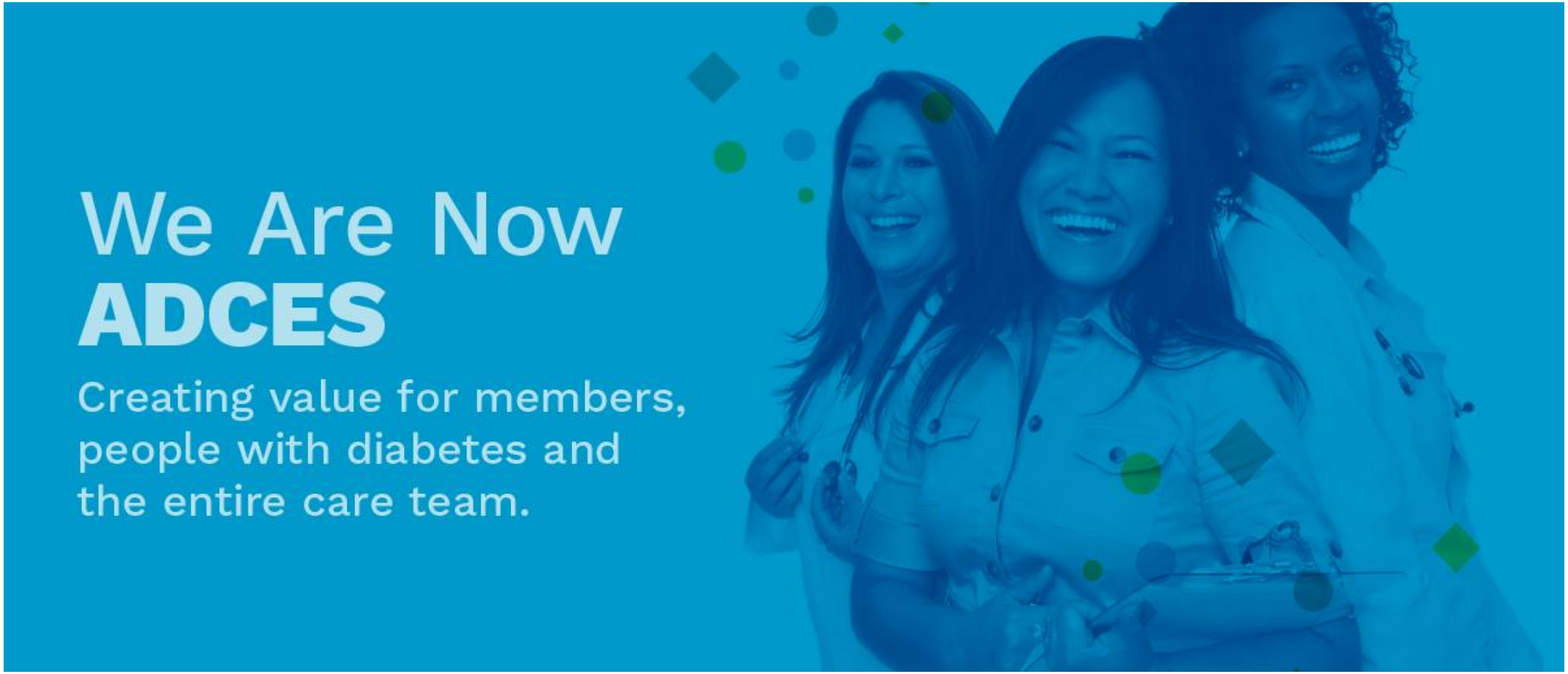
DSMES: An essential service for improved outcomes

Sacha Uelmen, RDN, CDCES
Director of Diabetes Education & Prevention Programs
Association of Diabetes Care & Education Specialists
suelmen@adces.org | 312-601-4846

ADCES Association of Diabetes Care & Education Specialists

wait….what happened to AADE?



Objectives

GOAL

Increase the number of people with diabetes who benefit from diabetes self-management education and support (DSMES) in rural health centers across Louisiana

At the end of this presentation, you'll be able to:

- Recognize the value of accredited & recognized DSMES programs and when and how to refer.
- Describe how DSMES improves clinical and behavioral outcomes
- Discuss how accredited and recognized programs address social determinants of health and other individualized needs.
- Describe the value and ROI of DSMES in the rural health setting
- Explain how DSMES advances the quadruple aim for rural health centers

What is DSMES?

Diabetes self-management education and support is the ongoing process of facilitating the knowledge, skills, and ability necessary for diabetes self-care as well as activities that assist a person in implementing and sustaining the behaviors needed to manage his or her condition on an ongoing basis, beyond or outside of formal self-management training.

2020 DSMES CONSENSUS REPORT

ADCES Association of Diabetes Care & Education Specialists

2020 DSMES Consensus Report

Diabetes Self-Management Education and Support in Adults with Type 2 Diabetes: A Consensus Report

Published Online June 2020

To access the report visit
DiabetesEducator.org/ConsensusReport

A joint report from:

American Diabetes Association

Association of Diabetes Care & Education Specialists

Academy of Nutrition and Dietetics

American Academy of Family Physicians

American Academy of PAs

American Association of Nurse Practitioners

American Pharmacist Association

Each patient carries his own doctor inside him. They come to us knowing that truth. We are at our best when we give the doctor who resides in each patient, a chance to work.

-- Albert Schweitzer, MD

Education is the most powerful weapon which you can use to change the world.

