

**National Diabetes Education Program Webinar**  
**Are We Ready to Meet Today's Challenges with Diabetes Education: Plight or Promise?**  
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Good afternoon, everyone, and thank you for joining the National Diabetes Education Program's webinar, "Are We Ready to Meet Today's Challenges with Diabetes Education: Plight or Promise?" I'm Joanne Gallivan, Director of the National Diabetes Education Program at the NIH.

As a joint program of the NIH and the CDC, our mission is to reduce the burden of diabetes in the United States by facilitating the adoption of proven strategies to prevent or delay the onset of diabetes and its complications. As many of you know, we host a variety of webinars through the year to support all of you who are working to improve diabetes management outcomes and prevent or delay the onset of type 2 diabetes.

A little bit about today's webinar: All your lines are muted. There will be a question-and-answer session after the presentation, so if you have questions, please write them down, and we'll call on you after the presentation's over. We are recording the webinar today, and it will be put up on the NDEP website in the next couple of weeks.

Please complete the evaluation survey that you get after the completion of the webinar. We really value your opinion of the presentation, and we also ask you for additional ideas for topics.

If you need a certificate from the NDEP that you participated in this webinar, you can request one at the URL on the screen, [ndep@hagerssharp.com](mailto:ndep@hagerssharp.com), and there will be CE credits available from the AADE for eligible participants. We are very happy to be presenting this webinar and co-sponsoring it with AADE.

The disclosures on the slide outline the requirements for successful completion to obtain CE credits from AADE if you are eligible. AADE is providing CE credits for this webinar for nurses, dietitians, and pharmacists. AADE will follow up with eligible attendees after the webinar with an evaluation survey and CE credit. And this is some additional disclosures from AADE.

I want to briefly just talk about the presenters today. We are really thrilled to have three outstanding presenters on today's webinar. First is Dr. Linda Siminerio, who is a nationally prominent advocate for diabetes care education and funding. She is professor of medicine at the University of Pittsburgh Division of Endocrinology and Metabolism. Her academic focus centers on the translation of research and diabetes quality improvement, self-management, community interventions, and overcoming barriers to diabetes care in underserved populations. Dr. Siminerio is co-author of the *2015 Joint Position Statement on Diabetes Self-Management Education and Support*, which was published by the American Diabetes Association, the American Association of Diabetes Educators, and the Academy of Nutrition and Dietetics. And as I think many of you know, she is current chair of the NDEP.

Dr. Maggie Powers conducts research and has a clinical practice as a registered dietitian and diabetes educator at the International Diabetes Center in Minneapolis. Her research focuses on improving diabetes outcomes, including factors that affect the clinical, psychological, and behavioral aspects of diabetes. She has been in the American Diabetes Association for more than 25 years, and she serves as the founding editor of *Diabetes Spectrum* and, again, one of the lead authors on the *2015 Joint Position Paper on DSME*. She is the current president of health care and education for the American Diabetes Association.

And we also have Joan Bardsley. Joan Bardsley is a Joslin Diabetes Center–trained registered nurse and certified diabetes educator, and she has more than 35 years of experience in diabetes education and management. The depth of her experience includes providing diabetes self-management education, the professional education for multidisciplinary teams, advocacy for access and reimbursement for DSME, clinical trial management, and executive administrative—assistant vice president of MedStar Health Research Institute, which supports research within a 10-hospital health system. She is, again, another co-author of the *2015 Joint Position Paper on DSME*. And she is also past president of the American Association of Diabetes Educators. She’s a recognized subject matter expert regarding the knowledge and support of people with diabetes and the need to self-manage their disease. She has served as co-investigator for diabetes management research and has developed and implemented comprehensive training for clinical research coordinators throughout the MedStar Health System.

So we’re very, very happy to have these three experts with us today, and I will turn the program now over to Dr. Siminerio.

**Linda Siminerio, Ph.D., RN, CDE — Chair, National Diabetes Education Program; Professor of Medicine, Division of Endocrinology and Metabolism — University of Pittsburgh**

Thank you, Joanne. “Are We Ready to Meet Today’s Challenges with Diabetes Education: Plight”—I think it’s promise, and we will be talking about that.

Our objectives for today are to describe and share some of the challenges associated with delivering DSME, including reimbursement and referral for services with leading diabetes organizations, systems, policy-makers; explain how diabetes educators can use the evidence for DSME and the algorithms included in the Joint Position Statement to develop innovative models for increased referrals and participation; and summarize the critical time for assessing and providing diabetes education based on the Joint Position Statement. And I’m glad to be joined by co-authors—and our leading author of this position statement, Maggie and Joan.

Well, what are the realities? Many of you joining this webinar today are already familiar with them, but I’ll repeat them just to set the stage. We’ve got a growing number of people with diabetes; the numbers are growing exponentially. Thirty percent of our hospital admissions now have a diabetes-related diagnosis. Many education programs have reported closing. We have a national shortage of the very providers who provide diabetes care, like endocrinologists and primary care practitioners. We also have a limited number of educators that are associated with a direct number of people who we’re about to serve,

and we haven't really widely communicated the evidence. And that's the background for the position statement.

