Diabetes Self-Management Education and Support (DSMES) Technical Assistance Guide

The following tool is designed to assist state health departments and their partners in planning and implementing activities to increase use of DSMES programs, focusing on access, health care provider referrals, and reimbursement. The tool identifies four key drivers integral to this work: 1) DSMES programs, 2) payers and payment mechanisms, 3) referral policies and practices in health care systems, and 4) willingness of people with diabetes to participate in DSMES programs. These drivers represent the necessary elements for successful implementation and spread of DSMES. Each key driver includes information on assessing current conditions/gaps in DSMES services, activities to address the needs or gaps identified, facilitating factors, and barriers/risks. The bulleted items below provide some additional guidance and definitions to help in using the tool.

How to use the guide (see definitions below):

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

Definitions:

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

Current Gaps/Needs: Current conditions that potentially require intervention

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

Activities: Potential activities to address identified gaps/needs

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

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

*Note: This driver diagram is focused specifically on work with the American Diabetes Association (ADA)-recognized and the American Association of Diabetes Educators (AADE)-accredited DSMES programs (primary or satellite sites). These programs meet national quality standards and are more likely to be sustained long term.

	Key drivers (necessary elements for a successful intervention)			
	DSMES Programs ("programs"): ADA-recognized, AADE-accredited DSMES programs (primary or satellite sites)	***Payers and payment mechanisms: Public and private insurance coverage of DSMES***	***Referral policies and practices in health care systems: Policies and practices in place within the health care system to connect people with diabetes (PWD) to DSMES programs***	***Willingness of PWD to participate in DSMES programs: Awareness, capacity, and willingness of PWD to participate in DSMES programs when other drivers are in place***
Current Gaps/Needs *(Current conditions that potentially require intervention)*	□ Limited number of programs in the state relative to burden □ Low % of counties or health service areas with programs □ Limited number of programs with ADA recognition/AADE accreditation; remote areas with limited DSMES access □ State accredited programs not meeting *National Standards for Diabetes Self-Management Education and Support* □ High program turnover	□ No or limited Medicaid coverage □ No or limited state/public employee coverage □ Limited coverage by some private insurers □ Low reimbursement rates □ High copays or coinsurance □ Coverage not promoted well	□ Limited provider referrals to DSMES programs □ Referral form/process and paperwork burdensome for some providers □ Low DSMES participation rates relative to incidence and prevalence of PWD with A1c>9 in the general population or specific populations □ Providers lacking current clinical information/skills necessary for managing diabetes □ Providers lacking knowledge/information about the benefits of DSMES, locations of ADA-recognized/AADE-accredited DSMES programs, or referral processes	□ Low participation rates among insured PWD (general population or specific population[s] with a high burden of diabetes) □ DSMES coverage not adequately promoted to PWD □ Importance of DSMES as a necessary step to manage diabetes not adequately communicated to PWD □ Low awareness of availability and need for DSMES among PWD, particularly until they develop complications and/or change therapy (e.g., go on insulin) □ Poor cultural tailoring of effective programs to PWD
Assessment Data *(Potential data sources to assess and identify current gaps and needs)*	□ Locations of ADA-recognized, AADE-accredited program sites and other programs □ Data on diabetes burden/poor diabetes control (BRFSS, health care system data) □ Standards used for state-accredited programs	□ Status of Medicaid/Medicaid Managed Care Organization (MCO) coverage and coverage details □ Status of state/public employee coverage and coverage details □ Status of mandate for private insurance coverage for DSMES (applies to 46 states and District of Columbia [2016]	□ Data/information on DSMES referrals (rates, sources, barriers, etc.) from DSMES program providers, all-payer claims data, private insurers, state/public employee claims data, Medicaid claims, etc. (Supporting Activity: Determine availability of staff or partners to access and analyze claims data) □ Number and location of health care systems/practices using electronic health records (EHRs) that track referrals	□ DSMES program participation data (e.g., program utilization rates, barriers to access, source[s] of patient referrals, etc.) □ BRFSS data on diabetes education □ Locations of ADA-recognized, AADE-accredited program sites

