

Successful Diabetes Management: A Two Way Street

2023 AAPA National Conference
Nashville

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RDN, CDCES, EMT



Objectives

- Describe diabetes care workload; what it means to cover all the bases
- Advance use of PWD: Persons with Diabetes
- Discuss the concept of a therapeutic alliance and its mutually beneficial impact on PAs and PWD
- Detail DSMES's role in your practice; the who, when and how of using it



Demographic Question

In a given week, about what percentage of your patient case load receive diabetes management education.

- 5%
- 10%
- 20%
- 30%
- >40%

Pre-Test Question #1



Your primary care practice cares for a large number of persons with diabetes (PWD). You have recently heard about Diabetes Self-Management Education and Support (DSMES) services and wonder which times are considered critical times to refer your patient for this type of service. Which of the following are these times?

1. At diagnosis
2. Annually
3. When complications arise
4. When transitions of care take place
5. All of the above situations

Pre-Test Question #2



You have just referred your patient with type 2 diabetes for Diabetes Self-Management Education and Support (DSMES). Which of the following outcomes would you expect based on their completion of this program?

1. Increased hospital admission
2. Increased patient confusion about their diabetes
3. Improved quality of life & coping
4. No appreciable change in HbA1c

Description

- Managing diabetes consumes large portions of PAs' time and energy and is a "part-time" job to PWD



Partnership

- US annual diagnosed diabetes numbers are a staggering 28.7 million and 96 million with pre-diabetes
- Can you go it alone?
 - generating a therapeutic alliance supporting lifelong learning and patient empowerment model is essential



**RISK OF SHARK ATTACK:
1 IN 11.5 MILLION**

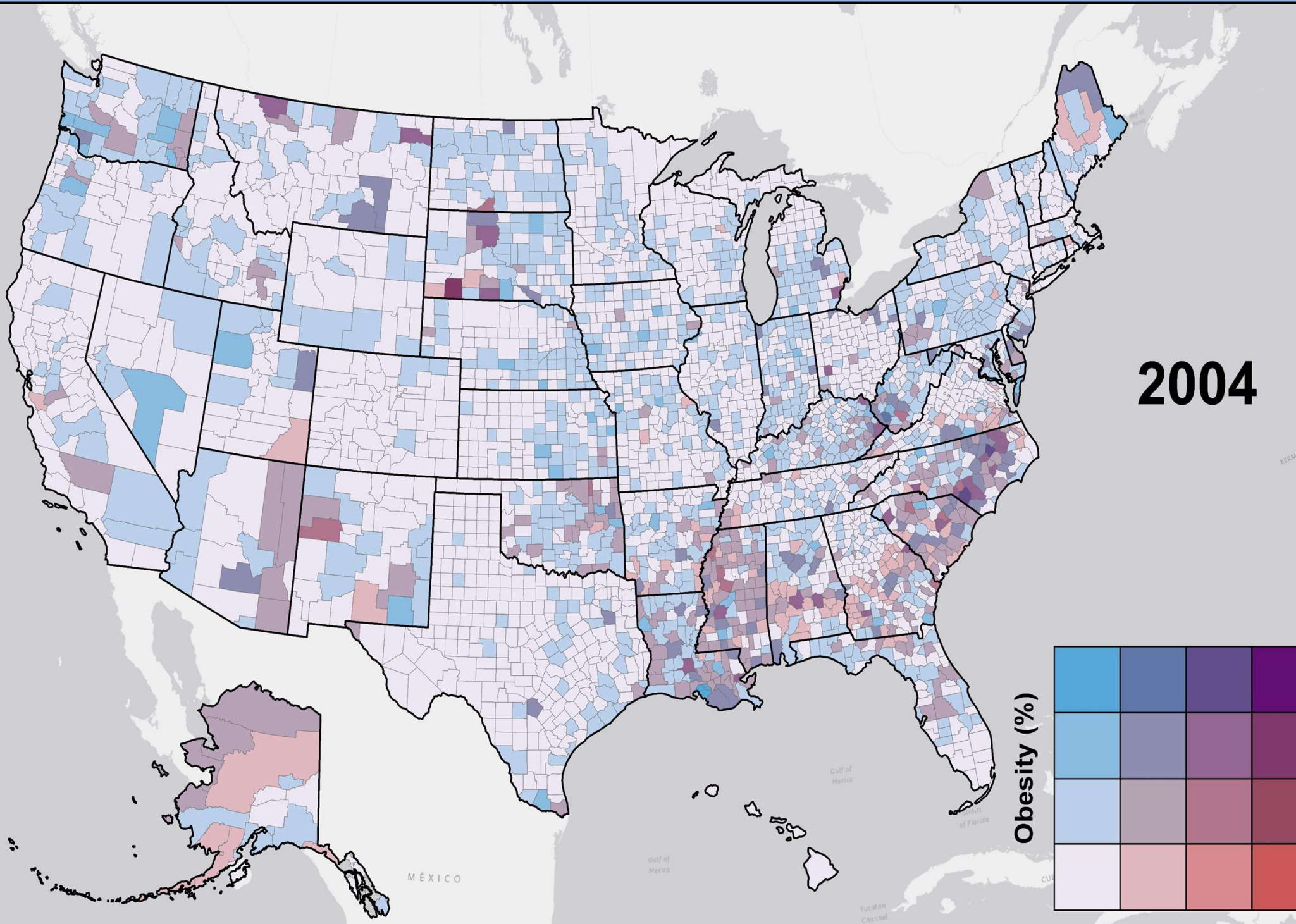
**RISK OF PREDIABETES:
1 IN 3 ADULTS**

DoIHavePrediabetes.org



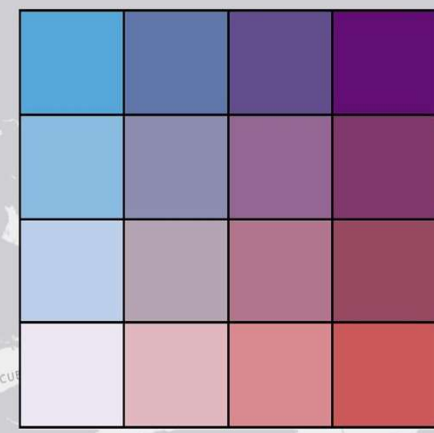


**Age-Adjusted Prevalence of Diagnosed
Diabetes and Obesity Among Adults, by
County, United States
(2004, 2009, 2014, 2019)**



