Understanding and Applying the ADA Standards of Care in Community Healthcare Settings

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Sandra Leal, PharmD, MPH, FAPhA, CDE
EVERY 21 SECONDS

Someone in the U.S. is Diagnosed with Diabetes

34 million People in the U.S. (1 in 11)

Source: CDC. National Diabetes Statistics Report, 2020
84 MILLION
American Adults have Prediabetes

90% of Americans with prediabetes don’t know they have it

https://www.diabetes.org/risk-test
THE DIABETES CRISIS

PRIMARY FACTORS FUELING THE CRISIS

SOCIAL DETERMINANTS
- Poverty; lack of access to adequate health care, health insurance, nutritious foods, outdoor space and medications

BIOLOGICAL FACTORS
- Age, genetics and ethnicity

LIFESTYLE FACTORS
- Unhealthy food and physical inactivity leading to obesity
Our Mission

To prevent diabetes

To cure diabetes

To improve the lives of those with diabetes!
Diabetes disproportionately affects various ethnic and minority populations.
Rates of Diagnosed Diabetes by Race/Ethnic Groups

7.5% of non-Hispanic Whites
9.2% of Asian Americans
12.5% of Hispanics/Latinos
11.7% of non-Hispanic Blacks
14.7% of American Indians/Alaskan Natives

Asian Americans:
5.6% of Chinese
10.4% of Filipinos
12.6% of Asian Indians
9.9% of other Asian Americans

Latino/Hispanic Adults:
8.3% of Central and South Americans
6.5% of Cubans
14.4% of Mexican Americans
12.4% of Puerto Ricans
Statistics by State

The Burden of Diabetes in Arizona

Diabetes is an epidemic in the United States. According to the Centers for Disease Control and Prevention (CDC), over 34 million Americans have diabetes and face its devastating consequences. What’s true nationwide is also true in Arizona.

Arizona’s diabetes epidemic:
- Approximately 572,000 people in Arizona, or 10.8% of the adult population, have diagnosed diabetes.
- An additional 164,000 people in Arizona have diabetes but don’t know it, greatly increasing their health risk.
- There are 1,893,000 people in Arizona, 34.5% of the adult population, who have prediabetes with blood glucose levels that are higher than normal but not yet high enough to be diagnosed as diabetes.
- Every year an estimated 37,000 people in Arizona are diagnosed with diabetes.

Diabetes is expensive:
People with diabetes have medical expenses approximately 2.3 times higher than those who do not have diabetes.
- Total direct medical expenses for diagnosed diabetes in Arizona were estimated at $5.1 billion in 2017.
- In addition, another $1.7 billion was spent on indirect costs from lost productivity due to diabetes.

Improving lives, preventing diabetes and finding a cure:
In 2019, the National Institute of Diabetes and Digestive and Kidney Diseases at the National Institutes of Health invested $16,715,748 in diabetes-related research projects in Arizona.

The Division of Diabetes Translation at the CDC provided $1,831,139 in diabetes prevention and educational grants in Arizona in 2018.

Learn more at diabetes.org | 1-800-DIABETES (800-343-2363) 02/2020

Statistics

Take a Closer Look: Statistics by State

Fact sheets
- Alabama
- Alaska
- Arizona
- Arkansas
- California
- Colorado
- Connecticut
- Delaware

diabetes.org/take-closer-look-statistics-state
Despite Increasing Number of New Diabetes Medications and Technologies …

- Achievement of individualized targets declined from 69.8% to 63.8%

Despite Increasing Number of New Diabetes Medications and Technologies …

- The percentage with HbA1c >9.0% increased from 12.6% to 15.5%
Disruption is Needed to Improve Care Quality in Diabetes Type 2 Diabetes Trends in the U.S. 2006-2013

Advances in health technology, drug therapies and policy have NOT translated to improvements in diabetes care quality

Therapeutic Advances Over Past 20 Years

ADA Standards of Care
1989

SGLT-2 Inhibitor
Bromocriptine
DPP-4 inhibitor
Pramlintide
GLP-1R agonist
Meglitinide
TZD
Basal insulin
Rapid-acting insulin
α-Glucosidase inhibitor
Metformin

Insulin
SFU

What’s Wrong with this Picture?

