



AADE19 Education Track Descriptions

AADE7 IN PRACTICE

OVERVIEW

The AADE7 Self-Care Behaviors™ are the core of successful diabetes self-management education and support. This track explores these essential behaviors in detail and the many teaching strategies, tools, and resources used within innovative delivery models.

WHAT WE'RE LOOKING FOR

AADE encourages proposals that address the wide range of diabetes educator skill levels, expertise in working with a variety of patient populations and providing AADE7 in all types of practice settings. The AADE19 Planning Committee seeks full session proposals (30-60 minutes), short case studies (30 minutes) or short presentations (30 minutes). *Full session proposals that include case studies, panel discussions and interactive learning methods have priority selection.*

Here are some topics we are especially interested in:

Healthy Eating

- Diet variations in diverse population groups
- Nutrigenomics
- Extreme eating plans: myths and evidence
- Teaching techniques and case studies for healthy eating, grocery store tours, cooking demos, home set up, etc.
- Whole foods and plant-based meals in low income neighborhoods

Being Active

- Creative exercise options for diverse population groups
- Benefits of exercise and how to implement this evidence based intervention with fidelity
- Simple approaches to implement into your patient practice and for patients at home
- Active environment initiatives in rural areas that promote community engagement

Taking Medication/Monitoring/Problem Solving

- Blood glucose management case studies and success stories
- Problem solving within medication management
- Problem solving using a hybrid closed loop system
- Empowering patients to use technology for improving diabetes management

- Beyond blood glucose: BP and lipid medication management and why it's important to the person with diabetes.
- Non-medical switching, Step Therapy and Advocacy

Healthy Coping

- Stress management
- Thriving with Type 1 Diabetes (college, work, travel, etc.)

Reducing Risks

- Sessions and case studies focused on reducing cardiovascular risks
- Reducing risks in diverse population groups
- Best practices and case studies for putting "safe at school" into practice. Partnerships that work (e.g., RN, CDE and parents)
- Identifying and reducing risks for LGBTQ people with diabetes.

Collaborations and new approaches

- Managing transitions in diverse settings and populations. (Including topics such alcohol, sex, aging)
- Creating an education plan that meets the individual needs of people with diabetes, using effective assessment tools (literacy, numeracy, etc).
- Utilizing paraprofessionals and multidisciplinary team members to expand and scale your program
- Considering the impact of culture, ability, and learning style on increased impact and self-management outcomes in diverse populations
- Looking at the AADE7 as a whole and how it impacts the community, including partnership, goals, and outcomes

THE BUSINESS OF DIABETES

OVERVIEW

To sustain and help DSMES services thrive in healthcare's ever changing environment, diabetes educators and managers need keen business acumen, health economics savvy and the resources to build diverse revenue-producing programs. Providing value-based diabetes business models which focus on cost avoidance and cost savings can support reduced healthcare utilization as well as help ACOs, PCMHs meet HEDIS, quality and budgetary measures. They will include multiple revenue streams; address claims denials, coding and billing processes; have a solid marketing plan; and measure ROI not only on revenue and A1cs, but also on healthcare economics and quality. Expanding business horizons means working smarter, not harder, and leveraging existing staff, budget and resources to exceed the expectations of our organizations.

WHAT WE'RE LOOKING FOR

The AADE19 Planning Committee seeks full session proposals (30-60 minutes), short case studies (30 minutes), or short presentations (30 minutes) related to:

- **Your DSMES team**
 - Optimized the roles, responsibilities and skills of your full team
 - Utilizing paraprofessionals and clinical professionals in your staffing model?
 - Do you have an interdisciplinary team? How have you been able to harness the full potential of a multidisciplinary workforce? Are you providing MNT, MTM, DSMES, MDPP? If so, describe.
 - Using competencies and training skills to evaluate and build your DSMES team.
 - Mentoring for the next generation of diabetes educators?

- **Business planning and reimbursement**
 - The Triple Aim Framework
 - Cost: revenue vs. cost avoidance:
 - What other billable services can enhance your program: MNT, CGM, using alternate codes. How to evaluate these services.
 - Quality: what needs to be measured and how to use that data to show viability: and communicate outcomes to show what DEs are doing and why we need them.
 - Experience: What programs are offered for the PWD and how does the PWD get from referral to discharge. Discuss how you use a navigation center, a team approach vs. silo working structure.
 - How do you build a business case and teach fundamental budgeting principles?
 - How do you talk so the CFO/CEO will listen? Share your pearls.
 - Share how you have implemented a business model for underserved persons, community pharmacies, valued based, population health, managed care contracts, or where ROI is based on quality measures/HEDIS.
 - How have you revitalized your program to fit into new models of care?