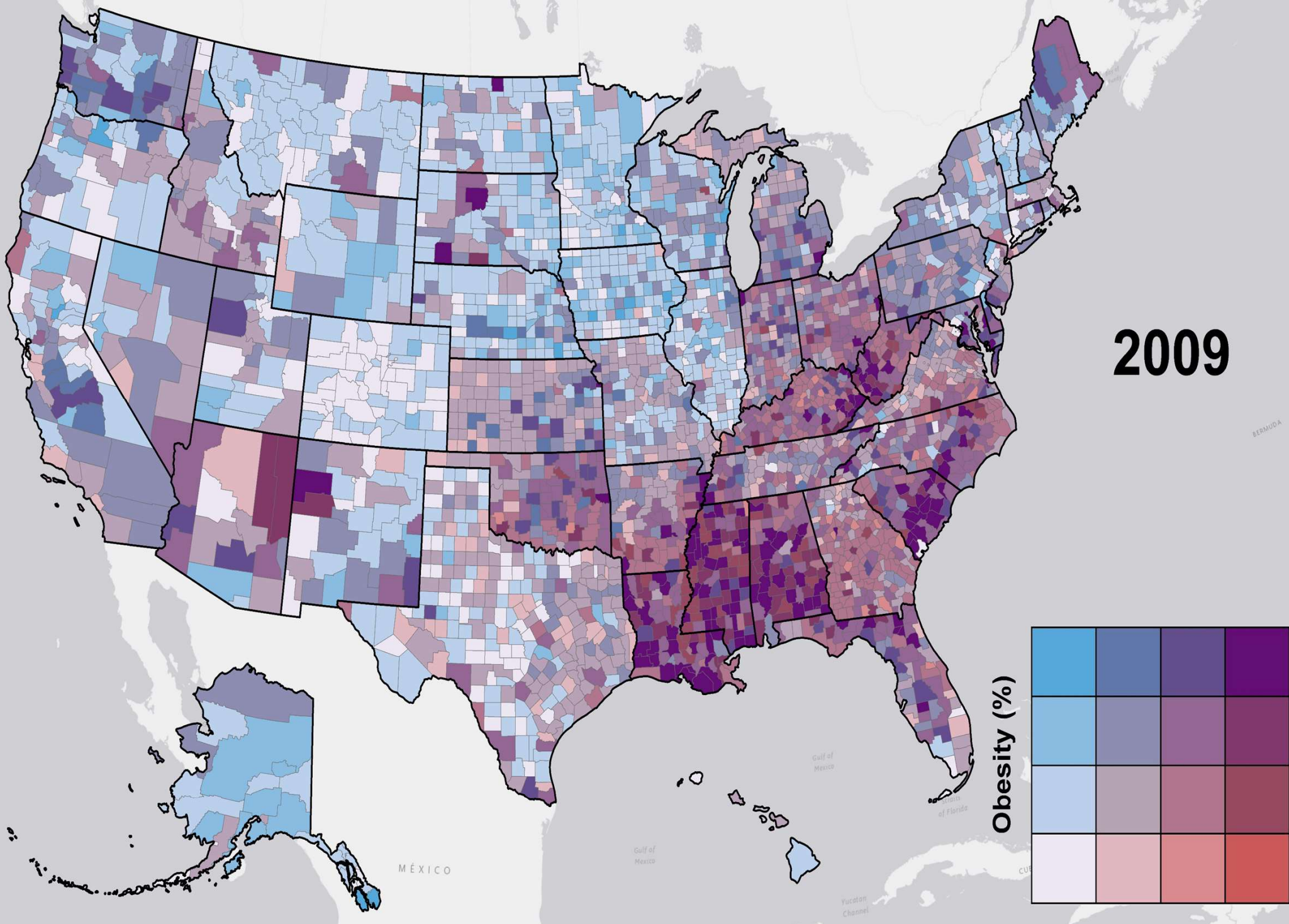
2004

Obesity (%)



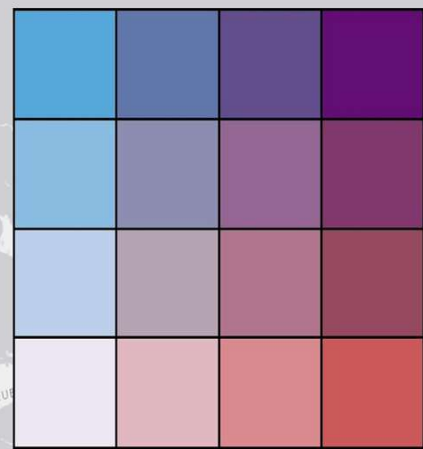
Diagnosed Diabetes (%)

Diagnosed Diabetes and Obesity estimates are percentage; natural breaks were used to create categories using all data from 2004-2019; Diagnosed Diabetes (%): <7.1, 7.1-8.6, 8.6-10.5, >10.5; Obesity (%): <21.2, 21.2-25.5, 25.5-30.5, >30.5



2009

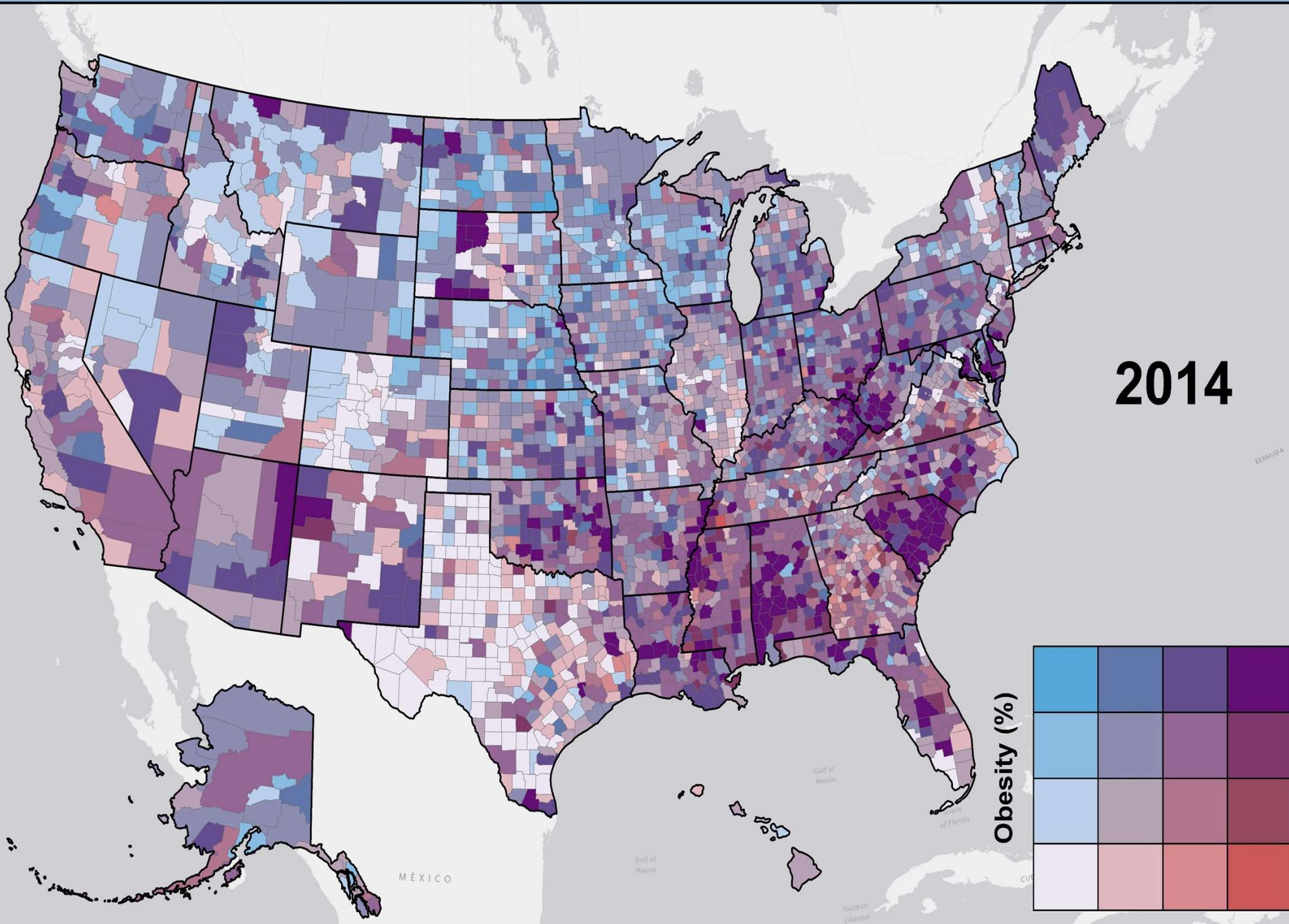
Obesity (%)



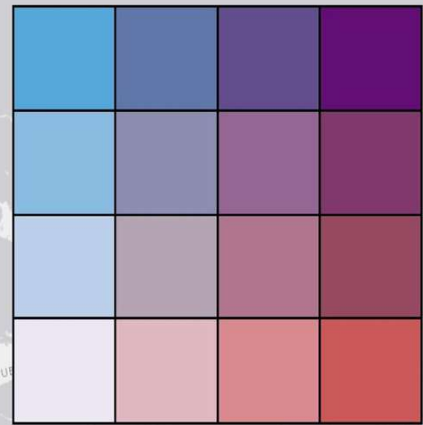
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2014