There's many forces that have implications for diabetes education. The Affordable Care Act—many of you know that this is right now enacted, so there's a lot of talk; there's a lot of examining; there's a lot of things that we need to think about in rolling all of the elements out. But many of the elements, the key elements of this act, do have implications for the very work that we, diabetes educators, do. And we have to ask ourselves, "Are we ready for these national implications?" because the Affordable Care Act, as it relates to diabetes education—we're supposed to be the very providers who think about prevention, both primary prevention and secondary prevention. It's our job to be able to help folks to prevent hospital re-admissions, and those of you who are associated with hospitals know that this is a big driver in our health care system: preventing hospital re-admissions. People need to be able to be comfortable and leave the hospital educated.

We need processes to improve primary care. This is a key element in the Affordable Care Act. And maybe we need to start exploring primary care opportunities where 90 percent of people with type 2 diabetes receive their care. Health disciplines need to practice at their highest levels, revisiting our scope of practice to make sure that we are reaching our highest level of the therapeutic management and goals that we can do within our own disciplines.

We have to think about technology and technological approaches—how they're applied to education, be it telemedicine, be it phone apps, be it Web-based programs. We need the reach, and technology offers those opportunities. And with all of these national changes, there's changes in our payment structures that also have implications for the delivery of education.

One of the impetuses for the development of this position statement that we're going to hear more about was just the data that was startling. So, for example, when we learned that only 6.8 percent of insured newly diagnosed adults 18 to 65 years of age participate in DSME during the first year of diagnosis—startling. Only 4 percent of Medicare participants receive DSME and/or MNT.

DSME programs have been reported to struggle to cover their costs, even when they're operating at peak service loads—31 percent of PCPs of a national survey, 65 percent of specialists, reporting having access to educator availability in their practice setting. And in a national survey that we conducted through the NDEP, only 7 percent of the participants who reported in that survey received DSME—pretty disappointing numbers. So we have some work to do.

One of the things that's been considered is our access to self-management education. And again, this is in the survey that was done, and we found that referrals may be part of the problem. Providers in this survey that's referenced on this slide say they want patients to receive education, but they also say they weren't sure when to refer. Some of them also reported having some conflicts regarding management goals and philosophy, and some, albeit a smaller number now, feared that a referral to an educator would have implications for a referral to a specialist.

We do have a fragmented system. Our education programs grew out of hospital-based programs, yet 90 percent of diabetes is managed in primary care, and often the systems aren't connected. Our hospital-based programs may not have direct access, for example, to the electronic medical record systems and the opportunity to share this documentation, treatment plans, et cetera with the patient who's receiving care in a primary care office.

We do have regulations, many that, in many ways, benefited us in education's delivery—some that can cause some challenges. We do have recognition programs with both the ADA and the AADE. They're necessary because they do assure quality, and they're necessary for at least Medicare reimbursement, because oftentimes our commercial insurers take hold of what the Medicare rules are.

One of the challenges, in some situations, is, you must have a provider referral. That's a Medicare regulation. So people who want to get education can't self-refer. Medicare says in their statement that it only covers 10 hours of initial education. Is that a reasonable thing to say based on the literature that you're going to hear more about? At diagnosis, does somebody really require 10 hours of education, or should that 10 hours be spread out?

Follow-up education, according to the regulations—only reimbursement for two hours annually. Support for diabetes is lifelong, and there are changes where potentially people need more than two hours or less than two hours annually.

DSME and MNT—this can be a barrier for the person who's traveling. It cannot be billed on the same date, and oftentimes, that can be a challenge for a patient. There's deductibles now with many of our new regulations that are higher and co-pays that can cause an access problem.

In many cases, if education is provided in a hospital setting, there's a facility charge, which is an additional cost for the patient. There's some confusion regarding scopes of practice, of who can do what, and their roles in helping the patient with their treatment goals. And as I already mentioned, DSME programs have been, in recent years, struggling to cover their costs.

So how do we get the word out about expertise? How can we increase referrals and participation? Given the numbers, this is our challenge.

I think this cartoon nicely depicts what we need to be thinking about. We're ready to begin the next phase of really keeping things exactly the way they are. Well, obviously, we cannot, and it's our challenge for those of us who care so passionately about this service.

We are at a tipping point, and I don't see it as plight. I see it as promise.

I would like to turn this over to get some of the evidence presented to you by my colleague, Joan Bardsley.

**Joan Bardsley, M.B.A., RN, CDE, FADE — Assistant Vice President, MedStar Health Research Institute**

Thank you, Linda. Thank you, everybody, for being on this call. We're talking about the evidence. What do we know that makes us, as educators, really get the passion for what we do? We know that diabetes self-management education improves outcomes. There are some pivotal studies, and they're listed on your slide, that actually talk about some of the things that we do know about diabetes education. It's effective, and it's cost-saving. We also know that the team-based care may have better improved outcomes, and we'll talk a little bit more about that with a recent study that was done. There might be an association with nurses associated with the program with improving outcomes, and the technology approaches are somewhat new but are also showing promise. So this is evidence that we know. This is not controversial; this is something that we know can happen with diabetes education.

