Advancing Agricultural Worker Health

Lessons Learned from Diabetes Prevention and Diabetes Self-Management Education and Support

Association of Diabetes Care & Education Specialists

Hello!

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Association of Diabetes Care & Education Specialists

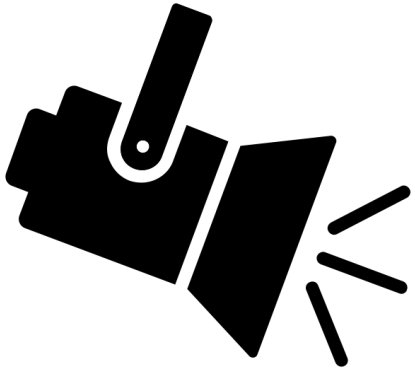
Chicago, Illinois

Learning Objectives

At the end of today's webinar, participants will be able to:

- Define the National Diabetes Prevention Program and the National Standards for DSMES
- Discuss strategies to enroll, engage, and retain participants in both services, highlighting best practices for clinical referrals, community engagement, and leveraging other health education resources
- Identify approaches to address health-related social needs that are often barriers to retention and adoption of healthy self-care behaviors

Community Health Center Spotlights!



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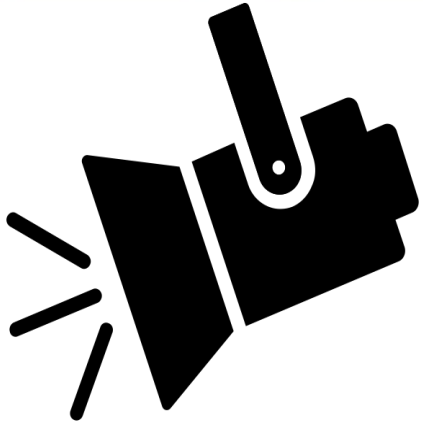


Gateway Community Health Center, Inc. (Laredo, TX)

ADCES Association of Diabetes Care & Education Specialists

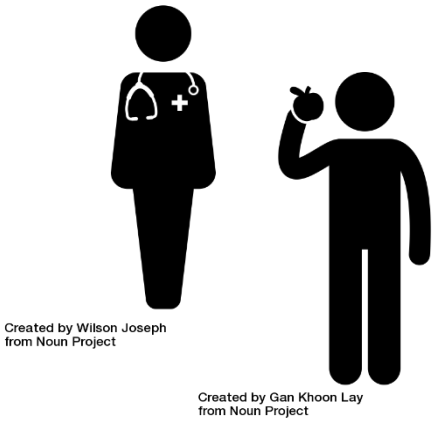
Diabetes Prevention and Diabetes Self-Management Education and Support

Parallel pathways to serve your community

Diabetes Prevention Program (DPP)

- An intensive 12-month lifestyle change program focused on healthy eating, being active, self-monitoring, and healthy coping
- Intended for people with prediabetes + overweight/obesity at greatest risk of developing type 2 diabetes
- Group programs led by community health workers and other trained lifestyle coaches in clinical, community, and faith-based settings
- Reimbursement available from Medicare, some state Medicaid programs, and private payers

DPP Benefits



DPP

58%

10-year follow up

34%

Participants over 60 reduced risk by 71%

10-year follow up

21%

An intensive 12-month lifestyle change program focused on healthy eating, being active, self-monitoring, and healthy coping was TWICE as effective as medication in reducing risk of developing type 2 diabetes

Centers for Disease Control and Prevention

CDC provides the "seal of approval" to organizations that achieve program goals, setting national standards to:

- Ensure quality, fidelity, and broad use of proven prevention programs
- Maintain a national registry of organizations that deliver effective diabetes prevention programs
- Provide technical assistance to organizations to achieve and maintain recognition status

Diabetes Self-Management Education and Support (DSMES)

- A collaborative, individualized, ongoing process that helps people with diabetes develop the knowledge, skills, and behaviors to make decisions to manage their diabetes and stay healthy
- Intended for people diagnosed with type 1 or type 2 diabetes
- One-on-one and group programs led by diabetes care & education specialists, health professionals and paraprofessionals, and community health workers
- Reimbursement available from Medicare, some state Medicaid programs, and private payers

Diabetes Self-Management Education and Support (DSMES) Benefits

Summary of DSMES benefits to discuss with people with diabetes

- Provides critical education and support for implementing treatment plans.
- Reduces emergency department visits, hospital admissions and hospital readmissions.
- Reduces hypoglycemia.
- Reduces all-cause mortality.
- Lowers A1C.
- Promotes lifestyle behaviors including healthful meal planning and engagement in regular physical activity.
- Addresses weight maintenance or loss.
- Enhances self-efficacy and empowerment.
- Increases healthy coping.
- Decreases diabetes-related distress.
- Improves quality of life.

No negative side effects | Medicare and most insurers cover the costs

Powers MA, Bardsley JK, et al. DSMES Consensus Report, The Diabetes Educator, 2020

If DSMES were a pill, would you prescribe it?

Comparing the benefits of DSMES/MNT vs metformin therapy

CRITERIA	Benefits rating: DSMES/MNT	Benefits rating: METFORMIN
Efficacy	High	High
Hypoglycemia risk	Low	Low
Weight	Neutral/Loss	Neutral/Loss
Side effects	None	Gastrointestinal
Cost	Low/Savings	Low
Psychosocial benefits*	High	N/A

N/A, not applicable. *Psychosocial benefits include *improvements to* quality of life, self-efficay, empowerment, healthy coping, knowledge, self-care behaviors, meal planning, healthier food choices, more activity, use of glucose monitoring, lower blood pressure and lipids and *reductions in* problems in managing diabetes, diabetes distress, and the risk of long-term complications (and prevention of acute complications).

Powers MA, Bardsley JK, et al. DSMES Consensus Report, The Diabetes Educator, 2020

ADCES

POLLING QUESTION #1:

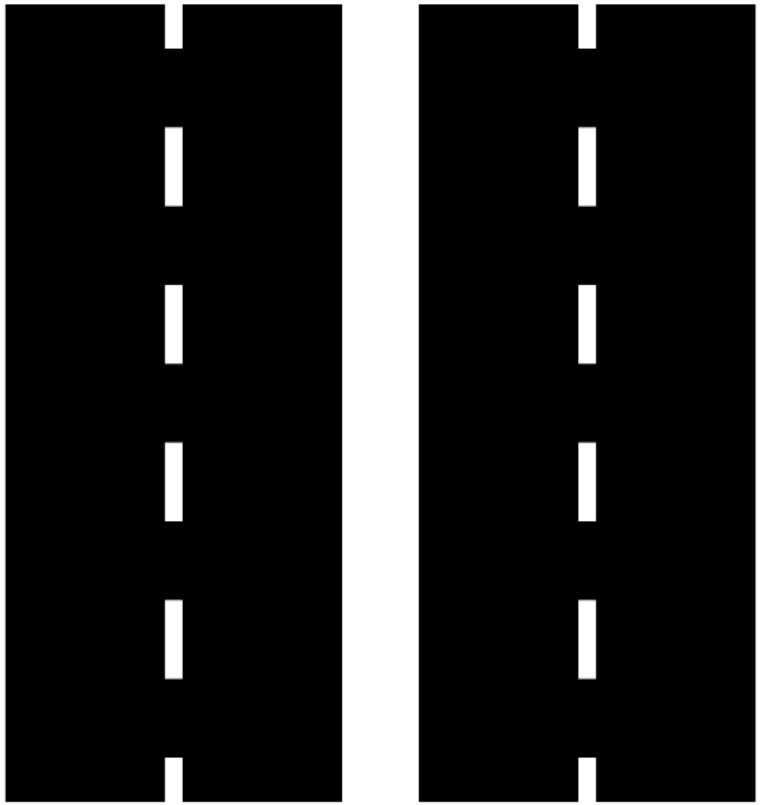
Which service would you recommend to a friend who has had Type 2 diabetes for 6 years?

- ❑ Diabetes Self Management Education & Support
- ❑ Diabetes Prevention Program

Centers for Medicare and Medicaid Services

- Medicare regulations state that a DSMT program must be accredited by a National Accreditation Organization (NAO) so that Medicare can determine if the DSMT program meets the program requirements
- ADCES is one of two certified National Accrediting Organizations (NAO) for Medicare (CMS)
- DEAP = Diabetes Education Accreditation Program

High-level overview



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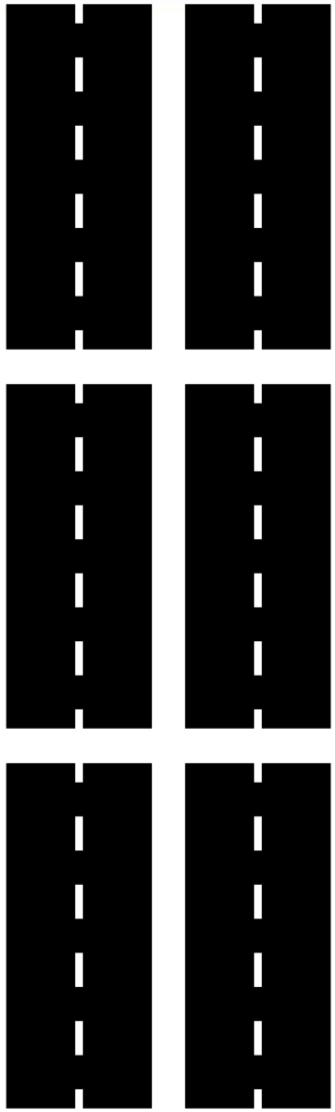
- National Standards and Accreditation/Recognition
- Billing Medicare
- Staffing
- Delivery modes
- Training
- Curriculum
- Quality Assurance

National Standards

DSMES

National Standards for DSMES

- Updated by ADA and ADCES every 5 years.
- Currently under way for publication in 2022.
- **Interpretive Guidance** for programs applying and maintaining accreditation.



Prevention

CDC Diabetes

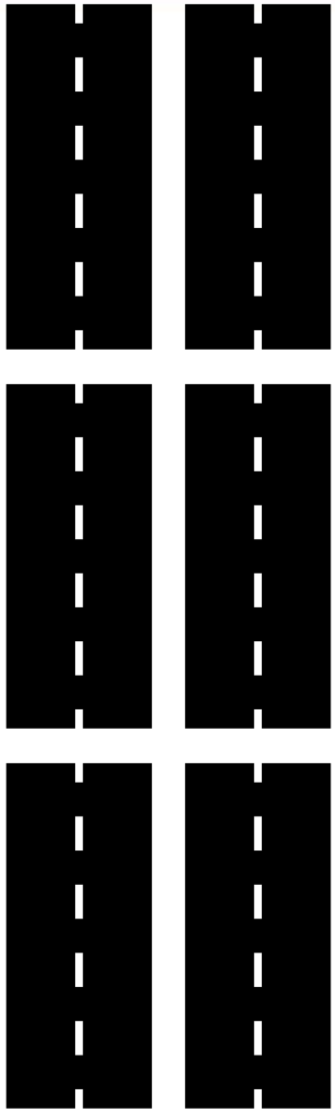
- Updated by the Centers for Disease Control and Prevention every 3 years
- NEW STANDARDS arriving soon! (May 2021)
- CDC Customer Service Center

Recognition or Accreditation

DSMES

2 National Accrediting Organizations for Medicare

- ADCES
  - DEAP
  - DSMT Accreditation
- ADA
  - ERP
  - DSMT Recognition



Prevention

A single National Recognition Organization with three levels of recognition

- Centers for Disease Control and Prevention
- Levels: Pending, Preliminary, and Full Recognition
- Those with Preliminary and Full recognition have standing to become Medicare DPP suppliers through a separate process

Definitions

DSMES

- Diabetes self-management education and support (DSMES)
- Diabetes self-management training (DSMT)

Prevention

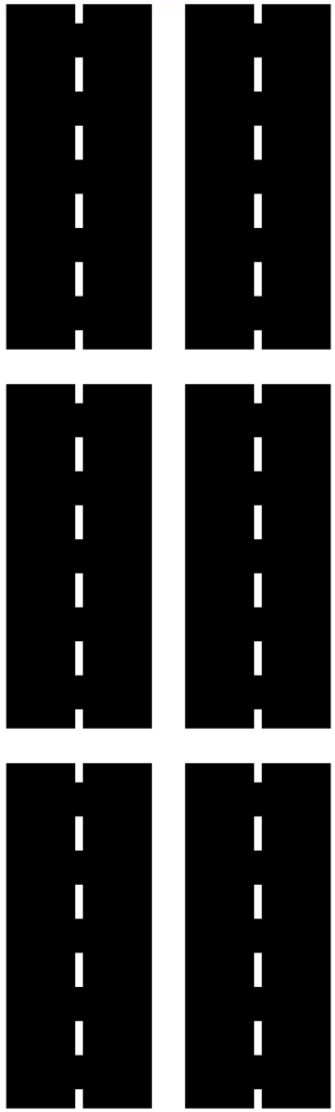
Alphabet Soup!