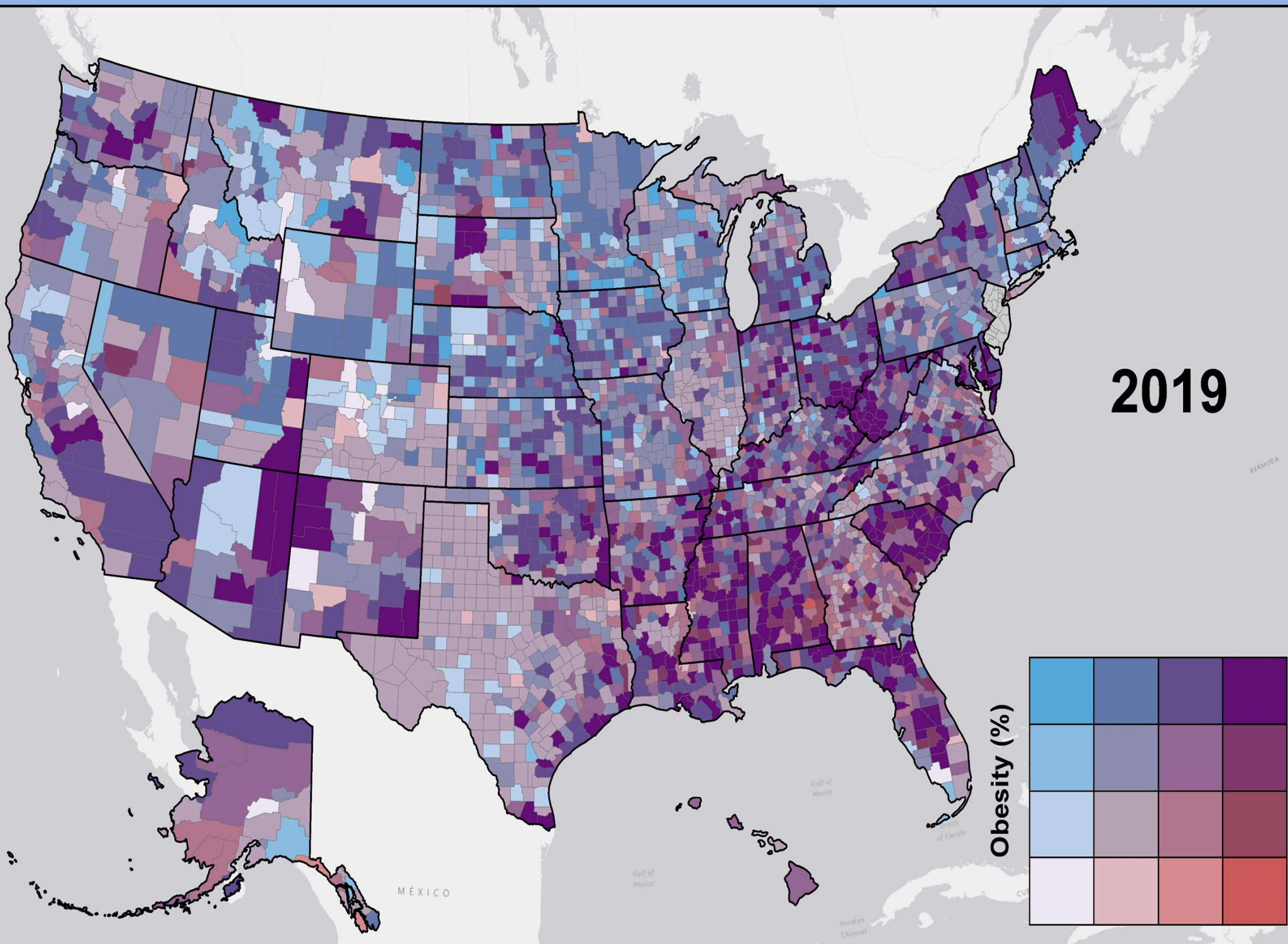


Obesity (%)



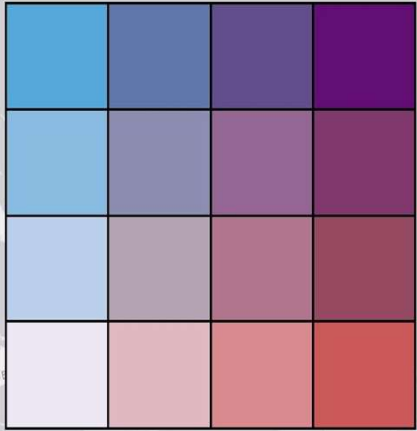
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2019

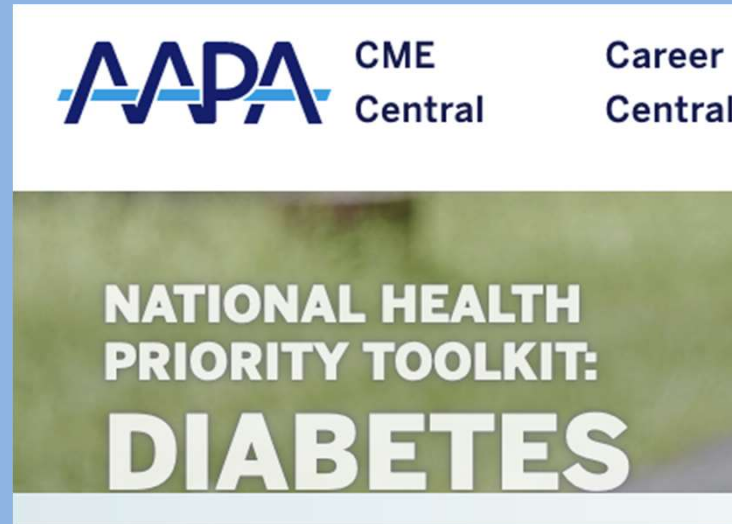
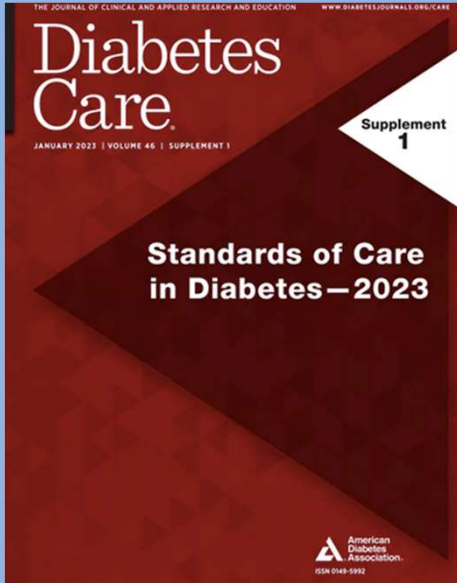
Obesity (%)



Diagnosed Diabetes (%)

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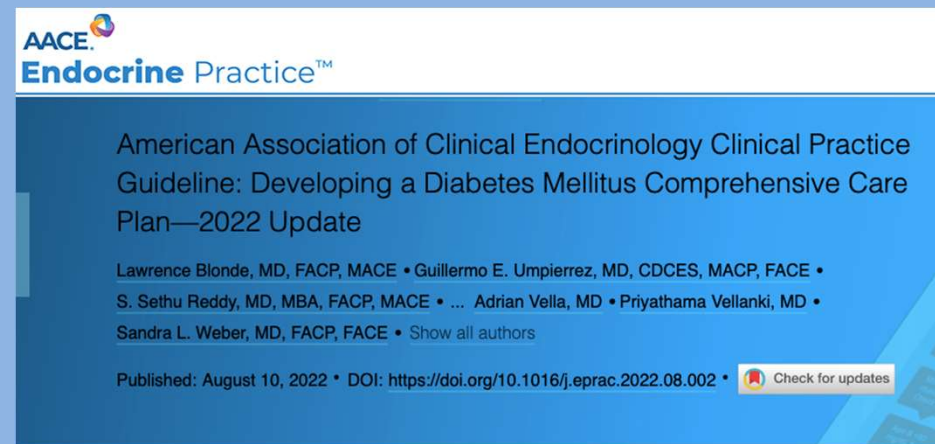
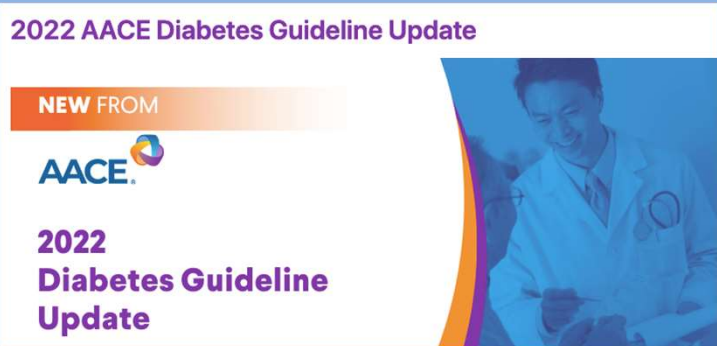
Esri, HERE, Garmin, (c) OpenStreetMap contributors, and the GIS user community




