

Are We Ready to Meet Today's Challenges with Diabetes Education: Plight or Promise?

National Diabetes Education Program Webinar Series

Wednesday, May 25, 2016

2-3 PM ET



National Diabetes Education Program

A program of the National Institutes of Health and the Centers for Disease Control and Prevention



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Planners: Leslie E. Kolb, MBA, BSN, RN - None

Linda Siminerio, RN, PhD, CDE - None

Presenters: Maggie Powers, PhD, RD, CDE – Education Advisory Board, Lilly; Research funding, Sanofi

Joan Bardsley, MBA, RN, CDE, FADE – Salary, support for AHRQ grant for health services research MHRI; Consultant, Eli Lilly Education Advisory Board; Advisor, on PICORI Grant Johns Hopkins University

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Activity-Type: Knowledge-based



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About the Presenters

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Presenter Disclosure

No disclosures.

Are We Ready to Meet Today's Challenges with Diabetes Education: Plight or Promise?

Linda Siminerio, PhD, RN, CDE



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Objectives

1. Describe and share challenges associated with delivering DSME/S, including reimbursement and referral for services with leading diabetes organizations, health systems and policy-makers
2. Explain how diabetes educators can use the evidence for DSME/S and the algorithm included in the Joint Position Statement to develop innovative models for increased referrals and participation in DSME/S
3. Summarize the critical times for assessing and providing diabetes education based on the Joint Position Statement's diabetes education algorithm of care



Diabetes Realities

- Growing number of people with diabetes
- 30% hospital admissions have diabetes-related diagnosis
- Education programs closing
- Shortage of endocrinologists and PCPs
- Limited number of educators
- Haven't widely communicated the evidence



Affordable Care Act: The Forces on Diabetes Education

Are we ready?

- Prevention-Primary & Secondary
- Averting hospital readmissions
- Processes to improve primary care
- Health disciplines to practice at highest level
- Technological approaches applied to education
- Changes in payment structures



Consider Participation Rates

- 6.8% insured, newly diagnosed adults (18-65 years) participated in DSME during 1st year after DX
- 4% of Medicare participants – receive DSME and/or MNT
- DSME programs struggle to cover their costs, even operating at peak service load
- 31% of PCPs (65% of specialists) report having a diabetes educator available to them in their practice setting
- 7% receive DSME (cite NDEP survey)



Access to Self-Management Education

- Referral practice findings
 - Providers want patients to receive education
 - Not sure when to refer
 - Conflict regarding management goals and philosophy
 - Fear of referrals to specialists
- Fragmented system
 - Hospital-based programs
 - 90% diabetes managed in primary care



The Regulations...

- Recognition assures quality/necessary for reimbursement
- Must have a provider referral
- Medicare covers 10 hours of initial education
- Reimburse 2 hours annually
- DSME & MNT cannot be billed on same date
- Deductibles & co-pays
- Hospital programs – facility charge
- Confusion regarding scope of practice
- DSME programs struggle to cover their costs
 - Even operating at peak service load



So...

- How do we get the word out about expertise?
- How can we increase referrals?
- And participation?



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“We’re ready to begin the next phase of keeping things exactly the way they are.”

PC
VEY
N
COLLECTION



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Are we at a tipping point?



Evidence of the Impact of DSME

Joan Bardsley, MBA, RN, CDE, FAADE



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The Evidence

DSME improves outcomes (A1C by 0.76%)

- Education is effective and cost-saving
- Team-based care best predictor of improved glycemia
- Access to a nurse associated with improved outcomes
- Technological approaches are showing promise

Norris SL, et al. Effectiveness of self-management training on type 2 diabetes: a systematic review of randomized controlled trials. *Diabetes Care*. 2001.

Robbins, J. et al Nutritionist visits, diabetes classes and hospitalization rates and charges. *Diabetes Care*. 31, 2008.

Funnell, et al: Steering toward a new DAWN in diabetes management. *The Diabetes Educator, Journal Supplement for Continuing Education*, 2005.

Heisler M: Building peer support programs to manage chronic disease: Seven models for success. Oakland, CA, California Health Care Found, 2006.