- CDC Lifestyle Change Program (CDC LCP)
- National Diabetes Prevention Program (National DPP)
- Medicare Diabetes Prevention Program (MDPP)

Billing Medicare

DSMES

- Requires a referral from a qualified provider
- Individual and group benefit with annual limits beginning the first year of Medicare coverage
- Differences with FQHCs and rural health centers



Prevention

- Individuals can “self-refer” into Medicare DPP
- Group benefit
- Once-in-a-lifetime benefit for Medicare beneficiaries
- In-person program with some tele-health flexibilities
- Can be offered at clinical and community sites

Billing Medicare

DSMES

- Requires a referral from a qualified provider
- Individual and group benefit with annual limits beginning the first year of Medicare coverage
- Differences with FQHCs and rural health centers

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Referrals (DSMT)

ORDER FORM

Diabetes Self-Management Education & Support/Training & Medical Nutrition Therapy Services

MEDICARE COVERAGE: Diabetes self-management education and support/training (DSMES/T) and medical nutrition therapy (MN
are separate and complementary services to improve diabetes self-care. Individuals may be eligible for both services in the same year. Research indicates MNT combined with DSMES/T improves outcomes.

DSMES/T: 10 hours initial DSMES/T in 12-month period from the date of first session with written referral from the treating qualified provider, plus 2 hours follow-up per calendar year.

MNT: 3 hrs initial MNT in the first calendar year, plus 2 hours follow-up MNT annually. Additional MNT hours available for change in medical condition, treatment and/or diagnosis with a written referral from the treating physician.

Medicare coverage of DSMES/T and MNT requires the treating qualified provider to provide documentation of a diagnosis of diabetes based on **one of the following:**

- ☐ fasting blood glucose greater than or equal to 126 mg/dl on two different occasions
- ☐ 2 hour post-glucose challenge greater than or equal to 200 mg/dl on 2 different occasions
- ☐ random glucose test over 200 mg/dl for a person with symptoms of uncontrolled diabetes

*Other payors may have other coverage requirements. (Source: Volume 68, #216, November 7, 2003, page 63261/Federal Register)

PATIENT INFORMATION

Last Name _____ First Name _____ Middle _____

Date of Birth ____/____/____ Gender: ☐ Male ☐ Female ☐ _____

Address _____ City _____ State _____ Zip Code _____

Home Phone _____ Cell Phone _____ Email address _____

DIAGNOSIS

Please send recent labs that support diagnostic criteria for patient eligibility & outcomes monitoring

☐ Type 1 ☐ Type 2 ☐ Gestational Diagnosis code _____

Diabetes Self-Management Education & Support /Training (DSMES/T)

Check type of training services and number of hours requested

- ☐ Initial DSMES/T 10 or ____ hours
- ☐ Follow-up DSMES/T 2 hours
- ☐ If more than 1 hour (1:1) for initial training please check special needs that apply:
  - ☐ Vision
  - ☐ Hearing
  - ☐ Language
  - ☐ Cognitive
  - ☐ Physical
  - ☐ Social distancing during pandemic
  - ☐ Other (specify)

☐ All DSMES/T content areas OR

Specific Content areas (Check all that apply)

- ☐ Monitoring diabetes
- ☐ Psychological adjustment
- ☐ Nutritional management
- ☐ Medications
- ☐ Diabetes as disease process
- ☐ Physical activity
- ☐ Goal setting, problem solving
- ☐ Prevent, detect and treat acute complications
- ☐ Prevent, detect and treat chronic complications
- ☐ Preconception, pregnancy, gestational diabetes
- ☐ Device Training

diabeteseducator.org/referdsmes

ADCES Association of Diabetes Care & Education Specialists · eat right. Academy of Nutrition and Dietetics · American Diabetes Association. Connected for Life

Diabetes Self-Management Education & Support/Training and Medical Nutrition Therapy Services

This document and the accompanying *Diabetes Services Order Form* were prepared by the Association of Diabetes Care & Education Specialists, the Academy of Nutrition and Dietetics and the American Diabetes Association. This backgrounder is designed to provide necessary information for providers of DSMES/T* and MNT services and their billing departments to support the referral and billing processes, thereby improving access and education to individuals with diabetes.

The order form meets requirements set forth by Medicare and most insurance companies. For private insurance companies consult each payer's DSMES/T and MNT policies for specific requirements. Medicaid coverage for DSMES/T and MNT varies by state. Contact your state Medicaid office for coverage and specific requirements in your state.

BACKGROUND

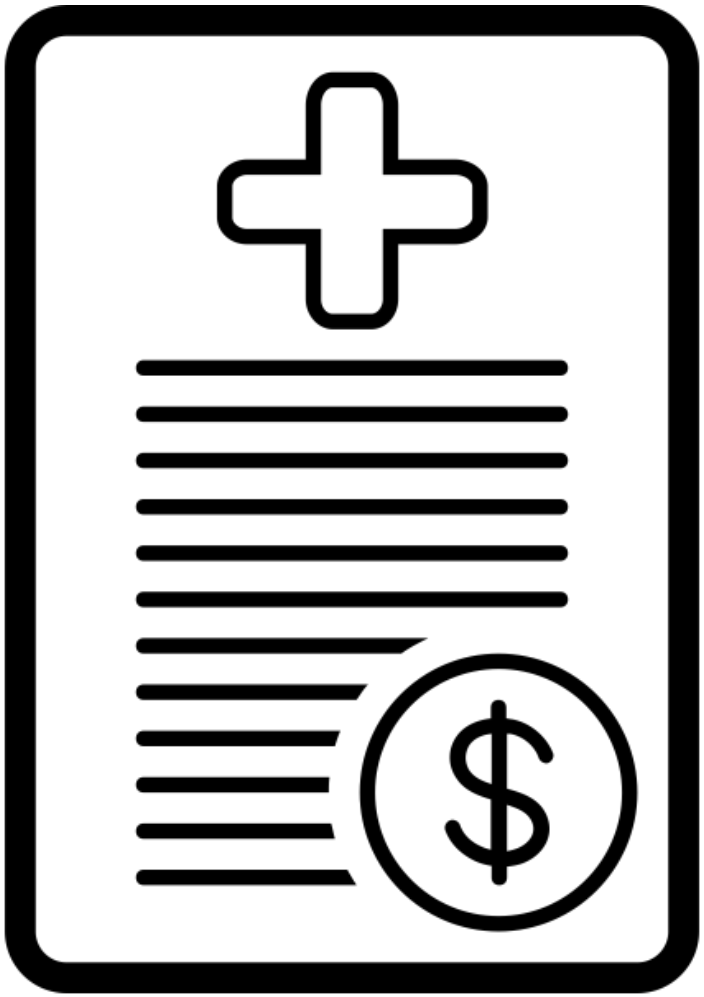
DSMES/T and MNT are separate but complementary services used to improve diabetes care. DSMES/T is provided by an individual or team including diabetes care and education specialists who are licensed or nationally registered healthcare professionals and provide overall guidance related to all aspects of diabetes to increase the individual's self-management skills and reduce risk of diabetes-related complications. DSMES/T providers work with their clients to create individualized care plans that focus on the whole health of an individual, considering factors like culture, language, lifestyle and social determinants of health. MNT is provided by a registered dietitian nutritionist (RDN) and is an intensive, focused, and comprehensive individualized nutrition therapy service that relies heavily on follow-up to provide repeated reinforcement to aid with sustained adoption of healthy food choices and eating behaviors. Before making a referral for DSMES/T or MNT services, check your state licensure laws to determine who is considered a qualified provider of these services.

Because DSMES/T and MNT provide a variety of behavioral modification techniques (i.e., group-based offerings for basic knowledge and reinforcement of positive behaviors as well as individual attention that focuses on diet and behavior change over time), they are complementary and may be more medically effective for some beneficiaries than receiving just one of the benefits. Research indicates MNT combined with DSMES/T improves outcomes. Both provide ongoing follow-up and can be ordered in the same year. They have different referral requirements but can be ordered together.

DSMT (Diabetes Self-Management Training)

- 10 hours of initial training (once under Medicare)
  - Up to 1 hour of DSMES can be individual
  - 9 hours must be billed as GROUP unless barriers to group learning are identified by referring provider or no group class available within 2 months
- 2 hours of follow-up available annually starting year 2 with referral
  - Can be individual or group
- Federally Qualified Health Centers and Rural Health Centers
  - FQHC: Reimbursement for individual DSMES (not group)
  - RHC: Individual visits can be added to cost report

DSMT Reimbursement



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DSMT Billing Codes

CMS Payment per 30 min:

- **G0108** $52.50
- **G0109** $14.58

(2021 Physician Fee Schedule)

Medicare allows:

- **10 hours** initial (once in lifetime of beneficiary)
- **2 hours** every year

With diagnosis of diabetes and referral order signed by appropriate provider

Billing Medicare

Created by Yaroslav Samoylov from Noun Project

Prevention

- Individuals can “self-refer” into Medicare DPP
- Group benefit
- Once-in-a-lifetime benefit for Medicare beneficiaries
- In-person program with some tele-health flexibilities
- Can be offered at clinical and community sites

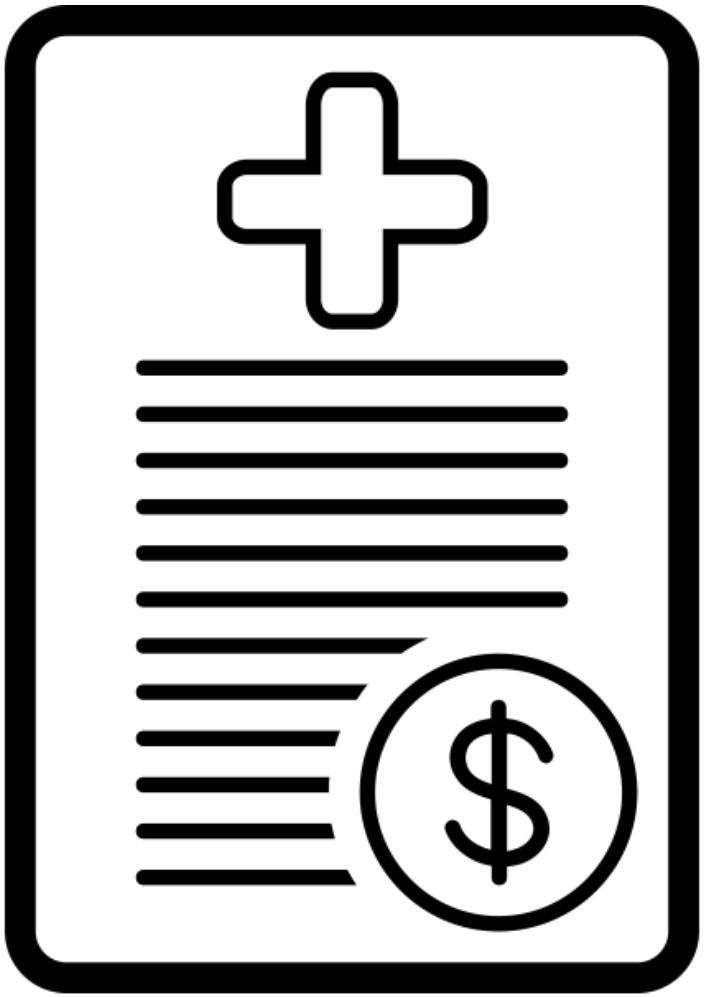
Referrals (Medicare DPP)