A project is going on to really help define how we can better utilize diabetes self-management education. How can there be better referrals for this service that we know that works? And this is happening at the University of Pittsburgh, and the project is A Goal to Glucose: A Model to Support Diabetes Management Education in Primary Care, because we also know that most of diabetes is taken care of in the primary care setting, and yet primary care providers often do not have the resources or the knowledge to refer for an education program.

The objective of this study is to determine if the deployment of the patient-centered model where diabetes education service is coordinated with the practice—so there's actually a diabetes educator with the primary care practice, and does this improve the referrals and the participation as compared to the traditional delivery system, where a physician or a provider has to refer out in the traditional way? Is having an educator there—does this make a big difference? And hopefully, we'll have positive outcomes with this.

The process for this was to identify practices in the community, and that's very important: that this is community-based; it's not hospital-based. The process was to meet with practices to determine the methods for identifying high-risk patients—for instance, those who have an elevated A1C or blood pressure problems. EMR resources are also being used in this project, and it's important to know that EMR is really an emerging field as far as diabetes education and identifying patients.

The intent is to adopt a more aggressive approach by reaching out to the patients, as opposed to passive—a much more active approach—establish a method for communication, and then, of course, deliver the program, bill for the DSME, and collect and report the data. But I think it's important to know that the first five steps happen before the program even is delivered, so it's a much more active way of getting participants to enter into the program.

And the intent is that having this type of model will increase the greater proportion of patients receiving DSME and achieving improvements in diabetes key outcomes. So looking at integration with the primary

care versus having a hospital clinical-based program will hopefully increase the number of patients who receive this service that we know is critically important for the management of diabetes.

There has been evidence all over with looking at how diabetes management education really improves outcomes. A systematic review was sponsored by American Association of Diabetes Educators in August of 2015, and the intent of this was to build on the evidence that Norris did in 2001 of seeing the latest papers that were involved in diabetes self-management education and to provide clarity on what effective programs look like and what the evidence confirms. What was found is that the mode of diabetes self-management delivery really made a difference. Each of the different ways that education was delivered did make a difference. If you looked at group, it was an absolute difference in A1C of 0.52. If it was an individual session, it was 0.50. If it was remote, such as using technology, it was lower at 0.38. However, if you look at the arrow, the combination of individual and group delivery of diabetes self-management education actually decreased the A1C by 0.88 percent, so that was a huge decrease by having the combination. So we got a better look at what an effective program looks like, and it's looking at individual sessions in addition to group.

It also looked at a single versus a team delivery of diabetes self-management education. These came out pretty equivocal. The absolute difference was about 0.57 versus 0.56. So we do know that single versus team-based is pretty equal.

We also know—and this goes back to what Linda was saying in her preliminary discussion—is that those who received 10 hours or less of diabetes self-management education had a decrease in A1C of about 0.46, where those who received over 10 hours had a decrease of 0.69. So we're locked into this 10 hours being covered by Medicare, and yet the evidence shows that over 10 hours actually had better outcomes than those people who received 10 hours or less. So it means that there's a true disconnect in what is reimbursed and what the government is saying can be paid for versus what the evidence shows is effective in the delivery of diabetes self-management education.

So, in summary, engaging adults with type 2—and this study was specifically done on type 2—really results in an improvement and clinically meaningful decrease in hemoglobin A1C. Both the group and the individualized engagement result in the greatest improvement. There's a greater likelihood of DSME resulting in an improvement with the team rather than single individual in many of the papers, but the actual result was about the same. The data suggest that limiting DSME contact time to 10 hours may not be sufficient.

So, based on all of the evidence that we have, Maggie is going to be discussing an algorithm of care that hopefully will increase the referrals for diabetes self-management education and help those patients with a decrease and an improvement in their care.

**Maggie Powers, Ph.D., RD, CDE — President, Health Care & Education — American Diabetes Association International Diabetes Center — Park Nicollet Health Services**

Thank you, Joan, and thank you, Linda, and thank you, NDEP, for sponsoring this webinar. A big part of our position statement that I'm going to be introducing in just a minute is, this first year of it being out there is disseminating it, making people aware of it so that you can ask questions about it—start using it. And so, my portion of today's webinar is to introduce you to the position statement and specifically two figures that it contains that we call the algorithm of care.

So this is all part of answering our title today: “Are You Ready to Meet Today's Challenges with Diabetes Education?” We feel that this position statement is helping all educators meet the challenge and increase access to diabetes education. So this is part of addressing that.

I am going to be talking about several topics, introducing the Joint Position Statement, and then giving you some specific insight into what the algorithm is and how you can use it. So first of all, to introduce this Joint Position Statement, I had been actually looking at different algorithms that were out there for diabetes care and realized that they detailed very nicely how to start and initiate diabetes medications and gave very good decision aid—type of guidelines, but what they were lacking—and not any fault of theirs—was a further description of what we do in diabetes self-management education. So—felt that it was necessary that we develop a diabetes education algorithm that defines diabetes self-management education and support for those with type 2 diabetes, defining when education should be given, what should be provided, and how to provide it—very similar to the medication algorithm helping clinicians make decisions about the when, what, and how, only this is of education versus medication.