Project Title: Glucose to Goal: A Model to Support Diabetes Management in Primary Care

- The overall objective of this feasibility study is to determine if the deployment of a patient-centered model, where diabetes educator service is coordinated with primary care practice, improves PCP referrals and DSME participation as compared to the traditional DSME delivery system



Glucose to Goal: Process Steps

1. Identify practices in community
2. Meet with practices to determine methods for identifying high risk patients, (e.g. A1C, BP)
3. Use EMR resources
4. Adopt a more aggressive approach by reaching out to patients
5. Establish method for communication
6. Deliver program
7. Bill for DSME
8. Collect and report data

We hypothesize that the **Glucose to Goal** model will improve PCP referrals resulting in a greater proportion of patients receiving DSME and achieving improvements in key diabetes outcomes

A. Traditional Model (hospital/clinic-based DSME program)



Current evidence suggests:

- Outcome improvements are limited to small proportion of total DM population

B. Glucose to Goal Model (integrated primary care DSME program)



We hypothesize:

- Outcome improvements will occur in larger proportion of total DM population



Evidence Confirmed

AADE: Systematic Review of the Impact of Diabetes Self-Management Education on Glycemic Control in Adults with Type 2 Diabetes

Annals of Internal Medicine

REVIEW

Behavioral Programs for Type 2 Diabetes Mellitus: A Systematic Review and Network Meta-analysis for Effect Moderation

Jennifer Pillay, BSc; Mami J. Armstrong, PhD, RCEP; Sonia Butalia, MD, MSc; Lois E. Donovan, MD; Ronald J. Sigal, MD, MPH; Ben Vandermear, MSc; Pritam Chordia, BDS, MSc; Sanjaya Dhakal, MBBS, MPH; Lisa Hartling, PhD; Megan Nuzupl, BSc; Robin Featherstone, MLIS; and Donna M. Dryden, PhD

Background: Behavioral programs may improve outcomes for individuals with type 2 diabetes, but there is a large diversity of behavioral interventions and uncertainty about how to optimize the effectiveness of these programs.

Purpose: To identify factors moderating the effectiveness of behavioral programs for adults with type 2 diabetes.

Data Sources: 6 databases (1993 to January 2015), conference proceedings (2011-2014), and reference lists.

Study Selection: Duplicate screening and selection of 132 randomized, controlled trials evaluating behavioral programs compared with usual care, active controls, or other behavioral programs.

Data Extraction: One reviewer extracted and another verified data. Two reviewers independently assessed risk of bias.

Data Synthesis: Behavioral programs were grouped on the basis of program content and delivery methods. A Bayesian network meta-analysis showed that most lifestyle and diabetes self-management education and support programs (usually offering ≥ 11 contact hours) led to clinically important improvements in glycemic control ($\geq 0.4\%$ reduction in hemoglobin [Hb] A_{1c}), whereas most diabetes self-management education programs

without added support—especially those offering 10 or fewer contact hours—provided little benefit. Programs with higher effect sizes were more often delivered in person than via technology. Lifestyle programs led to the greatest reductions in body mass index. Reductions in HbA_{1c} seemed to be greater for participants with a baseline HbA_{1c} level of 7.0% or greater, adults younger than 65 years, and minority persons (subgroups with $\geq 75\%$ nonwhite participants).

Limitations: All trials had medium or high risk of bias. Subgroup analyses were indirect, and therefore exploratory. Most outcomes were reported immediately after the interventions.

Conclusion: Diabetes self-management education offering 10 or fewer hours of contact with delivery personnel provided little benefit. Behavioral programs seem to benefit persons with suboptimal or poor glycemic control more than those with good control.

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Ann Intern Med. doi:10.7326/M15-1400

For author affiliations, see end of text.

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Change in A1C by Mode of DSME Delivery

Mode	Number of interventions	Intervention (SD)	Control (SD)	Absolute difference in A1C with DSME added
<i>All Models Together</i>	118	-0.74(0.63)	-0.17(0.5)	0.57
Combination Group	22	-1.0(0.6)	-0.22(0.62)	0.88
Individual	33	-0.62(0.46)	-0.10(0.42)	0.52
Remote	47	-0.78(0.63)	-0.28(0.46)	0.50
	12	-0.50(0.67)	-0.17(0.46)	0.33



Change in A1C: Single Versus Team DSME

Provider	Number of interventions	Intervention (SD)	Control (SD)	Absolute Difference in A1C with DSME added
Single	69	-0.74(0.63)	-0.17(0.49)	0.57
Team	46	-0.74(0.64)	-0.18(0.54)	0.56



Time	Number of interventions	Intervention (SD)	Control (SD)	Absolute Difference in A1C with DSME added
≤ 10 hours	55	-0.71(0.55)	-0.25(0.47)	0.46
> 10 hours	36	-0.84(0.65)	-0.15(0.55)	0.69



