Closer to Home: Enhancing Access to Diabetes Education via Training Clinic Staff in Primary Care

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Presenter: Alison Evert, MS, RD, CDE – No COI/Financial relationship to disclose
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Our Story ~ Can Be YOUR Story

Outline:
Using 6 steps of program management
- Describe opportunities for CDEs in primary care & enhancing access
- “Train the Trainer” program
- Evaluating outcomes & continuation

Program Development: 6 Steps

Is YOUR Status Quo Not Working?
- Declining enrollment?
- Fewer participants completing class series?
- Are costs of receiving care at specialty clinic more expensive than care at primary care clinic (PCC)?
- Is long-term support & follow up difficult for patient?
Current Reality: “Bad Math”
- 29.1 million people with diabetes (PWD)
- 86 million people with pre-diabetes
- < 5,500 board-certified endocrinologists
- > 19,300 Certified Diabetes Educators (CDE)
- > 930 Board Certified-Advanced Diabetes Management
- Majority of PWD receive care from PCP
- Lack of trained support staff

Vigersky RA: J Clin Endo Metab, 2014; 9:3112-3121
NCBDE Website: As of January 1, 2016
AADE Presentation: 8/7/2015

New Reality: Provide Care Closer to Home - Primary Care Clinics

Why Provide DSME in Primary Care?
- PCPs don’t have time (16-18 minute per visit)
- Acute concerns crowd out chronic care management
- Limited training in behavior change
- Don’t feel very effective in counseling of lifestyle intervention strategies for PWD


Rethinking How DSME Is Provided

Diabetes Self-management Education and Support in Type 2 Diabetes
A Joint Position Statement of the American Diabetes Association, the American Association of Diabetes Educators, and the Academy of Nutrition and Dietetics

Why Provide DSME in Primary Care?
- Less than 45% of primary care visits for adults with diabetes, obesity, hyperlipidemia, hypertension include diet counseling
- Only 30% of visits include physical activity counseling

How Does This Relate to the CDE?

- CDEs have important window of opportunity into primary care world
- Primary care is an ideal place for CDEs
  - Teach diabetes self management education classes
  - Provide chronic disease management & prevention
  - “Train – the – Trainer” of existing PCC staff
- Urgent need to recognize this opportunity for our profession

Identify: Your Goals & Primary Care Goals

- Determine how you can be a part in improving outcomes and increasing reimbursement!
- For example:
  - Increase access to care
  - Reduce A1Cs in PWD over 9%
  - Create new source of revenue by providing new service
  - Better utilization of staff to teach group education vs. 1:1 sessions

CDEs & Other Health Professions in Primary Care

- # CDEs not known!
- # PharmDs not known
- # Social Workers not known
- # RDs
  - 15% working in ambulatory or outpatient facilities
  - Estimate ~ 4% work in primary care

Identify: Key DSME Stakeholders

- Care management RN/RD + PCP
- RD in private practice + PCP (can provide MNT too)
- Pharmacist + PCP (form collaborative practice agreements)
- CDE in hospital-based clinic + medical director of the PCC
- Coordinator of diabetes education at hospital-based program + director clinical services in primary care clinic system

Step 2: Definition Phase (aka What)

- Identify YOUR primary care goals
- Identify key stakeholders
- Formalize Relationship
- Financial considerations

Formalize Relationship

Memorandum of Understanding
Between
UW Medicine Diabetes Care Center
And
UW Medicine Neighborhood Clinics

GENERAL PROVISIONS
This agreement is entered into by UW Medicine – Diabetes Care Centers (DCC) and UW Neighborhood Clinics (GAMC) for the purpose of establishing the provision of diabetes education for UWMC patients.

TERM
This agreement is effective beginning January 1, 2016, and will continue annually thereafter. Either party, at their option, may terminate this agreement at any time. This agreement will be reviewed annually. Either party may give to the other written notice of its desire to terminate this agreement not less than sixty (60) days prior to the date of such termination.
Financial Considerations

COMPENSATION AND REVENUE:
UW Medicine DCC will prepare and deliver to UWNC an invoice for education coordination services provided by a Certified Diabetes Educator to UWNC based on clinical FTE of 0.2 including benefits. The amount of the reimbursement will be re-evaluated annually. UWNC will retain any revenues associated with billing for these services.

Step 3: Design (How?)