So with that background, I had conversations with the American Diabetes Association; the American Association of Diabetes Educators; the Academy of Nutrition and Dietetics and their practice group, the Diabetes Care and Education Practice Group; and NDEP. Everybody was supportive of this position statement and wanted to be at the table. We had representatives from each of these organizations that resulted in a position statement being published by the three organizations that actually publish journals the beginning of June of last year. They all published them online, same day, same time. It was quite a remarkable feat.

But the point is that there is solid support for the information that is in this position statement. I'm going to summarize it for you, and then I'm going to go through some of the details about the specific algorithm. And I'm going to read through each of these points, because I think it's important to understand the full scope of the position statement.

First of all, it provides the evidence base for the value of diabetes education. It includes the evidence that both Linda and Joan have presented to you.

Two, it provides clinicians and health systems with a framework to establish and coordinate patient-centered diabetes care; identifies the four critical times to assess, adjust, and provide diabetes education—remember, one of the points that Linda made is, primary care providers did not know when to provide education; they didn't know when to refer. So we have very clearly outlined in this position statement four critical times to assess, adjust, and refer for education. The position statement lists objective criteria

for referral and summarizes the content and topics to address in self-management education. So, clearly, what we highlight here is the when and the what, and then I'm also going to go over the how.

So let's look at the when, the four critical times; and the what, the action steps. So these two figures are included in the position statement, and I'm not expecting you to be able to read them on the slides, but I want you to see them visually, because I'm going to talk about what they each contain, and then I'm going to go over the four times in a little more detail.

So the first slide on the left is the overall algorithm of care, and it highlights the four critical times to assess, provide, and adjust diabetes self-management education. I'd like to highlight up at the top—the American Diabetes Association publishes standards of care every year. They go through a very rigorous process, where they look at the research and they grade it and they make recommendations. So the January supplement of *Diabetes Care* always contains the standards of care, and those are accessible free online at [diabetes.org](http://diabetes.org).

So ADA gives a grade A to “Nutrition is needed for all people with diabetes, education is needed, and also the emotional health needs to be assessed and provided as needed.” So we have combined all of that into our algorithm. So we're not saying we don't need nutrition therapy; we're saying that that's, in this respect, part of diabetes self-management education.

And so, we thought, “When do you need to refer? What do we tell the primary care providers when to refer somebody for diabetes?” Well, at diagnosis, as Linda pointed out, it's a very low rate. Why are they not referring? Do they not think that diabetes education can be helpful at that time? Do they think they only need to refer when the A1Cs are above a certain percentage or when somebody has a wound, then while referred to get them under better control?

Well, we struggled with this; the writing team struggled with this, but we came up with the four times. And I'll walk through them and define them in detail. But I want to show you that the other figure that is included in this position statement is that we define exactly what should happen at each of those time periods. So if somebody is making a referral, it's known that this is what would be covered in diabetes education.

So two things I'm going to point out on this slide, and then I'll go into some more detail—but up at the top is a checklist of what would be normally expected of primary care providers, endocrinology, clinical care—their areas of focus and action steps. So we're not saying, “Just refer somebody to diabetes education; they're going to do it all.” It's a team approach. We all need to be talking the same language and supporting each other. So there are certain things that need to be done in the clinical setting, and then we, in diabetes education programs, can support that. And there's checkboxes, as you can see—areas of focus and action steps. So in a way, it's prescriptive, but as you read it, it's very individualized and patient-centered care.

So let's look at the four areas. I have a slide on each of the four areas, because I want to just touch on a couple of points. The actual position statement has written information describing these four areas in more detail. But for the person at diagnosis—and we say for all persons with type 2 diabetes—and a little checkbox that somebody can use to check off—and we actually have had—and Joan's going to get into implementation a little bit more, but some people actually take these algorithms and put them up in provider offices so that they know exactly when to refer, so they can look up and see—“Okay, newly diagnosed; that means all newly diagnosed individuals with type 2 should receive self-management education.” And also, we want to ensure that both nutrition and emotional health are appropriately addressed in education or make separate referrals.

So that's the “when.” It's very clear; it's very specific. This is the when, and it's based on evidence.

And then the other part of the algorithm—the action steps actually denote what the provider—the clinical office would do, and that we have—as they would answer questions and provide emotional support; they provide an overview of treatment and goals; they teach the survival skills; they get them going on the immediate requirements for starting medication, introducing basic eating guidelines. But then, in diabetes education, we know that we do the assessment; we do a lot more with medications; we do a lot with monitoring, with nutrition. And so, it's all outlined there so that the referring clinician knows exactly what is happening.

