Successful Implementation of Diabetes Self-Management Education at Your Practice

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March 22, 2019
Objectives

• Review HSAG and the Everyone with Diabetes Counts (EDC) program.
• Discuss successful strategies and lessons learned by other practices who have implemented a diabetes self-management education (DSME) Program.
• Discover ways to implement diabetes self-management in your practice.
HSAG is the Medicare QIN-QIO for Arizona, California, Florida, Ohio, and the U.S. Virgin Islands.
QIO Task Areas

- Cardiac Health
- Disparities in Diabetes
- Transforming Clinical Practice
- Antibiotic Stewardship in Communities
- Coordination of Care
- Behavioral Health
- Healthcare-Acquired Conditions in Nursing Homes
- Support of Clinicians in the Quality Payment Program
- Improve Hand Hygiene and Injection Practices in ASCs*

Patient is at the center of care
The EDC Program

EDC

Everyone with Diabetes Counts
Disparities Exist in Diabetes Care

- African Americans
- Hispanics/Latinos
- American Indians/Native Americans/Alaska Natives
- Asians/Pacific Islanders
- People living in rural areas/Appalachia
- Dual-eligible beneficiaries
- Low income housing
Minority Areas of Focus

• Top 10 counties by target population:
  1. Cuyahoga – 10,920
  2. Hamilton – 5,634
  3. Franklin – 5,492
  4. Montgomery – 3,227
  5. Lucas – 2,797
  6. Summit – 2,274
  7. Mahoning – 1,389
  8. Stark – 958
  9. Lorain – 923
  10. Butler – 687
Priority Areas of Focus

• Rural
  – Muskingum – 2,094
  – Erie – 1,890
  – Hancock – 1,886
  – Marion – 1,756
  – Ross – 1,705
  – Fairfield – 1,685
  – Ashtabula – 1,419
  – Scioto – 1,243
  – Wayne – 1,238
  – Defiance – 1,206
HSAG’s Role in EDC

• Increase adoption and implementation of DSME.
  – Diabetes Empowerment Education Program™ (DEEP™), University of Illinois at Chicago (UIC)
  – Diabetes Self-Management Program (DSMP), Stanford University

• Train individuals and organizations statewide to offer DSME.

• Impact more than 4,000 Medicare beneficiaries with diabetes or pre-diabetes.

• Provide DSME sustainability throughout the state.
DEEP™

Program description:

– Evidence-based program
– Six weekly workshops
– Each class is two hours long
– Taught by one certified DEEP™ peer educator
– Can be delivered in any language
– Interactive, hands-on, group learning activities, and games, including visual aids and demonstrations
– Weekly module evaluations allowing peer educator to adjust delivery, address challenges of participants, etc.
DEEP™ Modules

- Diabetes risk factors and complications
- Nutrition
- Physical activity
- Use of the glucose meter
- Medications
- Building partnerships with healthcare team
- Psychosocial effects of illness
- Problem-solving strategies
- How to access community diabetes resources
“Tell me and I forget, teach me and I may remember, involve me and I learn.”

-Benjamin Franklin
Interactive Demonstrations
Understanding a Food Label

Cheeseburger
Fast food cheeseburger; single, large patty with condiments and vegetables (233 g)

Nutrition Facts
Serving Size 233 g

Amount Per Serving
Calories 480  Calories from Fat 215

% Daily Value*
Total Fat 24g   37%
- Saturated Fat 9g  45%
- Trans Fat 1g
Cholesterol 79mg  26%
Sodium 897mg   37%
Total Carbohydrate 39g  13%
- Dietary Fiber 3g  13%
- Sugars 9g
Protein 27g

Calcium 22%  Iron 24%

*Percent Daily Values are based on a 2,000 calorie diet. Your daily values may be higher or lower depending on your calorie needs.

NutritionData.com

Cola Soda
Carbonated beverage, cola, contains caffeine, one can 12 fluid ounces (368 g)

Nutrition Facts
Serving Size 368 g

Amount Per Serving
Calories 136  Calories from Fat 1

% Daily Value*
Total Fat 0g   0%
- Saturated Fat 0g
- Trans Fat 0g
Cholesterol 0mg  0%
Sodium 15mg  1%
Total Carbohydrate 35g  12%
- Dietary Fiber 0g
- Sugars 33g
Protein 0g

Calcium 1%  Iron 2%

*Percent Daily Values are based on a 2,000 calorie diet. Your daily values may be higher or lower depending on your calorie needs.

NutritionData.com

Fries
Fast food, potato, french fried in vegetable oil, 1 large (169 g)

Nutrition Facts
Serving Size 169 g

Amount Per Serving
Calories 539  Calories from Fat 259

% Daily Value*
Total Fat 32g  44%
- Saturated Fat 7g  34%
- Trans Fat 7g
Cholesterol 0mg  0%
Sodium 328mg  14%
Total Carbohydrate 63g  21%
- Dietary Fiber 6g  24%
- Sugars 1g
Protein 6g

Calcium 2%  Iron 13%

*Percent Daily Values are based on a 2,000 calorie diet. Your daily values may be higher or lower depending on your calorie needs.