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

Resources for Diabetes Education



Role We Play



PA

Modifiable Variables Impact Treatment and Glycemic Control of T2DM

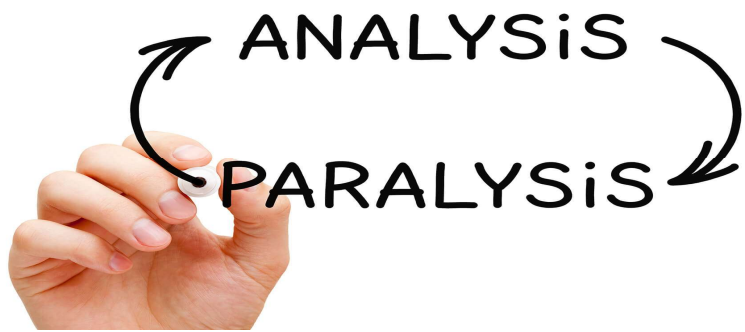
Three Modifiable Variables Accounted for 48% Variance in Diabetes Control

- ▶ Initial HbA1c
- ▶ **Clinical inertia**
- ▶ Visit frequency and patient participation

Greater attention to:

- ▶ early diagnosis and treatment
- ▶ ensuring regular healthcare visits
- ▶ **overcoming therapeutic inertia**

Could improve diabetes control and health equity



PA Physician Barriers^[a-b]

- Concerns about weight gain
- Concerns about hypoglycemia
- Lack of staff support
- Lack of training
- Lack of time to educate patients

Patient Barriers^[c-e]

- Concerns about weight gain
- Concerns about hypoglycemia
- Lack of family support
- Sense of failure
- Lack of confidence
- Perception that insulin is complex



**Clinical
Inertia**

How to Identify, Understand, and Unlearn Implicit Bias in Patient Care



Taking steps to recognize and correct unconscious assumptions toward groups can promote health equity.

Jamie is a 38-year-old woman and the attending physician on a busy inpatient teaching service. On rounds, she notices several patients tending to look at the male medical student when asking a question and seeming to disregard her. Alex is a 55-year-old black man who has a history of diabetic polyneuropathy with significant neuropathic pain. His last A1C was 7.8. He reports worsening lower extremity pain and is frustrated that, despite his bringing this up repeatedly to different clinicians, no one has addressed it. Alex has been on gabapentin 100 mg before bed for 18 months without change, and his physicians

ABOUT THE AUTHORS

Dr. Edgoose is an associate professor in the Department of Family Medicine and Community Health at the University of Wisconsin School of Medicine and Public Health (UW-SMPH) in Madison, Wis., where she directs the school's Diversity and Inclusion Advocates Program and her department's Office of Community Health. Dr. Quiogue is an assistant clinical professor in the Department of Family Medicine, Kaiser Permanente School of Medicine, Kern County Medical Center in Bakersfield, Calif. She serves on the school's Equity, Inclusion, and Diversity Subcommittee and is a former president of the California Academy of Family Physicians. Dr. Sidhar is a third-year family medicine resident in the UW-SMPH Department of Family Medicine and Community Health. Author disclosures: no relevant financial affiliations disclosed.

KEY POINTS

Implicit bias is the **unconscious** collection of stereotypes and attitudes that we develop toward certain groups of people which affect our patient relationships and care decisions

Overcome implicit bias by first discovering your blind spots

Actively work to dismiss stereotypes and attitudes affecting your own interactions.

AAFP. July/August 2019

Pretending to Have Diabetes



What the PA Must Do for a PWD?

The 2 Way Street



Diagnosing DM: The Easiest Part

Diagnosis and Physiology of DM: The Easiest Part?

Type 1

Type 2

Monogenic Diabetes

Cystic Fibrosis

Diseases Exocrine Pancreas

Chemical/Drug Induced DM

GDM

What is Meant by a Comprehensive Medical Evaluation?

Comprehensive Medical Evaluation and
Assessment of Co-Morbidities. Diabetes
Care. 2023;46 (Supplement 1).

History

Symptoms	Prior A1C Values	Eating Patterns	Current Treatment
Diabetes Medication	Exercise	Acute Complications	Infections Feet, GU teeth
Other Medication	Smoking Etoh/Drug	Other Conditions	Cultural Issues
Sexual History	Family History	Chronic Complications	Psycho-social

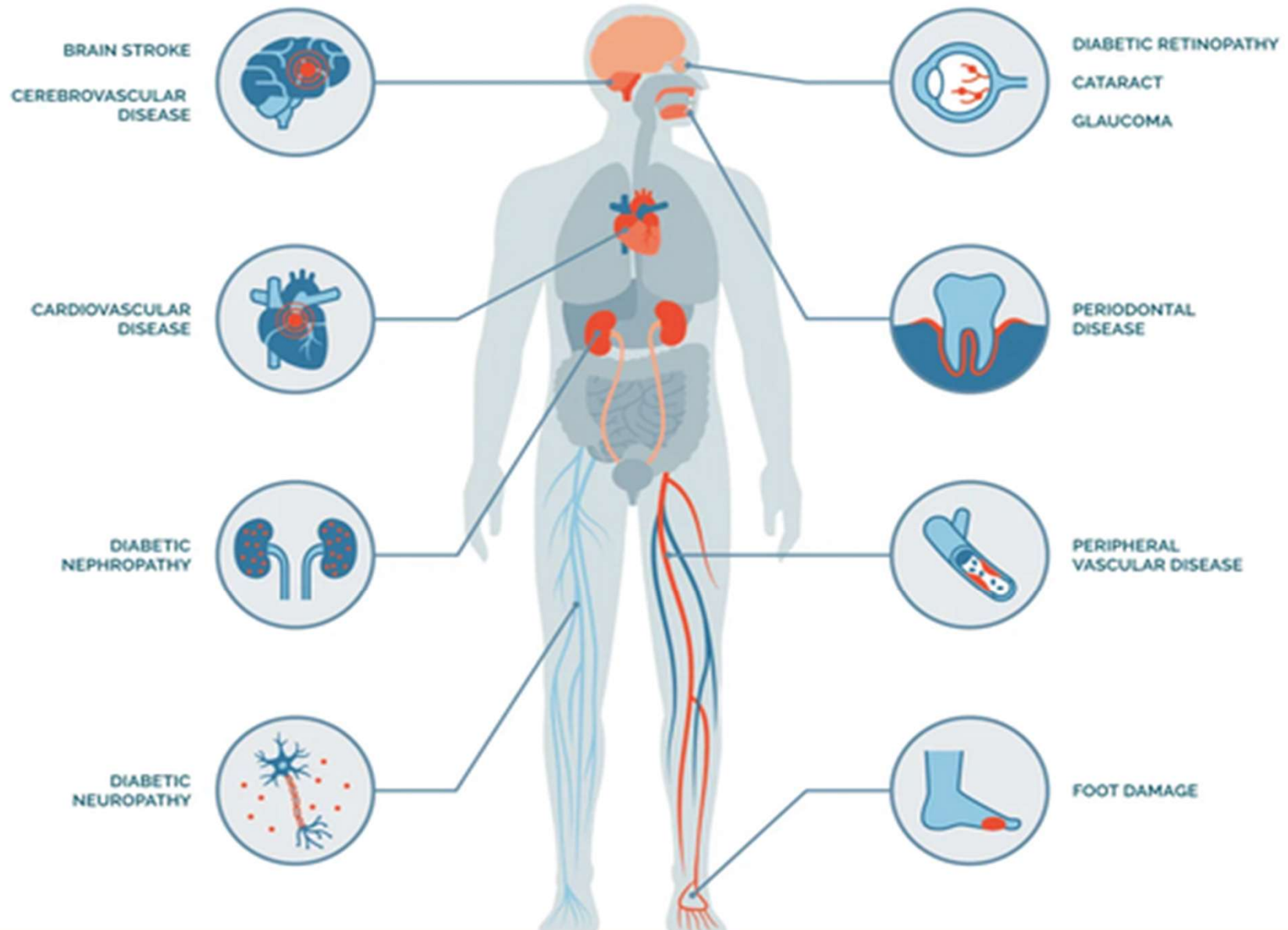
Physical Exam

Height Weight/BMI	Maturity Tanner	BP, BP, BP,	Fundoscopy
Oral Exam	Thyroid Palpation	Cardiac EKG, EST	Hepatic Enlargement
Pulses: Pedal, ABI if diminished	Hand/finger	Foot Check	Skin: Acanthosis nigricans
Neuro: Vibration, temperature, Monofilament	Cognitive Performance	Secondary DM	Depression Screen/anxiet y, disordered eating

