State Public Health Actions to Prevent and Control Diabetes, Heart Disease, Obesity and Related Risk Factors, and Promote School Health (1305)

Diabetes Self-Management Education (DSME) Technical Assistance Guide

The following tool is designed to assist grantees in planning and implementing activities to address Domain 4, Strategy 1: "Increase use of DSME programs in community settings (focusing on access, referrals, and reimbursement)" in the *State Public Health Actions (1305)* Funding Opportunity Annoucement. The tool identifies four key drivers for this strategy: 1) DSME programs, 2) payers and payment mechanisms, 3) referral policies and practices/health care systems, and 4) people with diabetes "willing to go" to DSME programs. These drivers represent the necessary elements for successful implementation of this strategy. Each key driver includes information on assessing current conditions/gaps in DSME services , activities to address the needs or gaps identified, facilitatating factors, and barriers/risks. The bulleted items below provide some additional guidance and definitions to help in using the tool.

How to use the table (see definitions below):

- Review the "Current Gaps/Needs" for each key driver* to determine if any of the bulleted items apply.
- Review "Assessment Data" to determine potential data sources for assessing and identifying current gaps/needs.
- Review "Grantee Activities" to determine potential activities to implement to address the key drivers.
- Review "Facilitators" to determine supporting resources.
- Reivew "Barriers/Risks" to determine potential barriers and risks.

Definitions:

Key Drivers: The necessary elements to have in place in order to address this strategy. These drivers are not mutually exclusive, and gaps and activities may overlap.

Current Gaps/Needs: Current conditions that potentially require intervention

Assessment Data: Potential data sources to assess and identify current gaps and needs

Grantee Activities: Potential activities to address identified gaps/needs

Facilitators: Individuals, conditions, etc. that support the establishment or improvement of a key driver

Barriers: Individuals, conditions, etc. that hinder the establishment or improvement of a key driver

*Note: This driver diagram is focused specifically on work with ADA-recognized and AADE-accredited DSME programs (primary or satellite sites), and does not include Stanford Diabetes Self-Management Programs (DSMP).

Diabetes Self-Management Education (DSME) Technical Assistance Guide (June, 2014)

	Key drivers (necessary elements for a successful intervention)			
	DSME Programs ("programs"): ADA-recognized, AADE-accredited DSME programs established (primary or satellite sites)	***Payers and payment mechanisms: Public and private insurance coverage of DSME***	***Referral policies and practices/health care systems: Policies and practices in place within the health system to efficiently connect people with diabetes (PWD) to DSME programs***	***PWD "willing to go" to DSME programs: Awareness, capacity, and willingness of PWD to attend DSME Programs when other drivers are in place***
Current Gaps/Needs *(Current conditions that potentially require intervention)*	□ Limited programs in state relative to burden □ Low % of counties or health service areas with programs □ Limited programs with ADA recognition/AADE accreditation; remote areas with limited DSME access □ State accredited programs not meeting *National Standards for Diabetes Self-Management Education and Support* □ High program turnover □ CMS Diabetes Quality Improvement Project (DQIP) interventions that establish new (parallel) infrastructure for patient education instead of using existing recognized/accredited DSME programs to meet identified needs	□ No/limited* Medicaid coverage (fee-for-service, managed care organizations [MCOs]) □ No State employee coverage □ Limited coverage by some private insurers □ Low reimbursement rates □ High copays or coinsurance for DSME □ DSME coverage not promoted well for people with diabetes	□ Low provider referrals to programs □ Referral form and paperwork burdensome for some providers □ Low DSME participation rates relative to incidence, prevalence, PWD with A1c>9 in the general population or specific populations with a high burden of diabetes □ Providers lacking current clinical information/skills necessary for managing diabetes	□ Low participation rates among insured PWD (general population or specific population[s] with a high burden of diabetes) □ DSME coverage not adequately promoted to PWD □ Importance of DSME as a necessary step to manage diabetes not adequately communicated to PWD □ Low awareness of availability and need for DSME among PWD, particularly until they develop complications and/or change therapy (e.g., go on insulin) □ Poor cultural tailoring of effective programs to PWD
Assessment Data *(Potential data sources to assess and identify current gaps and needs)*	□ Locations of ADA-recognized , AADE-accredited program sites and other programs □ Data on diabetes burden/poor diabetes control (BRFSS, health care system data) □ Standards used for state accredited programs	□ Status of Medicaid/Medicaid MCO coverage and coverage details □ Status of State employee insurer coverage and coverage details □ Status of mandate for private insurance coverage for DSME (applies to 46 states) □ Status of private insurance coverage utilization rates for all types of payers	□ Data/information on DSME referrals (rates, sources, barriers, etc.) from DSME program providers, All Payer claims data, private insurers, State employee claims data, Medicaid, etc. (Supporting Activity: Determine availability of staff or partners to access and analyze claims data) □ Number and location of health care systems/practices using electronic health records (EHRs) that track referrals	□ DSME program participation data (e.g., program utilization rates, barriers to access, source[s] of patient referrals, etc.) □ BRFSS data on diabetes education □ Locations of ADA-recognized , AADE-accredited program sites and other programs □ Data on diabetes burden/poor diabetes control (BRFSS, health care system data)
1305 Activities (*Potential Activities to address*	□ Convene and/or survey key stakeholders (program providers, employers, payers, health system representatives, etc.) for planning to address gaps in program availability and	□ Convene key stakeholders (program providers, employers, payers, health system representatives, etc.) for planning to address gaps in coverage	□ Convene key stakeholders (program providers, employers, payers, health system representatives, etc.) for planning to address barriers to referrals	□ Convene key stakeholders (program providers, employers, payers, health system representatives, etc.) for planning to address barriers to DSME access