-- Nelson Mandela

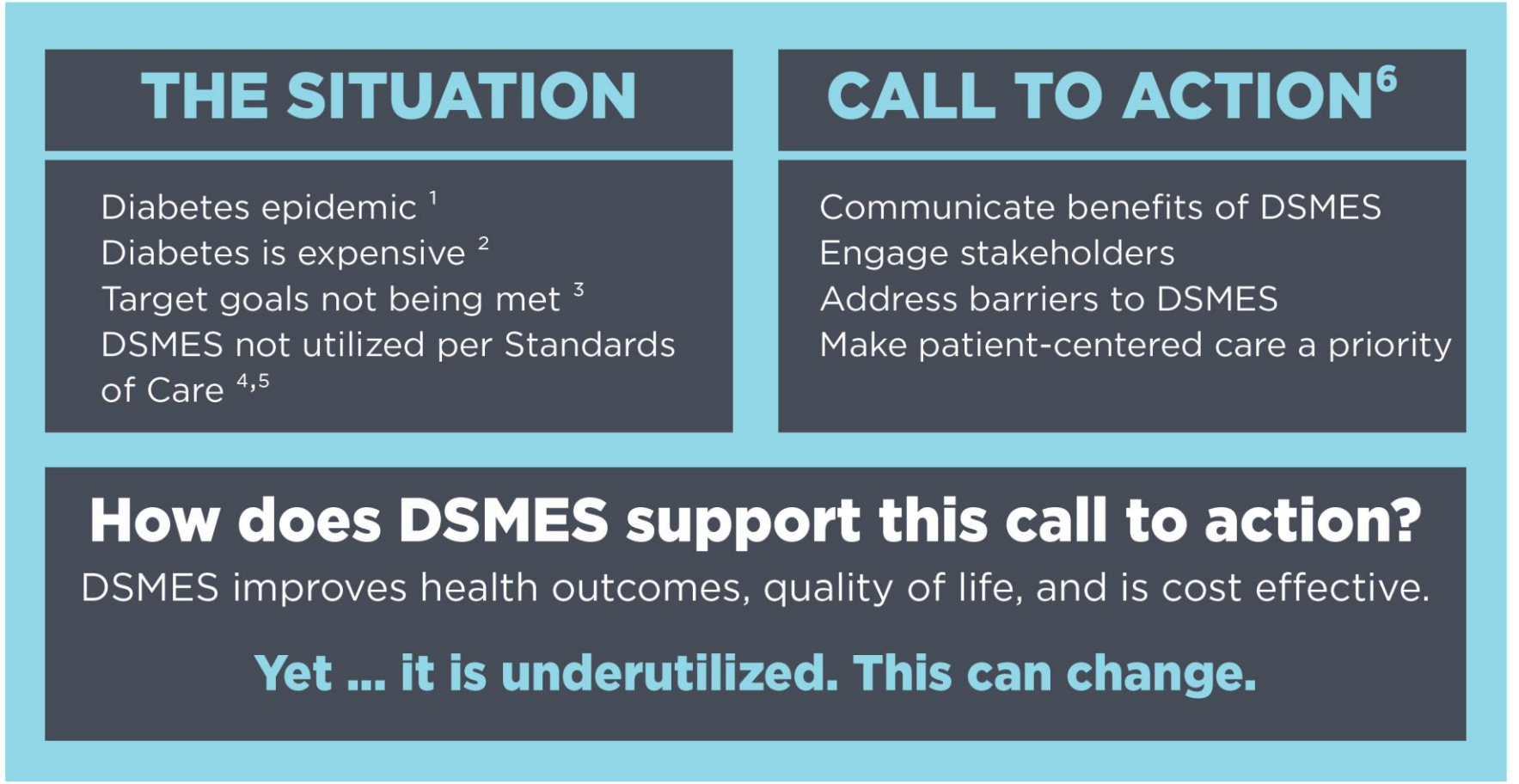
All people with diabetes should participate in diabetes self-management education and receive the support needed to facilitate the knowledge decision-making and skills mastery necessary for diabetes self-care.

-- ADA Standards of Medical Care 2020

There are four critical times to provide and modify diabetes self-management education and support.

-- 2020 DSMES Consensus Report

DSMES is underutilized



1. Lin J, et al. Population Health Metrics, 2018
2. ADA. Diabetes Care, 2018
3. Kazemian P, et al. JAMA Internal Medicine, 2019
4. ADA. Standards of Medical Care, Diabetes Care, 2020
5. Strawbridge LM, et al. Health Educator, 2015
6. Powers MA, Bardsley JK, et al. DSMES Consensus Report, The Diabetes Educator, 2020

ADCES

DSMES is underutilized

ONLY

Of **MEDICARE** beneficiaries with newly diagnosed diabetes used DSMT services[1]

ONLY

Of individuals with newly diagnosed T2D with **PRIVATE HEALTH** insurance received DSMES within 12 months of diagnosis[2]

1. Li R, et al. Morbidity Mortality Weekly Report, 2014
2. Strawbridge LM, et al. Health Educator, 2015

ADCES

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

ADCES

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

If DSMES were a pill, would you prescribe it?

Prescribe DSMES

Diabetes Services Order Form (DSMT and MNT Services)

*Indicates required information for Medicare order

PATIENT INFORMATION

Patient's Last Name | First Name | Middle

Date of Birth ___/___/___ | Medicare HICN # _____ | Gender ___ Male ___ Female

Address | City | State | Zip Code

Home Phone | Work Phone | Other Contact Phone

Diabetes self-management training (DSMT) and medical nutrition therapy (MNT) are individual and complementary services to improve diabetes care. For Medicare beneficiaries, both services can be ordered in the same year. Research indicates MNT combined with DSMT improves outcomes.

DIABETES SELF-MANAGEMENT TRAINING (DSMT)

Medicare: 10 hours initial DSMT in 12-month period, plus 2 hours follow-up DSMT annually

**Check type of training services and number of hours requested:*

- ☐ Initial group DSMT: ☐ 10 hours or ___ no. hrs. requested
- ☐ Follow-up DSMT: ☐ 2 hours or ___ no. hrs. requested
- ☐ Additional insulin training: ___ no. hrs. requested

*** Patients with special needs requiring individual DSMT**

Check all special needs that apply:

- ☐ Vision ☐ Hearing ☐ Physical ☐ Cognitive Impairment
- ☐ Language Limitations ☐ Other _____

*** DSMT Content**

- ☐ All ten content areas, as appropriate
- ☐ Monitoring diabetes
- ☐ Psychological adjustment
- ☐ Nutritional management
- ☐ Medications
- ☐ Preconception/pregnancy management or gestational diabetes management
- ☐ Diabetes as disease process
- ☐ Physical activity
- ☐ Goal setting, problem solving
- ☐ Prevent, detect and treat acute complications
- ☐ Prevent, detect and treat chronic complications

MEDICAL NUTRITION THERAPY (MNT)

Medicare: 3 hours initial MNT in the first calendar year, plus two hours follow-up MNT annually. Additional MNT hours available for change in medical condition, treatment and/or diagnosis.