Laboratory Evaluation

- Hgb A1C% within past 3 months
- Fasting lipid profile, Total cholesterol, HDL, LDL, triglycerides
- Spot urinary albumin-to-creatinine ratio
- Serum creatinine (adults), calculate eGFR
- TSH in type 1 and if needed in type 2
- +/- Electrocardiogram in adults
- Urine for ketones, protein and sediment
- Serum potassium levels in people with diabetes on ACE inhibitors, ARBs, or diuretics
- Liver Function Test
- B12 if on metformin

Diabetes Complications



HbA1c Goal is Not a “One-size-fits-all”

**More Stringent
(as close to 6%
as possible)**

**ADA < 7%
AACE ≤
6.5%**

**Less Stringent
(< 8%)**

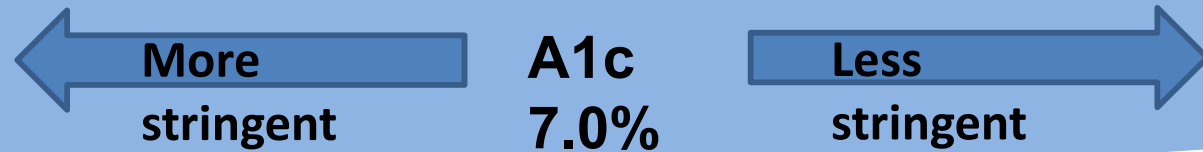
- ▶ Short diabetes duration
- ▶ Long life expectancy
- ▶ No cardiovascular disease

ADA = American Diabetes Association
AACE = American Association of Clinical Endocrinologists

- ▶ Long diabetes duration
- ▶ Short life expectancy
- ▶ Complications, comorbidities
- ▶ History of severe hypoglycemia

ADA: Approach to the Management of Hyperglycemia

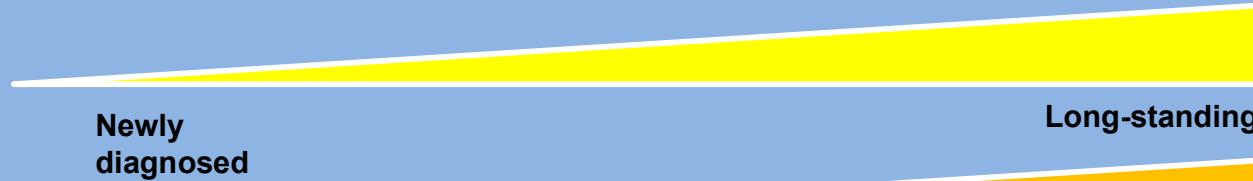
Patient/Disease Features



Risks potentially associated with hypoglycemia and other drug adverse effects



Disease duration



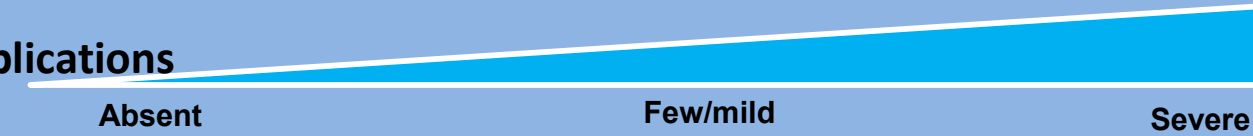
Life expectancy



Relevant comorbidities



Established vascular complications



Patient attitude and expected treatment efforts



Resources and support system



Usually not modifiable

Potentially modifiable

What is Meant by a Comprehensive Medical Evaluation?

- Its not only the History and Physical
 - person-centered and strength-based language
 - active listening
 - elicit patient preferences and beliefs
 - and assesses literacy
 - numeracy
 - potential barriers to care

Definition

Health Literacy:

“The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.”

<https://www.ahrq.gov/professionals/quality-patient-safety/pharmhealthlit/pharmlit/pharmtrain2.html>

Possible Indicators of Low Health Literacy

- Excuses: “I forgot my glasses.”
- Lots of papers folded up in purse/pocket
- Lack of follow-through with tests/appts.
- Seldom ask questions
- Questions are basic in nature
- Difficulty explaining medical concerns or how to take meds

Low Literacy and Medication Use

- ↓ Ability to identify their own medications
12-18 x greater odds
- ↓ Understanding of how to take medications
 - Take med every 6 hrs 52% correct
 - Take med on empty stomach 46% correct
- ↓ Understanding of drug mechanisms and side effects
 - Warfarin works by thinning blood 70% correct
 - Bleeding/bruising most common SE 49% correct
- ↑ Misinterpretation of common warning labels
3-4 x more likely to misinterpret

NEW LABEL / WHAT'S DIFFERENT

Servings:
larger,
bolder type

Nutrition Facts

8 servings per container
Serving size 2/3 cup (55g)

Amount per serving
Calories 230

% Daily Value*

Total Fat 8g 10%

Saturated Fat 1g 5%

Trans Fat 0g

Cholesterol 0mg 0%

Sodium 160mg 7%

Total Carbohydrate 37g 13%

Dietary Fiber 4g 14%

Total Sugars 12g

Includes 10g Added Sugars 20%

Protein 3g

Vitamin D 2mcg 10%

Calcium 260mg 20%

Iron 8mg 45%

Potassium 235mg 6%

* The % Daily Value (DV) tells you how much a nutrient in a serving of food contributes to a daily diet. 2,000 calories a day is used for general nutrition advice.