- Decline in % of patients at HbA1c <7%
- At best, only about 50% of patients at Goal
- Increase in % of patients with very poor control
- Unacceptable level of morbidity and mortality
- Diabetes-related costs to society are tremendous

ALL THIS DESPITE MORE THAN 40 NEW T2D TREATMENT OPTIONS APPROVED SINCE 2005
The Root of the Problem...

Therapeutic Inertia
What is Therapeutic Inertia?

THERAPEUTIC INERTIA is the failure to initiate or intensify (or sometimes de-intensify) the therapy regimen when a patient’s therapeutic goals are not met.

CLINICAL INERTIA typically also includes underuse of therapies and interventions known to prevent or delay negative outcomes including DSMES, lack of screening, risk assessment, preventive measures, and referrals.
Decision Cycle for Patient-Centered Glycemic Management in Type 2 Diabetes

**Goals of Care**
- Prevent complications
- Optimize quality of life

**Review AND Agree ON Management Plan**
- Review management plan
- Mutual agreement on changes
- Ensure agreed modification of therapy is implemented in a timely fashion to avoid clinical inertia
- Decision cycle undertaken regularly (at least once/twice a year)

**Assess Key Patient Characteristics**
- Current lifestyle
- Comorbidities i.e. ASCVD, CKD, HF
- Clinical characteristics i.e. age, HbA1c, weight
- Issues such as motivation and depression
- Cultural and socio-economic context

**Ongoing Monitoring and Support Including:**
- Emotional well-being
- Check tolerability of medication
- Monitor glycemic status
- Biofeedback including SMBG, weight, step count, HbA1c, BP, lipids

**Consider Specific Factors Which Impact Choice of Treatment**
- Individualized HbA1c target
- Impact on weight and hypoglycemia
- Side effect profile of medication
- Complexity of regimen i.e. frequency, mode of administration
- Choose regimen to optimize adherence and persistence
- Access, cost, and availability of medication

**Implement Management Plan**
- Patients not meeting goals generally should be seen at least every 3 months as long as progress is being made; more frequent contact initially is often desirable for DSMES

**Agree On Management Plan**
- Specify SMART goals:
  - Specific
  - Measurable
  - Achievable
  - Relevant
  - Time limited

**Shared Decision-Making To Create A Management Plan**
- Involves an educated and informed patient (and their family/caregiver)
- Seeks patient preferences
- Effective consultation includes motivational interviewing, goal setting, and shared decision-making
- Empowers the patient
- Ensures access to DSMES
The American Diabetes Association is internationally recognized and trusted as an authority in diabetes care.
Reach and Creditability

Our evidence-based, peer-reviewed Standards of Medical Care in Diabetes guides health care practitioners and informs diabetes educators around the country and the world.

[Link to ADA Standards of Care app]

[adastandardsapp.diabetes.org/ada-web-app/home/]

[American Diabetes Association logo]
Your Diabetes Care and Management Plan

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Lead Your Diabetes Care Team
Manage Your Blood Sugar
Protect Your Heart Health
Protect Your Kidney Health
Protect Yourself from Other Diabetes Complications
Your Diabetes Care and Management Plan Summary

It's really important that people with diabetes know that following a diabetes care plan can help them stay healthier.

Diabetes tends to change over time. At first, diet and exercise might be enough. But down the line, most people will need medication to stay healthy.

If you need one or more medications does not mean you failed. It just means your diabetes is progressing—and you didn’t do anything wrong.

