>
</tbody>
</table>
• **Deborah Greenwood**, PhD, RN, BC-ADM, CDE, FAACE
  – Research Scientist and Clinical Performance Improvement Consultant, in the Office of Patient Experience at Sutter Health
  – Program Director, Sutter Health Integrated Diabetes Education Network
  – Immediate Past President of the American Association of Diabetes Educators

• **Margaret (Maggie) Powers**, PhD, RD, CDE
  – Clinician and Research Scientist at the International Diabetes Center
  – Current President, Health Care & Education of the American Diabetes Association
Together2Goal®
AMGA Foundation
July 2016

Refer to Diabetes Self-Management Education and Support Programs

A Joint Position Statement of the American Diabetes Association, the American Association of Diabetes Educators, and the Academy of Nutrition and Dietetics
Faculty

Deborah Greenwood, PhD, RN, BC-ADM, CDE
Clinical Performance Improvement Consultant, Research Scientist
Sutter Health, Office of Patient Experience
Sacramento, CA
Immediate Past President, AADE

Margaret (Maggie) Powers, PhD, RDN, CDE
Clinician and Research Scientist
International Diabetes Center at Park Nicollet
Minneapolis, MN
President, Health Care & Education, ADA
Objectives

Attendees will be able to:

1. Support patient access to diabetes self-management education programs by understanding their value in promoting health outcomes, reducing costs, increasing patient satisfaction and increasing pay-for-performance payments

2. Discuss and design diabetes self-management education referral systems based on the practice guidelines described in the recent DSMES position statement and ADA Standards of Medical Care.
DSME/S Position Statement

Background, Purpose, Evidence
DSME/S Position Statement: Collaboration

Writing Team
Margaret A. Powers (Chair), ADA
Joan Bardsley, AADE
Marjorie Cypress, ADA
Paulina Duker, ADA
Martha M. Funnell, NDEP
Amy Hess Fischl, Acad N & D
Melinda D. Maryniuk, Acad N & D
Linda Siminerio, NDEP
Eva Vivian, AADE

Definitions

**Diabetes Self-management Education (DSME)**
Ongoing process of facilitating the knowledge, skill, and ability necessary for diabetes self-care

**Diabetes Self-management Support (DSMS)**
Activities that assist in implementing and sustaining the behaviors needed to manage diabetes

Referral to DSME

- Referral is required for DSME reimbursement
- Recognized or Accredited
- Medicare covers 10 hours the first year, then 2 hours every year
- Typically groups
- Sample program:
  - Individual assessment (one hour)
  - 4 classes, 2 hours each
  - Individual follow-up
- Nationally referral rates are low
- Position statement to increase awareness of DSME and encourage referral
AADE Self Care Behaviors™

- AADE has defined the AADE7 Self-Care Behaviors™ as a framework for patient centered diabetes self-management education (DSME) and care.
  - Healthy Eating
  - Being Active
  - Monitoring
  - Taking Medications
  - Problem Solving
  - Healthy Coping
  - Reducing Risks
Sample Referral Forms

ADA

AADE

AND
http://dbcms.s3.amazonaws.com/media/files/8e6c5fe8-1ec8-42a2-bfa0-2c6ae7502c1e/MNTReferral%20FormDCE2014.pdf
Purpose of Position Statement

• Address triple aim - Improve patient experience of care and education, improve health of individuals and populations, reduce diabetes-associated per capita health care costs

• Provide health care teams with information required to better understand the educational process and expectations for DSME and DSMS and their integration into routine care

• Create a diabetes education algorithm that defines when, what, and how DSME/S should be provided for adults with type 2 diabetes

Benefits Associated with DSME/S

• Improved health outcomes
  – Reduced A1c by as much as .88%
  – Reduced onset and/or advancement of complications
  – Reduced hospital admissions and readmissions

• More healthful eating patterns and regular activity

• Enhanced self-efficacy and empowerment
  – Increased healthy coping
  – Improved quality of life

**NOTE:** 1) Benefits of education decrease over time, 2) sustained improvement requires time and follow-up, and 3) effectiveness directly correlated to amount of time spent with educator

<table>
<thead>
<tr>
<th>PICOS component</th>
<th>Study question</th>
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<tbody>
<tr>
<td>P Patient population or problem</td>
<td>Adults with type 2 diabetes</td>
</tr>
<tr>
<td>I Intervention</td>
<td>Diabetes Self-Management Education</td>
</tr>
<tr>
<td>C Comparison group</td>
<td>Usual care</td>
</tr>
<tr>
<td>O Outcomes</td>
<td>A1C</td>
</tr>
<tr>
<td>S Setting</td>
<td>Randomized controlled trials</td>
</tr>
</tbody>
</table>

## Participants

<table>
<thead>
<tr>
<th></th>
<th>Intervention Group (SD)</th>
<th>Usual Care Controls (SD)</th>
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</thead>
<tbody>
<tr>
<td>Mean Age</td>
<td>58.5 (5.21)</td>
<td>58.7 (5.35)</td>
</tr>
<tr>
<td>Mean Baseline A1C</td>
<td>8.55 (1.11)</td>
<td>8.48 (1.08)</td>
</tr>
<tr>
<td>Number Enrolled</td>
<td>11,854</td>
<td>11,093</td>
</tr>
<tr>
<td>Number at Follow-up A1C</td>
<td>11,584</td>
<td>10,466</td>
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</tbody>
</table>