		http://www.ncsl.org/research/health/diabetes-health-coverage-state-laws-and-programs.aspx), □ Status of private insurance DSMES utilization rates		□ Data on diabetes burden/poor diabetes control (BRFSS, health care system data)
Activities (*Potential Activities to address "Identified Gaps/Needs")*	□ Convene and/or survey key stakeholders (program providers, employers, payers, health care system representatives, etc.) to identify and address gaps in program availability and sustainability □ Provide support (e.g., link to recognition/ accreditation resources or access to consultants or other DSMES sites that can offer guidance or mentor) health care systems (federally qualified health centers [FQHCs]/community health centers [CHCs], local health departments [LHDs] and other safety net organizations serving vulnerable, high risk populations) to establish new ADA-recognized/AADE-accredited DSMES programs □ Provide support to existing DSMES programs to assist them in obtaining ADA-recognition/AADE-accreditation □ Obtain a statewide umbrella license from the ADA or AADE for the state Department of Health to facilitate expansion of recognized/accredited	□ Convene key stakeholders (program providers, employers, payers, health care system representatives, etc.) to identify and address gaps in coverage □ Clarify status/extent of Medicaid/MCO DSMES coverage □ Clarify statutory requirements for DSMES coverage by private insurers (applies to 46 states and District of Columbia with insurance mandates for diabetes treatment [2016] http://www.ncsl.org/research/health/diabetes-health-coverage-state-laws-and-programs.aspx), Medicaid, and state/public employees, if applicable □ Share information on group visit models with bundled services with health care providers/staff and DSMES program providers to maximize reimbursement □ Provide technical assistance to DSMES program providers on appropriate billing practices to maximize reimbursement □ Work with state/public employee health plans and the State Medicaid Agency to extend coverage where needed □ Work with established DSMES programs to consider additional services that may be offered (e.g., Medical Nutrition Therapy, Medication Therapy Management, National Diabetes Prevention Program lifestyle change program) where it makes sense to supplement program income	□ Convene key stakeholders (program providers, employers, payers, health care system representatives, etc.) to identify and address barriers to referrals □ Use targeted marketing/social media approaches to reach providers/health care systems (e.g., CDC 1,2,3 Approach to Provider Outreach (http://www.cdc.gov/arthritis/marketing-support/1-2-3-approach/) □ Provide technical assistance/training or engage in academic detailing to increase DSMES referrals (Use AADE materials on communicating information on DSMES benefits, making referrals, and working with diabetes educators: (https://www.diabeteseducator.org/practice/provider-resources/) □ Build EHR-generated or other systems to facilitate and track referrals and enhance decision support □ Integrate DSMES programs/referrals into coordinated care (e.g., Patient-Centered Medical Homes) □ Work with MCOs to integrate DSMES into performance improvement plans/programs □ Integrate referral to DSMES with other disease clinics (e.g., tuberculosis) □ Implement systems and increase partnerships to facilitate bi-directional referral between community resources and health care systems (e.g., 800 numbers, 211 referral systems, etc.) □ Develop cross-referral systems for PWD between community programs (e.g., Chronic Disease Self-Management Programs	□ Convene key stakeholders (program providers, employers, payers, health system representatives, etc.) to identify and address barriers to DSMES access □ Link organizations and government agencies serving PWD to health care systems with DSMES programs □ Promote *STOP Diabetes At Work* campaign http://www.diabetes.org/in-my-community/awareness-programs/stop-diabetes-at-work/ □ Use Community Health Workers to link PWD to DSMES programs and to assist as part of the team in delivering DSMES □ Integrate DSMES into Patient-Centered Medical Homes □ Issue grants/scholarships to community organizations to help increase use of DSMES by high-risk populations □ Promote alternative locations for delivery of DSMES that are appealing to both patients and referring providers (e.g.,