- Describe evolution of diabetes education in primary care, specialty practices or population health
- Do you meet with your billing department to review denied claims and work together to resubmit? Tell us how this relationship was developed and how it works?
- Has your program survived the change to a PCMH or ACO? Tell us your story
- Do you know how to tap into all payers in your area; Medicaid, Medicare, managed care, private payers, employer wellness programs, third party payers?
- How are you addressing transitions of care in your DSMES service and Health Care Team? How is your DSMES service looking at the full health and education needs of your participants across the continuum of care?
- Have you adjusted your business plan to extend services to Employer based partnerships? Work with employee health plans to provide DSMES, DPP, MNT, MTM?
- How does your DSMES service support your organizations moved to PCMH status? Work with your ACO?

- **Marketing**

- What tools do you use to gather information about how you market your services and tell us how you've used these marketing tools to increase referrals and improve patient retention?
 - Do you use your outcome measures, testimonials, previous participants to market your services?
 - Do you survey your referring and potential referring providers to help increase your visibility?
 - Have you utilized social media, local radio station interviews, news articles, Facebook to increase your visibility?
 - How have you used the Joint Position Statement to increase referrals and grow your program?
- Have you partnered with local community centers, pharmacies, medical centers, YMCAs, physical/occupational health and others to increase your visibility and provide potential support services for your participants?
- Have you offered support groups in your local library, community center, Churches, hospital, etc.
- How are you thinking out of the box for marketing and extending the reach of your DSMES service?
- How do you market yourself as a Leader in Diabetes Education? In your organization, in your community, in your colleague network, with your state/community leaders?

CLINICAL DIABETES MANAGEMENT STRATEGIES

OVERVIEW

Clinical therapeutics of hyperglycemia and management of diabetes complications are among the most challenging and rewarding prescriptions for diabetes self-care. Diabetes educators must be prepared to evaluate the evolving evidence to individualize and implement the optimal therapeutic plan of care to treat diabetes and avoid associated complications.

WHAT WE'RE LOOKING FOR

AADE encourages proposals that address the wide range of diabetes educator skill levels and practice settings. The AADE19 Planning Committee seeks full session proposals (30-60 minutes), short case studies (30 minutes) or short presentations (30 minutes). *Full session proposals that include case studies, panel discussions and interactive learning methods will be privileged for selection.*

Presentation topics may focus on one specific area or combine multiple elements:

Insulin initiation, titration and safety

- Safety with new insulin products and concentrations
- Insulin therapy for uninsured and underinsured patients
- Best practices to initiate and titrate insulin
- Evaluation of evidence to translate insulin research into practice

Medication safety, monitoring and team-based care

- Practical, systematic solutions to reduce risk of hypoglycemia within healthcare teams
- Medication reconciliation and transitions of care
- Challenges and best practices with inpatient and outpatient management
- Use of interprofessional teams to improve glycemic control
- Effective strategies to educate and train interprofessional teams

Evidence-Based Medication Practice

- Implementation of treatment algorithms for glycemic control
- Application of new and emerging evidence into clinical practice
- Approaches to glycemic management of patients with multiple comorbid conditions

Identification and management of special populations

- Transplant
- Genetic
- Celiac disease
- Cystic fibrosis

Cardiovascular disease identification and management

- Hypertension
- Dyslipidemia
- Stroke
- Heart failure (including preserved and reduced ejection fraction)

Impact of obesity on diabetes

- Current theories, interventions and treatment strategies to concurrently manage obesity and diabetes
- Pharmacotherapy for obesity
- Bariatric surgery and follow-up care

Identifying and treating microvascular complications and comorbidities

- Vision
- Kidney
- Peripheral vascular
- Dermatology
- Neuropathy-peripheral and autonomic

INCLUSIVE DIABETES CARE

OVERVIEW

This track focuses on empowering populations that are underrepresented in typical diabetes care. These are generally populations of non-majority or atypical groups, including but not limited to populations of minority race, ethnicity, language, or culture; those with atypical sensory, physical, or mental ability and disability; persons of exceptionally large or small size; transgender or gender-nonconforming persons or those of minority sexual orientation; or persons with low economic status.

The goal is to explore teaching strategies, tools and resources for effective and innovative delivery models to reach and serve diverse populations touched by diabetes, as well as methods for effective evaluation including feedback from the target population.

WHAT WE'RE LOOKING FOR

AADE encourages proposals that will provide learners greater understanding of the needs, concerns and practices of the identified population. In keeping with participatory traditions, the expertise of the identified population is valued, and individuals from that population are welcome to contribute their words and wisdom to the content and presentation.