Serving sizes
updated

Calories:
larger type

Updated
daily
values

Actual
amounts
declared

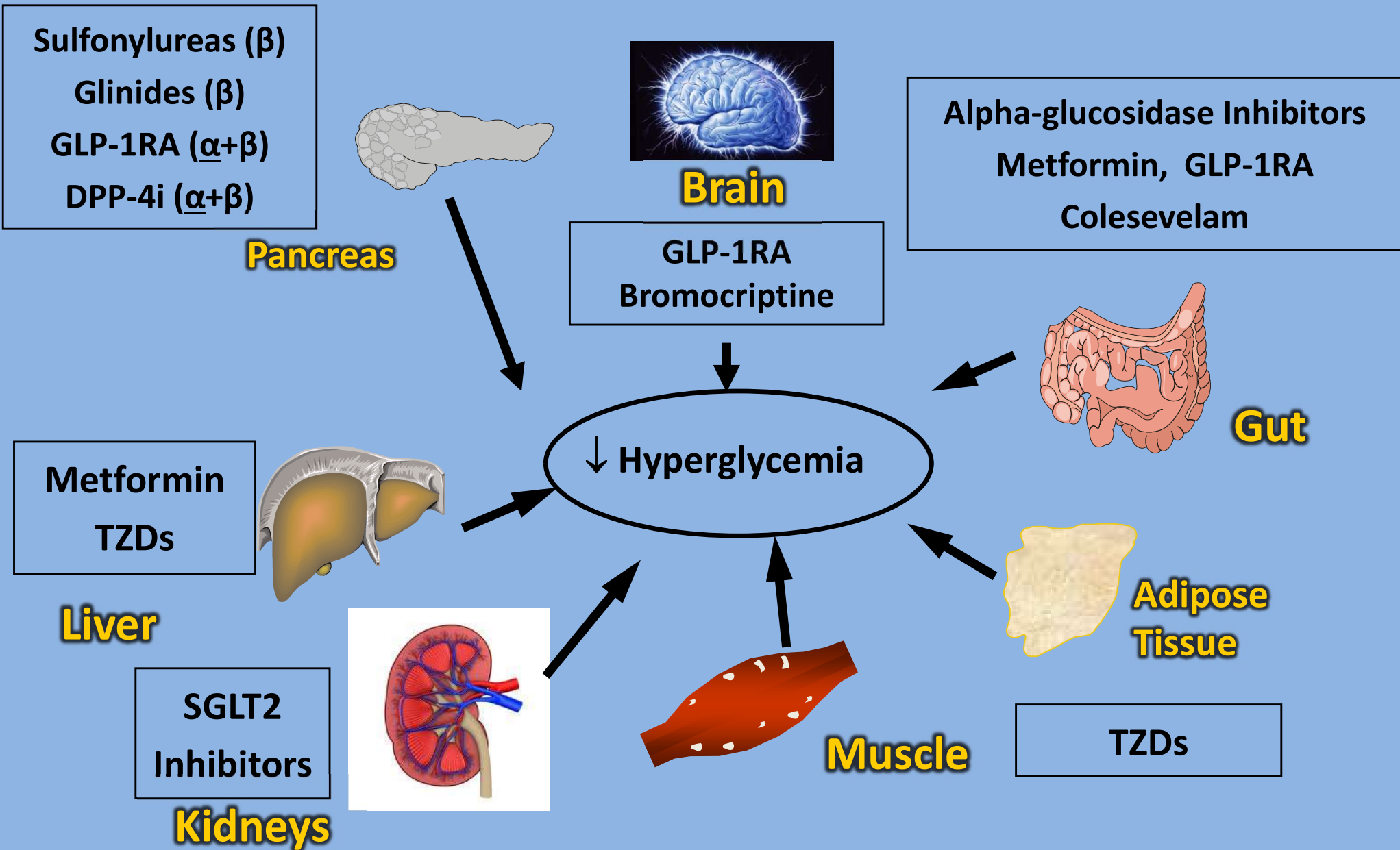
New
footnote

Food Labels: Words and Numbers

New:
added sugars

Change
in nutrients
required

8 Target Sites of Action



DPP-4 = dipeptidyl peptidase-4; TZDs – thiazolidinediones, GLP-1RA = glucagon like peptide – Receptor Agonists, SGLT2 = sodium-glucose transporter-2
 Holst JJ, Ørskov C. *Diabetes*. 2004;53:S197-S204; Lebovitz HE. *Diabetes Rev*. 1999;7:139-153; Prescribing Information for Actos® (pioglitazone HCl), Amaryl® (glimepiride), Avandia® (rosiglitazone maleate), Glyset® (miglitol tablets), Glucophage® (metformin), Januvia™ (sitagliptin), Prandin® (repaglinide), Precose® (acarbose tablets).

Have Diabetes



What is First-Line Therapy?

FIRST-LINE Therapy is Metformin and Comprehensive Lifestyle (including weight management and physical activity)

INDICATORS OF HIGH-RISK OR ESTABLISHED ASCVD, CKD, OR HF¹

CONSIDER INDEPENDENTLY OF BASELINE A1C OR INDIVIDUALIZED A1C TARGET

ASCVD PREDOMINATES

- Established ASCVD
- Indicators of high ASCVD risk (age ≥ 55 years with coronary, carotid or lower extremity artery stenosis $>50\%$, or LVH²)

PREFERABLY
GLP-1 RA with proven CVD benefit¹

OR
SGLT2i with proven CVD benefit¹ if eGFR adequate³

If A1C above target

If further intensification is required or patient is now unable to tolerate GLP-1 RA and/or SGLT2i, choose agents demonstrating CV safety:

- For patients on a GLP-1 RA, consider adding SGLT2i with proven CVD benefit¹
- DPP-4i if not on GLP-1 RA
- Basal insulin⁴
- TZD⁵
- SU⁶

HF OR CKD PREDOMINATES

- Particularly HF² (LVEF $<45\%$)
- CKD: Specifically eGFR 30-60 mL/min/1.73 m² or UACR >30 mg/g, particularly UACR >300 mg/g

PREFERABLY

SGLT2i with evidence of reducing HF and/or CKD progression in CVDs if eGFR adequate³

OR
If SGLT2i not tolerated or contraindicated or if eGFR less than adequate³ add GLP-1 RA with proven CVD benefit¹

If A1C above target

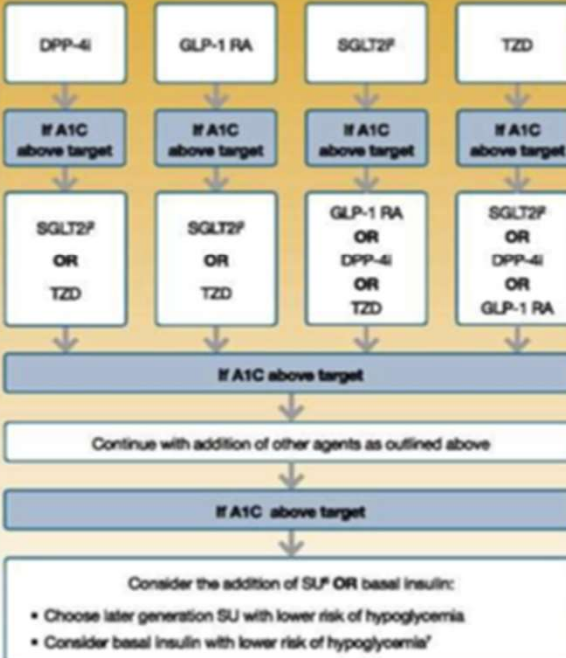
• Avoid TZD in the setting of HF
Choose agents demonstrating CV safety:

- For patients on a SGLT2i, consider adding GLP-1 RA with proven CVD benefit¹
- DPP-4i (not saxagliptin) in the setting of HF (if not on GLP-1 RA)
- Basal insulin⁴
- SU⁶

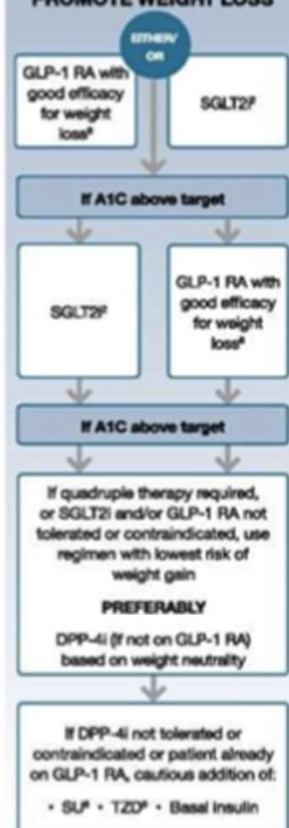
NO

IF A1C ABOVE INDIVIDUALIZED TARGET PROCEED AS BELOW

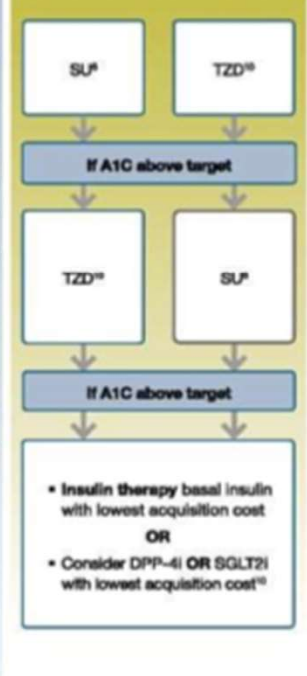
COMPELLING NEED TO MINIMIZE HYPOGLYCEMIA



COMPELLING NEED TO MINIMIZE WEIGHT GAIN OR PROMOTE WEIGHT LOSS



COST IS A MAJOR ISSUE^{9,10}



1. Proven CVD benefit means it has label indication of reducing CVD events
2. Be aware that SGLT2i labeling varies by region and individual agent with regard to indicated level of eGFR for initiation and continued use
3. Empagliflozin, canagliflozin and dapagliflozin have shown reduction in HF and to reduce CKD progression in CVDs. Canagliflozin has primary renal outcome data from CREDENCE. Dapagliflozin has primary heart failure outcome data from DAPA-HF
4. Degludec or U100 glargine have demonstrated CVD safety
5. Low dose may be better tolerated though less well studied for CVD effects

6. Choose later generation SU to lower risk of hypoglycemia, Glimepiride has shown similar CV safety to DPP-4i
7. Degludec / glargine U300 < glargine U100 / detemir < NPH insulin
8. Semaglutide > liraglutide > dulaglutide > exenatide > lisdexamfetamine
9. If no specific comorbidities (i.e. no established CVD, low risk of hypoglycemia and lower priority to avoid weight gain or no weight-related comorbidities)
10. Consider country- and region-specific cost of drugs. In some countries TZDs relatively more expensive and DPP-4i relatively cheaper

† Acted on whenever these become new clinical considerations regardless of background glucose-lowering medications.