- Although individuals can self-refer into the program, a “quality referral” from a healthcare provider can increase enrollment, engagement, and retention
- Bidirectional communication between the lifestyle change program and the referring provider can increase referrals
- Individuals can begin services and one FQHC and complete them at another (bridge payment)—navigation versus referral

Other Medicare DPP Complexities

- Separate process to become a Medicare DPP provider—FIRST reach preliminary or full recognition with CDC THEN apply to CMS
- FQHCs, rural health centers, hospitals, churches, and community-based organizations are treated equally under Medicare DPP
- There's a whole second year of Medicare DPP—Ongoing Maintenance—but only for those who achieve 5% weight loss in year one and maintain it on an ongoing basis

Medicare DPP Reimbursement



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MDPP Billing Codes

- Claims are based on individual outcomes
- 15 G-Codes (!) related to attendance, retention, and weight loss
- Reimbursement can range for $704 to $203
- Research shows that those over 65 “overperform” in the CDC LCP

Medicare DPP Reimbursement

HCPCS G-Code	Payment Amount	Description	May be VM
G9873	$26	1st core session attended	NO
G9874	$52	4 total core sessions attended	YES
G9875	$95	9 total core sessions attended	YES
G9876	$15	2 core maintenance sessions attended in months 7-9, weight loss goal not achieved or maintained	YES
G9877	$15	2 core maintenance sessions attended in months 10-12, weight loss goal not achieved or maintained	YES

Medicare DPP Reimbursement

HCPCS G-Code	Payment Amount	Description	May be VM
G9878	$63	2 core maintenance sessions attended in months 7-9, weight loss goal achieved or maintained	YES
G9879	$63	2 core maintenance sessions attended in months 10-12, weight loss goal achieved or maintained	YES
G9880	$169	5% weight loss from baseline achieved	NO
G9881	$26	9% weight loss from baseline achieved	NO
G9882	$52	2 ongoing maintenance sessions attended in months 13-15, weight loss goal maintained	YES
G9883	$52	2 ongoing maintenance sessions attended in months 16-18, weight loss goal maintained	YES

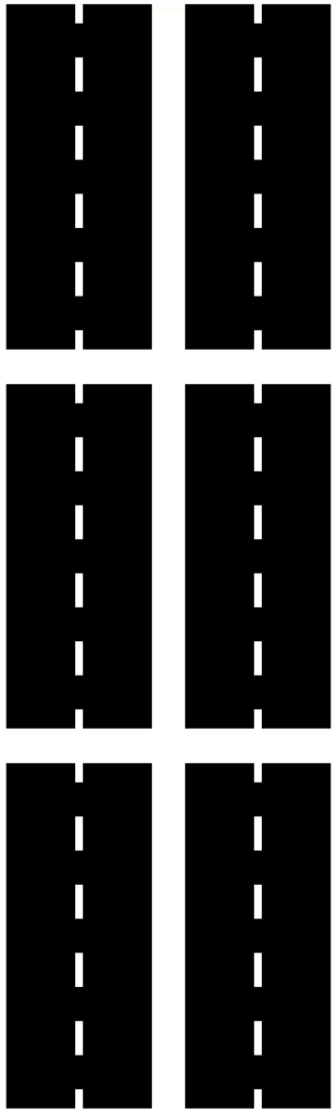
Medicare DPP Reimbursement

HCPCS G-Code	Payment Amount	Description	May be VM
G9884	$53	2 ongoing maintenance sessions attended in months 19-21, weight loss goal maintained	YES
G9885	$53	2 ongoing maintenance sessions attended in months 22-24, weight loss goal maintained	YES
G9890	$27	Bridge payment—first session furnished by MDPP supplier to an MDPP beneficiary who has received services from a different MDPP supplier	YES
G9891	$0	MDPP session reported as a line-item on a claim for a payable HCPCS G-code for a session that counts toward achievement of the attendance performance goal for the payable MDPP services HCPCS G-code	YES

Program Settings

DSMES

- Federally Qualified Health Centers
- Rural Health Centers
- Pharmacies
- Health Centers
- Hospital based clinics
- Medical Practices
- Community Centers



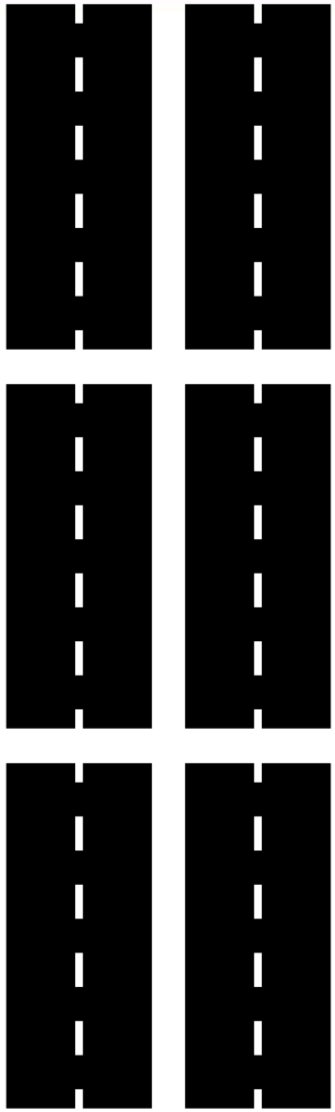
Prevention

- Almost anywhere—strong community bias!
- YMCA
- University Extension
- Faith and Community-Based Organizations
- Hospitals and health centers
- FQHCs, rural health centers, and CHCs
- Pharmacies
- Private businesses
- ONLINE (Except Medicare)

Program Oversight

DSMES

- Quality Coordinator
- Professional Instructor



Prevention

- Program Coordinator
- Lifestyle Coaches
- Data Specialist

Staffing

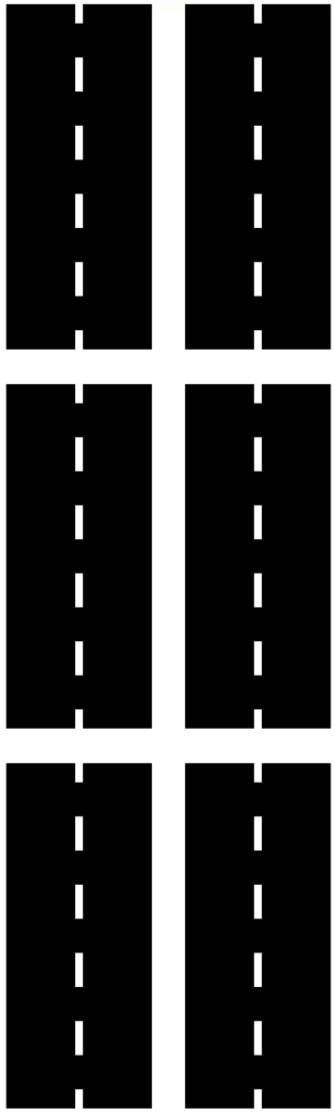
DSMES

Professional Instructor:

- RN
- RDN
- PharmD
- CDCES
- NP
- PA

Paraprofessional:

- MA, CHW, EP, and others



Prevention

Lifestyle Coach:

- DPP graduate
- CHW/promotora

Given the reimbursement, CHWs and others make ideal coaches with RDNs, RNs, and other health professionals supporting program management and data analysis

Format and delivery modes

DSMES

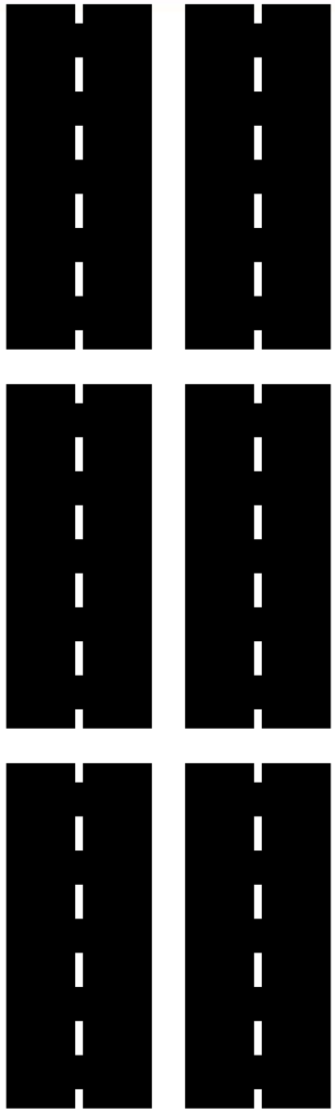
Format:

- Individual
- Group

Modalities:

- Tele-health
- In-person
- By phone

Additional accommodations available with tele-health delivery due to COVID-19.



Prevention

Format:

- Group
- Individual make-ups

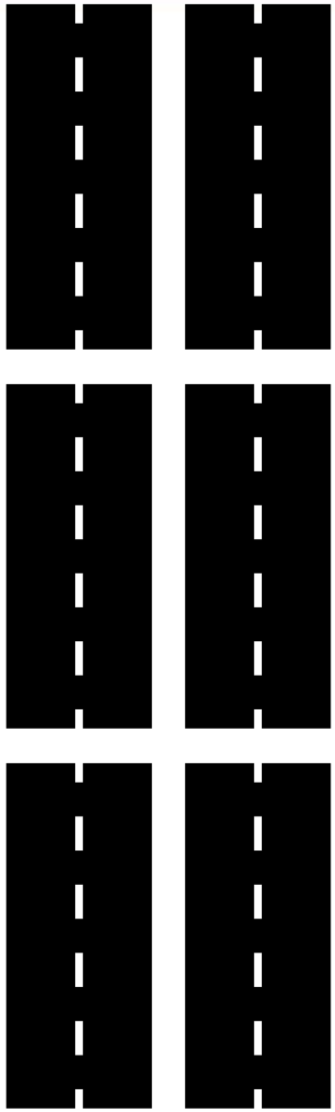
Modalities:

- Distance learning (synchronous phone or Zoom)
- Virtual (Online asynchronous)
- In-Person
- Combination (It's complicated!)