	DSMES programs throughout the state □ Work with established DSMES programs to improve sustainability (e.g., explore compatible revenue streams [Medical Nutrition Therapy, Medication Therapy Management, National Diabetes Prevention Program lifestyle change program]; see also Payer/Payment Mechanism driver activities) □ Promote alternative locations for delivery of DSMES that are appealing to both patients and referring providers (e.g., telehealth, pharmacies, churches, community centers, etc.) □ Convert state accredited programs to ADA-recognized or AADE-accredited programs if they are not meeting the national standards □ Use pharmacists/pharmacies to expand access to DSMES		[CDSMP], Tobacco Quitlines, etc.) and recognized/accredited DSMES programs □ Add DSMES referral/attendance to pay-for-performance models	telehealth, pharmacies, churches, community centers, etc.) □ Use strategic communication approaches to reach PWD about the importance of DSMES and DSMES benefits/coverage (e.g., DSMES waiting room triggers)
Facilitators (Individuals, conditions, etc. that support the establishment or improvement of a key driver)	□ Established partnerships with key organizations that also have a stake in expanding access to, participation in, and reimbursement for DSMES □ Identify DSMES champions, particularly among health care	□ Established partnerships with key organizations that also have a stake in expanding access to, participation in, and reimbursement for DSMES □ Identify DSMES champions, particularly among payers (e.g., State Medicaid, private insurers)	□ Established partnerships with key organizations that also have a stake in expanding access to, participation in, and reimbursement for DSMES □ Identify DSMES champions, particularly among health care providers (e.g., family practice physician, endocrinologist)	□ Established partnerships with key organizations that also have a stake in expanding access to, participation in, and reimbursement for DSMES □ Identify DSMES champions, particularly among health care

	providers, diabetes educators □ Include increasing availability of DSMES programs as a priority in the State Diabetes or Chronic Disease Plan	□ Include expanding coverage for DSMES as a priority in the State Diabetes or Chronic Disease Plan	□ Include increasing provider referrals to DSMES as a priority in the State Diabetes or Chronic Disease Plan	providers, PWD (customer testimonial for DSMES) □ Include promoting participation in DSMES as a priority in the State Diabetes or Chronic Disease Plan
Barriers/ Risks (*Individuals, conditions, etc. that hinder the establishment or improvement of a key driver*)	□ Difficulty attaining/maintaining adequate patient volume (e.g. rural populations) □ Limited clinical professionals in the area (e.g., Health Professional Shortage Areas [HPSAs]/Medically Underserved Populations [MUPs]) □ High percentage of uninsured populations □ Administrative/resource challenges associated with starting up and maintaining an ADA-recognized or AADE-accredited DSMES program □ Limited reimbursement, contributing to challenges in program sustainability □ Limited resources for administrative and marketing activities □ Lack of support for DSMES among health care system administrators or health care providers □ Unknowns associated with the impact of health care reform	□ Inconsistent operational definitions of DSMES □ Limited coverage for DSMES; lack of Medicaid expansion in some states, which could impact the ability to offer DSMES as a covered benefit for Medicaid beneficiaries with diabetes □ Medicare beneficiaries not fully utilizing DSMES benefits (only 12 months available to use the initial 10 visits of Medicare-funded DSMES after referral) □ Medicare denial of coverage for DSMES when other Medicare services are offered at non-Medicare rates	□ Limited coverage for DSMES □ Limited awareness of DSMES benefits among providers □ Lack of knowledge of how/where to refer patients □ Difficulty accessing claims data for assessment □ Difficulty capturing referral data □ Lack of relationships between hospitals and community DSMES programs (Many hospitals provide initial education.) □ Potential instability of DSMES programs receiving referrals	□ Limited programs with language/cultural-specific curricula/appropriate staff □ Prohibitive cost/co-pays □ Inconvenient hours □ Inconvenient and/or undesirable locations □ Limited awareness of DSMES benefits among PWD □ Competing demands for time and attention, particularly among populations with limited income/resources □ Transportation and childcare issues, particularly among populations with limited income/resources □ Lack of reimbursement for Community Health Workers assisting with DSMES