** Check the type of MNT and/or number of additional hours requested:*

- ☐ Initial MNT ☐ Annual follow-up MNT
- ☐ Additional MNT services in the same calendar year, per RD recommendations ___ no. additional hrs. requested

Please specify change in medical condition, treatment and/or diagnosis:

CURRENT DIABETES MEDICATIONS

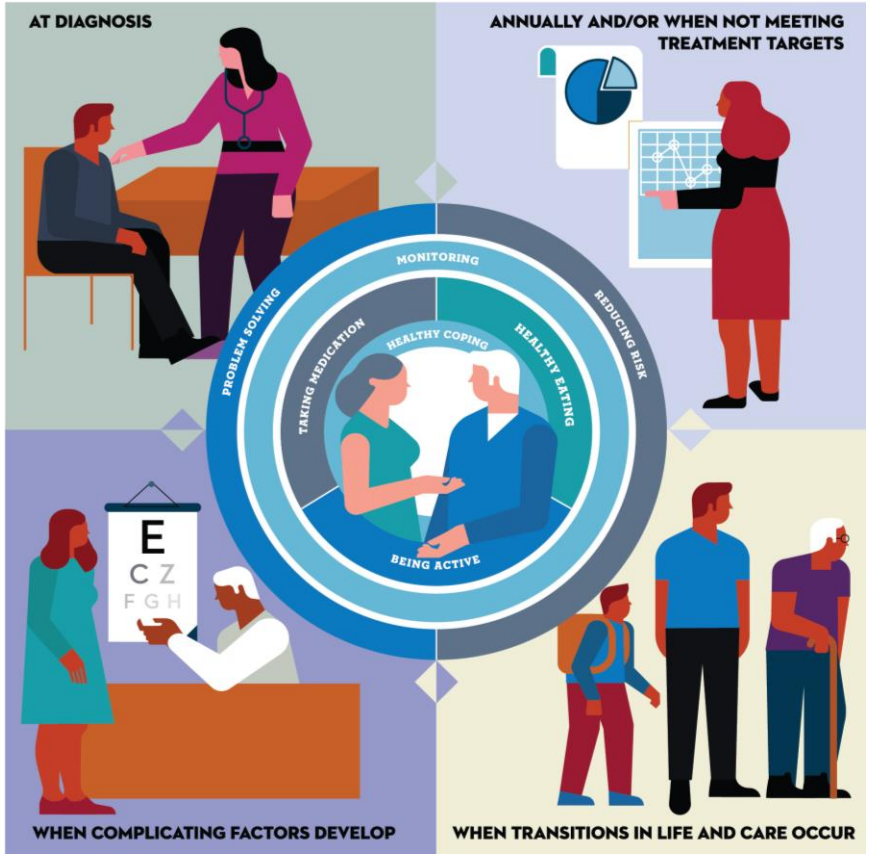
Specify type, dose and frequency

Oral:

Insulin:

DSMES requires a referral

Four critical times to provide and modify DSMES

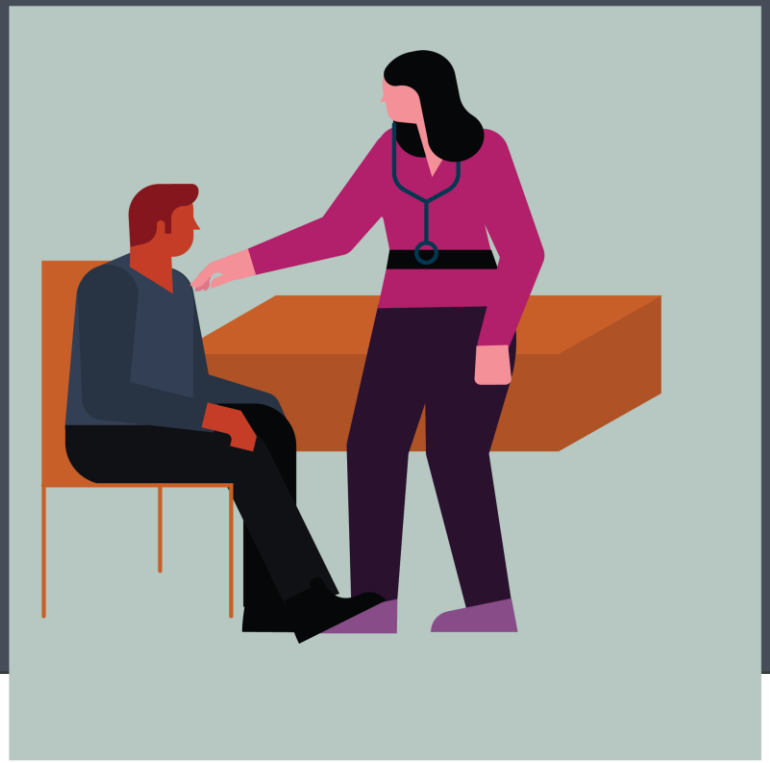


1) At diagnosis.
2) Annually and/or when not meeting treatment targets.
3) When complicating factors develop.
4) When transitions in life and care occur.

Powers MA, Bardsley JK, et al. DSMES Consensus Report, The Diabetes Educator, 2020
ADCES. AADE7 Self-Care Behaviors, The Diabetes Educator, 2020

Factors that indicate referral to DSMES services

At diagnosis



- All newly diagnosed.
- Ensure that both nutrition and emotional health are addressed or make separate referrals.

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

Factors that indicate referral to DSMES services

Annually and/or when not meeting treatment targets

- When knowledge and skills need to be assessed.
- Long-standing diabetes with limited prior education.
- Treatment ineffective.
- Change in medication, activity, or nutritional intake or preferences.
- Maintenance of positive clinical and quality of life outcomes.
- Unexplained or frequent hypo- or hyperglycemia.
- When psychosocial and behavioral support is needed.

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

Factors that indicate referral to DSMES services

When complicating factors develop

Change in:

- Health conditions or health status requiring changes in nutrition, physical activity, or medication.
- Physical limitations.
- Emotional well-being.
- Basic living needs.
- Planning pregnancy or pregnant.

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

Factors that indicate referral to DSMES services

When transitions in life and care occur

- Change in living situation.
- Discharge from inpatient to outpatient.
- New clinical care team.
- Initiation or intensification of medication, devices or technology.
- Insurance coverage changes.
- Age-related changes.

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

What needs to be done at the four critical times?

- Checklist available in DSMES consensus report.
- Provides content guidance for each critical time.
- Shows key points for provider's team versus DSMES team.