	Key drivers (necessary elements for a successful intervention)			
	DSME Programs ("programs"): ADA-recognized, AADE-accredited DSME programs established (primary or satellite sites)	***Payers and payment mechanisms: Public and private insurance coverage of DSME***	***Referral policies and practices/health care systems: Policies and practices in place within the health system to efficiently connect people with diabetes (PWD) to DSME programs***	***PWD "willing to go" to DSME programs: Awareness, capacity, and willingness of PWD to attend DSME Programs when other drivers are in place***
"Current Gaps/Needs")	sustainability □ Provide support (e.g., link to recognition/ accreditation resources, access to consultants or other DSME sites that can offer mentoring, guidance, etc.) to health systems (FQHCs/CHCs, local health departments [LHDs] and other safety net organizations serving vulnerable, high risk populations) to establish new ADA-recognized/AADE-accredited DSME programs □ Provide support to existing DSME programs to assist them in obtaining ADA-recognition/AADE-accreditation □ Obtain a statewide umbrella license from the ADA or AADE for the State Dept. of Health to facilitate expansion of recognized/accredited DSME programs throughout the state □ Work with established DSME programs to improve sustainability (e.g., explore compatible revenue streams [Medical Nutrition Therapy, Medication Therapy Management, National Diabetes Prevention Program lifestyle change program]; see also Payer/Payment Mechanism driver activities) □ Promote alternative locations for delivery of DSME that are appealing to both patients and referring providers (e.g., telehealth, pharmacies, churches, community centers, etc.) □ Convert state accredited programs to ADA-recognized or AADE-accredited programs if they are not meeting the national standards □ Use health care extenders (e.g. pharmacists/pharmacies) to expand access to	□ Clarify status/extent of Medicaid/MCO DSME coverage □ Clarify statutory requirements for DSME coverage by private insurers (applies to 46 states with insurance mandates for DSME), Medicaid, and State employees, if applicable □ Share information on group visit models with bundled services with health care providers/staff and DSME program providers to maximize reimbursement □ Provide technical assistance to DSME program providers on appropriate billing practices to maximize reimbursement □ Work with State Employee Health Plans and the State Medicaid Agency to extend coverage where needed □ Work with established DSME programs to considering additional services that may be offered (e.g., Medical Nutrition Therapy, Medication Therapy Management, National Diabetes Prevention Program lifestyle change program) where it makes sense to supplement program income	□ Use targeted marketing/social media approaches to reach providers/health care systems (e.g., CDC 1,2,3 Approach to Provider Outreach http://www.cdc.gov/arthritis/interventions/marketing-support/1-2-3-approach/) □ Provide technical assistance/training/ academic detailing on DSME referrals and reimbursement (Use AADE materials on communicating information on DSME benefits, coverage, and referral mechanisms: (http://www.diabeteseducator.org/ProfessionalResources/Library/) □ Build EHR-generated or other systems to facilitate and track referrals and enhance decision support □ Integrate DSME programs/referrals into coordinated care (e.g., Patient-Centered Medical Homes) □ Work with MCOs to integrate DSME into Performance Improvement Plans/Programs □ Integrate referral to DSME with other disease clinics (e.g. TB) □ Implement systems and increase partnerships to facilitate bi-directional referral between community resources and health care systems (e.g. 800 numbers, 211 referral systems, etc.) □ Develop cross-referral systems for PWD between community programs (e.g., Chronic Disease Self-Management Programs [CDSMP]; Tobacco Quitlines, etc.) and recognized/accredited DSME programs □ Add DSME referral/attendance to pay-for-	□ Link organizations and government agencies serving PWD to health care systems with DSME programs □ Promote *STOP Diabetes At Work* Campaign http://www.diabetes.org/in-my-community/awareness-programs/stop-diabetes-at-work/ □ Use Community Health Workers to link PWD to DSME programs and to assist as part of the team in delivering DSME □ Integrate DSME into Patient-Centered Medical Home (PMCH) programs □ Issue grants/scholarships to community organizations to help increase use of DSME by high risk populations (Note: CDC funds should not be used to pay for the direct delivery of DSME to PWD.) □ Promote alternative locations for delivery of DSME that are appealing to both patients and referring providers (e.g., telehealth, pharmacies, churches, community centers, etc.) □ Use strategic communication strategies to reach PWD about the importance of DSME and DSME benefits/coverage (e.g. DSME waiting room triggers)

