Improving Community Outreach for Diabetes Self Management Education & Support

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Background

Sentara RMH Medical Center (SRMH) has had an established Diabetes Self-Management Education and Support (DSMES) program, recognized by the American Diabetes Association/Association of Diabetes Care and Education Specialists (ADA/ADCES) since 2006 for meeting National Standards for Diabetes Self-Management Education.

A Patient-Centered Medial Home (PCMH) is best described as a model or philosophy of primary care that is patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety. It is a model for achieving primary care excellence so that care is received in the right place, at the right time, at the right cost and in the manner that best suits a patient's needs.

Diabetes care has long been aligned with the key principles of both the PCMH and the Chronic Care Model, with early recognition of the importance of patient-centered care, self-management, patient empowerment, and team-based care as keys to optimal diabetes care.

Diabetes self-management is a benefit covered by Medicare and most health plans when provided by a diabetes care and education specialist within an accredited/recognized program .

In 2013 SRMH began exploring the role of diabetes care and education specialists in community clinic settings.

Statement of Problem

National research has shown
- fewer than 60 percent of people with diabetes have had any formal diabetes education
- less than 53% of people with diabetes have safe A1C values (less than 7%)
- A1C values within safe limits greatly decrease diabetes complications, the person feels better and enjoys a more productive life

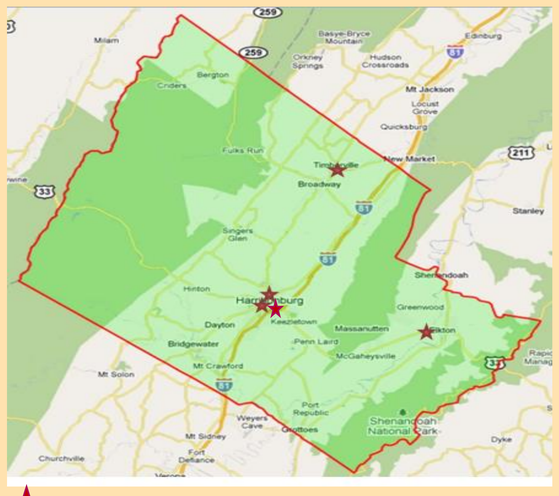
Healthy People 2020 and 2030 have made increasing the number of people receiving diabetes education a priority.

Research also shows people who have received diabetes education are more likely to:
- use primary care and preventive services
- take medications as prescribed
- control their blood glucose, blood pressure, cholesterol levels
- have lower health costs

Methodology

- Clinic physicians requested onsite DSMES
- An office was dedicated for DSMES in the primary care clinics with the Certified Diabetes Care and Education Specialist (CDCES) becoming a “provider” in the clinics
- Chronic Care Mangers at the clinic became an integral part of the team
  - recruiting for diabetes education
  - scheduling the patients or “making the sell”
  - assisting with follow up of comorbidities
- Office staff provided support for administrative duties: scheduling, reminder calls, etc.
- Program began as ½ day each week at one clinic then expanding to other clinics, eventually becoming multiple full days at various clinic sites.
- Services were brought to the people in the community—their familiar environment—and also gave a resource to the physicians for assisting in the care of diabetes.

Findings



DSMES Sites

Consults tripled in three years that education provided onsite at clinics.

In 2019 workload was saturated so additional staff, including a Community Health Worker, were added.

Results

A1C values decreased post visit and were sustained.

AL COUNT (or "n")	1600	779	1031	840	793	667	642	566	517
AVERAGES	9.06	7.95	7.80	7.87	7.78	7.91	7.78	7.91	8.03
	Pre-class	3-mo Post	6-mo Post	9-mo Post	12-mo Post	15-mo Post	18-mo Post	21-mo Post	24-mo Post

442	426	356	291	254	239	193	157
8.08	7.99	7.93	8.14	7.99	7.88	7.87	7.90
27-mo Post	30-mo Post	33-mo Post	36-mo Post	39-mo Post	42-mo Post	45-mo Post	48-mo Post

During 2018-2020, statistically (SRMH $p < 0.00001$) there were less ED visits and admissions for participants who attended SRMH DSMES as compared to those who do not attend.

Early in the pandemic telehealth was implemented to maintain services to this high-risk population.

In 2021 due to budget cuts three staff were let go, so appointments were limited.

Conclusions

•Patients are receiving diabetes education that otherwise would not have driven to the hospital setting
•A1C values consistently decreased, nearing safe glycemic target of 7% or lower
•No show rate is less than 10% at the clinics whereas it was ~30% at the hospital.
•Physicians are readily accessible for discussion of complex diabetes care.

•Medical practice changes have occurred:
- clinic physicians are increasingly changing/adding medication in a timelier fashion (following evidence-based practice) to promote improved glycemic control addressing clinical inertia
- hospitalists have also verbalized feeling more comfortable starting insulin in the hospital for clinic patients since they know these patients will have adequate follow up

•Diabetes Prevention Program has been added at sites
•In cost analysis, SRMH DSMES generates $4.17 in medical care cost-avoidance benefits for every $1 spent

Team Members

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