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

Evidence for greatest impact of DSMES

Engaging adults with type 2 diabetes in DSMES results in statistically significant and clinically meaningful improvements in A1C. The greatest improvements are achieved when DSMES:

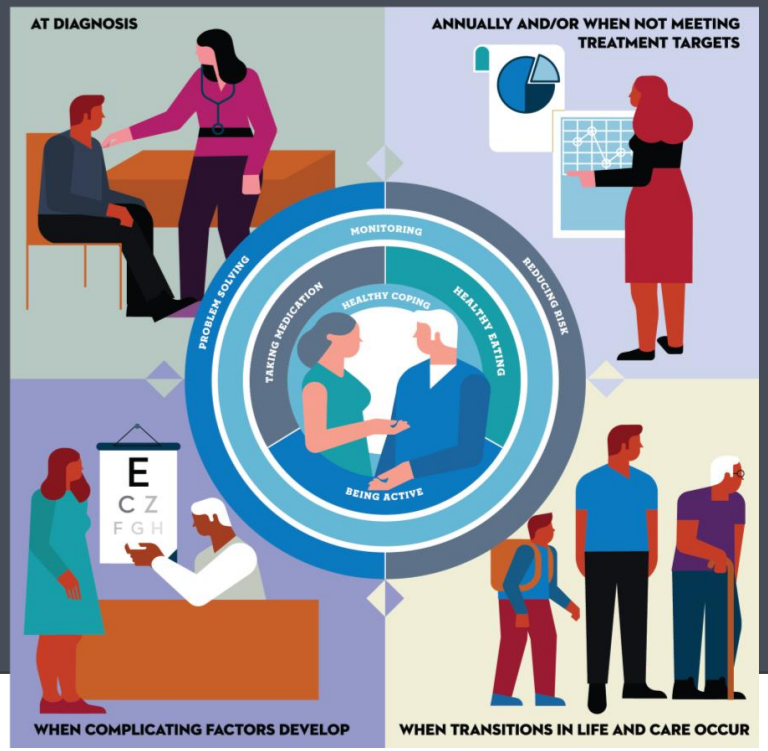
- Involves both group and individual education.
- Is provided by a team vs a single individual.
- Participants attend more than 10 hours.
- Is tailored to the individual participant.
- Is focused on behaviors and engages the participant rather than didactic interventions.

Chrvala CA, et al. Patient Education and Counseling, 2016

ADCES

DSMES consensus report recommendations

Recommendations: for providers

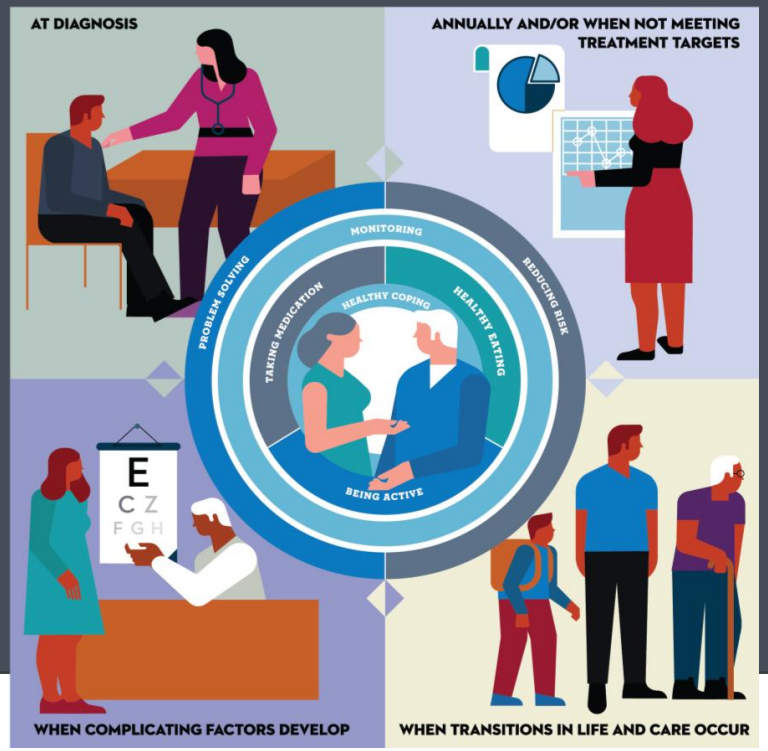


- Discuss with all persons with diabetes the benefits and value of initial and ongoing DSMES.
- Initiate referral to and facilitate participation in DSMES at the 4 critical times: (1) at diagnosis, (2) annually and/or when not meeting treatment targets, (3) when complicating factors develop, and (4) when transitions in life and care occur.
- Ensure coordination of the medical nutrition therapy plan with the overall management strategy, including the DSMES plan, medications and physical activity on an ongoing basis.
- Identify and address barriers affecting participation with DSMES services following referral.