	Key drivers (necessary elements for a successful intervention)			
	DSME Programs ("programs"): ADA-recognized, AADE-accredited DSME programs established (primary or satellite sites)	***Payers and payment mechanisms: Public and private insurance coverage of DSME***	***Referral policies and practices/health care systems: Policies and practices in place within the health system to efficiently connect people with diabetes (PWD) to DSME programs***	***PWD "willing to go" to DSME programs: Awareness, capacity, and willingness of PWD to attend DSME Programs when other drivers are in place***
	DSME		performance models	
Facilitators (Individuals, conditions, etc. that support the establishment or improvement of a key driver)	□ Established partnerships with key organizations that also have a stake in expanding access to/participation in/reimbursement for DSME □ DSME champions □ DSME addressed as a priority in the State Diabetes or Chronic Disease Plan	□ Established partnerships with key organizations that also have a stake in expanding access to/participation in/reimbursement for DSME □ DSME champions □ DSME addressed as a priority in the State Diabetes or Chronic Disease Plan	□ Established partnerships with key organizations that also have a stake in expanding access to/participation in/reimbursement for DSME □ DSME champions □ DSME addressed as a priority in the State Diabetes or Chronic Disease Plan	□ Established partnerships with key organizations that also have a stake in expanding access to/participation in/reimbursement for DSME □ DSME champions □ DSME addressed as a priority in the State Diabetes or Chronic Disease Plan
Barriers/ Risks[1] (Individuals, conditions, etc. that hinder the establishment or improvement of a key driver)	□ Difficulty attaining/maintaining adequate patient volume (e.g. rural populations) □ Limited clinical professionals in area (e.g., Health Professional Shortage Areas [HPSAs]/Medically Underserved Populations [MUPs]) □ High percentage of uninsured population □ Administrative/resource challenges associated with starting up and maintaining an ADA-recognized or AADE-accredited DSME program □ Limited reimbursement, contributing to challenges in program sustainability □ Limited resources for administrative and marketing activities □ Lack of support for DSME among health care system administrators □ Unknowns associated with the impact of health care reform	□ Inconsistent operational definitions of DSME □ Limited coverage for DSME; lack of Medicaid expansion in some states, which could impact the ability to offer DSME as a covered benefit for Medicaid recipients with diabetes □ Medicare patients not fully utilizing DSME benefit; only 12 months available to use the initial 10 visits of Medicare-funded DSME after referral □ Medicare denial of coverage for DSME when other Medicare services are offered at non-Medicare rates	□ Limited coverage for DSME □ Limited awareness of DSME benefits among providers □ Lack of knowledge of how/where to refer patients □ Difficulty accessing claims data for assessment □ Difficulty capturing referral data □ Lack of relationships between hospitals and community DSME programs (Many hospitals provide initial education.) □ Potential instability of programs receiving referrals	□ Limited programs with language/cultural-specific curricula/appropriate staff □ Prohibitive cost/co-pays □ Inconvenient hours □ Inconvenient and/or undesirable locations □ Limited awareness of DSME benefits among PWD □ Competing demands for time and attention, particularly among populations with limited income/resources □ Transportation and childcare issues, particularly among populations with limited income/resources □ Lack of reimbursement for Community Health Workers assisting with DSME