## Change in A1C by Mode of DSME Delivery

<table>
<thead>
<tr>
<th>Mode</th>
<th>Number of interventions</th>
<th>Intervention (SD)</th>
<th>Control (SD)</th>
<th>Absolute difference in A1C with addition of DSME</th>
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</thead>
<tbody>
<tr>
<td>All Models Together</td>
<td>118</td>
<td>-0.74(0.63)</td>
<td>-0.17(0.5)</td>
<td>0.57</td>
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<tr>
<td>Combination - Group &amp; Ind</td>
<td>22</td>
<td>-1.0(0.6)</td>
<td>-0.22(0.62)</td>
<td>0.88</td>
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<tr>
<td>Group</td>
<td>33</td>
<td>-0.62(0.46)</td>
<td>-0.10(0.42)</td>
<td>0.52</td>
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<tr>
<td>Individual</td>
<td>47</td>
<td>-0.78(0.63)</td>
<td>-0.28(0.46)</td>
<td>0.50</td>
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<tr>
<td>Remote</td>
<td>12</td>
<td>-0.50(0.67)</td>
<td>-0.17(0.46)</td>
<td>0.33</td>
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</table>

If DSME was a pill, would you prescribe it?

<table>
<thead>
<tr>
<th>Benefits of DSME*</th>
<th>Benefits of Metformin+</th>
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<tbody>
<tr>
<td>Efficacy</td>
<td>High</td>
</tr>
<tr>
<td>Hypo Risk</td>
<td>Low</td>
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<tr>
<td>Weight</td>
<td>Neutral / Loss</td>
</tr>
<tr>
<td>Side Effects</td>
<td>None</td>
</tr>
<tr>
<td>Costs</td>
<td>Low / Savings</td>
</tr>
<tr>
<td>Psychosocial benefits</td>
<td>High</td>
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</tbody>
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*Powers MA. Diabetes Spectrum (In press)

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<tr>
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<tbody>
<tr>
<td>Efficacy</td>
<td>High</td>
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<td>Hypo Risk</td>
<td>Low</td>
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<td>Weight</td>
<td>Neutral / Loss</td>
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<tr>
<td>Side Effects</td>
<td>GI</td>
</tr>
<tr>
<td>Cost</td>
<td>Low</td>
</tr>
<tr>
<td>Psychosocial benefits</td>
<td>NA</td>
</tr>
</tbody>
</table>

DSME/S Position Statement

Current State and Barriers
Sorry State of DSME/S

• 6.8% of individuals with newly diagnosed T2D with private health insurance received DSME/S within 12 months of diagnosis

• 5% of Medicare participants received DSME/S

Li et al. MMWR. (2014)
Barriers to DSME/S

- Time
- Location
- Referral
- Diversity
- Value confusion
- Clear expectations
- Cost, reimbursement
DSME/S Position Statement

When and What - 4 Critical Times

• When is DSME/S recommended?
• What DSME/S is needed at various times and by whom?
• How is DSME/S best provided?
Establishing Diabetes Standards of Care

Research / Evidence

ADA. Diabetes Care (2016)
Establishing Diabetes Standards of Care

ADA. Diabetes Care (2016)
When

4 Critical times to assess, adjust, provide DSME
1. At diagnosis
2. Annually
3. When complicating factors occur
4. When transitions in care occur

Areas of focus and action steps by
- Primary care providers /endocrinologists/ clinical care team
- Diabetes self-management education
When

- Newly diagnosed. All newly diagnosed individuals with type 2 diabetes should receive DSME/S.
- Ensure that both nutrition and emotional health are appropriately addressed in education or make separate referrals.

What

- Answer questions and provide emotional support regarding diagnosis.
- Provide overview of treatment and treatment goals.
- Teach survival skills to address immediate requirements (safe use of medication, hypoglycemia if needed, introduction of eating guidelines).
- Identify and discuss resources for education and ongoing support.
- Make referral for DSME/S and MNT.

Diabetes self-management education and support for adults with type 2 diabetes: Algorithm of care

Adopt Standards of Medical Care in Diabetes recommends all patients be assessed and referred for:

- Nutrition: Registered dietitian for medical nutrition therapy.
- Education: Diabetes self-management education and support.
- Emotional Health: Mental health professionals, if needed.

Four critical times to assess, provide, and adjust diabetes self-management education and support:

1. At diagnosis
2. Annual assessment of education, nutrition, and emotional needs
3. Where new complicating factors influence self-management
4. When transitions in care occur

When primary care provider or specialist should consider referral:

- Newly diagnosed. All newly diagnosed individuals with type 2 diabetes should receive DSME/S.
- Ensure that both nutrition and emotional health are appropriately addressed in education or make separate referrals.