And so, the second critical time—we have it labeled as “annually,” because if somebody has diabetes, if they have an annual visit, sometimes they're returning to clinic every three or four months or every six months, then at least annually. And so, we feel that an assessment of education, nutrition, and emotional health needs should be done at that time, and referrals for education should certainly be made if the person has not had prior education. And we also state in the text—or if it's been a while since education—there's been a change in medication—of course, if the A1C's out of range—planning a pregnancy—or they need support to obtain or sustain behavior changes, we know that about every six months, we need to provide the reinforcement. And so, if somebody—even if they know what to do, we're talking about psychosocial issues and behavior change. It is not easy, so we can help provide that—a person has weight or other nutrition concerns, new life situations—competing demands.

Somebody once asked me, “Well, if somebody got a divorce, what critical area would you put that in?” And so, I thought, “Well, I'd probably put that in under ‘new life situations.’” So there will be things that might not fit neatly into a box, but we try to be as clear, with clear expectations, as possible to take out any reason for not referring—not knowing why and when to refer.

So let's look at the third area, and this is with complicating factors. So when new complicating factors influence self-management, such as health conditions, physical limitations, emotional factors, or basic living needs, we feel that—actually, with critical times 3 and 4 is when we don't get referrals. And we want to highlight that, yes, we, as diabetes educators, can be a big asset to the patient and to the others in the health team at these particular times. So if somebody has cancer—somebody had a stroke. They have physical limitations. How are they going to check their blood sugar? How are they going to be eating? Do

they have to make adjustments in their food plan because they can't cut their food or, for some reason, food is not tasting the same? They're having chemotherapy. People's food tastes change. We can help them with a plan.

So we're highlighting—this is a critical time to also consider referring to diabetes education. And we actually think that you, if you can use this and highlight this and the value that you bring at these times—that we can have more referrals to diabetes education, and not just because we want to rack up our numbers but because we really are providing a service.

And the fourth critical time to highlight is transitions, when transitions in care occur. So somebody has a living situation change. They're going from maybe inpatient to outpatient. They're going from their home to assisted living. They're going home to nursing care. Somebody needs to be overseeing the everyday self-management aspects of diabetes to be sure that it's coordinated and the person can maintain their care as best they can. If they have a change in medical care, if they have a change in insurance coverage, we know how that can complicate just some of the basics of diabetes care—and obviously age-related changes.

What we feel that we've done is, we've taken things that we've known that have never been outlined like this before. We have just said, "The person should come to diabetes education; we can help them do lots of things." This algorithm of care specifically highlights where we can be very helpful. It gives guidelines for the referral and exactly what the expectations are.

So that's the when and what, and now I'm going to highlight this last slide. Briefly, it's the how, the guiding principles to define—to deliver diabetes education. So when we were writing the position statement, we started with the evidence, and we started with guiding principles. And then we had the four critical times and really worked very hard on the specific content to be included in there. We engaged a lot of others outside of the writing team. We included other disciplines in providing input, feedback—and maybe some of you listening today were part of that feedback loop, and we really appreciate it, because we took every comment to heart, and it actually made changes; it made a difference.

So we have five guiding principles. You will understand these as educators, but we felt that we needed to include them, because it is something that's very important to us, and it's how we deliver care, and so we wanted it to be part of the position statement.

The first one is engagement, and that's providing education and care that reflects a person's life, their preferences, priorities—and you know that this is patient-centered care, it's engagement, it's personalized, it's individualized. This is what we're about.

Information sharing is number two—determining what the patient needs to make decisions about self-management. It's very focused. This is really that personalization. It's not saying, "We're just going to do a data dump, because you have diabetes, and we're going to give you all this information," but it really is information sharing that is personalized to that person and what they need. And we do that always

remembering the psychological and behavioral support needs of the person. We often, in the paper, several times, actually, say that self-management education reflects the clinical needs of a person, the psychosocial needs, and their behavioral needs. We cannot do one without the other.

Our fourth guiding principle is integration with other therapies, and that's—ensure the integration referrals with and for other therapies as part of a team approach. We're not working in isolation.

And the fifth guiding principle is the coordination of care, cross-specialty care, facility-based care, and also community organizations. We know that a lot of our patients go to community organizations for ongoing support, and we need to be working with them so that we're collaborating and delivering the same message and the same quality care.

So with all of this, we feel that we've taken a big step in defining the when and the what and including the guiding principles of the how. But it really is, next, the implementation of this. And Joan is going to speak a little bit more about implementation, but I want to read to you a paragraph that we include at the end of our position statement. And we say—and this is a strong position statement; remember it's coming from three national organizations that signed off on this position statement: “It is recommended that all health care providers and/or systems develop processes to guarantee that all patients with type 2 diabetes receive DSME and support services and ensure that adequate resources are available in their respective community to support these services.”

So with that, I'm going to turn it back to Joan, who's going to delve a little more into the implementation aspect of the position statement.

**Joan Bardsley, M.B.A., RN, CDE, FADE**

Thank you, Maggie. As you know, when we developed this position paper, you hope that everyone would adapt it very easily and willingly and go forth, but we know that hope is not a plan. So we actually tried to come up with some targeted areas where this can be marketed and addressed to hopefully have more people use the position paper to provide guidance to them and to actually refer for more diabetes self-management education services.

This is just the infancy. You know, it's a whole process; it's not just a checkoff. It's a process that we're involved in, and things like this webinar actually are part of the implementation—and getting the word out about the paper.