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

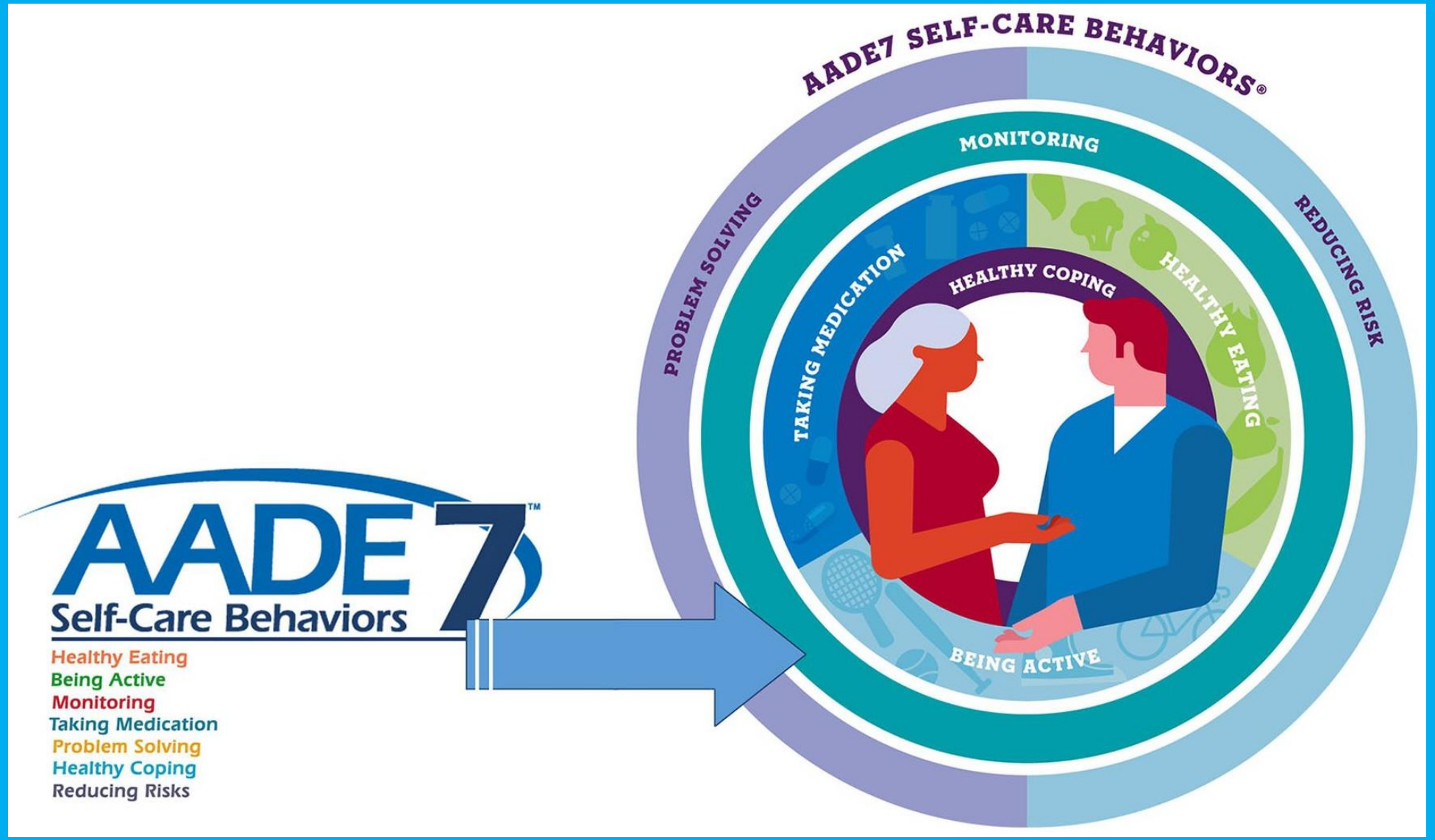
DSMES consensus report recommendations

Recommendations for: health policy, payers, systems, providers, care teams



- Expand awareness, access, and utilization of innovative and non-traditional DSMES services.
- Identify and address barriers influencing providers influencing referrals to DSMES services.
- Facilitate reimbursement processes and other means of financial support in consideration of cost savings related to the benefits of DSMES services.

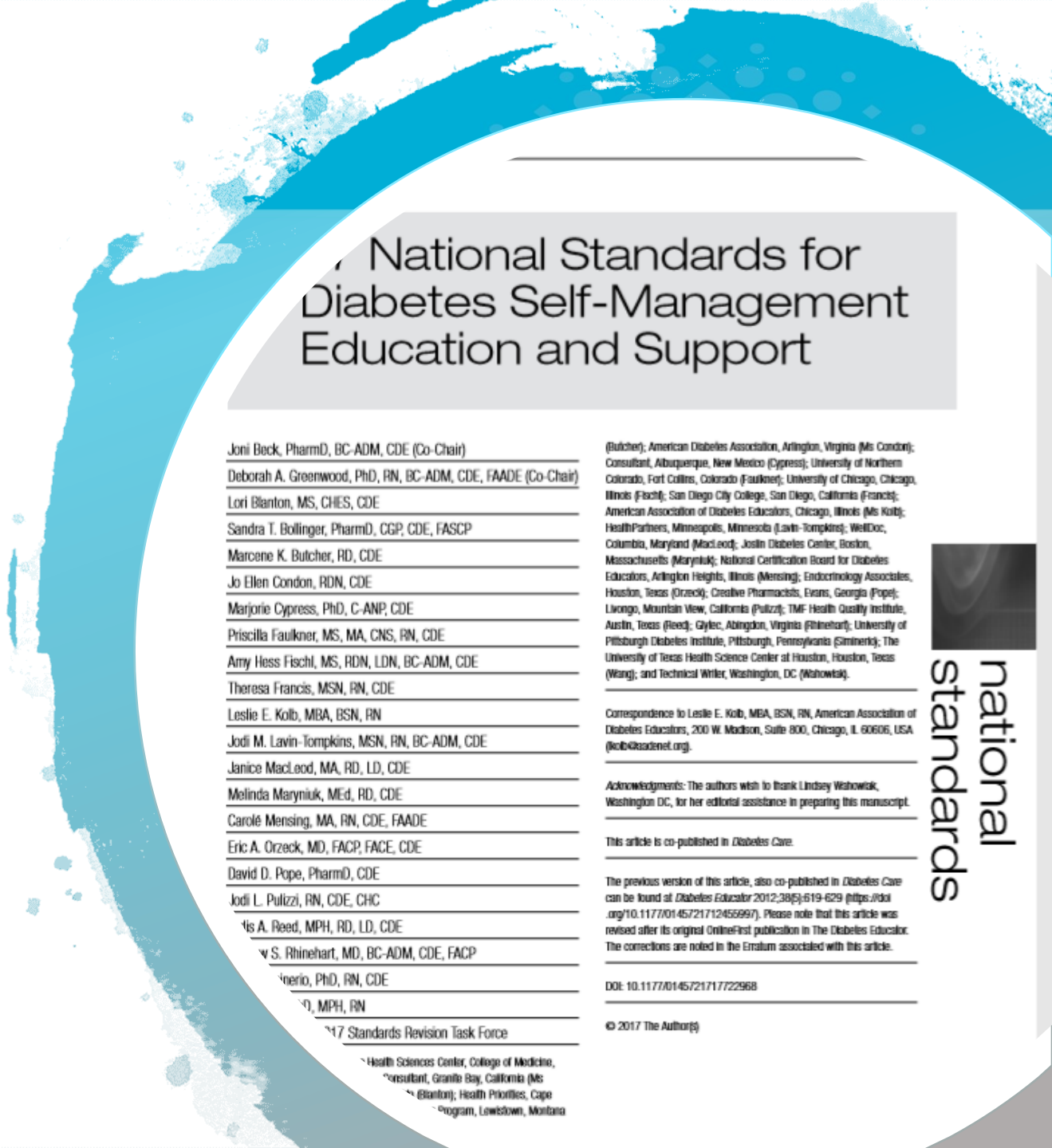
Powers MA, Bardsley JK, et al. DSMES Consensus Report, The Diabetes Educator, 2020



ADCES. AADE7 Self-Care Behaviors, The Diabetes Educator, 2020

2017 National Standards for DSMES

- The Standards define timely, evidence-based DSMES services *to ensure wide application and quality*
- The Standards are designed to define **quality** DSMES and assist those who provide DSMES services
- Provide evidence as a tool for payers reviewing DSMES reimbursement and consider change to align with their beneficiaries' preferences and lives.