LVH = Left Ventricular Hypertrophy; HF² = Heart Failure reduced Ejection Fraction
UACR = Urine Albumin-to-Creatinine Ratio; LVEF = Left Ventricular Ejection Fraction

Where You Going?



Lifestyle Management?

What is Lifestyle Management?

- Fundamental aspect of diabetes care
 - Diabetes self-management education and support (DSMES)
- Medical nutrition therapy (MNT)
- Physical activity
- Smoking cessation counseling
- Psychosocial care: Diabetes Distress?

Help Is On The Way



Definitions

Diabetes Self-management Education (DSME)*

The process of facilitating the knowledge, skill, and ability necessary for diabetes self-care

Diabetes Self-management Support (DSMS)*

Support required for implementing and sustaining coping skills and behaviors needed to self-manage on an ongoing basis

Medical Nutrition Therapy (MNT)

Application of nutrition care process; includes individualized nutrition assessment, nutrition diagnosis, intervention and monitoring and evaluation; if not included in DSME program, refer to RDN

* CMS/Medicare uses DSMT – Diabetes Self-Management Training

Diabetes Self Management Education and Support

Why?

What

?

Who?

Where?

How?

When?

**Tools
you
can use**

Under-utilized



ONLY



Of **MEDICARE** beneficiaries with newly diagnosed diabetes used DSMT services¹

ONLY



Of individuals with newly diagnosed T2D with **PRIVATE HEALTH** insurance received DSMES within 12 months of diagnosis²

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

AAPA Supports DSMES

Diabetes Self-management Education and Support in Adults With Type 2 Diabetes: A Consensus Report of the American Diabetes Association, the Association of Diabetes Care and Education Specialists, the Academy of Nutrition and Dietetics, the American Academy of Family Physicians, the American Academy of PAs, the American Association of Nurse Practitioners, and the American Pharmacists Association

Diabetes Care 2020;43:1–14 | <https://doi.org/10.2337/dci20-0023>



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Sacha Uelman¹²*

What Are The Barriers to DSME?



Patient Factors

- Readiness
- Other medical concerns
- Time
- Finances/cost
- Literacy/numeracy
- Culture/language
- Educational background
- Competing priorities



Provider & System Factors

- Providers not convinced of benefit
- Make assumptions – not needed
- Time
- Location / access
- Insurance /billing

Why? Evidence for the Benefits of DSME

Improves

Knowledge and behavior

...

Clinical outcomes (HbA1c, weight)

Quality of life & healthy coping

Cost

Improvements enhanced when...

DSME is longer duration

Follow-up support is given (“Diabetes Self-Management Support” / DSMS)

Is individualized (age, culturally appropriate, etc.)

Change in HbA1c by Mode of DSME/S Delivery

Does DSME/S improve HbA1c in T2D adults as compared with those who received usual care (and no DSME)?

References: Chrvala et al. Pt Ed & Counselling 2016;99:926-943

Patient Education and Counseling 99 (2016) 926–943

Contents lists available at ScienceDirect

Patient Education and Counseling

journal homepage: www.elsevier.com/locate/pateducou

ELSEVIER

PEC

Review article

Diabetes self-management education for adults with type 2 diabetes mellitus: A systematic review of the effect on glycemic control

Carole A. Chrvala^a, Dawn Sherr^{b,*}, Ruth D. Lipman^b

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^bAmerican Association of Diabetes Educators, 200 W. Madison Street, Chicago, IL 60606, USA

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ARTICLE INFO

ABSTRACT

Article history:
Received 8 May 2015
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Accepted 5 November 2015

Keywords:
Type 2 diabetes
Diabetes self-management education
Glycemic

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Results: This review included 118 unique interventions, with 61.9% reporting significant changes in A1C. Overall mean reduction in A1C was 0.74 and 0.17 for intervention and control groups; an average absolute reduction in A1C of 0.57. A combination of group and individual engagement results in the largest

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A1c Improvements with DSMES

Mode	Interventions (#)	Intervention (SD)	Control (SD)	<u>Absolute difference in A1C with DSME added</u>
<i>All Models Together</i>	118	-0.74(0.63)	-0.17(0.5)	0.57
Combo (group & indiv.)	22	-1.0(0.6)	-0.22(0.62)	0.88
Group	33	-0.62(0.46)	-0.10(0.42)	0.52
Individual	47	-0.78(0.63)	-0.28(0.46)	0.50
Remote	12	-0.50(0.67)	-0.17(0.46)	0.33

If DSMES were a pill, would you prescribe it?



If DSME was a pill, would you Rx it? ^{1, 2}

Benefits of DSMES

Efficacy.....High
Hypo Risk.....Low
Weight.....Neutral / Loss
Side Effects.....None
Costs.....Low/Savings
Psychosocial benefits..High

Benefits of Metformin

Efficacy.....High
Hypo Risk.....Low
Weight.....Neutral / Loss
Side Effects.....GI
Costs.....Low
Psychosocial benefits.....NA

An individualized MNT program is recommended for all people with diabetes as an effective component of the overall treatment plan
All PWD should participate in DSMES both at diagnosis and as needed

ADA: Standards Guide Diabetes Education - 2023

Facilitating Positive Health Behaviors and Well-being to Improve Health Outcomes: Standards of Care in Diabetes—2023

Nuha A. ElSayed, Grazia Aleppo, Vanita R. Aroda, Raveendhara R. Bannuru, Florence M. Brown, Dennis Bruemmer, Billy S. Collins, Marisa E. Hilliard, Diana Isaacs, Eric L. Johnson, Scott Kahan, Kamlesh Khunti, Jose Leon, Sarah K. Lyons, Mary Lou Perry, Priya Prahalad, Richard E. Pratley, Jane Jeffrie Seley, Robert C. Stanton, Deborah Young-Hyman, and Robert A. Gabbay, on behalf of the American Diabetes Association

The “Standards”:

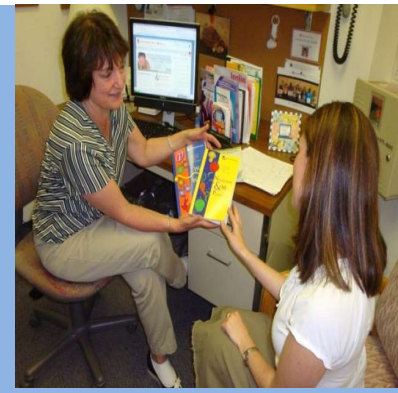
- Define *quality* for education programs
 - who* can teach
 - what is taught*
 - what is evaluated*
- Model for *reimbursement*
- New emphasis on prevention /pre-diabetes
- More focus on *ongoing support*

Standards Guide Diabetes Education - 2023

Building positive health behaviors and maintaining psychological well-being are foundational for achieving diabetes treatment goals and maximizing quality of life.

Essential to achieving these goals are diabetes self-management education and support (DSMES), medical nutrition therapy (MNT), routine physical activity, tobacco cessation counseling when needed, health behavior counseling, and psychosocial care.

Who? Delivery of DSMES



- Medical care providers: MD/DO, NPs, PAs
- Diabetes educators (RN, RDN, Pharmacist),
Advanced certificates (CDCES, BC-ADM)
- Peer counselors; community health workers
- Care managers
- “Diabetes champions” – in medical care practices

Where? How do you find DSME/S?

Individual care providers

- RDN: www.eatright.org
- Diabetes educator: www.diabeteseducator.org
- CDCES: www.ncbde.org

Recognized or accredited education programs

- **ADA Recognized** program:
<https://diabetes.org/tools-support/diabetes-education-program>
- **AADE Accredited** program:
www.diabeteseducator.org/deap

Check This Out

- <https://www.diabeteseducator.org/living-with-diabetes/find-an-education-program>



How? A Patient-Centered Approach

How is diabetes affecting your daily life and that of your family?