— Dr. K. Allen.
# Diabetes Care Plan Summary

## Your Diabetes Tests and Targets

Work with your diabetes care team to set targets together, based on your health care needs.

<table>
<thead>
<tr>
<th>Test</th>
<th>How Often</th>
<th>Target Values</th>
<th>Date &amp; Results</th>
<th>Date &amp; Results</th>
<th>Date &amp; Results</th>
<th>Date &amp; Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example A1C Target</td>
<td>Every 3 to 6 months</td>
<td>6.5</td>
<td>6.0</td>
<td>9/30/2020</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A1C Target</td>
<td>Every 3 to 6 months</td>
<td>6.5</td>
<td>6.0</td>
<td>9/30/2020</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glucose – Fasting</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Glucose – 2 hours after eating</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Time in Range (TIR)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>Every clinic visit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cholesterol (lipid profile)</td>
<td>Every year</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye Exam</td>
<td>Every year</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Foot Exam</td>
<td>Every clinic visit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flu Shot</td>
<td>Every year</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kidney Function (ACR or eGFR)</td>
<td>Every year</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dental Exam</td>
<td>Every 6 months</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**NOTES:** __________________________

American Diabetes Association
1-800-DIABETES (342-2363)  diabetes.org
### Your Current Medications

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Date Prescribed</th>
<th>Dosage</th>
<th>Days of Week Taken</th>
<th>Time of Day Taken</th>
<th>Reason</th>
<th>New or Changed Medicine?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Example: Metformin</td>
<td>10/01/2020</td>
<td>500 mg</td>
<td>twice every day</td>
<td>with AM and PM meals</td>
<td>Manage blood glucose</td>
<td>New</td>
</tr>
</tbody>
</table>

### Lifestyle Change Goals:
- Weight loss goal: ________________
- Eating and nutritional changes: ________________
- Physical activity—resistance training: ________________
- Physical activity—aerobic training: ________________
- Stop smoking

### Referrals Recommended:
- Diabetes self-management education and support (DSMES)
- Behavioral health specialist
- Medical nutrition therapy (MNT)
- Social worker/therapist (emotional health)
- Eye doctor (optometrist or ophthalmologist)
- Cardiologist (heart health)
- Foot doctor (podiatrist)
- Kidney doctor (nephrologist)
- Endocrinologist (additional diabetes health support)
- Dentist
- Exercise specialist/physical therapist
- Pharmacist
- Vaccines/Immunizations
  - Pneumonia
  - Hepatitis B
  - Tdap
  - Zoster
  - Other

### Notes:

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1-800-DIABETES (1-800-342-3233) [diabetes.org](http://diabetes.org)
Improving Standards of Care

50K health care practitioners' certifications delivered via ADA in-person and online programs

1,600+ diabetes education programs at 3,600 sites have received ADA recognition—qualifying them for Medicare reimbursement

20K professional members of the American Diabetes Association
Promotores de Salud, Community Health Workers (CHWs)

1. Community members who work almost exclusively in community settings and who serve as connectors between health care consumers and providers to promote health.

2. Uniquely qualified as connectors because they speak the language of their community, know what is meaningful, and recognize cultural buffers.

“The definition of insanity is doing the same thing over and over and expecting different results.” - Albert Einstein

Therapeutic Inertia:
State Laws

Figure 1: States with Select CHW Laws in Effect, December 2012

Source: https://www.cdc.gov/dhdsp/pubs/docs/chw_state_laws.pdf
# Infrastructure, Identity, Workforce, Financing