Of course, the first people we have to address are providers and clinicians, because as we know, referrals are needed for referring to a diabetes self-management education program, so they need to know about this. Primary care providers are people who see many of the patients with diabetes, and so we're trying to target them in many different ways. We've had presentations at the American Association of Physician Assistants to increase the awareness among that group. Endocrinologists also need to be aware of it; they need to be champions. Many endocrinologists, of course, know about diabetes educators, but how are they working with their other colleagues to talk about the importance of it? People who are hospitalists,

those who are in the inpatient setting, need to know how to refer so when a patient leaves the hospital—are they going to get the proper follow-up? Are they going to get the education when they leave the hospital?

There are a lot of professional associations who were included when this position paper was developed. Some of those are the American College of Physicians, the PAs looking at the nurse practitioners groups—and drafts of the position paper actually went to them ahead of time for their input. When we met with them, they said, “This is what we need; we need to know about the what and the where and the how,” just as Maggie described. So hopefully, this is addressing it for them, and we’re continuing to communicate with them.

In student training programs, this is an area that we really haven’t targeted in the past, but are they learning early on, both in the medical and the nursing and other fields, that there is diabetes education and it’s important to refer? So those are the providers and the clinicians that need to be and are in the process of being targeted.

The diabetes self-management education programs that are accredited by the American Diabetes Association or the American Association of Diabetes Educators need to have this position paper as part of what they do. As we’ve talked to many groups of AADE, what we’ve found is, some of the educators did not know this existed, yet they’re the very ones who are affected when referrals are not made. So we’re making a concerted effort through webinars—publications that all programs know that this position paper is available for them to use. We’ve had e-mails and evidence that some of the education programs have actually sent the position paper out to all of their referring providers to talk about what this does. We’ve had some people who have included it in their electronic medical records. So these are important groups that have to use the position paper but also help disseminate it.

Looking at health systems, it’s important that the evidence that’s listed here is used in health systems as they are developing their models of care, particularly if their models of care change with the different insurances and the ACA. Looking at medical homes, it’s critical that this diabetes education is included. And how do we make it easy? How do we make it—that the medical home does automatic referrals—it knows about it automatically, as opposed to later on down the path? State health programs and health departments are another targeted area for these programs so that we know that we have the support of regulators and those who are involved in population health. People with diabetes are sometimes a group that is overlooked as far as dissemination, but we have to really work with people with diabetes so that they’re asking for diabetes self-management education, not waiting for someone else to prescribe it but to actually specifically ask to use this benefit. Educators, I’ve mentioned under the diabetes self-management education program. The National Certification Board of Diabetes Educators is another important group, and they are being very helpful in letting the people know, when they are registering to take the exam or when they’re renewing, that this position paper is out there.

It was very exciting that we actually had many blogs when the position papers were dropped simultaneously. The people picked up on it and were blogging about it in the virtual type of network.

We also look to our industry reps. Many of our industry representatives that we see all the time have wide access, and they're our partners. Although some hospitals don't have industry reps going in, they have a very useful way of helping disseminate information not only about the products that they may be representing but also about services et cetera, such as this paper.

So it all comes down, however, to each individual person. It could be a top-down, but it also needs to be a bottom-up. So it's really important that people individually use this paper to promote themselves and their services.

We've had evidence of press releases that took place at local levels. We've known that letters to all providers in the system were sent out. We know that diabetes program advisory board presentations should be including this. Medical directors are also very critical when they're setting the tone, when they're setting the overall emphasis on diabetes education, because they know that it's cost-saving and they know that better outcomes can occur.

We did have, on the national level, a press release at the American Diabetes Association last June. There was a publication, as Maggie and Linda have discussed, in the collaborating organizations' journals. There are slide decks in process so that anybody can go on any of the websites for these national organizations and actually have a download of slides. You currently can go on any of these organizations' websites and actually pull down the algorithm itself; it's a freestanding document that can be pulled down.

National diabetes meetings, we are continuing to present. I know Maggie is presenting at the American Diabetes Association, and several of us are presenting at the American Association of Diabetes Educators. It's included in the standards of care and also at provider meetings, so those things need to take place, because the providers are the ones who actually initiate the referral.

But what needs to be done? Each and every person, as I've indicated—so we have to take personal responsibility for getting this information out. Every educator needs to promote the evidence, every educator needs to promote the algorithm, and every educator needs to be aware of this paper and what is included in it so that they can speak very freely about it.

So at this, I'm going to turn it over to Linda, who's going to be talking about other resources that are available to help increase the referrals for diabetes self-management education. Thank you.

**Linda Siminerio, Ph.D., RN, CDE**

Thank you, Joan. There's so many patients for us to see, so much to do. I always say, "Don't reinvent the wheel," because we've got a lot of great resources from our organizations, and I'm going to present some of those to you. I'll start with our related resources from NDEP, and there's lots of direct patient information that's indicated on this slide—for example, taking care of your diabetes and your heart, knowing more about your blood sugar numbers.