• Choose type of education program
• Provide staff development
• Confirm referral process & work flow
• Monitor for billing issues/concerns
• Market the classes

Choose Type of Education Recognition Program

AADE
$900 all programs
• Community Sites – (free maximum of 10)
• Branch Sites – $100.00 per location (maximum 30)
• Corporations and Large Organizations (dealt with individual basis)

American Diabetes Association
$1,100 main site
• Expansion Site – (no fee, no limit on number)
• Multi-site – ($100 each additional site)

Billing for DSME

• In a health system?
  – Work with finance department or billing services
• “How to” bill for services?
  – Paper “fee sheet” or electronic health record
• Who are major insurance plans in your area?
  – Do they require specific billing codes?
• Need more help?
  – Local networking or consultant

Work Flow – Who’s Going To Do What?

• You? Receptionist? Health Navigator?
• Organize referrals
• Schedule appointments
• Insurance questions/coverage determination
• Appointment reminders
Marketing
- In-clinic fliers or posters
- Cards
- TV Monitor advertisements
- Online presence
- Staff meetings

Design and Implementation
With program goals in mind…
1. Engage stakeholders
   - Confirm instructor team and interest
   - Assess learning needs
   - Agree on approach to training
2. Implement the training
3. Implement the DSME

Pair & Share
Pair with the person next to you and share your ideas to answer the following questions:
1. What would a program like this look like in your practice setting?
2. Who could benefit from the program?
3. Who should be involved in teaching it?

Stakeholders: Who are they?
- Clinic nurses, dietitians, social workers, pharmacists
- Clinic leadership
- Health System leadership
- Front desk staff
- Patient advocate
- Other?

Step 4: Development
See One, Do One, Teach One
Development of a Train the Trainer Program for primary care diabetes education

See one, Do one, Teach one model
Baseline Assessment
- DM Knowledge and Skills
Observation: “See one”
- Demonstration of DSME 3-class series
Adaptation and customization
- Slides adapted by clinic staff to their clinic culture and needs
See one, Do one, Teach one model

Practice: “Do one”
- “Teach-back” of DSME class
- Coaching and feedback
- Reflection and development

Actual teaching: “Teach one”
- Staff conducted “live” DSME class with coach present
- Coaching and feedback, reflection
- Goal setting for development

Learning Assessment: Knowledge

Diabetes Survival Skills Workshop

Individualizing training
- Baseline assessments used to develop individual education and coaching plans
- Ongoing work with staff to promote confidence and competency
Lessons learned

• Baseline: everyone starts from a different place
• Self-awareness of learning needs varies
• Reflection
  • Useful to frame learning needs
• Instructional styles
  • Aligning individual styles with class needs is important
• Coaching and feedback are key to development

Acknowledgement and performance recognition

Step 5: Implementation

What do I need to implement a DSME program?

• Curriculum
• Staff
• Space
• Teaching tools

Educational Curriculum:

Who will be served?  What are the needs?

Original Program  DIY  Purchase

Change based on your population

Program Curriculum

Individualizing Curriculum

• Can be done pre- or post- program evaluation
  – Participant barriers
  – Differing abilities or expectations of participants

What is Swag?
Step 6: Evaluation

• Pre & Post-class Assessments
• Anonymous Class Evaluations
• Diabetes Outcomes Tracking
• Continuous Quality Improvement (CQI) Project

DSME Pre-assessment:

• Assess:
  - DM knowledge & how the person lives with their diabetes day-to-day
  - Learning needs and influences

• Consider:
  – Pertinent information
  – Methods to conduct
  – Support persons

Anonymous Class Evaluations

Outcomes Tracking: Chronicle

Knowledge Assessments

CQI Project

• Obtained clinical data from EHR and patient self-assessment documents

Manuscript

• Microsoft Excel & SPSS Statistical Software
• Compared pre- and post-class clinical measures (A1C and weight) using paired student’s t-test
Patient Health Demographics

<table>
<thead>
<tr>
<th>N = 49 (75% female)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diabetes Diagnosis</strong></td>
</tr>
<tr>
<td>Type 1</td>
</tr>
<tr>
<td>Type 2</td>
</tr>
<tr>
<td><strong>Race</strong></td>
</tr>
<tr>
<td>White</td>
</tr>
<tr>
<td>Hispanic</td>
</tr>
<tr>
<td>Black</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td><strong>Risk Factors</strong></td>
</tr>
<tr>
<td>Hyperlipidemia</td>
</tr>
<tr>
<td>Hypertension</td>
</tr>
<tr>
<td>Kidney Disease</td>
</tr>
<tr>
<td><strong>Mental Health</strong></td>
</tr>
<tr>
<td>Depression Diagnosis</td>
</tr>
<tr>
<td>Other Mental Health Diagnosis</td>
</tr>
<tr>
<td><strong>Insurance</strong></td>
</tr>
<tr>
<td>Commercial</td>
</tr>
<tr>
<td>Medicare</td>
</tr>
<tr>
<td>Medicaid</td>
</tr>
</tbody>
</table>

Attending at least one class of DSME at this PCC was correlated with significant reduction of A1c at three and six months after education.