Summary

- Engaging adults with type 2 diabetes in DSME results in statistically significant and clinically meaningful improvement in A1C
- These data demonstrate that DSME that involves both group and individualized engagement results in the greatest improvement in A1C
- The data suggest that there is a greater likelihood of DSME resulting in statistically significant improvement when a team rather than a single individuals is involved in its provision
- The data suggest that limiting DSME contact time to 10 hours may not be sufficient

DSME/S Algorithm of Care

Maggie Powers, PhD, RD, CDE



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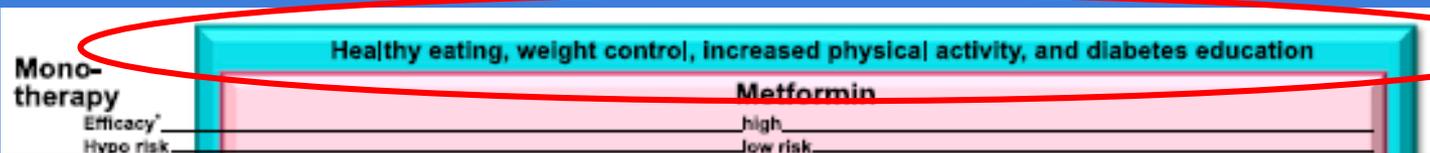
National Institutes
of Health



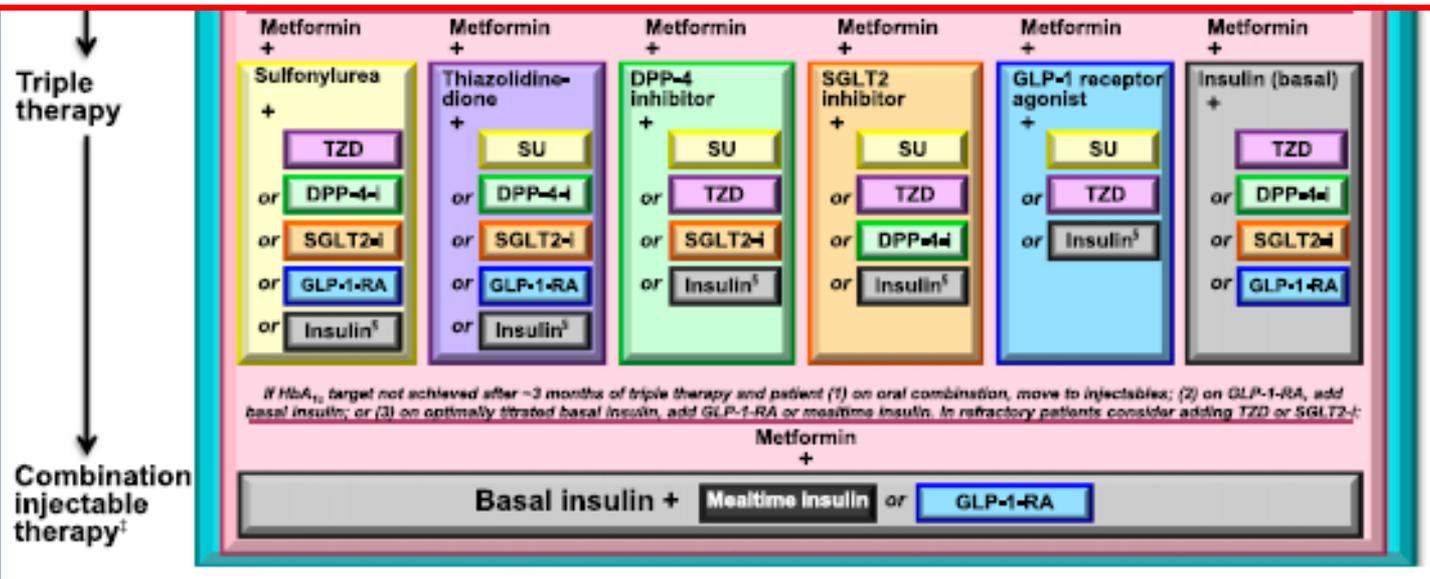


Topics

- Joint Position Statement
- DSME/S Algorithm of Care and Action Steps
 - **When:** 4 critical times for DSME/S
 - **What:** Action steps for providers and educators
 - **How:** Guiding principles to deliver DSME/S



We need a diabetes education algorithm that defines DSME/S for those with type 2 diabetes – *when, what and how of DSME/S*



