Implementing Evidence Based Programs for Diabetes Care

Presented By: Maria Bustamante
November 14, 2023

Developed by National Center Farmworker Health (NCFH)
The National Center for Farmworker Health is a private, not-for-profit organization located in Buda, Texas, whose mission is “To improve the health of farmworker families”.

- Population specific data resources and technical assistance
- Workforce development and training
- Health education resources and program development
- Board Governance training
- Program Management
Ag Worker Access Campaign

A national initiative to increase the number of Migratory & Seasonal Agricultural Workers & their families served in Community and Migrant Health Centers.

Increasing Access to Quality Healthcare for America's Agricultural Workers

http://www.ncfh.org/ag-worker-access.html

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Learning Objectives

- Demonstrate understanding of improved diabetes quality measures through DSMES and DPP programs.
- Access tools and strategies for successful implementation of diabetes prevention and management through evidence-based programs.
- Identify the requirements and support needed to begin the DSMES and/or DPP accreditation process.
world diabetes day
14 November

Celebrate yourself!

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DIABETES: SPIRALLING OUT OF CONTROL

New figures from the International Diabetes Federation reveal the alarming growth in the prevalence of diabetes around the world.

1 in 10 adults have diabetes

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High prevalence of Diabetes and Prediabetes

High need for improvement in the prevention and treatment of diabetes.

Americans (11.3%) have diabetes

Americans (33%) have prediabetes

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Key Diabetes Highlights:

📈 The total annual cost of diabetes has reached $412.9 billion, including $306.6 billion in direct medical costs.

🏥 A staggering $1 out of every $4 spent on healthcare is now allocated to individuals with diabetes.

💉 Diabetes results in an additional $12,022 in health care expenditures annually per affected individual.


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A Diabetes Action Plan
RoadMap
What will your goal be?

Examples of goals to be achieved:
- 80% of people with diabetes are diagnosed.
- 80% of people diagnosed have a good control of blood glucose.
- 80% of people diagnosed have a good control of blood pressure.
- 100% of people with type 1 diabetes have access to affordable insulin treatment and self-monitoring blood glucose.
The Diabetes Action Plan serves as an avenue to create tactics to preemptively decrease the prevalence of diabetes by creating a:

- framework for organizational activities
- care model
- quality improvement team
- plan for Implementation, Evaluative, and Sustainment activities
HgbA1c is a clinical quality metric that aligns across all payer incentive programs.

- DPP program includes a minimum of 35% of participants having a blood-based test indicating prediabetes with a HgbA1c of 5.7 to 6.4. Research estimates a mean HgbA1c reduction of 0.1 percentage points for each 1 kg of reduced body weight for the overall population.

- DSMES program includes participants with diagnosed diabetes and/or uncontrolled blood sugar levels.
Prevention

• National Diabetes Prevention Program – National DPP

Treatment

• Diabetes Self Management Education and Support - DSMES

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Program Goal: to make it easier for people with prediabetes to participate in affordable, high-quality lifestyle change programs to reduce their risk of type 2 diabetes and improve their overall health.”

Patients who participate in a National DPP lifestyle change program may reduce their risk of developing type 2 diabetes by more than half.
A key part of the National DPP is a lifestyle change program that provides:

- A trained lifestyle coach
- CDC-approved curriculum
- Group support over the course of a year
Program Eligibility

To join CDC’s National DPP† Lifestyle Change Program:

Meet ALL of these:
- 18+ years or older
- Overweight
- Not diagnosed with T1 or T2 diabetes
- Not currently pregnant

AND

Meet ONE of these:
- Blood test
- Diagnosed with prediabetes
- Previously diagnosed with gestational diabetes
- High-risk result on prediabetes risk test

* NATIONAL DIABETES PREVENTION PROGRAM
No referral is needed

Anyone who qualifies can attend a National Diabetes Prevention Program lifestyle change group—no referral is needed!
Anyone who qualifies can “self-refer” into a Medicare DPP lifestyle change group—no referral is needed!
Check Medicaid DPP policies for your state, but referrals are usually not needed!
## National DPP Benefits

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<th>Patient Benefits:</th>
<th>Health Center Benefits:</th>
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<td><strong>Early detection and treatment</strong> lowers the risk of type 2 diabetes, heart disease, and stroke</td>
<td><strong>Increased revenue</strong> through more billable services</td>
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<td><strong>Support from a coordinated care team</strong> to address social drivers of health and connect patients to high value care that addresses their needs</td>
<td><strong>Integrated diabetes care team</strong> that connects patients to the care they need including blood glucose testing, blood pressure monitoring, intensive behavioral treatment for obesity, and more!</td>
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<td><strong>Increased access</strong> to evidence-based interventions that improve health</td>
<td><strong>Obtain Incentive payments</strong> for improved overall performance in Clinical Quality Measures</td>
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Apply for CDC Recognition

The Diabetes Prevention Recognition Program (DPRP) sets the standards for the National DPP.