Table 2: States with Select CHW Laws in Effect, December 2012

<table>
<thead>
<tr>
<th>State</th>
<th>Infrastructure</th>
<th>Professional Identity</th>
<th>Workforce Development</th>
<th>Financing</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Establish CHW advisory body</td>
<td>CHW scope of practice</td>
<td>CHW certification or training process</td>
<td>State reimburses or creates incentives for CHW services</td>
</tr>
<tr>
<td>AK</td>
<td>Yes</td>
<td>Yes</td>
<td>Required¹</td>
<td>Authorized¹</td>
</tr>
<tr>
<td>CA</td>
<td></td>
<td></td>
<td></td>
<td>Authorized¹</td>
</tr>
<tr>
<td>DC</td>
<td></td>
<td>Authorized¹</td>
<td></td>
<td>Authorized¹</td>
</tr>
<tr>
<td>MD</td>
<td></td>
<td></td>
<td></td>
<td>Authorized¹</td>
</tr>
<tr>
<td>MA</td>
<td>Yes</td>
<td>Yes</td>
<td>Authorized¹</td>
<td>Authorized¹</td>
</tr>
<tr>
<td>MN</td>
<td></td>
<td>Required¹</td>
<td>Authorized¹</td>
<td>Authorized¹</td>
</tr>
<tr>
<td>NM</td>
<td>Yes</td>
<td>Yes</td>
<td>Authorized¹</td>
<td>Authorized¹</td>
</tr>
<tr>
<td>NY</td>
<td></td>
<td></td>
<td></td>
<td>Authorized¹</td>
</tr>
<tr>
<td>OH</td>
<td>Yes</td>
<td>Required*</td>
<td>Required*</td>
<td>Authorized¹</td>
</tr>
<tr>
<td>OR</td>
<td>Yes</td>
<td>Yes</td>
<td>Required*</td>
<td>Required*</td>
</tr>
<tr>
<td>RI</td>
<td>Yes</td>
<td>Yes</td>
<td>Required*</td>
<td>Required*</td>
</tr>
<tr>
<td>TX</td>
<td>Yes</td>
<td>Yes</td>
<td>Required*</td>
<td>Required*</td>
</tr>
<tr>
<td>UT</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>VA</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>WA</td>
<td>Yes</td>
<td>Yes</td>
<td>Authorized¹</td>
<td>Required¹</td>
</tr>
<tr>
<td>WV</td>
<td></td>
<td></td>
<td>Required*</td>
<td>Required*</td>
</tr>
</tbody>
</table>

Empty cells indicate that state law is silent on this issue or no law was identified.
Yes indicates state law either authorizes or requires in full or in part the select recommendation.
*Law has exceptions or only applies in certain circumstances (i.e., tuberculosis control).
Core Competencies to Consider

- Communication Skills
- Interpersonal Skills
- Service Coordination Skills
- Capacity Building Skills
- Advocacy Skills
- Teaching Skills
- Organization Skills
- Knowledge Base Skills

Source: Texas A&M: https://nchwtc.tamhsc.edu/chpromotora-certification-course-overview/
Conceptual Framework of CHWs and Patients as Partners in Health

Perceptions and experiences of promotoras and pharmacists in an academic-community partnership providing telephonic MTM services to a Spanish-speaking, rural population: a focus group study

Blanca Guerra, PharmD; Shannon Vellis, MPH; David R. Axon, PhD, MPH, MS; Sandra Leal, PharmD, MPH, FAPhA; Terri Warholak, PhD, RPh, FAPhA; Ann M. Taylor, MPH, MCHES; and Nicole Scovis, PharmD

What is already known about this subject

• Promotoras are Hispanic, lay health workers who assist patients in their communities by serving as intermediaries between medical providers, pharmacists, and other clinical staff.
• In 2014, an academic-based medication management center began collaborating with community clinics and independent pharmacies to provide telephonic medication therapy management (MTM) services to patients in rural Arizona as part of the Rural Arizona Medication Therapy Management (RAMTM) program.
• Limited data exist regarding the collaboration between pharmacists/pharmacy interns and promotoras in health care settings.

What this study adds

• This study provided insight into the perceptions and opinions of pharmacists/pharmacy interns and promotoras who participated in the RAMTM program.
• This study adds to the body of literature on strategies to improve collaborative care using pharmacists/pharmacy interns, promotoras, and other health care providers.