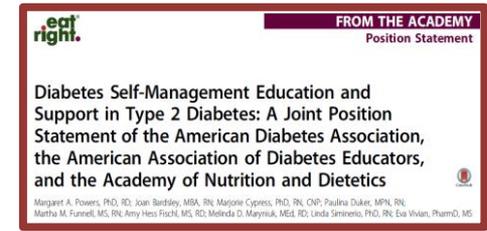
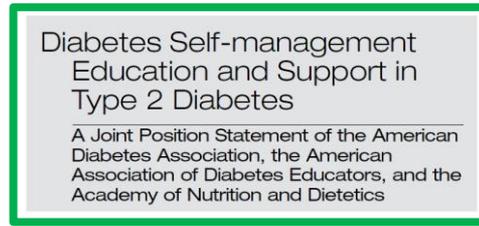


Collaboration



Writing Team

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- Martha M. Funnell
- Amy Hess Fischl
- Melinda D. Maryniuk
- Linda Siminerio
- Eva Vivian





The DSME/S Position Statement

1. Provides the evidence base for the value of diabetes education
2. Provides clinicians & health systems with framework to establish & coordinate patient-centered diabetes care
 - Identifies the four critical times to assess, adjust, and provide DSME/S
 - Lists objective criteria for referral
 - Summarizes the content/topics to address in DMSE/S

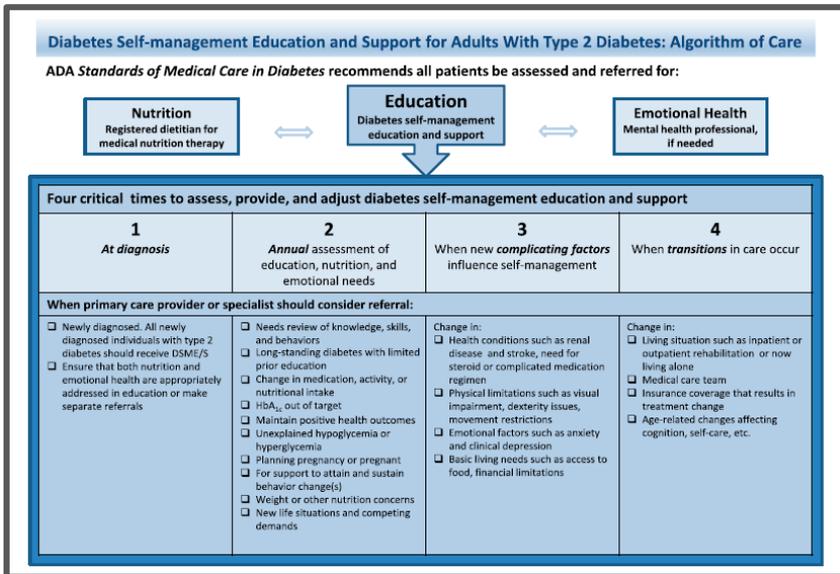


Topics

- Joint Position Statement
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DSME/S Algorithm of Care and Action Steps