Proposals about qualitative methodologies for learning about and understanding diverse populations are also appropriate. For example, presentations about systematic planning, implementing, and analyzing focus groups, in-depth interviews, or participatory action research would be welcome.

The purpose of this track is to equip diabetes educators with the skills and expertise necessary to work with a wide variety of patient populations. The AADE19 Planning Committee seeks, full session proposals (30-60 minutes), short case studies (30 minutes) or short presentations (30 minutes). Full session proposals that include case studies, panel discussions and interactive learning methods are of particular interest.

Diverse populations: Populations we seek to understand

- Persons of minority race, ethnicity, language, culture
- Persons with diverse sensory, physical, emotional, or mental ability
- Persons who have unusual size - individuals living in very large or very small bodies
- Persons who have diverse sexual orientation or gender identity: lesbian, gay, bisexual, transgender, non-binary, and other gender non-conforming persons
- Sex-specific needs - female, male, transgender, and nonbinary issues related to diabetes care
- Economic status related to diabetes care
- Any other dimension of human diversity that affects diabetes care

Cultural Humility: The “ability to maintain an interpersonal stance that is other-oriented (or open to the other) in relation to aspects of cultural identity that are most important to the [person]”. (Hook et al. 2013, p.2). (Hook et al. 2013)

Defining and explaining cultural humility as an explicitly value-based concept that adds value to diabetes care

- What is cultural humility?
- Meeting the needs of these populations
- Diabetes-specific research that is missing for diverse populations
- Using related research to begin the learning process
 - For example, if a particular disability is not represented in the published literature about diabetes care, where else is information available?
- Using systematic qualitative inquiry to learn what we need to know about diverse groups

Programs that demonstrate cultural humility

- Model programs for particular populations: how can we serve a particular diverse population and promote engagement in self-management of their own diabetes care?
- Including elements of model programs in larger “mainstream” programs, so diverse groups feel welcome and have their needs met
- Partnering with consumers of several diverse cultures to plan and present programs

Outcome of programs for diverse populations

Review of the outcomes programs designed for diverse populations, particularly those that demonstrate cultural humility

- Web based programs for diverse consumers
- Resources such as translated education materials and materials in formats accessible to persons with sensory, physical, and mental disabilities
- Resources and training for use of adaptive equipment for persons with disabilities
- Teaching and partnering with other professionals who work with diverse populations and are not explicitly involved in diabetes care -for example, English as a second language teachers, special education teachers, blindness rehabilitation professionals, physical and occupational therapists, psychotherapists, social workers, and American Sign Language interpreters.
- Research outcomes and findings regarding any diverse population

Presentation Expectations

- The session will include an exploration of the language used to identify or describe the populations of non-majority or atypical group. Just as a person with diabetes doesn't describe themselves as a disease (diabetic), non-majority groups have chosen unique ways to self-identify, and diabetes educators should use preferred language. Using presentation time to help

professionals use preferred terminology demonstrates respect for the population under consideration.

For example,

- many Spanish speaking individuals do not consider themselves Latino
- A fat person is unlikely to identify with him/her/they as “Obese”
- A native person may not identify themselves as “Indian”,
- Individuals who have disabilities generally do not wish to be referred to as their disability (such as “the blind” or “the deaf”) any more than people with diabetes wish to be called “diabetics”.
- The populations of non-majority or atypical groups will not be pathologized in the presentation by their size, medical treatment, or limitations. The presenters will make every effort to portray these individuals as fully functioning human beings. The presenter(s) will avoid language that overtly or subtly pathologizes, stigmatizes, stereotypes, or otherwise uses negative language for non-majority or atypical individuals. Examples include:
 - “Obesity causes diabetes”
 - "Of course he has diabetes...he's fat"
 - "Yeah, he's an alcoholic, what do you expect?"
 - "He (referring to a gay man) is such a drama queen"
 - “She is wheelchair-bound.” (Most people who use wheelchairs experience their chairs as a means of liberation, not binding).
“Those people (any group) just don’t engage in diabetes care.”
 - “She’s African-American; she must love soul food.”
- The presentation will include at least 3 ways diabetes educators can demonstrate sensitivity to the attitudes, wishes, and needs of non-majority or atypical groups. Examples include:
 - How to effectively guide a person with low vision using sighted guide techniques
 - How to ask about the preferred name and pronouns for a transgender patient
 - How to ask preferred size identifiers for individuals living in larger bodies.
 - How to ask a person with hearing loss about what helps for effective communication, and what to try if the person has no suggestions

POPULATION HEALTH

OVERVIEW

The shift from fee-for-service and traditional reimbursement models to population health and value-based care is dramatically changing healthcare delivery. As a result, the role of diabetes educators has also expanded. The AADE19 Population Health track will provide diabetes educators the platform to share their expanded roles, initiatives and experiences and enable educators new to population health the chance to learn about opportunities that exist in their practice to further highlight their value.