Curriculum

DSMES

- Must be evidence based and reviewed annually
- Must be customized and individualized by programs to meet needs of population served
- Existing options are good:
  - *Life with Diabetes*
  - *ADCES Diabetes Care and Education Curriculum*
- Foundation of information provided to participants



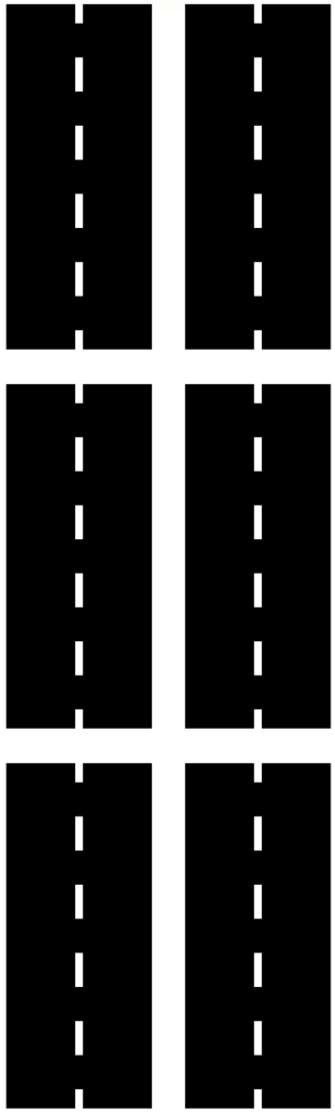
Prevention

- Must be approved by CDC
- Lots of FREE linguistically and culturally tailored options!
  - *PreventT2*
  - *Prevenga el T2*
  - *Dulce Mothers*
  - *Nuestra Vida*
  - *PreventT2 for All*
- Can submit your own for CDC review—12 months, appropriate intensity, set themes, evidence-based

Documentation/Medical Records

DSMES

- Electronic Medical Record
- Must be maintained for 6 years
- Secure and HIPAA compliant
- De-identified sample of documentation is required with your application, upon renewal, and upon audit



Prevention

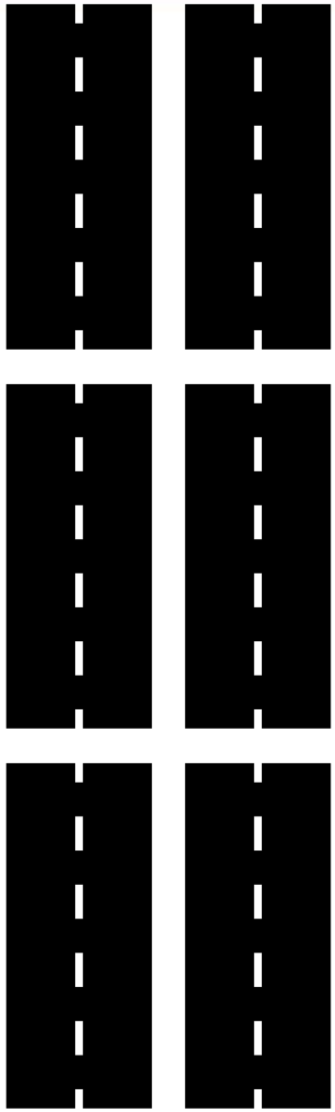
- Can be collected on Excel, EMR, or diabetes data platform such as DAPS
- Reports are submitted semi-annually to CDC
- Additional reporting requirements for Medicare (e.g. quarterly crosswalk report)

Data collection and reporting

DSMES

Annual Status Reporting

- Number of Participants
- Behavior Goal Achievement
- One other outcome measures chosen by program
- Quality Improvement



Prevention

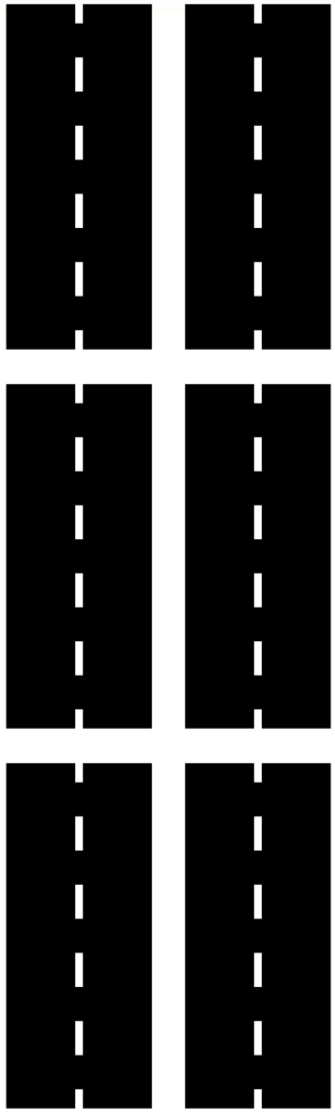
- CDC sets data collection standards
- Reports are submitted semi-annually to CDC—analysis of reports results in achievement of recognition levels
- Additional reporting requirements for Medicare (e.g. quarterly crosswalk report)

Ready to hit the road?

DSMES

Getting up and running

- Choose a curriculum that fits your community
- Find at least ONE eligible participant to complete a DSMES plan
- Develop or use an existing template to document DSMES assessment and encounters in EMR
- Begin application process with DEAP



Prevention

Getting up and running

- Choose a curriculum that fits your community
- Get your lifestyle coaches trained and ready
- Recruit a group of 10-15 individuals to start about 4-6 weeks out
- Apply to CDC for recognition
- Begin the program after your CDC approval date

What's next? DSMES!

- Read the National Standards for DSMES….twice
- Read ADCES Interpretive Guidance at least twice
- Start checking off standards that are in place and noting those that are not
- Make a plan to implement missing standards
- Implement your plan!
- Provide comprehensive DSMES to at least one participant
- Gather required documentation for all 10 standards
- You're ready…it's time to apply!

What's next? PREVENTION!

- Read the DPRP Standards
- Assess organizational capacity
- Consider what you're already doing—building on current assets
- Check out ADCES trainings, technical support, and technology
- Review other resources (NCFH, CDC, AMA, NACDD)
- Apply as a CDC site! *(10 minutes!)*


A JOURNEY OF A THOUSAND MILES
MUST BEGIN WITH A SINGLE STEP.

ADCES Association of Diabetes Care & Education Specialists

Successful Strategies to Enroll, Engage, and Retain Participants

Hello!

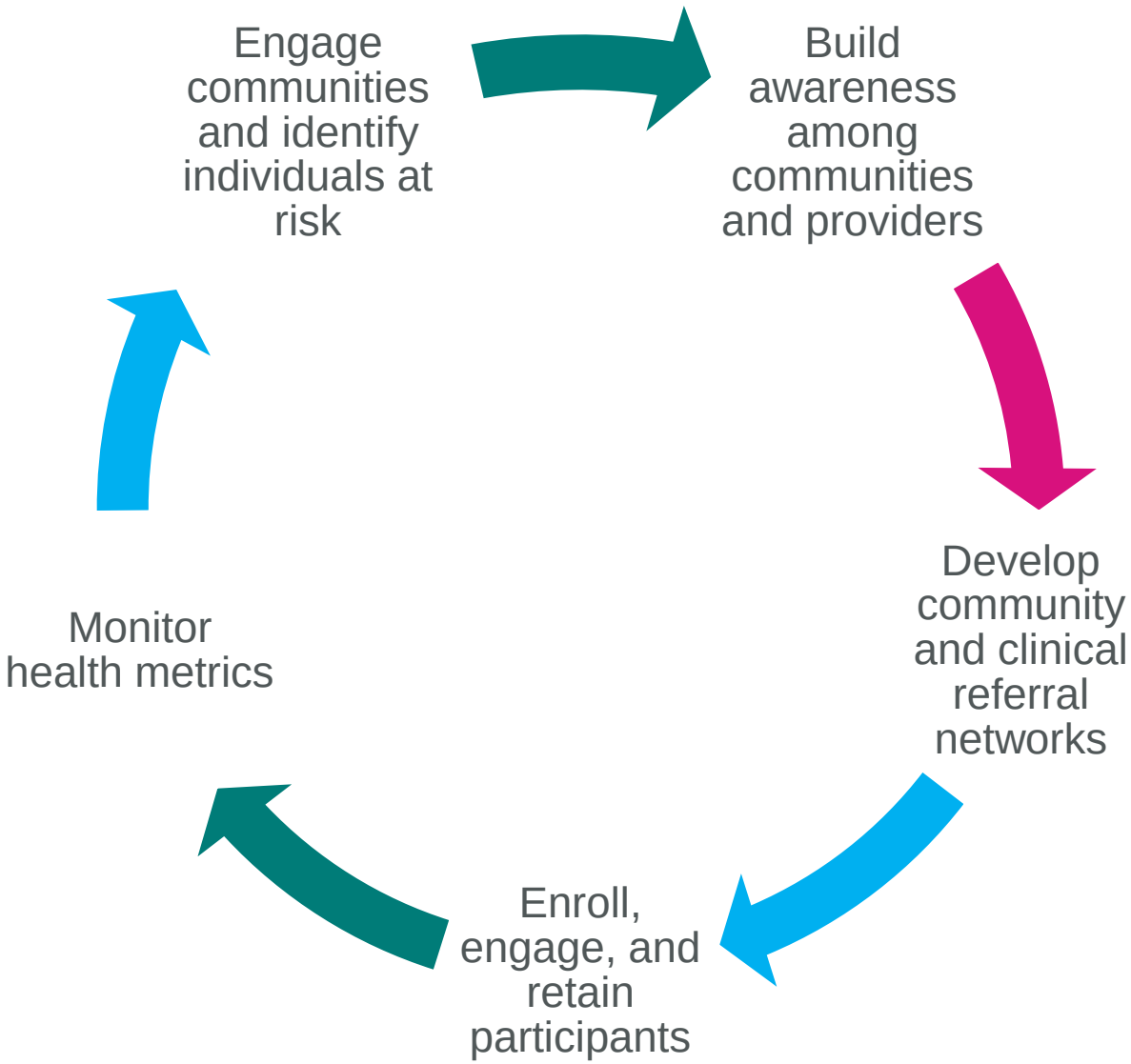
Angela M Forfia, MA

Senior Manager of Prevention

Association of Diabetes Care & Education Specialists

Chicago, Illinois

Two Programs, Common Strategies



Engage communities

34.1 million American adults have diabetes
About 1 in 5 don’t know it
Prevalence increases with age
Prevalence is highest among American Indians, people of Hispanic origin, non-Hispanic African Americans, and some AAPIs

Engage communities

Diabetes prevalence is approximately 17% higher in rural areas than urban areas

System-level barriers including low-SES, insurance coverage, medical access, specialty medical care and emergency services, and low level of exposure to diabetes education

Engage communities

- 88 million American adults have prediabetes
- About 8 in 10 don't know it
- Higher percentage of men than women have prediabetes (37.4% vs. 29.2%)
- Prevalence of prediabetes was similar among all racial/ethnic groups and education levels
- Prevalence increases with age—as does awareness

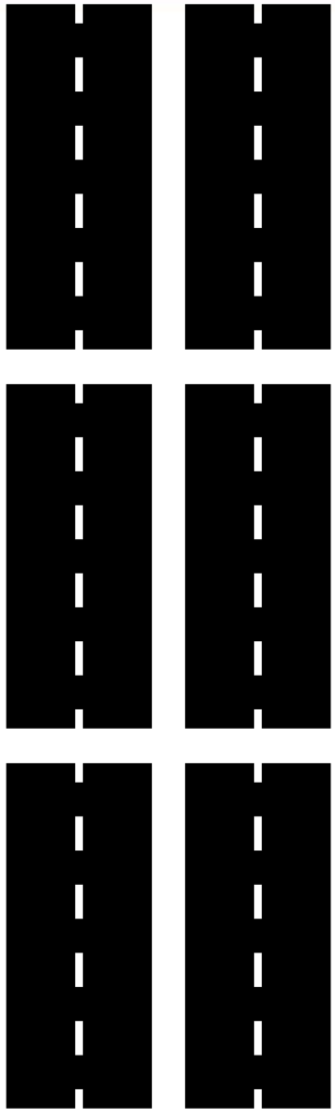
https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf

Identify individuals

DSMES

Identify people with diabetes:

- 4 Critical times
- Patient registry
- Provider schedules
- Primary care and other specialty clinics and offices