One of our premier pieces is our Diabetes HealthSense, which is a program that's designed to help folks with behavior change, with behavior change strategies. And all of this information gets presented in health sense, and all of our brochures are reviewed thoroughly by multidisciplinary groups with programs like HealthSense that have information for the individual with type 1 or type 2 diabetes, for family members, for communities, and for providers.

We also, from the NDEP, have the guiding principles. And I refer you to the guiding principles because they specifically refer to the importance of self-management and patient-centered care. And also, other resources that have just come up on the NDEP line—is the medication adherence website. And again, I think this provides an incredible amount of wonderful information and support tools that have been thoroughly reviewed—papers, analysis, et cetera—about how we get our patients to be motivated to adhere to very complex regimens with diabetes.

There's also resources from AADE and the ADA. The AADE has patient education resources, and the website's listed here—and also provider information, some of them in regards to referrals. And I know—I think there's lots of really helpful tools—that if you did want to meet with a primary care practice and introduce yourself, there's a lot of good tip sheets on how you go about that, how you can help them identify patients, and what this means, as Joan referred to, in their practice, because educators do an incredible job at improving outcomes. So when providers are receiving incentives or in a shared-savings program, an educator can only make the practice shine.

And the ADA also has a plethora of patient education resources. And also, their DiabetesPro site that's for health professionals has an abundance of resources for the diabetes educator. So all of our organizations are pitching in to make these reviewed resources accessible to you so that you have access to all of these.

And then each of our own institutions, of course, has resources. And this is information from the International Diabetes Center, where Maggie works, and they have diabetes clinical guidelines and protocols in regards to therapeutic management, et cetera, et cetera.

I will close with that and open it up for questions and answers, hopefully, and again refer you to the NDEP website and phone numbers and again remind you that you can get your certificate of completion from this particular website, and AADE will follow up with those eligible for CE credits. Thank you very much for your attention. We think this is really a great opportunity to get the message out about our important services.

**Stephanie Corkett**

Thank you, Dr. Siminerio. Our first question from the audience is, “What can we do to deregulate diabetes education so that patients can directly access our services without a referral?”

**Linda Siminerio, Ph.D., RN, CDE**

Joan and Maggie, I think I can take this one. Based on all of the hard work with the Joint Position Statement, gathering all the evidence, building the referrals process, we caught the attention—I mean, AADE has been pushing forward, you know, to get educators more opportunities for direct access, but I can also tell you that the American Diabetes Association—now we’ve been working really hard with the advocacy group who is reviewing all of the regs and what I consider some of the challenges, like barriers. One’s that you have to have a provider referral; that is a federal rule, but I can assure you it’s not going to happen tomorrow, because some of these acts are built into actual congressional changes with the association, along with partner organizations who are reviewing these, finding out what the challenges are, and seeing how we can, through advocacy efforts, revisit all of what I consider to be outdated rules. I hope that answers the question.

**Joan Bardsley, M.B.A., RN, CDE, FADE**

Hi, this is Joan. I’d like to add onto that just a little bit. Frequently, when advocacy efforts are taking place, there’s e-mails that go out from all of the organizations that say, you know, “Call your Congressmen; write your Congressmen”; they give you links et cetera. And many times, people just delete that. So I think this is an area where Congress and any of the regulators pay attention to numbers. So if you see these things coming across your e-mails and they’re asking for it and—for advocating for diabetes education or diabetes—whatever the e-mail is about, I really encourage people to pay attention to that. Send that note to your Senator or House Representative, because the more people are talking about it, it will raise awareness and will hopefully get the advocacy efforts to be successful.

**Stephanie Corkett**

Thank you. The next question is, “How do we get Medicare to reimburse for more than 10 hours of DSME?”

**Linda Siminerio, Ph.D., RN, CDE**

This is Linda again, and we have a laundry list of the challenges. That was a challenge, and now that we have this great meta-analysis from AADE that shows—I mean, we didn’t have all this data before. Now we have the data, and I can speak on behalf of the AADE efforts, because I have been working with them directly: This is one of the things that we are attempting to revisit on some of these rules.

I want to remind everybody that for this year, we are, as part of the normal process of review, looking at the national standards. All our organizations sit on this committee in revisiting those standards. This also, along with the position statement, gives us that impetus of opening the door to get our organizations to have the potential to have people like Medicare sit at the table. They are sitting at the table with us when we are revisiting and reviewing the standards for 2016.

**Joan Bardsley, M.B.A., RN, CDE, FADE**

And I also can add in that I know AADE has had meetings with Medicare to discuss this very issue, so it’s a coordinated effort, and it’s something that we have to raise awareness of. The 10 hours has been on the books for a long, long time since education was actually covered, but now there’s more evidence close to 20 years later that says it clearly isn’t enough.

**Maggie Powers, Ph.D., RD, CDE**

So I'd like just to add, you know, as Linda said, AADE has a laundry list that we've been working on; AADE has their list. If you feel, just by these first two questions, you have issues, if you want to be sure that your issue is part of this laundry list or that it's being heard, I would say submit a comment. Joanne, can we have them just submit to NDEP? Is that the easiest thing?—that if you have an issue that you want to be sure that we don't overlook, we want to hear your voice, too. But we certainly are, at a national level, working through the channels to make changes and to bring diabetes education up to date.