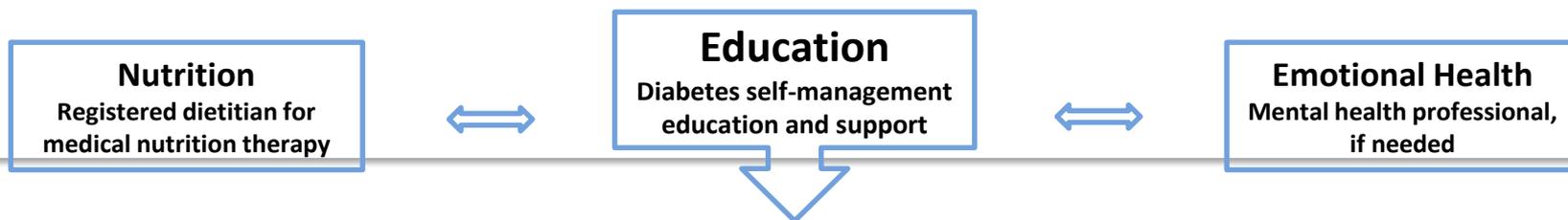


Diabetes Self-management Education and Support Algorithm: Action Steps

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

At diagnosis	Annual assessment of education, nutrition, and emotional needs	When new <i>complicating factors</i> influence self-management	When <i>transitions</i> in care occur
<p>Primary care provider/endocrinologist/clinical care team: areas of focus and action steps</p> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <ul style="list-style-type: none"> <input type="checkbox"/> Answer questions and provide emotional support regarding diagnosis <input type="checkbox"/> Provide overview of treatment and treatment goals <input type="checkbox"/> Teach survival skills to address immediate requirements (safe use of medication, hypoglycemia treatment if needed, introduction of eating guidelines) <input type="checkbox"/> Identify and discuss resources for education and ongoing support <input type="checkbox"/> Make referral for DSME/S and MNT </div> <div style="width: 50%;"> <ul style="list-style-type: none"> <input type="checkbox"/> Assess all areas of self-management <input type="checkbox"/> Review problem-solving skills <input type="checkbox"/> Identify strengths and challenges of living with diabetes </div> <div style="width: 50%;"> <ul style="list-style-type: none"> <input type="checkbox"/> Identify presence of factors that affect diabetes self-management and attain treatment and behavioral goals <input type="checkbox"/> Discuss effect of complications and successes with treatment and self-management </div> <div style="width: 50%;"> <ul style="list-style-type: none"> <input type="checkbox"/> Develop diabetes transition plan <input type="checkbox"/> Communicate transition plan to new health care team members <input type="checkbox"/> Establish DSME/S regular follow-up care </div> </div>			
<p>Diabetes education: areas of focus and action steps</p> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"> <p>Assess cultural influences, health beliefs, current knowledge, physical limitations, family support, financial status, medical history, literacy, numeracy to determine content to provide and how</p> <ul style="list-style-type: none"> <input type="checkbox"/> Medications—choices, action, titration, side effects <input type="checkbox"/> Monitoring blood glucose—when to test, interpreting and using glucose pattern management for feedback <input type="checkbox"/> Physical activity—safety, short-term vs. long-term goals/recommendations <input type="checkbox"/> Preventing, detecting, and treating acute and chronic complications <input type="checkbox"/> Nutrition—food plan, planning meals, purchasing food, preparing meals, portioning food <input type="checkbox"/> Risk reduction—smoking cessation, foot care <input type="checkbox"/> Developing personal strategies to address psychosocial issues and concerns <input type="checkbox"/> Developing personal strategies to promote health and behavior change </div> <div style="width: 50%;"> <ul style="list-style-type: none"> <input type="checkbox"/> Review and reinforce treatment goals and self-management needs <input type="checkbox"/> Emphasize preventing complications and promoting quality of life <input type="checkbox"/> Discuss how to adapt diabetes treatment and self-management to new life situations and competing demands <input type="checkbox"/> Support efforts to sustain initial behavior changes and cope with the ongoing burden of diabetes </div> <div style="width: 50%;"> <ul style="list-style-type: none"> <input type="checkbox"/> Provide support for the provision of self-care skills in an effort to delay progression of the disease and prevent new complications <input type="checkbox"/> Provide/refer for emotional support for diabetes-related distress and depression <input type="checkbox"/> Develop and support personal strategies for behavior change and healthy coping <input type="checkbox"/> Develop personal strategies to accommodate sensory or physical limitation(s), adapting to new self-management demands, and promote health and behavior change </div> <div style="width: 50%;"> <ul style="list-style-type: none"> <input type="checkbox"/> Identify needed adaptations in diabetes self-management <input type="checkbox"/> Provide support for independent self-management skills and self-efficacy <input type="checkbox"/> Identify level of significant other involvement and facilitate education and support <input type="checkbox"/> Assist with facing challenges affecting usual level of activity, ability to function, health beliefs, and feelings of well-being <input type="checkbox"/> Maximize quality of life and emotional support for the patient (and family members) <input type="checkbox"/> Provide education for others now involved in care <input type="checkbox"/> Establish communication and follow-up plans with the provider, family, and others </div> </div>			

DSME/S Algorithm of Care



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

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

When primary care provider or specialist should consider referral:

<ul style="list-style-type: none"> <input type="checkbox"/> Newly diagnosed. All newly diagnosed individuals with type 2 diabetes should receive DSME/S <input type="checkbox"/> Ensure that both nutrition and emotional health are appropriately addressed in education or make separate referrals 	<ul style="list-style-type: none"> <input type="checkbox"/> Needs review of knowledge, skills, and behaviors <input type="checkbox"/> Change in medication, activity, or nutritional intake <input type="checkbox"/> HbA_{1c} out of target <input type="checkbox"/> Unexplained hypoglycemia or hyperglycemia <input type="checkbox"/> Planning pregnancy or pregnant <input type="checkbox"/> For support to attain and sustain behavior change(s) <input type="checkbox"/> Weight or other nutrition concerns <input type="checkbox"/> New life situations and competing demands 	<p>Change in:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Health conditions such as renal disease and stroke, need for steroid or complicated medication regimen <input type="checkbox"/> Physical limitations such as visual impairment, dexterity issues, movement restrictions <input type="checkbox"/> Emotional factors such as anxiety or clinical depression <input type="checkbox"/> Basic living needs such as access to food, financial limitations 	<p>Change in:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Living situation such as inpatient or outpatient rehabilitation or now living alone <input type="checkbox"/> Medical care team <input type="checkbox"/> Insurance coverage that results in treatment change <input type="checkbox"/> Age-related changes affecting cognition, self-care, etc.
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Action Steps for Providers and Educators