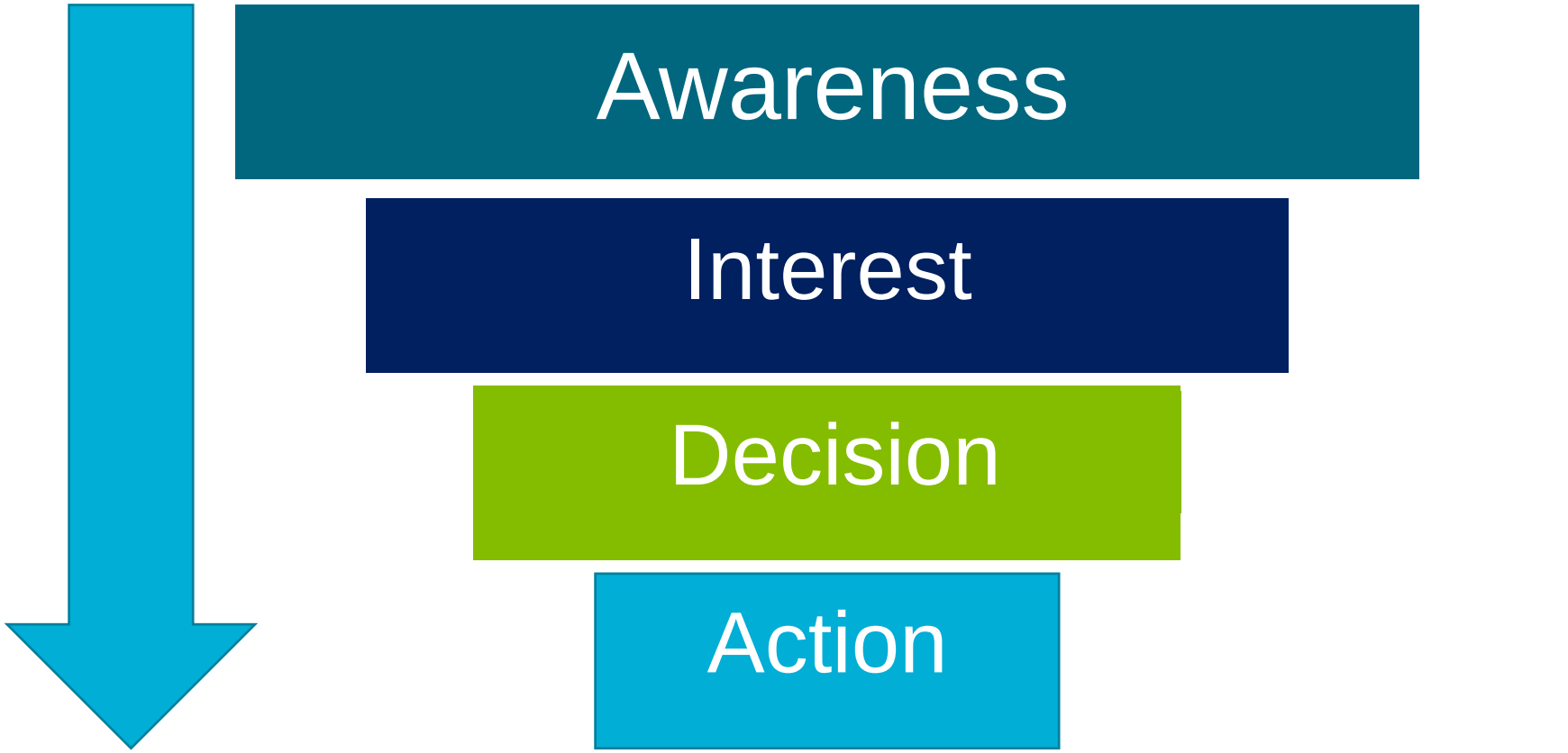


Prevention

Identifying people with prediabetes:

- EMR: BMI, adjacent co-morbidities
- Convenience screening (COVID vaccine)
- Other chronic disease self-management or groups

Build awareness



Problem aware→ Solution aware

Created by Margaret Hagan from Noun Project

I have diabetes, and I need support to help me prevent complications

Diabetes Care and Education Specialist
Diabetes Self-Management Education and Support

Created by Margaret Hagan from Noun Project

I have prediabetes, and I need support to prevent type 2 diabetes

Lifestyle Coach
Diabetes Prevention Program
CDC Lifestyle Change Program

One more step for DSMES!

I have diabetes, and I need support to help me prevent complications

Created by Margaret Hagan from Noun Project

Great! I will make a referral for you to speak to our diabetes care and education specialist

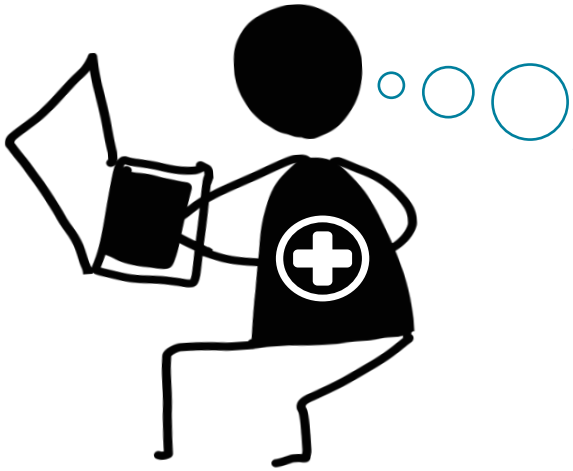
But sometimes providers don't know!

I have diabetes, and I need support to help me prevent complications

Created by Margaret Hagan from Noun Project

I have prediabetes, and I need support to prevent type 2 diabetes

Created by Margaret Hagan from Noun Project



I'm not sure if I know enough about these programs! Will I lose my patient? Can't my nurse just give this support in my office? What is the DPP? Does any of this work? Is it covered by insurance?

Build awareness among providers

- Providers are overwhelmed—limited time, competing priorities, and pop-up fatigue
- We live and breathe prevention and self-management but providers are focused on acute care
- They don’t understand the value for people with diabetes or prediabetes
- They may not get information back from these programs to see the value
- They worry that their patients can’t afford these programs
- Logistics!

Clinical referral networks (DSMES + Prevention)

- Identify providers who are seeing people at risk
- Recruit champions—think outside the “doc”
- Get on the agenda—keep it short, don’t assume they know what you do about prevention and self-management
- Send back success stories and patient updates
- Equip providers for “quality referrals”
- Set up systems and workflows to easily screen, test, and refer into your programs
- Start with your own staff—your first diabetes prevention group can be with your own employees!

Community referral networks (Prevention)

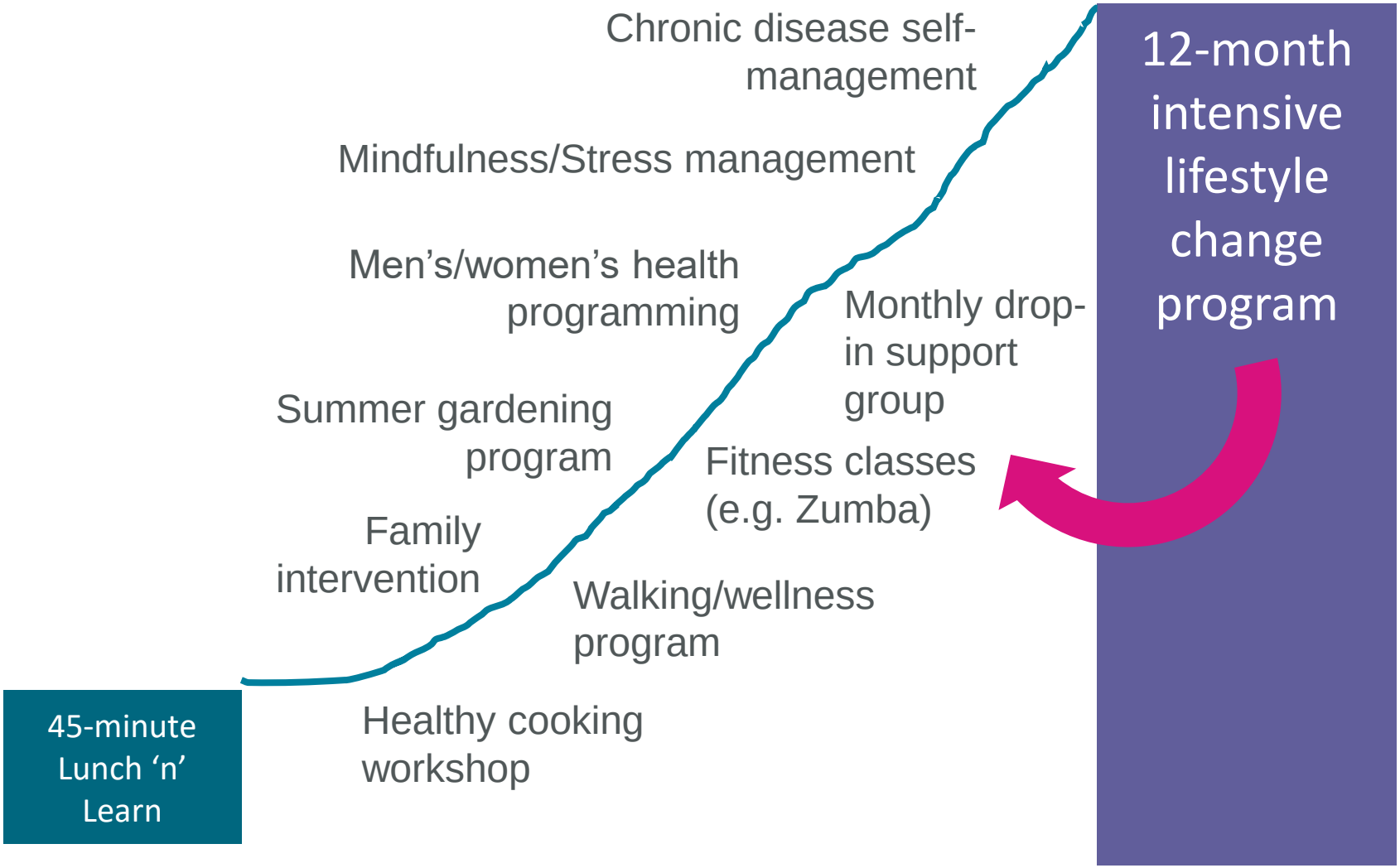
- Faith communities
- Schools and community colleges
- Senior centers and meal sites
- Childcare centers
- Food pantries
- Where people “hang out”
- Events
- Adapting for COVID

Created by Lorie Shaull from Noun Project

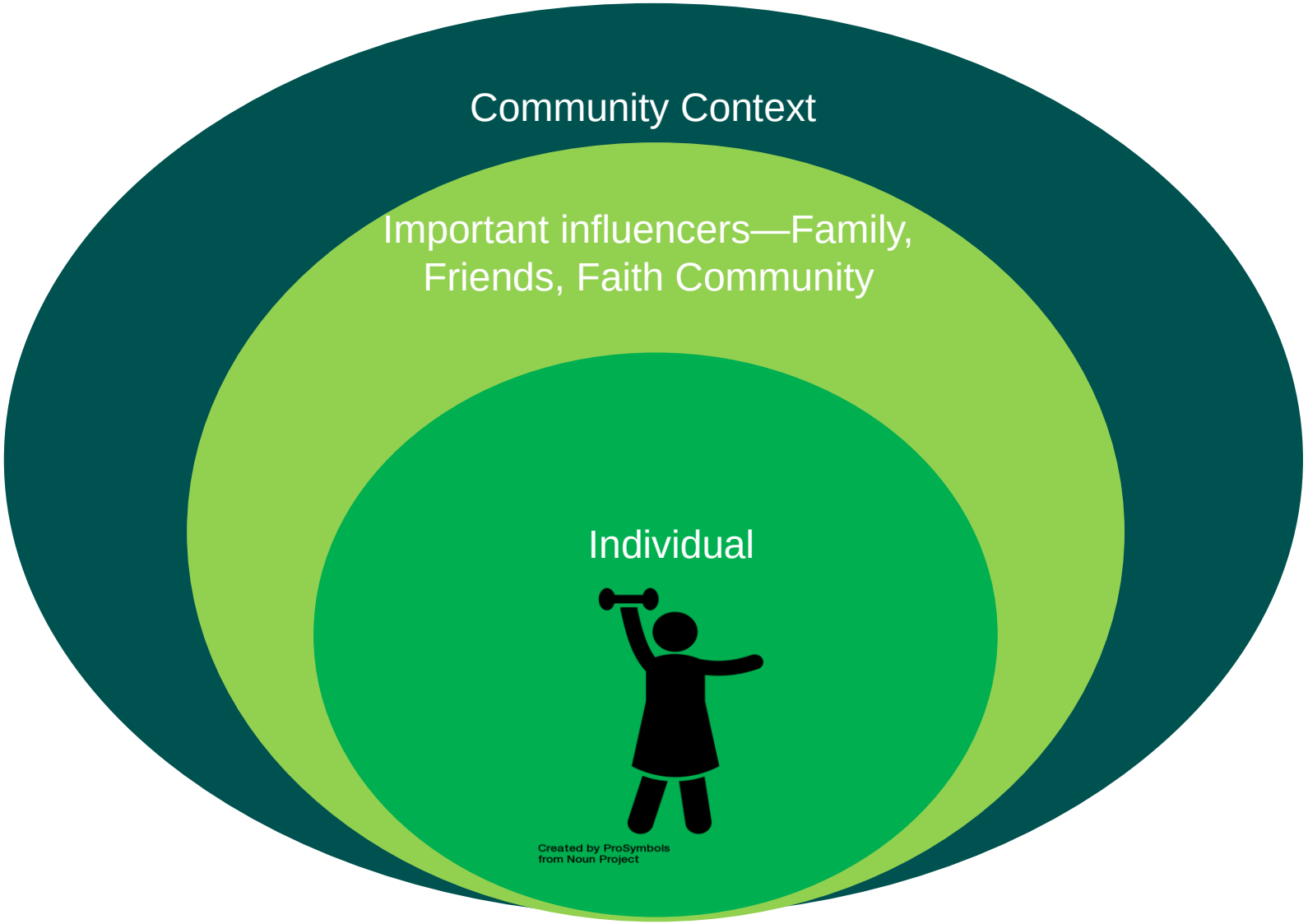
Community referral networks (Prevention)