Author affiliations

Blanca Guerra, PharmD, University of Arizona College of Pharmacy and SinicaRx, Tucson, AZ; Shannon Vellis, MPH, David R. Axon, PhD, MPH, MS; Terri Warholak, PhD, RPh, FAPhA, and Ann M. Taylor, MPH, MCHES, University of Arizona College of Pharmacy, Tucson, Sandra Leal, PharmD, FAPhA, SinicaRx, Tucson, AZ, and Nicole Scovis, PharmD, Nabila Khan HealthCare, Tucson, AZ.

AUTHOR CORRESPONDENCE: Shannon Vellis, 7143076022, vellis@pharmacy.arizona.edu

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Resources for Community Health Workers (CHW's)

Welcome community health workers (CHWs), promotores de salud, community health representatives, peer health educators and other frontline public health workers! As people who are trusted members of your community or of a close understanding of the communities you serve, you are critical partners in helping us to support people with and at risk for diabetes. We hope the resources below will be useful to both you and your patients/clients.

Check out our NEW CHW Professional Membership for only $35. ADA now has a Professional Member category for community health representatives, peer health educators and other frontline public health workers who help to support people with and at risk for diabetes. Become a Professional Member of the American Diabetes Association and expand your knowledge, enhance your perspective and grow your connections through exclusive opportunities and resources that come only with membership.

Become a Professional Member today.

We hope the resources below will be useful to both you and your patients/clients.

Resources for CHWs

Free Webinar Series: Health Disparities - Community Health Workers' Resources: Learn more about health disparities and community health workers with the American Diabetes Association's webinar series. View webcasts with free CME/CE credits from select webinars.

Standards of Care: Our Standards of Care highlight the importance of CHWs in diabetes prevention and management, especially among underserved communities.

"CHWs can be part of a cost-effective, evidence-based strategy to improve the management of diabetes and cardiovascular risk factors in underserved communities and health care systems.

"Improving care and promoting health in populations: Standards of Medical Care in Diabetes.

"The use of community health workers to support Diabetes Prevention Program efforts has been shown to be effective with cost savings."

"Prevention or delay of type 2 diabetes: Standards of Medical Care in Diabetes.

"There is growing evidence for the role of community health workers, as well as peer and lay leaders, in providing ongoing support [as part of a diabetes self-management education and support program]."

Clinical Corner

Standards of Care

COVID-19 and Diabetes

Patient Education Library

Know Diabetes by Heart

Focus on Diabetes - Eye Health Initiative

Overcoming Therapeutic Inertia

Diabetes is Primary

Free Program for Patients

Diabetes Core Update

Clinical Diabetes

Diabetes Spectrum

DiabetesPro SmartBrief

Medicare Mail-Order Program for Diabetes Testing Supplies

Acute and Chronic Complications

Compendia

Resources for Community Health Workers (CHW’s)

professional.diabetes.org/CHW
Health Disparities - CHW Webinar Series

Free Webinar Series: Health Disparities - Community Health Workers’ Resources

Overview

As part of the American Diabetes Association’s (ADA) Strategic Plan to Help People Living with Diabetes and Their Families Thrive, ADA continues to prioritize health disparities and health equity through various mission initiatives.

Community Health Workers (CHWs) are trusted, knowledgeable frontline health workers who typically come from the communities they serve. CHWs bridge cultural and linguistic barriers, expand access to coverage and care, and help to improve health outcomes. CHWs also build individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, and social support.

Learn more about health disparities and community health workers with the American Diabetes Association’s webinar series! Please Note: Only select webinars in the webinar series are designated for CME/CE credits.

Webcasts

View webcasts with free CME/CE credits from the select webinars.