National Standards for Diabetes Self-Management Education and Support

national standards

Joni Beck, PharmD, BC-ADM, CDE (Co-Chair)
Deborah A. Greenwood, PhD, RN, BC-ADM, CDE, FAADE (Co-Chair)
Lori Blanton, MS, CHES, CDE
Sandra T. Bollinger, PharmD, CGP, CDE, FASCP
Marcene K. Butcher, RD, CDE
Jo Ellen Condon, RDN, CDE
Marjorie Cypress, PhD, C-ANP, CDE
Priscilla Faulkner, MS, MA, CNS, RN, CDE
Amy Hess Fischl, MS, RDN, LDN, BC-ADM, CDE
Theresa Francis, MSN, RN, CDE
Leslie E. Kolb, MBA, BSN, RN
Jodi M. Lavin-Tompkins, MSN, RN, BC-ADM, CDE
Janice MacLeod, MA, RD, LD, CDE
Melinda Maryniuk, MEd, RD, CDE
Carolé Mensing, MA, RN, CDE, FAADE
Eric A. Orzeck, MD, FACP, FACE, CDE
David D. Pope, PharmD, CDE
Jodi L. Pulizzi, RN, CDE, CHC
[illegible]is A. Reed, MPH, RD, LD, CDE
[illegible]W S. Rhinehart, MD, BC-ADM, CDE, FACP
[illegible]nerio, PhD, RN, CDE
[illegible]D, MPH, RN
[illegible]17 Standards Revision Task Force
[illegible] Health Sciences Center, College of Medicine,
[illegible]onsultant, Granite Bay, California (Ms
[illegible] Blanton); Health Priorities, Cape
[illegible]rogram, Lewistown, Montana

(Butcher); American Diabetes Association, Arlington, Virginia (Ms Condon); Consultant, Albuquerque, New Mexico (Cypress); University of Northern Colorado, Fort Collins, Colorado (Faulkner); University of Chicago, Chicago, Illinois (Fischl); San Diego City College, San Diego, California (Francis); American Association of Diabetes Educators, Chicago, Illinois (Ms Kolb); HealthPartners, Minneapolis, Minnesota (Lavin-Tompkins); WellDoc, Columbia, Maryland (MacLeod); Joslin Diabetes Center, Boston, Massachusetts (Maryniuk); National Certification Board for Diabetes Educators, Arlington Heights, Illinois (Mensing); Endocrinology Associates, Houston, Texas (Orzeck); Creative Pharmacists, Evans, Georgia (Pope); Livongo, Mountain View, California (Pulizzi); TMF Health Quality Institute, Austin, Texas (Reed); Glytec, Abingdon, Virginia (Rhinehart); University of Pittsburgh Diabetes Institute, Pittsburgh, Pennsylvania (Siminerio); The University of Texas Health Science Center at Houston, Houston, Texas (Wang); and Technical Writer, Washington, DC (Wishowski).

Correspondence to Leslie E. Kolb, MBA, BSN, RN, American Association of Diabetes Educators, 200 W. Madison, Suite 800, Chicago, IL 60606, USA (lkolb@aadenet.org).

Acknowledgments: The authors wish to thank Lindsey Wishowski, Washington DC, for her editorial assistance in preparing this manuscript.

This article is co-published in *Diabetes Care*.

The previous version of this article, also co-published in *Diabetes Care* can be found at *Diabetes Educator* 2012;38(5):619-629 (https://doi.org/10.1177/0145721712455997). Please note that this article was revised after its original OnlineFirst publication in The Diabetes Educator. The corrections are noted in the Erratum associated with this article.

DOI: 10.1177/0145721717722968

History of the Acronyms

- DSMT – Billing for Medicare
- DSME
- DSME/T
- DSMS
- DSME/S
- DSMES – Currently in use

History of the National Standards

- 1984: Developed and Published The National Standards for Diabetes Self Management Education –Revisions: 1995, 2000, 2007, 2012 and **2017**
- National Accrediting Organization (NAO)
  - AADE in 2009
  - ADA in 1986
- 1987 – First recognized program utilizing the Standards
- 1997 – Centers for Medicare and Medicaid Services (CMS) began reimbursing for DSME in 1997

DSMES Accredited Programs

Understand the communities they serve

- Languages Spoken
- Cultural Influences
- Low vision
- Hearing impaired
- Disabled
- Low literacy
- SDOH
- Transportation needs