- Get to know frontline contacts
- Build relationships with key decision makers (HR, health ministry, club president)
- Identify champions within the community/organization to broker connections
- Listen and build trust
- Meet their needs FIRST (collaborate and be creative)
- Grow your partnership step-by-step over time (festival→presentation→screening→host LCP)

Community referral networks (Prevention)



Engage and retain participants



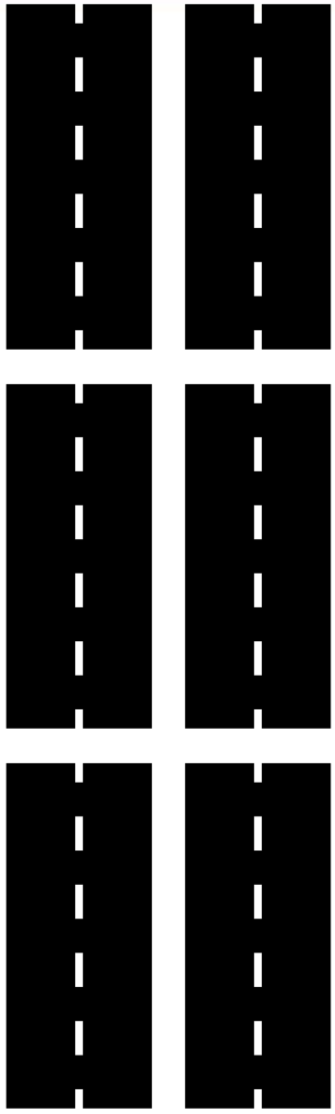
Engage and retain participants

- Make it easy for participants to join and stay
  - Time your sessions/program (date/time/season/frequency)
  - Address common challenges collectively
- Increase the importance to your participants so they join and stay
  - Quality healthcare provider referrals
  - Faith and community leaders
  - Spouse, partner, family member, friend, neighbor
- Build motivation, confidence, and readiness
  - Talk one-on-one with each participant
  - Individual/social contract
  - Engineer cohesion
  - Incentives
  - Contact at key times

Monitor health metrics

DSMES

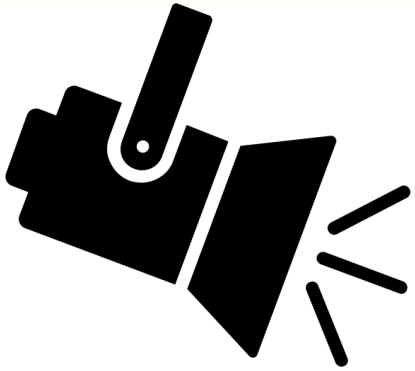
- Attendance/Retention
- Comprehensive DSMES Assessment
  - Health Status
  - Psychosocial Adjustment
  - Learning Level
  - Lifestyle Practices
- Behavioral Goal Achievement
- Other outcome measure chosen by program



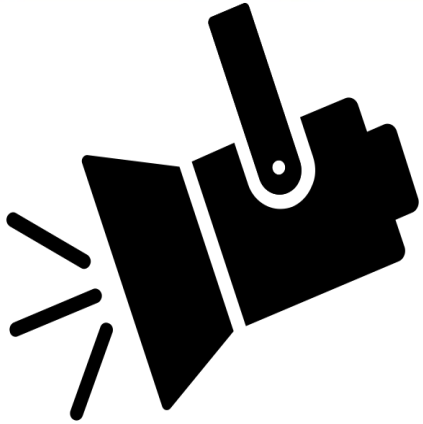
Prevention

- Attendance
- Retention
- Weight loss (3%, 4%, and 5%)
- Minutes of physical activity
- A1c reduction
- Program completion

Community Health Center Spotlight!



Created by Vectors Point
from Noun Project



Created by Vectors Point
from Noun Project

Gateway Community Health Center, Inc. (Laredo, TX)

GATEWAY COMMUNITY Health Center, Inc.

The Journey of Health Education During COVID-19 Pandemic: Prevent T2

Elvia Granados, MS, Lifestyle Coach
Program Manager

March 23, 2021

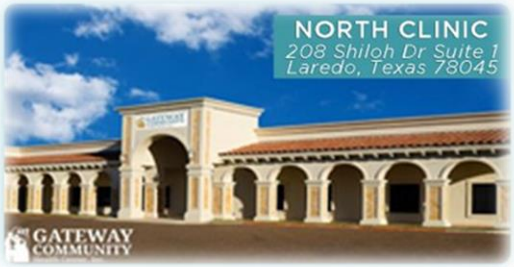
Gateway Community Health Center, Inc.

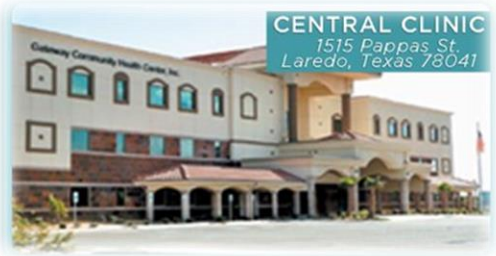
Elvia Granados, MS
Program Manager

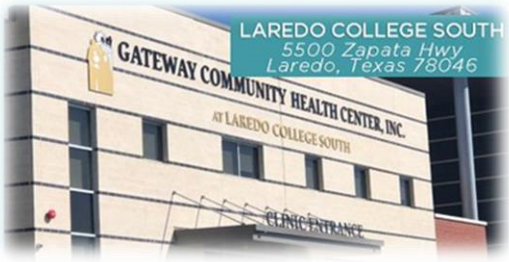
Gateway Community Health Center, Inc.

Federal Qualified Health Center

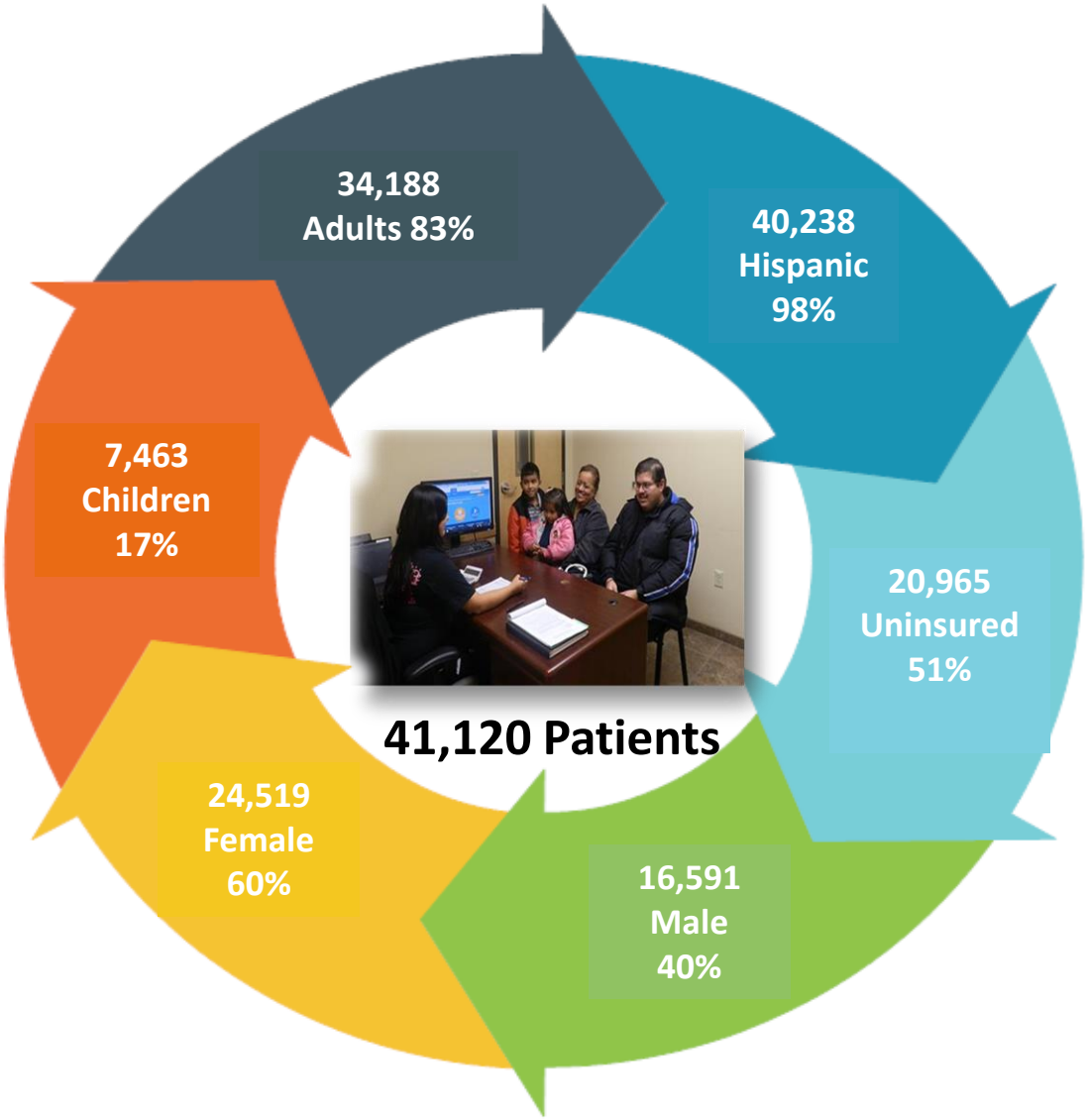
Six Locations in three counties: Webb, Zapata and Jim Hogg.