[1] These studies describe barriers associated with providing DSME for both health care providers and people with diabetes.

- Powell, PM, Glover SH, Probst JC, Laditka SB. Barriers Associated with the Delivery of Medicare Reimbursed Diabetes Self-management Education. Diabetes Educator. Volume 31, Number 6, November/December 2005.
- Peyrot M, Rubin RR, Funneil MM, Siminerio LM. Access to Diabetes Self-management Education. Diabetes Educator. Volume 35, Number 2, March/April 2009.
- Diabetes Self-Management Education Barrier Study. Maine Department of Health and Human Services. Maine Center for Disease Control and Prevention. September 2006. Access September 8, 2010. http://www.maine.gov/dhhs/bohdcfh/dcp/documents/BarrierReport_9_14.pdf
- Peyrot M, Rubin RR. Access to Diabetes Self-management Education. Diabetes Educator. Volume 34, Number 1, January/February 2008.

DSME Resources:

1. e-PACE Recording, Sept., 2012: *Sustainable Diabetes Self-Management Education—Expanding Access and Promoting Reimbursement*: http://epacelearning.org/sept2012/
2. ADA Diabetes Education Recognition Program: https://professional.diabetes.org/Recognition.aspx?typ=15&cid=84040
3. AADE Diabetes Education Accreditation Program: https://www.diabeteseducator.org/ProfessionalResources/accred/
4. Tribal DSME Programs: Guidance on Recognition/Accreditation: http://www.ihs.gov/MedicalPrograms/Diabetes/index.cfm?module=programsIDERP
5. National Standards for Diabetes Self-Management Education and Support: http://care.diabetesjournals.org/content/37/Supplement_1/S144.extract
6. Guidelines for the Practice of Diabetes Self-Management Education: http://www.diabeteseducator.org/DiabetesEducation/position/Practice_Guidelines.html
7. Promoting Diabetes Self-Management Education (DSME) to Providers—Resources Available from the American Association of Diabetes Educators (AADE)
    - DSME Benefits PowerPoint Presentation *Diabetes Educators: Supporting You, Empowering Your Patients*, which provides ready-made slides and a script you can personalize and deliver at meetings of medical professionals or during simple office visits.
    - Diabetes Services Order Form for Providers and accompanying Background Document providing important information on reimbursement and coding: *http://www.diabeteseducator.org/ProfessionalResources/Library/ServicesForm.html*
    - Tips for Reaching Prescribers: http://www.diabeteseducator.org/ProfessionalResources/Library/Tips_For_Reaching_Prescribers.html
8. US Department of Health and Human Services. Expanded coverage for diabetes outpatient self-management (final rule). Program memorandum B-01-40. 2001. (http://www.cms.hhs.gov/Transmittals/Downloads/B0140.pdf)