- Review the DPRP standards and operating procedures:
  - Program eligibility
  - Location requirements
  - Delivery modes
  - Staffing
  - Training
  - Requirements for recognition
- Plan for method of data collection and reporting
Diabetes Self Management Education and Support (DSMES)
Diabetes Self Management Education & Support

DSMES interventions include activities that support PWD to implement and sustain the self-management behaviors and strategies to improve diabetes and related cardiometabolic conditions and quality of life on an ongoing basis.
What is the purpose of DSMES?

“...to give PWD the knowledge, skills, and confidence to accept responsibility for their self-management. This includes:

• collaborating with their healthcare team
• making informed decisions
• solving problems
• developing personal goals and action plans
• coping with emotions and life stresses.”

PWD: Person/People with diabetes
Benefits of DSMES

- 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 and improves BP and cholesterol levels.
- Improves medication adherence.
- 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
• Outline the latest evidence for effective and sustainable DSMES services
• Provide a roadmap for practitioners to implement DSMES Services across a variety of practice settings
• Aimed to ensure QUALITY services are being delivered to PWD
• Serve as the basis for Accreditation or Recognition required to be reimbursed by Medicare for DSMT G-Codes
<table>
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<td>Population and Service Assessment</td>
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<td>3</td>
<td>DSMES Team</td>
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<td>4</td>
<td>Delivery and Design of DSMES Services</td>
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<td>5</td>
<td>Person-centered DSMES</td>
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<td>6</td>
<td>Measuring and Demonstrating Outcomes of DSMES Services</td>
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[https://doi.org/10.1177/26350106211072203](https://doi.org/10.1177/26350106211072203)
Patient Centered Care

- Strengths-based and inclusive language
- Reducing stigma for people living with cardiometabolic conditions
- Peer Support communities
- Empowering People
- Shared decision-making approaches
- Connecting with SDOH support
• Healthy coping
• Being Active
• Healthy Eating
• Taking Medication
• Monitoring
• Problem Solving
• Reducing Risks
When is DSMES recommended?

4 Critical to refer to DSMES:
• At Diagnosis
• Annually and/or when not meeting treatment targets
• When complicating factors develop
• When transitions in life and care occur
• First/Main site: $1,100
• Additional branches: $100. Branches are locations that use their own billing identification (ID) number.
• Free additional community sites. Community sites are locations that use the same billing ID.
• For location types available including umbrella and state, see Adding Delivery Sites.
• Valid for 4 years.

Renewal application fee structure is the same as above.
Online application – ADCES website and DEAP portal

- Supporting documentation required includes:
  1. Complete the online application.
  2. Gather and upload all supporting documentation.
  3. Complete virtual orientation.

- Application fee required
ADCES accreditation - Process Completion

- At least one patient must complete an entire DSMES intervention with multiple encounters before a program applies for accreditation.
- Applications are reviewed within 2 weeks; accreditation timeline varies based on completeness of application.
- Program selects one clinical and one behavioral outcome to report annually to ADCES.
- Yearly submission of Annual Status Report required.
ADCES accreditation

- Email and phone support
- Free member benefits including ADCES Connect online community, diabetes care and education webinars, online discussion groups, free continuing education for the whole care team
- Monthly Diabetes Education Accreditation Program (DEAP) webinars for quality coordinators, online tools and templates
- DEAP Coffee Break: Monthly Q&A for all DEAP programs
- Ask the Reimbursement Expert
- Journal and newsletters
- One-year complimentary ADCES membership with new and renewal applications.
ADCES accreditation – Billing for DSMES

Medicare
Medicaid
Private Insurers
1. The referring physician or qualified non-physician practitioner must maintain and document the plan of care and need for DSMES program/service in the beneficiary’s medical record.

2. The order for DSMES services must include:
   • A statement that the services are needed
   • The number of initial or follow-up hours ordered
   • The topics to be covered in the DSMES program/service
   • A determination of individual or group DSMES program/service

3. The DSMES provider must maintain documentation of the original order.
Pharmacy Led DSMES Guide
Additional Support and Technical Assistance

Does your HC have a DSMES program? Are you an accredited/recognized program?

➢ Reach out to us, Martinez@ncfh.org for additional support and TA
Thank you!

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Implementing Food Rx Programs to Improve Health Outcomes Webinar
December 5th, 2023
11:00 am PT/1:00 pm CT/2:00 pm ET

Social Risk Factors: Food Insecurity Learning Collaborative

4 Once a Week sessions, February 2024 from 12:00-1:30 pm CST.
NCFH Webinars

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NCFH Additional Resources

Helpline for Farmworkers and their families

• Connects Farmworkers to healthcare and social services
• Assists with limited financial resources for health services

Una Voz Para La Salud
Call for Health

1 (800) 377-9968
1 (737) 414-5121 WhatsApp
http://www.ncfh.org/callforhealth.html
The Farmworker Health Network works cooperatively with HRSA to provide training and technical assistance to over a thousand Community & Migrant Health Centers throughout the U.S.
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Thank you!

This project is 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 $1,742,242.00 with 0 percentage financed with nongovernmental sources. The contents are those of the authors and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government.

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