WHAT WE'RE LOOKING FOR:

AADE encourages proposals that address the wide range of diabetes educator expertise and experiences in population health-based care delivery across a variety of practice settings. The AADE19 Planning Committee seeks session proposals (30-60 minutes) for any of the following population health areas. Subtopics are provided for guidance only.

Session proposals that include case studies, panel discussions and interactive learning methods are of particular interest.

Population Health Defined:

- What is population health? The diabetes educator's connection to core population health pillars such as chronic disease management, public health, quality and safety, and health policy.
- The roles of diabetes educators in areas including population assessment and stratification, engagement, care coordination, care delivery, technology and outcomes selection and data
- Effective Electronic Health Record (EHR) utilization, challenges and solutions
- What outcome measures are considered? Why? Sources of assessment and outcome information (EHR, health system reports, CMS, public health data, etc.)
- HIPAA, HITECH, confidentiality laws, anti-trust, contracts, negligence, discrimination etc.

Risk Stratification Approaches for Effective Population Health Management

- Risk elements – how do you define risks and create clinical pathways?
- Stratification determination
- Use of computerized dashboards or disease registries – clinical and social determinants of health data
- Patient-care team engagement and care delivery design

Population Health Engagement & Management Strategies

- Expanded roles of diabetes educators

- New Models of DSME and clinical care
- Electronic and embedded referrals
- Clinical pathway development using evidence-based research and guidelines
- Decision support tools, including provider-order automation
- Patient engagement and enrollment strategies, shared decision-making
- Harnessing technology - Patient-generated health data, connected health
- Patient health portals
- Education resources
- Community-clinical linkage
- Outcomes – What? How? System, care team and patient? IT involvement and data alignment

Population Health Payment Models

- Overview of existing payment models
- Impact on / preparation requirements for health systems
- Role of the diabetes educator / coordinator to positively impact payment model

Workforce Training and Leveraging

- IHI Triple to Quadruple Aim – workforce satisfaction / value proposition
- Workforce mindset and training approaches
- Engagement and communication strategies
- System design needs and tools
- Approaches to the social determinants of health and population health

RISK REDUCTION/DELAY OF TYPE 2 DIABETES

OVERVIEW

DSMES programs are increasingly adding Diabetes Prevention Programs (DPP) to their list of services. With Medicare reimbursement beginning in April of 2018 and an overall move towards value-based care, the number of opportunities will continue to grow.

WHAT WE'RE LOOKING FOR

We're planning a rigorous multi-day training divided into topic areas. Each area will feature a kick-off lecture from a speaker or panel.

The AADE19 Planning Committee seeks to incorporate 30-60 minute sessions, which include your pearls, case studies, and short-form presentations to spur discussion and learning. Please note: *Presentations may be creatively combined by the Planning Committee for each module.*

Activation Strategies (*Cases/Presentations Requested*)

- Successes, noteworthy practices, and lessons learned?
- How can diabetes educator support lifestyle coaches
- Partnering with community- and faith-based organizations to expand the reach of your DPP

Technology Strategies (*Cases/Presentations Requested*)

- Data-informed insights
 - Utilizing your EHR to screen, test, and refer participants to your DPP
 - Incorporating technology into the ongoing management of your DPP
 - Utilizing insights on participant behavior and data (e.g. weight loss) to take your DPP from good to great
 - Using data to make the business case to internal and external audiences and calculate your ROI
- Distance learning and online programs
 - Incorporated tools. What works – and what doesn't?
 - Utilizing distance learning and online options for core maintenance, make-up sessions, and outreach within rural communities
 - Incorporating participant DPP data into your EHR
- Utilizing apps to support participant health behaviors
 - Using apps, trackers, web-based platform or other high or low tech. What works? What lessons can be shared?

Scaling and Sustainability (*Cases/Presentations Requested*)

- Recruit, enroll, engage, retain
 - Pearls and pitfalls at each stage of the DPP participant process from readiness to completion
- Take your program to a positive financial ROI

- Working with employers—including your own!
- Billing insurance companies
- Becoming a Medicare DPP supplier
- Medicare Billing-challenges and best practices

PSYCHOSOCIAL/BEHAVIORAL

OVERVIEW

In recent years, increased attention has been placed on psychosocial health for people with diabetes. Diabetes educators often have limited resources to help address and manage psychosocial and behavioral issues to help support people with and at risk for diabetes.