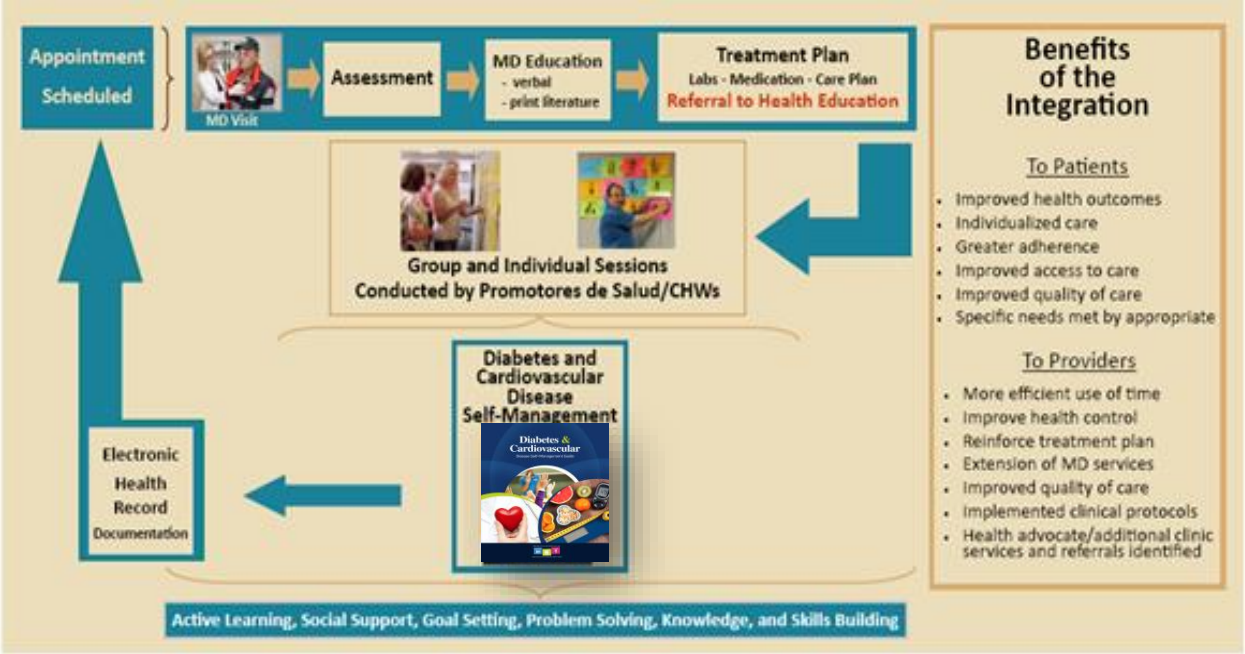


Gateway Community Health Center, Inc.



GATEWAY COMMUNITY Health Center, Inc.

Diabetes Diagnosis (2021): 7,259 Patients



Diabetes Management Goal:

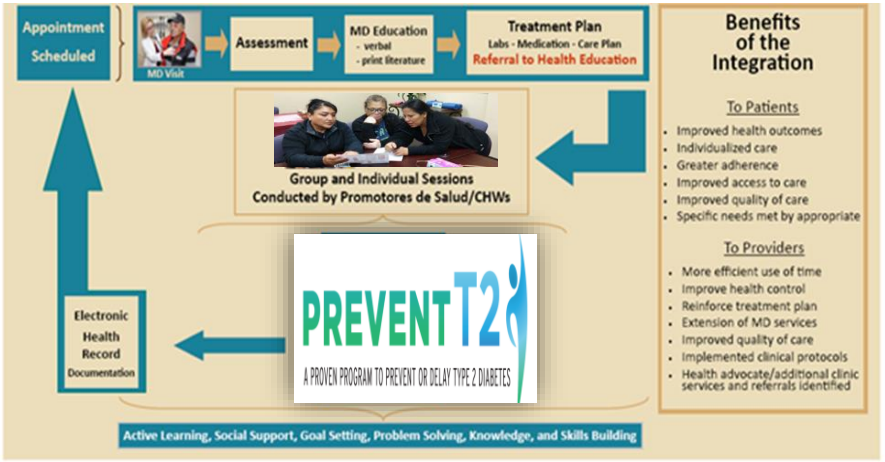
Ensure that the proportion of adult patients with diabetes with an HbA1c value greater than 9%, is at or below 34%.

2017	2018	2019	2020
N=937 - 30%	N=1,014 – 30%	N=995 - 26%	N=1,015 - 26%

Diabetes Prevention

Prediabetes Diagnosis (2021): 2,596 Patients

Intervention Model



Prevention Team: 2 Experienced Lifestyle Coaches
2 Experienced Health Educators
2 Lifestyle Change Program Champions

Champions of Gateway's DPP Lifestyle Change Program

Elmo López, Jr., MBA, CHW
Chief Executive Officer

Mery J. Cortes-Bergoderi, MD
Chief Medical Officer

GATEWAY COMMUNITY Health Center, Inc.

Prevent T2 &COVID-19 Intervention Responses

Patient's challenges

- Quarantine restrictions;
- Limited technology access ;
- Lack of technology knowledge;
- Emotional distress.

Program interventions

- Reinforcement of communication with patients;
- Prioritization of patients' needs (meeting patients where they are);
- Opportunities for education, guidance and support;
- Being flexible.

GATEWAY COMMUNITY Health Center, Inc.

Prevent T2 Engagement

- Increase access by offering Prevent T2 Program at different hours (morning and evening).
- Effective recruitment strategies are key: program promotion within healthcare providers, individualized phone communication, follow-up calls, in person contact, etc.
- Include interactive activities during the sessions: invite a guess speaker; integrate a physical activity section; include demonstrations; utilize visual aides; and provide participants with the time to ask questions, make suggestions and to interact among themselves to create an atmosphere of mutual support and coherence.
- Establish a relationship with participants that make them feel comfortable reaching out Lifestyle Coaches when needed.
- Monitor patients' progress and attendance to offer support in goal achievement.

GATEWAY COMMUNITY Health Center, Inc.

Prevent T2 Communication Engagement

1. Individual Phone Calls
2. Conference Calls
3. WhatsApp Web
4. ZOOM meetings

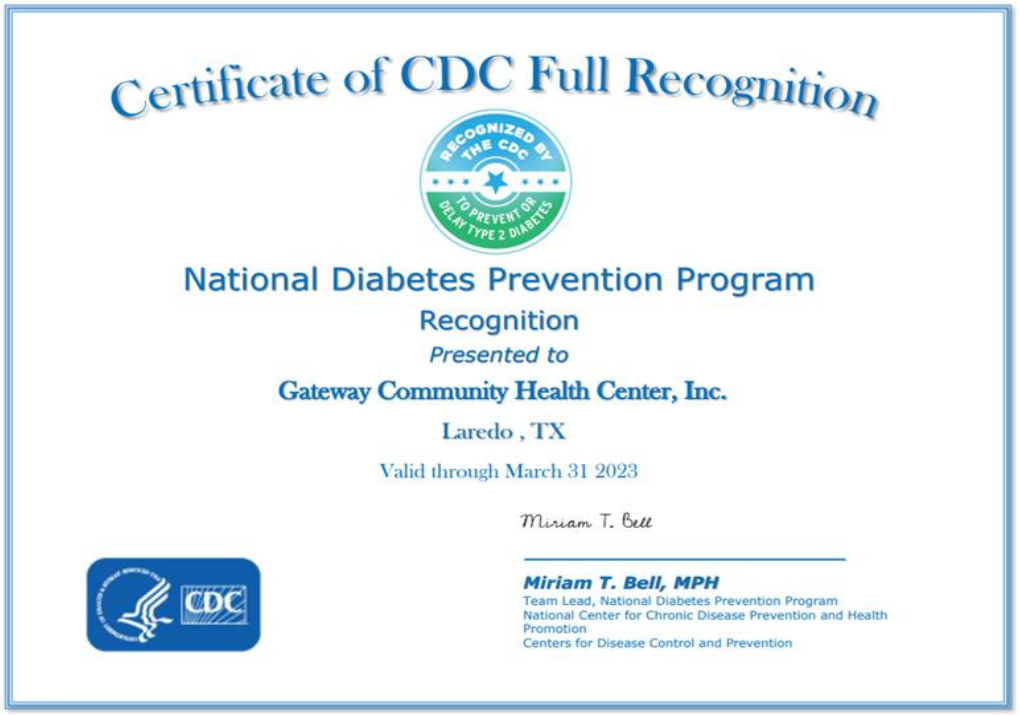
GATEWAY COMMUNITY Health Center, Inc.

Program Goals

- Deliver DPP-Prevent T2 to 6 cohorts
- Certify a minimum of two more Lifestyle Coaches
- Maintain CDC Full Recognition
- Sustain Prevent T2 Program by obtaining Medicare Supplier license.

GATEWAY COMMUNITY Health Center, Inc.

Program Accomplishments



Certificate of CDC Full Recognition

RECOGNIZED BY THE CDC — TO PREVENT OR DELAY TYPE 2 DIABETES

National Diabetes Prevention Program

Recognition

Presented to

Gateway Community Health Center, Inc.

Laredo , TX

Valid through March 31 2023

Miriam T. Bell

CDC

Miriam T. Bell, MPH

Team Lead, National Diabetes Prevention Program
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention

- Implementation of Prevent T2 Program
- ADCES Support and technical assistance-THANK YOU!
- Cohort 1 – Completion
- Cohorts 2 to 6 – In progress
- Patients health improvement (weight loss)

GATEWAY COMMUNITY Health Center, Inc.

ADCES Association of Diabetes Care & Education Specialists

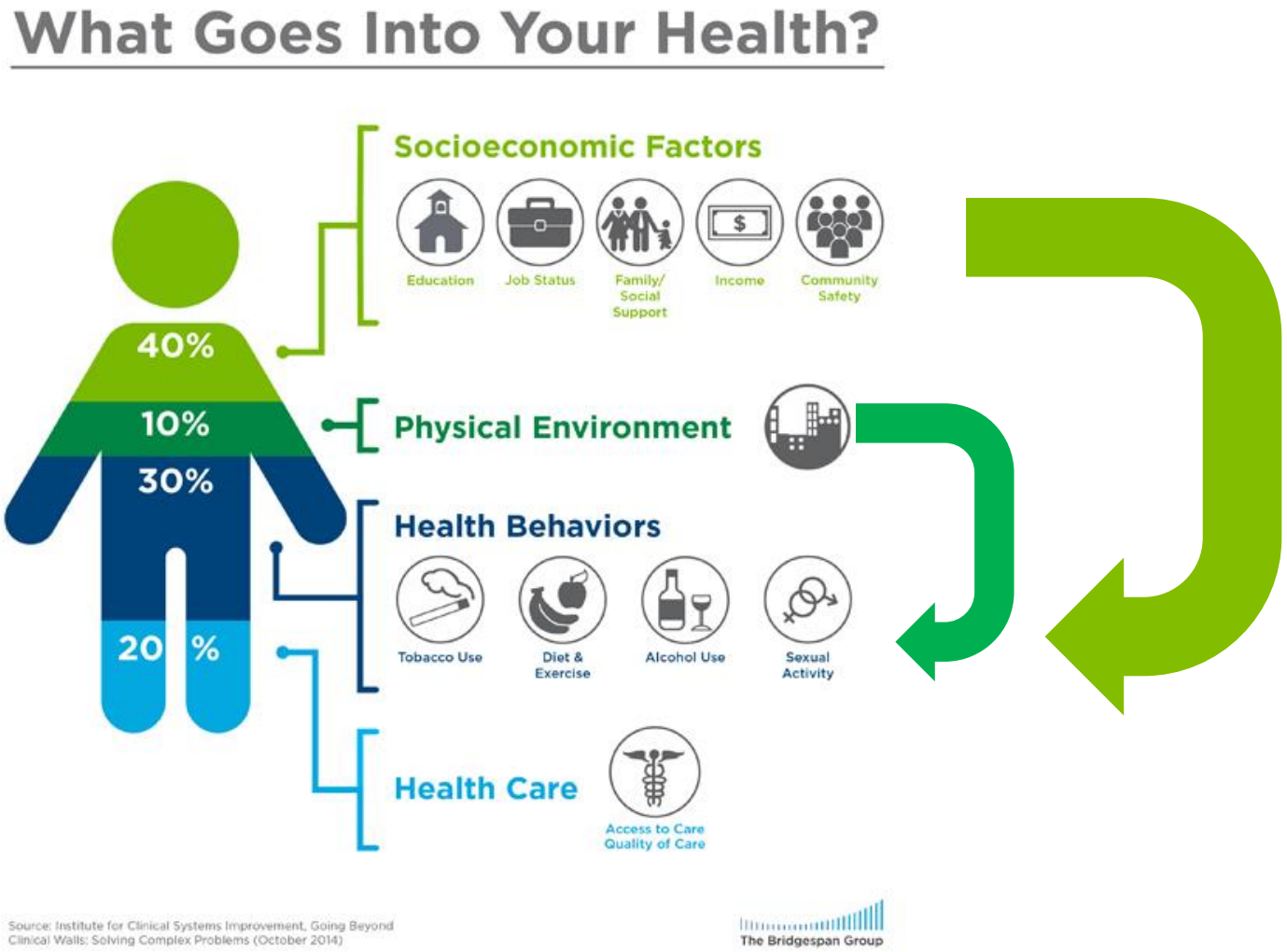
Social Determinants of Health

How to support healthy eating, physical activity, and other self-care behaviors

ADCES7

- Healthy eating
- Being active
- Taking medication
- Monitoring
- Problem solving
- Reducing risks

ADCES7


What Goes Into Your Health?
Socioeconomic Factors
Education
Job Status
Family/ Social Support
Income
Community Safety
40%
10%
30%
20 %
Physical Environment
Health Behaviors
Tobacco Use
Diet & Exercise
Alcohol Use
Sexual Activity
Health Care
Access to Care
Quality of Care
Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)
The Bridgespan Group

Healthy eating and food security

Screen

Hunger VitalSign™

The EveryONE Project™
Advancing health equity in every community

"Within the past 12 months we worried whether our food would run out before we got more money to buy more."