Diabetes Self-management Education and Support			
Four critical times to assess, provide, and evaluate diabetes self-management education and support			
At diagnosis	Annual assessment	When self-management behaviors are not optimal	When a transition in care occurs
Primary care provider/endocrinologist/clinical care team: areas of focus and action steps			
<ul style="list-style-type: none"> <input type="checkbox"/> Answer questions and provide emotional support regarding diagnosis <input type="checkbox"/> Provide overview of treatment and treatment goals <input type="checkbox"/> Teach survival skills to address immediate requirements (safe use of medication, hypoglycemia treatment if needed, introduction of eating guidelines) <input type="checkbox"/> Identify and discuss resources for education and ongoing support <input type="checkbox"/> Make referral for DSMES and other resources 	<ul style="list-style-type: none"> <input type="checkbox"/> Assess all areas of self-management <input type="checkbox"/> Review problem-solving skills <input type="checkbox"/> Identify strengths and challenges of living with diabetes 	<ul style="list-style-type: none"> <input type="checkbox"/> Identify presence of factors that affect diabetes self-management and attain treatment and behavioral goals <input type="checkbox"/> Discuss effect of complications and successes with treatment and self-management 	<ul style="list-style-type: none"> <input type="checkbox"/> Develop diabetes transition plan <input type="checkbox"/> Communicate transition plan to new health care team members <input type="checkbox"/> Establish DSME/S regular follow-up care
Diabetes education: areas of focus and action steps			
<ul style="list-style-type: none"> <input type="checkbox"/> Assess cultural influences, health beliefs, current knowledge, physical limitations, family support, financial status, medical history, literacy, numeracy to determine content to provide and how: <input type="checkbox"/> Medications—choices, action, titration, side effects <input type="checkbox"/> Monitoring blood glucose—when to test, interpreting and using glucose pattern management for feedback <input type="checkbox"/> Physical activity—safety, short-term vs. long-term goals/recommendations <input type="checkbox"/> Preventing, detecting, and treating acute and chronic complications <input type="checkbox"/> Nutrition—food plan, planning meals, purchasing food, preparing meals, portioning food <input type="checkbox"/> Risk reduction—smoking cessation, foot care <input type="checkbox"/> Developing personal strategies to address psychosocial issues and concerns <input type="checkbox"/> Developing personal strategies to promote health and behavior change 	<ul style="list-style-type: none"> <input type="checkbox"/> Review and reinforce treatment goals and self-management needs <input type="checkbox"/> Emphasize preventing complications and promoting quality of life <input type="checkbox"/> Discuss how to adapt diabetes treatment and self-management to new life situations and competing demands <input type="checkbox"/> Support efforts to sustain initial behavior changes and cope with the ongoing burden of diabetes 	<ul style="list-style-type: none"> <input type="checkbox"/> Provide support for the provision of self-care skills in an effort to delay progression of the disease and prevent new complications <input type="checkbox"/> Provide/refer for emotional support for diabetes-related distress and depression <input type="checkbox"/> Develop and support personal strategies for behavior change and healthy coping <input type="checkbox"/> Develop personal strategies to accommodate sensory or physical limitation(s), adapting to new self-management demands, and promote health and behavior change 	<ul style="list-style-type: none"> <input type="checkbox"/> Identify needed adaptations in diabetes self-management <input type="checkbox"/> Provide support for independent self-management skills and self-efficacy <input type="checkbox"/> Identify level of significant other involvement and facilitate education and support <input type="checkbox"/> Assist with facing challenges affecting usual level of activity, ability to function, health beliefs, and feelings of well-being <input type="checkbox"/> Maximize quality of life and emotional support for the patient (and family members) <input type="checkbox"/> Provide education for others now involved in care <input type="checkbox"/> Establish communication and follow-up plans with the provider, family, and others

1. At Diagnosis: *For all persons with type 2 diabetes*

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

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

Diabetes education: areas of focus

Assess cultural influences, health beliefs, current knowledge, physical limitations, family support, financial status, medical history, literacy, numeracy to determine content to provide and how:

- Medications—choices, action, titration, side effects
- Monitoring blood glucose—when to test, interpreting and using glucose pattern management for feedback
- Physical activity—safety, short-term vs. long-term goals/recommendations
- Preventing, detecting, and treating acute and chronic complications
- Nutrition—food plan, planning meals, purchasing food, preparing meals, portioning food
- Risk reduction—smoking cessation, foot care
- Developing personal strategies to address psychosocial issues and concerns
- Developing personal strategies to promote health and behavior change



2. Annually: DSME/S referral for ...

... Assessment of education, nutrition and emotional health needs, especially those with:

- No prior diabetes education
- Change in medication
- HbA1c out of range
- Planning a pregnancy
- Support to attain and/or sustain behavior change(s)
- Weight or other nutrition concerns
- New life situations and competing demands



3. Complicating factors: DSME/S referral ...

... When new complicating factors influence self-management such as

- Health conditions
- Physical limitations
- Emotional factors
- Basic living needs



4. Transitions: DSME/S referral ...

... When transition in care occurs

- Living situations
- Medical care team
- Insurance coverage
- Age related changes



Topics

- Joint Position Statement
- DSME/S Algorithm of Care and Action Steps
 - **When:** 4 critical times for DSME/S
 - **What:** Action steps for providers and educators
 - **How:** Guiding principles to deliver DSME/S

Guiding principles and key elements of initial and ongoing DSME/S

Engagement	Provide DSME/S and care that reflects person's life, preferences, priorities, culture, experiences, and capacity
Information sharing	Determine what the patient needs to make decisions about daily self-management
Psychosocial and behavioral support	Address the psychosocial and behavioral aspects of diabetes
Integration with other therapies	Ensure integration and referrals with and for other therapies
Coordination of care across specialty care, facility-based care, and community organizations	Ensure collaborative care and coordination with treatment goals



Implementing the Algorithm ...

“It is recommended that all health care providers and/or systems develop processes to guarantee that all patients with type 2 diabetes receive DSME/S services and ensure that adequate resources are available in their respective communities to support these services.”

Implementing and Marketing the DSME/S Algorithm of Care

Joan Bardsley, MBA, RN, CDE, FAADE



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Providers / Clinicians	Programs	Individuals
PCPs	DSME program	Persons with diabetes
Endos	ERP and DEAP programs	Educators
Hospitalists	Health system	Members of NCBDE
Professional organizations	Medical Homes	Bloggers
Student training programs	State health programs/health departments	Industry reps



Promotional Ideas: Local

- Press release
- Letter to all providers in a system
- DM program advisory board presentations
- MD directors



Promotional Ideas: National

- Press release at ADA
- Publication in collaborating organizations journals
- Slides decks in process
- National diabetes meetings
- Standards of Care
- Provider meetings



What Needs to Be Done

- You!
- Every educator needs to promote the evidence
- Every educator needs to promote the algorithm

Related Resources



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Related Resources from NDEP

www.ndep.nih.gov

4 Steps to Manage Your Diabetes for Life

NDEP National Diabetes Education Program
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Take Care of Your Feet for a Lifetime

A booklet for people with diabetes

NDEP National Diabetes Education Program

Caring Care of Your Diabetes Means Taking Care of Your Heart

Diabetes and Heart Disease

For people with diabetes, heart disease can be a serious health problem. Many people don't know that having diabetes means that you have a greater chance of having heart problems such as a heart attack or stroke. Taking care of your diabetes can also help you take care of your heart. Use the tools to take top steps to help. They are:

- A list of things you can do such as eating healthy foods and getting more active.
- A form to write down and track your A1C, blood pressure, and cholesterol numbers.

What you can do now

Ask your health care team these questions:

- What can I do to lower my chance of getting heart disease?
- What should my goals be for A1C, blood pressure, and cholesterol?
- When I take my medicine, how can I make sure I take it the way I should?
- Should I take medicine that can prevent my heart from getting a heart attack?

Ask any questions you have about diabetes and heart disease.

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Know Your Blood Sugar Numbers: Use Them to Manage Your Diabetes

Checking your blood sugar, also called blood glucose, is an important part of diabetes care. **Use them to help you.**

- why helps you to know your blood sugar numbers.
- how to check your blood sugar levels.
- what are target blood sugar levels.
- what to do if your blood sugar is too low or too high.
- how to keep track of blood sugar.

Why do I need to know my blood sugar numbers?

Your blood sugar numbers show how well your diabetes is managed. And managing your diabetes means that you can live longer, enjoy better health, and avoid the danger of having serious health problems.