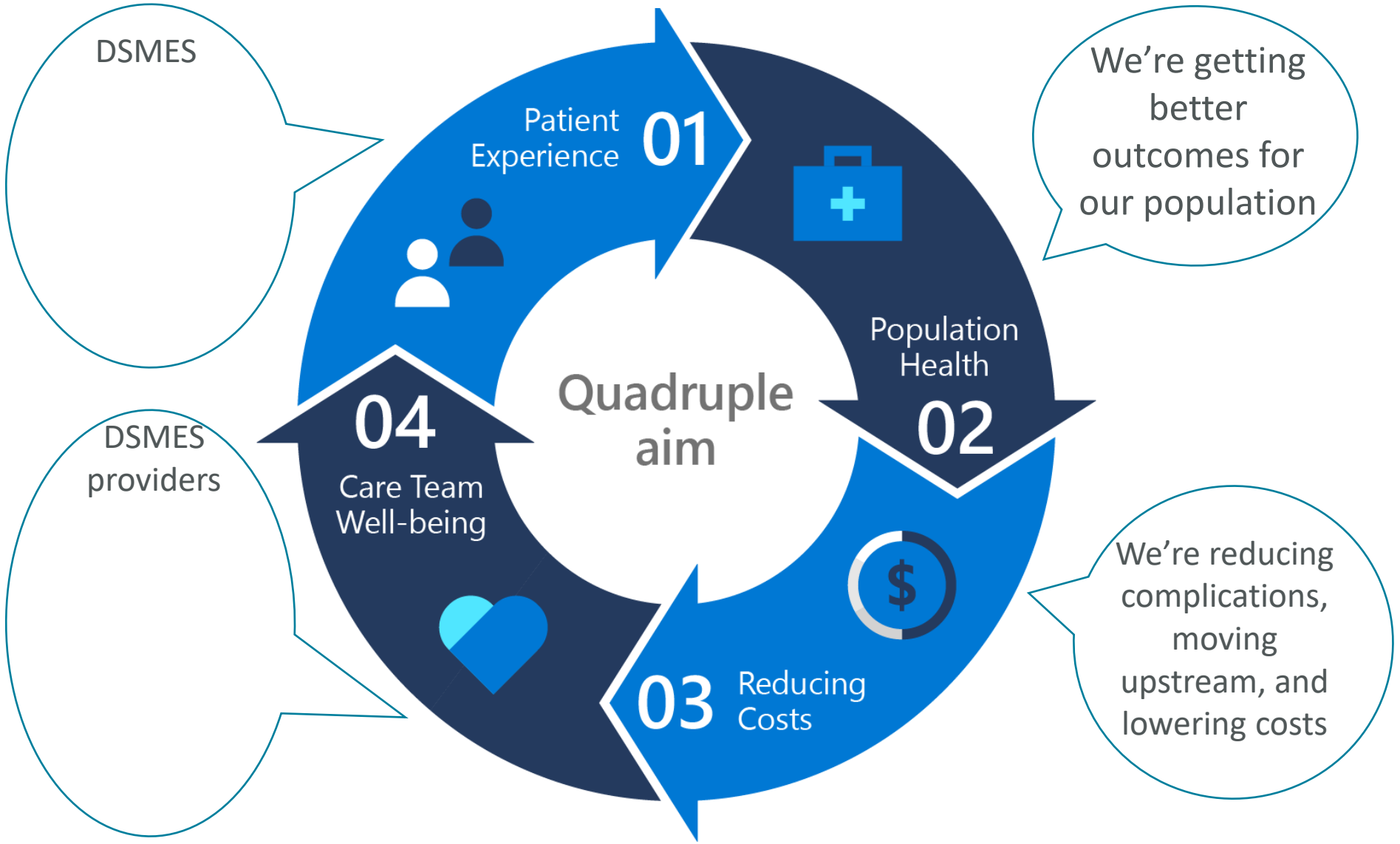
DSMES Accredited Programs meet and maintain the national standards

- ✓ Individualized diabetes specific assessment to determine skills necessary to live well and thrive with diabetes.
- ✓ Education and training plan based on participants goals, questions, needs and availability for visits.
- ✓ All plans and goals developed collaboratively with participant and dces
- ✓ Expanded access including individual visits, group classes, support groups, community resource connectors.
- ✓ Annual reporting to confirm adherence to national standards
- ✓ Audits to ensure maintenance of the highest quality DSMES

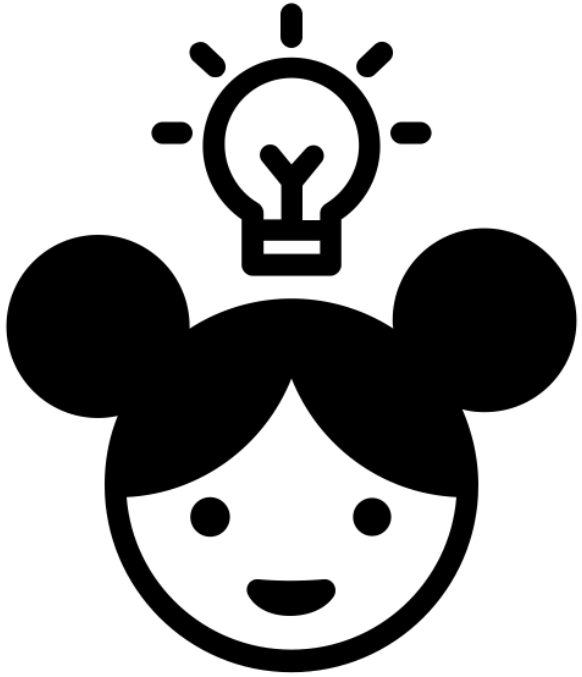
DSMES Accredited Programs take action to overcome access related issues:

- Socioeconomic
- Cultural
- Schedules
- Transportation
- No insurance or high deductible insurance
- Perceived lack of need