"Within the past 12 months the food we bought just didn't last and we didn't have money to get more."

U.S. Household Food Security Survey Module

6, 10, and 18 questions

Versions for youth, adults, and households with children

Spanish and Chinese versions

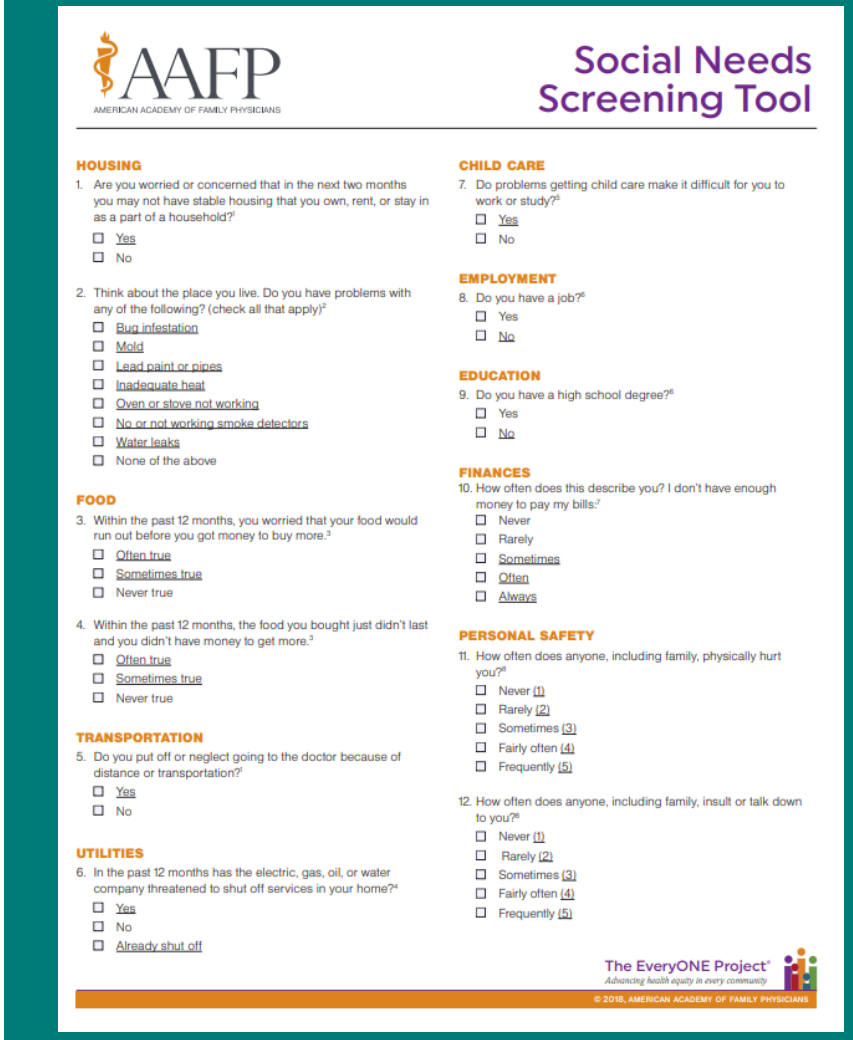
PRAPARE

In the past year, have you or any family members you live with been unable to get any of the following when it was really needed?
Food: Yes/No

Social Needs Tools & Resources

https://www.aafp.org/family-physician/patient-care/the-everyone-project/toolkit.html

The EveryONE Project™
Advancing health equity in every community



AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

Social Needs Screening Tool

HOUSING

1. Are you worried or concerned that in the next two months you may not have stable housing that you own, rent, or stay in as a part of a household?[1]
   - ☐ Yes
   - ☐ No

2. Think about the place you live. Do you have problems with any of the following? (check all that apply)[2]
   - ☐ Bug infestation
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Inadequate heat
   - ☐ Oven or stove not working
   - ☐ No or not working smoke detectors
   - ☐ Water leaks
   - ☐ None of the above

FOOD

3. Within the past 12 months, you worried that your food would run out before you got money to buy more.[3]
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

4. Within the past 12 months, the food you bought just didn't last and you didn't have money to get more.[3]
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

TRANSPORTATION

5. Do you put off or neglect going to the doctor because of distance or transportation?[1]
   - ☐ Yes
   - ☐ No

UTILITIES

6. In the past 12 months has the electric, gas, oil, or water company threatened to shut off services in your home?[4]
   - ☐ Yes
   - ☐ No
   - ☐ Already shut off

CHILD CARE

7. Do problems getting child care make it difficult for you to work or study?[5]
   - ☐ Yes
   - ☐ No

EMPLOYMENT

8. Do you have a job?[6]
   - ☐ Yes
   - ☐ No

EDUCATION

9. Do you have a high school degree?[6]
   - ☐ Yes
   - ☐ No

FINANCES

10. How often does this describe you? I don't have enough money to pay my bills:[7]
    - ☐ Never
    - ☐ Rarely
    - ☐ Sometimes
    - ☐ Often
    - ☐ Always

PERSONAL SAFETY

11. How often does anyone, including family, physically hurt you?[8]
    - ☐ Never (1)
    - ☐ Rarely (2)
    - ☐ Sometimes (3)
    - ☐ Fairly often (4)
    - ☐ Frequently (5)

12. How often does anyone, including family, insult or talk down to you?[8]
    - ☐ Never (1)
    - ☐ Rarely (2)
    - ☐ Sometimes (3)
    - ☐ Fairly often (4)
    - ☐ Frequently (5)

The EveryONE Project®
Advancing health equity in every community

13. How often does anyone, including family, threaten you with harm?[8]
    - ☐ Never (1)
    - ☐ Rarely (2)
    - ☐ Sometimes (3)
    - ☐ Fairly often (4)
    - ☐ Frequently (5)

14. How often does anyone, including family, scream or curse at you?[8]
    - ☐ Never (1)
    - ☐ Rarely (2)
    - ☐ Sometimes (3)
    - ☐ Fairly often (4)
    - ☐ Frequently (5)

ASSISTANCE

15. Would you like help with any of these needs?
    - ☐ Yes
    - ☐ No

SCORING INSTRUCTIONS:

For the housing, food, transportation, utilities, child care, employment, education, and finances questions: Underlined answers indicate a positive response for a social need for that category.

For the personal safety questions: A value greater than 10, when the numerical values are summed for answers to these questions, indicates a positive response for a social need for personal safety.

Sum of questions 11–14: _____
Greater than 10 equals positive screen for personal safety.

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AMERICAN ACADEMY OF FAMILY PHYSICIANS FOUNDATION Supported in part by a grant from the AAFP Foundation

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HOP19091130

One IDEA: Feeding America Pilot

HUNGER + HEALTH | FEEDING AMERICA®

The pilot project included implementation and evaluation of key activities:

1. Screening food bank clients for prediabetes risk
2. Providing 12-months of healthy, supplemental food (in addition to “regular” pantry services)
3. Referring clients to formal, community-based Diabetes Prevention Programs (DPP) and healthcare providers
4. Providing text-based health education and program information

https://hungerandhealth.feedingamerica.org/wp-content/uploads/2019/08/FEA-19-001-FEA-DiabetesPrevention_rd6_v1.pdf

Being active in safe places

- Safety
- Parks, playgrounds, and playstreets
- Walkability
- Active transportation options
- Access to fitness centers and gyms (e.g. Rx for fitness, shared use agreements)
- Culturally tailored programming
- Opportunities for people with disabilities

Screen

Physical Activity as a Vital Sign (PAVS)/Exercise as a Vital Sign (EVS)

Exercise is Medicine®

"On average, how many days a week do you perform moderate intensity physical activity or exercise, where your heart is beating faster and your breathing is harder than normal (such as a brisk walk)?"

"On average, how many total minutes of physical activity or exercise do you perform on those days?"

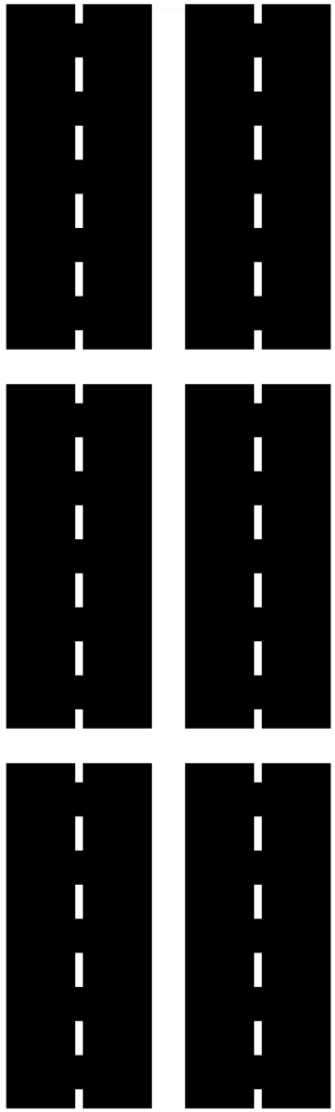
Routine Assessment and Promotion of Physical Activity in Healthcare Settings: A Scientific Statement From the American Heart Association

https://professional.heart.org/en/science-news/routine-assessment-and-promotion-of-physical-activity-in-healthcare-settings

Monitoring from scales to CGM

DSMES

- A1C and other labs
- Blood glucose trends
- Blood Pressure
- Body Weight
- PGHD: Patient Generated Health Data
  - Food intake
  - Physical activity



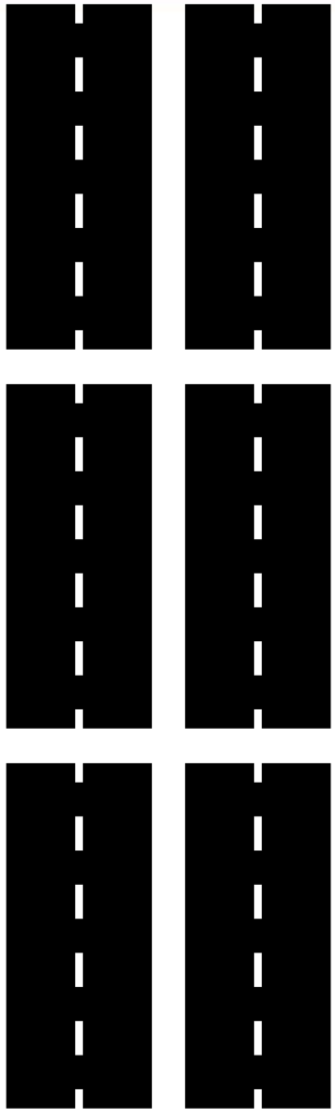
Prevention

- Scales
- Food logging
- Physical activity tracking
- A1c monitoring

Taking Medication

DSMES

- Review medications and their purpose
- Review timing and dose
- Address barriers or challenges
- Communication with referring providers/pharmacist if adjustments are needed



Prevention

- Review importance of taking medications as prescribed
- Referral to provider or pharmacist as needed


When in doubt, just take the next small step.
Paulo Coelho
quo.efancy

Final questions?

THANK YOU!

DPP@adces.org

DEAP@adces.org