As you check your blood sugar, you can see what makes your numbers go up and down. For example, you may see that after you eat, your blood sugar goes up. And, the next day when you eat the same food, your blood sugar goes up again. This information lets you know what is working for you and what needs to be changed.

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How to Help a Loved One Cope with Diabetes

When people have the support of their family and friends, they are able to better manage their diabetes. It is hard to know how to help. You can help your loved one cope with diabetes by showing your support. This tip sheet tells you how.

Learn about diabetes.

There is a lot to know about how people can live well with diabetes. Use what you learn to help your loved one manage his or her diabetes.

- Ask your loved one what you should know for to do in an emergency.
- Take a support group course or online course about living with diabetes.
- Check with your friend or your health care team about:
- Read about diabetes online. Visit www.NIDDK.nih.gov.
- Ask your loved one's health care team how you can learn more about managing diabetes.

Ask your loved one about coping with diabetes and how you can help.

Here are some questions:

- Do you ever feel down or overwhelmed about all you have to do to manage your diabetes?
- How are you going to manage your diabetes?
- What things seem to get in the way of reaching your goal?
- What can I do to help (strongly) for the things you do to make a better start for you to live with diabetes? If you want to be more active, will a help for you to walk together?
- How you talked to your health care team about your diabetes and how you want to reach your goal?

NDEP National Diabetes Education Program
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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institute of Diabetes and Digestive and Kidney Diseases

Diabetes HealthSense Resources for living well

HealthSense Home Make a Plan Actives Submit a Resource About HealthSense

Help Me

- Get healthy
- Be active
- Manage my weight
- Cope with stress and emotions
- Get goals
- Stop smoking
- Prevent diabetes-related health problems
- Check my blood glucose
- Take my medicine

I Am A

- Age
- Type of Resource
- Language

Diabetes HealthSense provides easy access to resources to help you live well and meet your goals—whether you have diabetes or are at risk for the disease.

Live well. Eat healthy. Be active. It's not easy, but it's worth it.

Setting Goals to Improve Your Health

Setting changes to prevent or manage diabetes is about setting goals that work for you. Breaking a goal down into small steps can make achieving it easier.

Selected Resources

Need help getting started, or feeling overwhelmed? Take a look at some of the resources below to help you get on the right track.

GUIDING PRINCIPLES

FOR THE CARE OF PEOPLE WITH OR AT RISK FOR DIABETES

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National Institute of Diabetes and Digestive and Kidney Diseases

Research & Funding for Scientists Health Information About NIDDK News

Promoting Medication Adherence in Diabetes

Resources for patients

Resources for health care teams

Scientific Evidence

Medication facts

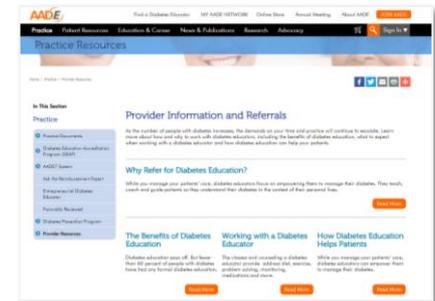
Submit a Resource or Article

Help NDEP Promote This Web Resource

Related Resources from AADE and ADA

- American Association of Diabetes Educators (AADE)
 - Patient Education Resources
 - www.diabeteseducator.org/patient-resources
 - Provider Information and Referrals
 - www.diabeteseducator.org/practice/provider-resources

- American Diabetes Association (ADA)
 - Patient Education Resources
 - www.diabetes.org
 - DiabetesPro: Diabetes Educator Resources
 - professional.diabetes.org/diabetes-education





Related Resource from the International Diabetes Center

- Diabetes Clinical Guidelines: 10 guidelines/protocols for diabetes medication management developed over many years of experience and updated annually by International Diabetes Center
 - www.idcpublishing.com

Questions-and-Answers



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www.ndep.nih.gov

1-800-860-8747

TTY: 1-866-569-1162

To request a certificate of completion: ndep@hagersharp.com

AADE will follow up with eligible participants for CE credits





Continuing Education Information



American Association of Diabetes Educators – Provider is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.



American Association of Diabetes Educators (AM001) is a Continuing Professional Education (CPE) Accredited Provider with the Commission on Dietetic Registration (CDR). CDR Credentialed Practitioners will receive 1 Continuing Professional Education units (CPEUs) for completion of this activities/materials.



The American Association of Diabetes Educators is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education. This program provides 1.0 contact hours (.1 CEU's) of continuing education credit.

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