The quadruple aim



Remember…

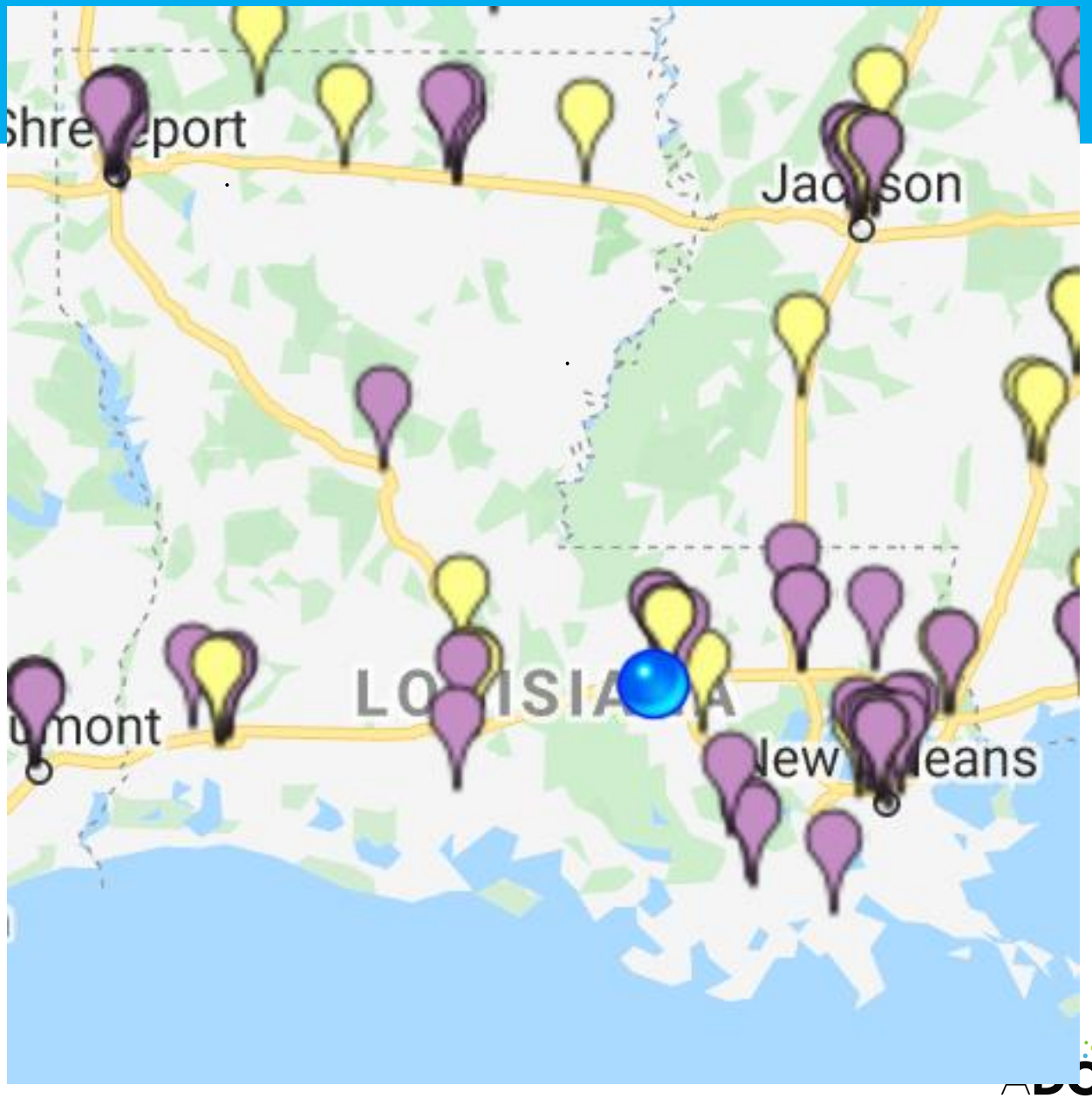


Created by HeadsOfBirds
from Noun Project

DPP and DSMES have a value BEYOND reimbursement…

- Reduce unscheduled visits, specialist visits, ED encounters
- Increase revenue to other services (e.g. labs, preventive care referrals, behavioral health)
- Help achieve pay for performance metrics
- Connect patients to your center as a medical home
- Support population health and health equity outcomes

DSMES in Louisiana



Need for DSMES in Rural Health Centers

- 17% higher prevalence of diabetes in rural versus urban areas**
- CDC researchers found that 62% of nonmetropolitan counties do not have a DSMES program.**
- The National Quality Forum (NQF) established a workgroup

**https://www.cdc.gov/ruralhealth/docs/RH-Policy-Brief-Diabetes-H.pdf

Rural Health Centers and Quality Measures

“NQF convenes the statutorily mandated Measure Applications Partnership (MAP) as a public-private partnership of healthcare stakeholders.

MAP provides input to the Department of Health and Human Services (HHS) on the selection of performance measures for public reporting and performance-based payment programs.

MAP also helps to identify gaps in measure development and encourages measure alignment across public and private programs, settings, levels of analysis, and populations.

In 2017, recognizing the lack of representation from rural stakeholders in the pre-rulemaking process, CMS tasked the National Quality Forum (NQF) to establish a MAP Rural Health Workgroup”

https://www.qualityforum.org/Publications/2020/09/MAP_Rural_Health_Final_Recommendations_Report_-_2020.aspx

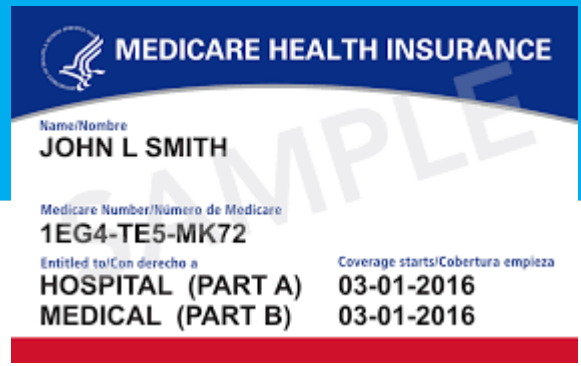
ADCES

DSMES can impact diabetes and cardiometabolic outcomes!

"Diabetes, hypertension, and chronic obstructive pulmonary disease (COPD). The Workgroup recognized these chronic conditions as highly prevalent in rural areas, requiring high levels of healthcare utilization and contributing to high costs of care for rural residents."

http://www.qualityforum.org/Publications/2018/08/MAP_Rural_Health_Final_Report_-_2018.aspx

DSMT for Medicare Beneficiaries in RHC's



10 hours of initial training (once under Medicare)

2 hours of follow-up available annually starting year 2 (with referral)

Rural Health Centers (RHCs): add 1:1 DSMT visits via G0108 to the RHC Cost Report

- RHC's are paid through an All-Inclusive Rate (AIR).
- DSMT visits have the potential to increase the center's all-inclusive rate if is not already capped.
- Services such as DSMES/DSMT, outside of the usual scope of RHC's are added to the cost report which is required for costs that are non RHC/FQHC daily services and for things like space, supplies, personnel, and overhead.

ADCES

FQHCs and RHCs: Covid-19 Telehealth

Prior to Covid-19, the only telehealth services reimbursable to FQHCs and RHCs were the “originating site” charges. This means they set up the patient in a room with screen where they could interact via videoconference with a provider from a “distant site”.

All providers from FQHCs and RHCs have been excluded from Medicare reimbursement for telehealth services.

The Cares Act, passed on March 27, expanded telehealth for FQHCs and RHCs during the Covid-19 PHE. CMS provided updated guidance on April 17.

CARES Act and DSMT via telehealth in the RHC

- FQHCs/RHCs: DSMT visits can be billed (using G0108) for telehealth during the PHE.
- Telehealth services can be provided by any healthcare practitioner working for the RHC or the FQHC within their scope of practice.
- For telehealth services furnished between July 1, 2020 and the end of the COVID-19, PHE, RHCs and FQHCs will use an RHC/FQHC specific G code (G2025) to identify services that were furnished via telehealth
- RHC and FQHC claims with the new G code will be paid at the $92 rate.

Summary

- There are many evidence-based benefits of DSMES. Of note are the many psychosocial benefits and behavioral improvements.
- DSMES is grossly underutilized.
- The DSMES consensus report:
  - Describes the 4 critical times to provide and modify DSMES.
  - Provides clear guidance as to when to refer to DSMES services.
  - Includes a checklist for providers and diabetes care and education specialists providing and modifying DSMES services.
- Health systems and providers should mobilize to ensure all people with type 2 diabetes have easy access to DSMES, including nutrition, physical and emotional health support.
  - Consider automatic referrals for DSMT and MNT; opt-out versus opt-in.

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

ADCES

To access the DSMES consensus report and related resources visit:

DiabetesEducator.org/ConsensusReport

ADCES Association of Diabetes Care & Education Specialists

Questions?

THANK YOU