* (P<0.00001)  ** (P<0.05)

Significant weight reduction was seen in class participants at three and six months post-class despite improved glycemic control.

* (P<0.01)  ** (P<0.05)
CQI Project: Discussion

• It works!
• Translatable:
  – Majority morbidly obese / super obese
  – Majority group had diabetes >10 years
  – Managing multiple medications (average 8, range 1-22)
  – Limited income
  – Nearly 50% with a mental health issue

Table 2: Effect of class intervention on mean A1c and weight

<table>
<thead>
<tr>
<th>Average All Patients</th>
<th>Pre-</th>
<th>Post-</th>
<th>Change</th>
<th>Pre-</th>
<th>Post-</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>49</td>
<td>52</td>
<td>3.6%</td>
<td>138.0</td>
<td>136.4</td>
<td>1.6</td>
</tr>
<tr>
<td>Diabetes Duration</td>
<td>a</td>
<td>Pre-</td>
<td>Post-</td>
<td>Pre-</td>
<td>Post-</td>
<td>Change</td>
</tr>
<tr>
<td>&lt; 5 years</td>
<td>15</td>
<td>0.9%</td>
<td>6.9%</td>
<td>119.3</td>
<td>116.2</td>
<td>3.1</td>
</tr>
<tr>
<td>5 to 9 years</td>
<td>7</td>
<td>7.6%</td>
<td>5.9%</td>
<td>129.9</td>
<td>123.5</td>
<td>6.4</td>
</tr>
<tr>
<td>10+ years</td>
<td>18</td>
<td>0.9%</td>
<td>0.8%</td>
<td>96.0</td>
<td>97.3</td>
<td>1.3</td>
</tr>
<tr>
<td>Medication Use</td>
<td>a</td>
<td>Pre-</td>
<td>Post-</td>
<td>Pre-</td>
<td>Post-</td>
<td>Change</td>
</tr>
<tr>
<td>Oral meds. only</td>
<td>22</td>
<td>0.5%</td>
<td>0.8%</td>
<td>112.6</td>
<td>110.7</td>
<td>1.9</td>
</tr>
<tr>
<td>Insulin use</td>
<td>25</td>
<td>0.8%</td>
<td>0.1%</td>
<td>105.7</td>
<td>105.7</td>
<td>0.0</td>
</tr>
<tr>
<td>Mental Health</td>
<td>a</td>
<td>Pre-</td>
<td>Post-</td>
<td>Pre-</td>
<td>Post-</td>
<td>Change</td>
</tr>
<tr>
<td>Depression Diagnosis</td>
<td>14</td>
<td>0.4%</td>
<td>3.9%</td>
<td>195.5</td>
<td>195.5</td>
<td>1.3</td>
</tr>
</tbody>
</table>

Roles of Care Team

<table>
<thead>
<tr>
<th>Care Manager</th>
<th>Educator</th>
<th>Offers 1:1 Consult</th>
<th>Low-Risk Introduction of Care Team Member</th>
</tr>
</thead>
<tbody>
<tr>
<td>RN</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>RD</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>MSW</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>PharmD</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Health Navigator</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
</tbody>
</table>

Who learned from the program?

“...The diabetes classes have helped me to understand and be more prepared to answer common (tough) questions patients with diabetes ask. They also helped me appreciate the fact that patients want to learn and understand their diabetes- but may have not had the venue to do that in the past.”

- Sarah, Primary Care RN
“I was a bit nervous when I started teaching class. Here we are two years later and diabetes class has become a favorite part of my job. Most of what I know about diabetes I learned since I started teaching class.

For me I know I would not be as effective with 1:1 if I had not started teaching classes. It has forced me to be proactive in learning about diabetes.”

- Carol, Primary Care RN

“Program Continuity

- Ongoing referrals
  - “Provider Champion”
  - Team-based care
- Outcomes presentations
- Reimbursement evaluation
- Annual Stakeholder meeting
- Adding education-recognized sites

Take a moment to think about your worksite.

What questions do you have?

“After my patients go to classes, they’re so much more knowledgeable about their disease and more motivated to take care of themselves. Plus, there is no way that I could spend SIX HOURS educating my patients, and that’s how I sell it to them. That’s 18 twenty-minute visits!”

- Michele Despreaux, Internal Medicine MD at Primary Care Clinic in Kent, WA

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Thank you!