WHAT WE'RE LOOKING FOR

The AADE19 Planning Committee seeks full session proposals (30-60 minutes), short case studies (30 minutes), or short presentations (30 minutes) related to:

Psychosocial Care for People with Diabetes (Diabetes distress, depression, anxiety, cognitive dysfunction, and serious mental illness)

- Interventions for diabetes-related distress
- Diabetes related distress vs. depression and management
- Definition and impact of psychosocial-related stigma on diabetes
- Resiliency and health care providers, care givers, and living with chronic conditions
- Shared decision making
- Suicidality and diabetes

Standards, Tools, and Skills

- How do diabetes educators culturally tailor delivery of DSMES for specific diverse population segments?
- How do diabetes educators address the psychosocial standards as part of DSMES?
- What strategies to diabetes educators use that have been successful for patient engagement in self-management behavior change?
- What resources do diabetes educators use to address psychosocial concerns for people with diabetes?
- Incorporating validated tools in the psychosocial/behavioral health area
- Evidence Based conversations and communication
 - Group dynamics/facilitation
 - Question-based
- How diabetes educators increase skills, capacities and role for assessing/detecting/intervening psychosocial concerns

Support Modalities

- Technology-addressing psychosocial concerns or behavioral concerns through technology
- Peer support communities improving psychosocial health for people with diabetes

TECHNOLOGY: DEVICES, DATA AND PATIENT GENERATED HEALTH DATA

OVERVIEW

Technology is poised to radically transform prevention, treatment and ongoing support for persons at risk for or affected by diabetes – and diabetes educators are perfectly positioned to direct this revolution. How are you using mobile apps, connected health devices and web-based data collection tools? What skills can you share with your colleagues about analysis, awareness, knowledge, and application of patient generated health data (PGHD)? What cases can you share around pattern management, population health data, virtual programming, and two-way communication between device and persons with diabetes and using customized education on-line or via text, web, phone, and online communities? Are you providing telehealth? Tell us how you are creating a telehealth environment for both the educator and the person with diabetes. For all aspects, let's consider the "art" and the "science!"

WHAT WE'RE LOOKING FOR

AADE encourages proposals that address the wide range of diabetes educator skill levels and practice settings. The AADE18 Planning Committee seeks full session proposals (30-60 minutes), short case studies (30 minutes) or short presentations (30 minutes). *Full session proposals that include case studies, panel discussions and interactive learning methods are of particular interest.*

Presentation topics may focus on one specific area or combine multiple elements:

Monitoring

- Art: "smart" meters and participant selection and engagement, case studies
- Science: Accuracy
- Glucose meters – considerations and best practices

Insulin Delivery and non-insulin injections

- Art: "Smart Pens" GLP-1 RA, inhalable and injectable, case studies
- Science: BID, QD, Weekly, Monthly and persistence data

Pumps

- Art: Hybrid Closed Loop-participant selection and engagement, case studies
- Science: challenges for wearable devices, challenges for participant adoption.

CGM

- Art: participant selection, features, interpreting data and shared data
- Science: dosing indications, CGM vs. BGM accuracy
- Transitioning to continuous glucose monitoring (CGM)
- Pearls on getting started and staying on CGM
- Data, Data, Data – how to use it, interpret it, incorporate it into workflow

Digital and Connected Health

- Exploring technology solutions that work and patients' self-management skills
- Decision making and tracking of activity, meals and carbohydrates
- How to overcome fears and barriers to use of technology for the people with diabetes
- How to overcome fears and barriers to use of technology for providers/diabetes educators
- Use of technology by people with visual impairment

Apps

- Art: participant selection, choosing apps wisely, engaging and evaluating apps
- Science: characteristics of successful apps. App coaching-what works, what doesn't?
- Possible data collection: food, activity, medications, blood glucose
- How do you help participants choose apps based on accuracy, usability, updating and security? What are the best apps out there?

Online communities

- How do you optimally refer people into the diabetes online or peer support community? Share your case studies – successes and pitfalls
- Sharing information for support
- Privacy, security, safety
- How do you know what is evidence based

Telehealth

- Success stories
- Challenges
- Platforms, processes

Utilization and importance of PGHD

- Leveraging Person Generated Health Data to improve individual and system outcomes
- How are online services incorporated into traditional services and beyond traditional services, in diverse populations, rural and underserved areas
- How to use data and translate that data into practical suggestions and for PWD to improve outcomes in device use.