NutritionData.com
### Total Fat, Salt, and Carbs

13 teaspoons of lard
½ teaspoon of sodium
28 teaspoons of sugar
Program Delivery Method

- Certified peer educator
- Only one leader required to lead workshop
- Allows for make-up sessions
Training Requirements

• Attend a three-day, train-the-trainer workshop, and receive certification to facilitate DEEP™ workshops as a peer educator.

• Peer-educator training is taught by lead trainers.

• Lead-trainer training is taught by senior trainers.

• No-cost training offered.
Data Collection and Sharing

• Pre/Post Surveys—Evaluates learning and behavior change
  – What is a retinal exam and nephropathy?
  – In the last week, how many days did you eat fruits/vegetables, exercise, take your medicine, check your blood sugar, and check your feet?
  – Do you feel comfortable communicating with your healthcare team?
  • 14 total questions
    – 4 questions: Diabetes knowledge
    – 5 questions: Coping with diabetes
    – 5 questions: Self-care methods

• Administered during first week and then again at the sixth week
Coping Questions

Analysis completed for all Medicare beneficiaries with diabetes (as reported on the demographic form) who completed a DSME class by 11/07/2018.

Knowledge Questions

Analysis completed for all Medicare beneficiaries with diabetes (as reported on the demographic form) who completed a DSME class by 11/07/2018.

Empowerment Questions

Analysis completed for all Medicare beneficiaries with diabetes (as reported on the demographic form) who completed a DSME class by 11/07/2018.

The goals of the Health Center Program Diabetes QI Initiative are:

1. Improve diabetes treatment and management;
2. Increase diabetes prevention efforts; and
3. Reduce health disparities.

The measures of the Health Center Program Diabetes QI Initiative are:

1. Reduce by 5% the number of patients who develop diabetes by year 2020.
2. Reduce by 5% the number of patients with diabetes with an HbA1c value greater than 9% by year 2020.
3. Increase by 5% the number of adult patients who receive weight screenings and counseling by year 2020.
4. Increase by 5% the number of pediatric patients who receive weight screenings and counseling by year 2020.
5. Reduce by 1% the disparities gap between racial and ethnic groups with the highest and lowest rates of diabetes by year 2020.
• Care Management (CM) and Support
  – CM Competency B – CM 08 (1 Credit)
    • Self-management plans: Includes a self-management plan in individual care plans

• Performance Management and QI
  – QI Competency A – QI 04 (Core)
    • B: Qualitative Data. Obtains feedback from patients/families/caregivers through qualitative means
      – Whole-person care/self-management support (May include provision of comprehensive care and self-management support ... and support for changing health habits and making health care decisions).
        o Also applies to vulnerable populations and/or health disparities section (QI 05 – 07)
Knowing and Managing Your Patients (KM)

- KM Competency A – KM 07 (1 credit)
  - Understands social determinants of health for patients, monitors at the population level, and implements care interventions based on these data.

- KM Competency C – KM 12 (Core)
  - Proactively and routinely identifies populations of patients and reminds them, or their families/caregivers, about needed services
    - C. Chronic or acute care services

- KM Competency F – KM 22 (1 credit)
  - Provides access to educational resources, such as material, peer-support sessions, group classes, and online self-management tools or programs

• QI Competency C: Reporting Performance
  – QI 18 (2 Credits) – Reporting Performance Measures to Medicare/Medicaid: Reports clinical quality measures to Medicare or to a Medicaid agency
    • One chronic or acute care clinical measure

QI = quality improvement
Partners

- Ohio Department of Aging
  - Area Agencies on Aging; https:// conta.cc/2UJtPpT
- Ohio Association of Community Health Centers
  - Federally Qualified Health Centers (FQHCs)
- Ohio Department of Health
  - Rural health clinics
- Physician practices
- Health plans
- Central State University Extension Office
- Community organizations
  - Senior housing
  - Senior centers
  - Faith-based community
- Evi-Base
Getting Started? Hurry!

- Gather a team for accountability.
- Establish consistent, ongoing workshops.
  - Determine where they will be held.
    - Practice, local library, hospital, etc.
- Identify the patient population.
  - HbA1c level over “x”
  - Patients with pre-diabetes
  - Patients recently discharged from hospital stay
- Determine a mode of referral.
  - Letter from provider
  - ‘Rx pad’
  - Post cards
  - Phone calls from practice staff members
Questions?
This material was prepared by Health Services Advisory Group, the Medicare Quality innovation Network-Quality Improvement Organization for Ohio, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication No. OH-11SOW-03052019-01