View the Webcasts

Upcoming Webinars

Past Webinars

Webinar #1 - Wednesday, December 11, 2019 - 1:00 PM ET
Community Health Workers (CHWs): Strong Evidence-base for Embracing CHWs into the Public Health and Healthcare Workforce

CE Credits Available: 1.0

Speakers

Daniel Fox, BS, CHW, JSA (John Snow Institute), National Association of Community Health Workers
Selay Rodriguez, BSN, MSN, CDE, Centers for Disease Control and Prevention

Learning Objectives
Diabetes Self-Management Education and Support

DSMES

www.diabetes.org/findaprogram
ADA Professional Membership

- New CHW Membership category only $35
- Professional Education opportunities
- CHW Webinar Series
  - Community Health Workers (CHWs): Strong Evidence-base for embracing CHWs into the public health and healthcare workforce
  - Diabetes 101: Resources for Community Health Workers
  - What Health Care Professionals Need to Know About Addressing Diabetes & Food Insecurity: Resources for Communities in Need
Patient Education Library

Over 100 patient information handouts on popular diabetes management and health promotion topics, guided by the American Diabetes Association Standards of Medical Care in Diabetes

professional.diabetes.org
Ask the Experts

- Monthly live Q&A series
- Participants can ask their questions – online or on the phone
- Register at diabetes.org/experts or text “EXPERTS” to 833-TXT-LIVE (833-898-5483)
Diabetes Food Hub

ADA’s cooking and recipe destination offers more than 700 diabetes-friendly recipes and tools to eat healthfully and save time.

New content published weekly
Interactive Meal Plan
Editable Shopping Lists
Advice and cooking tips from diabetes nutrition & cooking experts
Living With Type 2

- Available in English & Spanish
- Informational e-booklets
- Monthly eNewsletters
- Healthy Recipes and more
- Sign up at diabetes.org/livingwithtype2
Diabetes Is Primary

As advances in diabetes treatment evolve at a rapid-fire pace, Diabetes Is Primary targets clinicians on the frontlines of primary care. Diabetes Is Primary delivers easily accessible continuing education to meet the needs of busy primary care providers (PCPs).

The program is based on the ADA’s Standards of Medical Care in Diabetes, the gold standard in diabetes treatment. These guidelines, updated annually, ensure that patients receive up-to-date, evidence-based care.

Additionally, Diabetes Is Primary helps PCPs navigate the complex changes in the health care industry, including new therapies and their costs, population health, and more.

Benefits

- Learn about ADA guidelines most relevant to primary care
- Sharpen skills to individualize care based on specific patient needs
- Understand the latest treatment options in a rapidly changing landscape
- Improve patient outcomes with evidence-based strategies utilizing their entire care teams

Results

Diabetes Is Primary was developed by primary care providers for primary care providers. Last year’s attendees said:

- 97% felt the Diabetes Is Primary content gave them knowledge to improve their practice
- 91% plan on changing their practice as a result of what they learned
- 97% of survey respondents are likely to recommend Diabetes Is Primary to a colleague

- “Excellent overall program. Very clinically oriented with lots of practical recommendations.”
- “Exceeded my expectations. I learned so much.”
- “This was truly one of the most informative conferences that I have attended, providing useful information and handouts that will positively affect my practice and confidence.”
Become an ADA Professional Member Today!

➢ Enhance your patient care with ADA’s COVID-19 resources
➢ Regular webinars led by today’s experts on vital topics
➢ Popular discussions in the DiabetesPro Member Forum
➢ Access cutting-edge research, landmark studies, practical treatment pointers, and patient education related to diabetes care featured in the Association’s scholarly journals
➢ Sharpen your leadership skills by joining various communities like WIN ADA, Interest Group Leadership Teams and other opportunities
➢ Access to the best diabetes care research, treatment and care

JOIN AT PROFESSIONAL.DIABETES.ORG/MEMBER
Questions?

Visit diabetes.org

Center for Information
1-800-DIABETES
(800-342-2383)

askADA@diabetes.org