**Joanne Gallivan, M.S., RD**

And Maggie, yes, they can submit it to us, and we'll make sure that the three of you get that information.

**Maggie Powers, Ph.D., RD, CDE**

Thank you.

**Joan Bardsley, M.B.A., RN, CDE, FADE**

And we'll make sure to pass it onto the organizations, then.

**Joanne Gallivan, M.S., RD**

Great.

**Joan Bardsley, M.B.A., RN, CDE, FADE**

Thank you.

**Stephanie Corkett**

The next question says, "I see that this presentation addressed DSME for those with type 2 diabetes, as it is a covered service for the Medicare beneficiaries. Can the same be said about those with type 1 diabetes, or is there a different algorithm?"

**Linda Siminerio, Ph.D., RN, CDE**

I'll take that. When this group first convened, we actually were addressing all types of diabetes. And some of our initial writing had pre-diabetes, gestational, type 1 and type 2—all ages. And we soon realized that the majority of the evidence is with type 2, related to self-management education, and we needed to focus. And so, we focused on type 2. At the beginning of the position statement, approved by all organizations, it does say that similar principles apply to other types of diabetes. So we have that, the diabetes education, and the other types of diabetes for now. There are just some very preliminary conversations about doing this for the other types of diabetes.

**Stephanie Corkett**

The next question from a participant is, "Where can we access the algorithm?"

**Joan Bardsley, M.B.A., RN, CDE, FADE**

I can take this. If you go onto the websites of the American Association of Diabetes Educators, the American Diabetes Association, and/or the Academy of Nutrition and Dietetics, you can access it there. Joanne, can we send it out to the people who have signed up? Would that be okay to do?

**Joanne Gallivan, M.S., RD**

We can send a link, perhaps, to where people can find it. Yeah, maybe we can do that to all participants when we send the evaluation form. We'll figure out a way to send it to everybody, but we can send a link to it. It's also in the NDEP's Guiding Principles for Diabetes Care for People With and at Risk for Diabetes; we also have a link there. So if you can't find it, let us know, and we'll send you a link; maybe we can do that; if you can't find it, let us know, and we'll be happy to send you a link to it.

**Joan Bardsley, M.B.A., RN, CDE, FAADE**

Thank you very much.

**Stephanie Corkett**

Thank you. And the final question we have: "Can you please address reimbursement efforts for telehealth consults?"

**Joan Bardsley, M.B.A., RN, CDE, FAADE**

This is Joan. That is not my area of expertise. However, I know at AADE, there's a reimbursement specialist, and there's a reimbursement guide. So if you go on the AADE website, there's ways to contact for the reimbursement specialist, who can talk about that with more expertise than I can. Linda and Maggie, I don't know if you have more information.

**Linda Siminerio, Ph.D., RN, CDE**

Well, this is Linda. I think technology is faster than where we are with all the regs for payment. And I know, because I'd gotten them from AADE, that there was a slide set that—if you connect with the Recognition Group, there are slide sets that give you the different regs that apply to recognition. The challenge remains—is figuring out the links to reimbursement. But I would suggest you check with the AADE Recognition Group, and there are some very good slides to give you some details of what happens when you do education via telehealth. It's something that we absolutely need to think about for reimbursement, because this is the wave of the future, especially for those in underserved communities and reaching rural communities.

**Maggie Powers, Ph.D., RD, CDE**

And I would just add: I know, Linda, you have done research in that area, and it has shown that it is effective. We also have reimbursement for medical nutrition therapy via telehealth. And at the end of the position statement, we do highlight that we need to look at new models of care, and this is one of those new models of care. And as Linda said, when we look at the update of the education standards, that's going to be addressed in there. It's not promising that there is going to be ready reimbursement, but we're certainly looking at that, and that's one of the things that's on this laundry list of reimbursement issues that we're addressing.

**Linda Siminerio, Ph.D., RN, CDE**

I do want to add, just very quickly: There are a number of papers that are out, and some are in *The Diabetes Educator*, and I just read a review that we've done with Karen Cisner, when she was with the AADE, on telehealth and diabetes education, and I think it's a nice overview of telehealth and education.

**Joanne Gallivan, M.S., RD**

And this is Joanne again. I just wanted to mention that if you want to get to the consensus statement in the slides that we're going to be posting, it is cited there, so you can find the consensus statement in the slides, and we will posting them very soon. If you need it right away, let us know, and we'll send you the link. Are there any other questions, Stephanie?

**Stephanie Corkett**

That was it for now.

**Joanne Gallivan, M.S., RD**

Okay, well, thank you. I want to say thank you to Linda, Maggie, and Joan. That was an excellent presentation. I always learn a lot when I listen to the three of them. Thank you very much. We really appreciate you doing this wonderful presentation. And thank you to everybody for your participation today. Remember, you can get a certificate of participation from NDEP, and if you need continuing education, AADE will be getting in contact with you. Thank you, everybody, and have a pleasant afternoon.