What questions do you have?

What is the hardest part right now about your diabetes, causing you the most concern or most worrisome to you about your diabetes?

How can we best help you?

What is one thing you are doing or can do to better manage your diabetes?

When? 4 Critical Times to Provide DSME/S

Diabetes Self-Management Education and Support for Adults with Type 2 Diabetes: **ALGORITHM of CARE**

ADA Standards of Medical Care in Diabetes recommends all patients be assessed and referred for:



FOUR CRITICAL TIMES TO ASSESS, PROVIDE, AND ADJUST DIABETES SELF-MANAGEMENT EDUCATION AND SUPPORT

1 AT DIAGNOSIS

2 ANNUAL ASSESSMENT OF EDUCATION, NUTRITION, AND EMOTIONAL NEEDS

3 WHEN NEW **COMPLICATING FACTORS** INFLUENCE SELF-MANAGEMENT

4 WHEN **TRANSITIONS IN CARE** OCCUR

1

AT DIAGNOSIS

- Newly diagnosed. All newly diagnosed individuals with type 2 diabetes should receive DSME/S
- Ensure that both nutrition and emotional health are appropriately addressed in education or make separate referrals

2

ANNUAL ASSESSMENT OF EDUCATION, NUTRITION, AND EMOTIONAL NEEDS

- Needs review of knowledge, skills, and behaviors
- Long-standing diabetes with limited prior education
- Change in medication, activity, or nutritional intake
- HbA_{1c} out of target
- Maintain positive health outcomes
- Unexplained hypoglycemia or hyperglycemia
- Planning pregnancy or pregnant
- For support to attain or sustain behavior change(s)
- Weight or other nutrition concerns
- New life situations and competing demands



WHEN NEW
**COMPLICATING
FACTORS** INFLUENCE
SELF-MANAGEMENT

CHANGE IN:

- Health conditions such as renal disease and stroke, need for steroid or complicated medication regimen
- Physical limitations such as visual impairment, dexterity issues, movement restrictions
- Emotional factors such as anxiety and clinical depression
- Basic living needs such as access to food, financial limitations



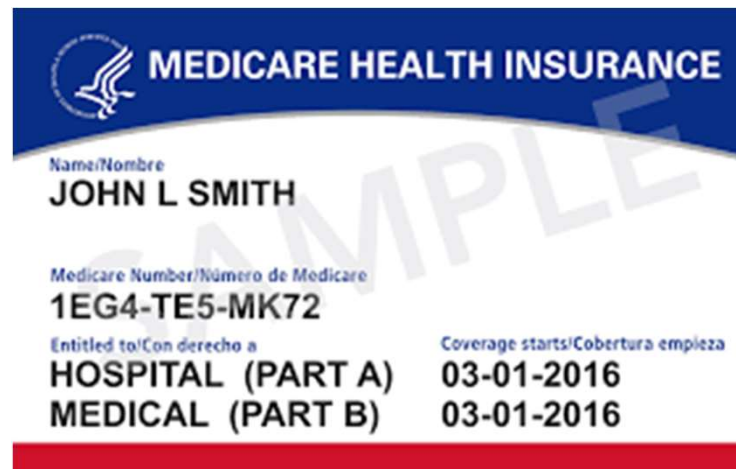
WHEN
**TRANSITIONS IN
CARE** OCCUR

CHANGE IN:

- Living situation such as inpatient or outpatient rehabilitation or now living alone
- Medical care team
- Insurance coverage that results in treatment change
- Age-related changes affecting cognition, self-care, etc.

DSMT Benefit verification

- 10 hours of initial training (once under Medicare)
 - 1 hour of DSMES can be individual session for assessment and/or insulin injection training.
 - 9 hours must be in group setting unless
 - Barriers to group learning are identified in referral
 - No group classes available for 2 months or more
- 2 hours of follow-up available annually starting year 2 with referral and can be individual or group session



Medicare Referral Requirements

Signed by provider overseeing diabetes care:

MD/DO, PA, NP, APRN

of hours

Topics ordered

Group or 1:1 training

If 1:1- special needs

DSMES service must maintain a record of the original referral order

If changed, the signature of referring provider required

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 (MNT) 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, plus 2 hours follow-up per calendar year with written referral from the treating qualified provider each 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 maintain documentation of a diagnosis of diabetes based on 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: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> _____					
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 one hour individual initial training requested, please check special needs that apply:
 - Vision Physical
 - Hearing No group sessions available within 2 months
 - Language
 - Cognitive Other (specify) _____

All content areas identified by DSMES Team on assessment 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

Medical Nutrition Therapy (MNT)

Check the type of MNT requested

- Initial MNT 3 hours Additional MNT hours for change in:
- Annual follow-up MNT 2 hours medical condition treatment diagnosis.

Signature of qualified provider certifies that he or she is managing the beneficiary's diabetes care.

Signature and NPI # _____ Date ____/____/____
Group/practice name, address and phone: _____

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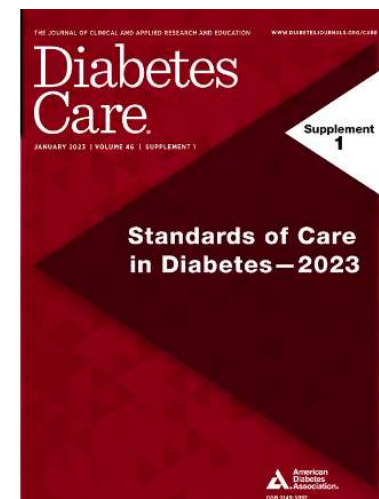
DSMT Referral order specifics

Obtain properly executed initial DSMT referral from physician (MD/DO) or qualified non-physician provider (NP, PA, APRN)

- Must be Medicare provider or in opt out status
- Must be treating beneficiary's diabetes

Medicare Definition of Diabetes Diagnosis

- Fasting blood sugar greater than or equal to 126 mg/dL on **two** different occasions
- Two-hour post glucose challenge greater than or equal to 200 mg/dL on **two** different occasions
- Random glucose test over 200 mg/dL on **one** occasion for a person with **symptoms** of uncontrolled diabetes
 - **Symptom examples:** Excessive thirst, excessive urination, excessive hunger, excessive fatigue, blurred vision, unintentional weight loss, non-healing cuts/wounds
- **What don't you see on this list? A1c**



Key Points

- Create a 2 way street
- Figure out your own biases/blockades
- You cannot do it all
- Find and utilize available resources; they are likely out there
- Promote empowerment
- Refresh your screen!

Post-Test Question #1



Your primary care practice cares for a large number of persons with diabetes (PWD). You have recently heard about Diabetes Self-Management Education and Support (DSMES) services and wonder which times are considered critical times to refer your patient for this type of service. Which of the following are these times?

1. At diagnosis
2. Annually
3. When complications arise
4. When transitions of care take place
5. All of the above situations

Post-Test Question #2



You have just referred your patient with type 2 diabetes for Diabetes Self-Management Education and Support (DSMES). Which of the following outcomes would you expect based on their completion of this program?

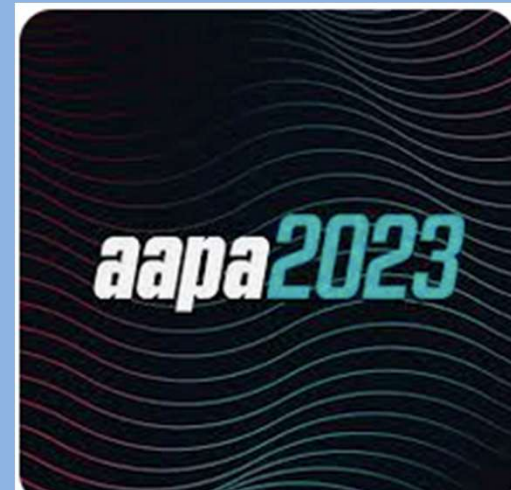
1. Increased hospital admission
2. Increased patient confusion about their diabetes
3. Improved quality of life & coping
4. No appreciable change in HbA1c

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

Nelson Mandela

***"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



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