Diabetes education: Areas of focus and action stage

- Assess cultural influences, health beliefs, current knowledge, physical limitations, family support, financial status, medical history, literacy, numeracy to determine content to provide and how:
  - Medications—choices, action, titration, side effects.
  - Monitoring blood glucose—when to test, interpreting and using glucose pattern management for feedback.
  - Physical activity—safety, short-term vs. long-term goals/recommendations.
  - Preventing, detecting, and treating acute and chronic complications.
  - Nutrition—food plan, planning meals, purchasing food, preparing meals, portioning food.
  - Risk reduction—smoking cessation, foot care.
  - Developing personal strategies to address psychosocial issues and concerns.
  - Developing personal strategies to promote health and behavior change.

1. At diagnosis

- All individuals with type 2
- Include medical nutrition therapy (for all) and emotional health, as needed

2. Annually

Annual assessment of education, nutrition and emotional health needs

Refer if:
- Limited prior education
- Change in medication, activity, or nutritional intake
- HbA1c out of range
- Planning pregnancy
- Weight or other nutrition concerns
- New life situations and competing demands

Refer to:
- Maintain positive health outcomes
- Provide support to attain and sustain behavior change(s)

3. Complicating factors

*When new complicating factors influence self management, such as:*
  - Health conditions
  - Physical conditions
  - Emotional factors
  - Basic living needs

4. Transitions

*When transition in care occur, such as:*
  - Living situations
  - Medical care team
  - Insurance coverage
  - Ages related change

Case Study

• Sophie Jones is 58 years old and has had type 2 diabetes for 5 years. She is taking metformin (1000 mg twice a day).
• She has hypertension, hyperlipidemia, obesity, and depression and takes an additional three pills a day for these conditions.
• Over the past 5 years her A1c has been <8% until now – it was 8.5%.

• Should a referral be made to DSME program (and registered dietitian)?
  – Critical stage #2 – Annual assessment of education, nutrition and emotional health needs
  – Know on-going support is critical for maintaining behavior change(s)
  – Know lifestyle decisions and changes can affect A1c; need review of eating patterns and activity
  – Know that diabetes is a progressive disease; may need medication change based on food patterns, activity, and glucose patterns
  – Know that diabetes can be a burden; may need support to cope with the ongoing burden of diabetes
Case Study

• Sophie Jones is 68 years old and has had type 2 diabetes for 15 years. She is taking insulin (mealtime and background; 4 shots a day) and metformin (1000 mg twice a day).
• She has hypertension, hyperlipidemia, sleep apnea, obesity, and depression and takes an additional six pills a day for these conditions.
• Over the past 15 years her A1c has been 7-8% “when I am on track” and goes up to 8% to 10% “when I get overwhelmed and tired of working on my diabetes.”
• Sophie recently was diagnosed with cancer and is starting chemo therapy.

• Should a referral be made to the DSME program (and registered dietitian)?
  – Critical stage #3 – *When complicating factors occur*
  – Know that health outcomes improve when A1c goals are met
  – Know chemo can increase glucose; may need to start NPH
  – Know Sophie gets overwhelmed; may need to simplify self-management plan
  – Know chemo can affect eating (taste, desire to eat, time to prepare food); may need changes in food plan and mealtime and background insulin
  – Maintain contact for continued evaluation, support and adjustments
DSME/S Position Statement

Guiding Principles
DSME/S Algorithm of Care: Guiding Principles

1. **Engagement** Provide DSME/S and care that reflects person’s life, preferences, priorities, culture, experiences, and capacity

2. **Information sharing** Determine what the patient needs to make decisions about daily self-management

3. **Psychosocial and behavioral support** Address the psychosocial and behavioral aspects of diabetes

4. **Integration with other therapies** Engage integration and referrals with and for other therapies

5. **Coordination of care** Ensure collaborative care and coordination with treatment goals of DSME/S is provided across specialty care, facility-based care, and community organizations

Game changer: 4 critical times

• This position statement and algorithm provide the evidence and strategies for the provision of education and support services to all adults living with type 2 diabetes. It is imperative that the health care community, responsible for delivering quality care, mobilizes efforts to address the barriers and explores resources for DSME/S in order to meet the needs of adults living with and management type 2 diabetes.

DSME/S Position Statement

Implementation
Using the Guidelines

- Provides the evidence base for the value of education and the current referral patterns
- Ties the referral to the 4 times that education is critical
- Provides the objective criteria for referral
- Provides the HCP with the framework to make a referral and what to expect from the referral
- Resource for health systems when designing decision-support guidance for diabetes education
## Target audiences for implementation

<table>
<thead>
<tr>
<th>Providers / Clinicians</th>
<th>Programs</th>
<th>Individuals</th>
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<tbody>
<tr>
<td>PCPs</td>
<td>DSME program</td>
<td>Persons with diabetes</td>
</tr>
<tr>
<td>Endocrinologists</td>
<td>ERP and DEAP programs</td>
<td>Educators</td>
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<td>Hospitalists</td>
<td>Health system</td>
<td>Members of NCDBE</td>
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<td>Professional organizations</td>
<td>Medical Homes</td>
<td>Bloggers</td>
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<tr>
<td>Student training programs</td>
<td>State health programs / health departments</td>
<td>Industry reps</td>
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</table>
Thank you.
Questions?