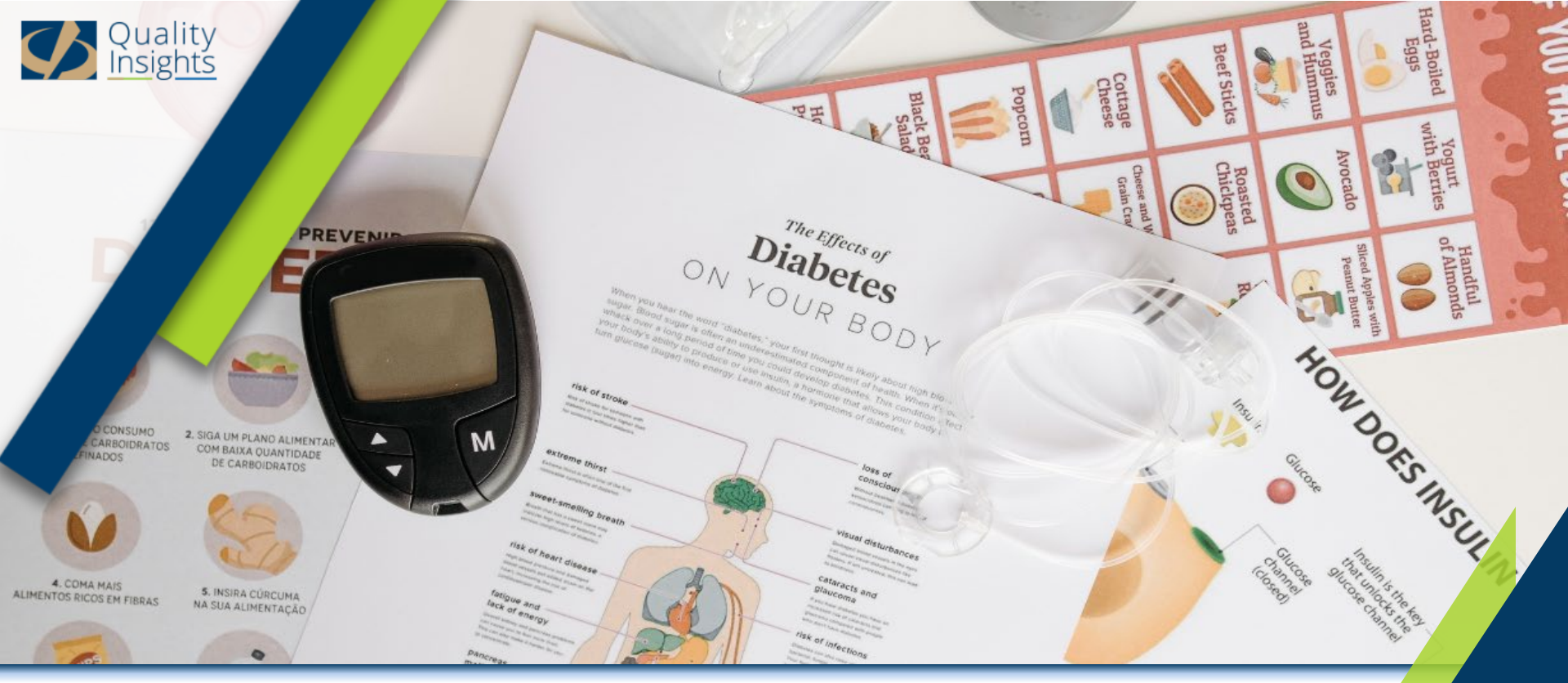
Quality Insights



Evidence-Based Opportunities to Improve Diabetes and Prediabetes Control and Prevention

None of the planners for this educational activity have relevant financial relationship(s) to disclose with ineligible companies whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

AmeriHealth Caritas Delaware

Quality Insights

MSD Medical Society of Delaware

Claiming CME Credit

Evidence-Based Opportunities to Improve Diabetes & Prediabetes Control and Prevention - Event Date: 5.15.24

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  Note… New User needs to set up account (one time process)
- **Confirm Attendance:** Complete Survey

Please ensure that you disable browser extensions or add-ons to ensure any third-party firewall that was set up on your device/network lets you through to the site.

Quality Insights Overview

- Non-profit organization focused on data-driven community solutions to improve health care quality in pursuit of better care, smarter spending, and healthier people.
- Change agent, trusted partner, and integrator of organizations collaborating to improve care.

Learning Objectives

- Participants will be able to describe the prevalence diabetes and prediabetes in Delaware.
- Participants will be able to identify at least two programs and/or resources available in Delawareans living with diabetes and prediabetes.
- Participants will be able to identify two ways in which health literacy can affect diabetes outcomes.

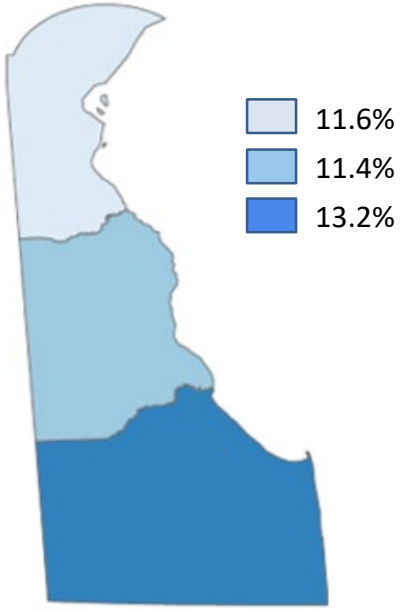
Quality Insights Presenter

Courtney Masterson, MHA, RDN/LDN
Practice Transformation Specialist
Quality Insights

Prediabetes Screen, Test, Refer

Quality Insights

Diabetes in Delaware



Source: DHSS, 2023.

Source: DHSS, 2023.

12%

of all DE adults who reported being **diagnosed with diabetes** in 2021

12.6%

of DE residents diagnosed with **prediabetes**

25,000

Estimated number of undiagnosed Delawareans living with diabetes

Source: DHSS, 2021; DHSS, 2023.

Prediabetes in Adults

Adults with prediabetes don't know they have it.

Source: CDC, n.d.

Who is at risk?

Who's at Risk for Prediabetes or Type 2 Diabetes?

You could have prediabetes or type 2 diabetes and not know it – there often aren't symptoms. That's why it makes sense to know the risk factors:

35+ years old

Physically active less than 3 times/week

Family history of type 2 diabetes

High blood pressure

History of gestational diabetes*

Overweight

Having Polycystic Ovary Syndrome

*Diabetes during pregnancy. Giving birth to a baby weighing 9+ pounds is also a risk factor.

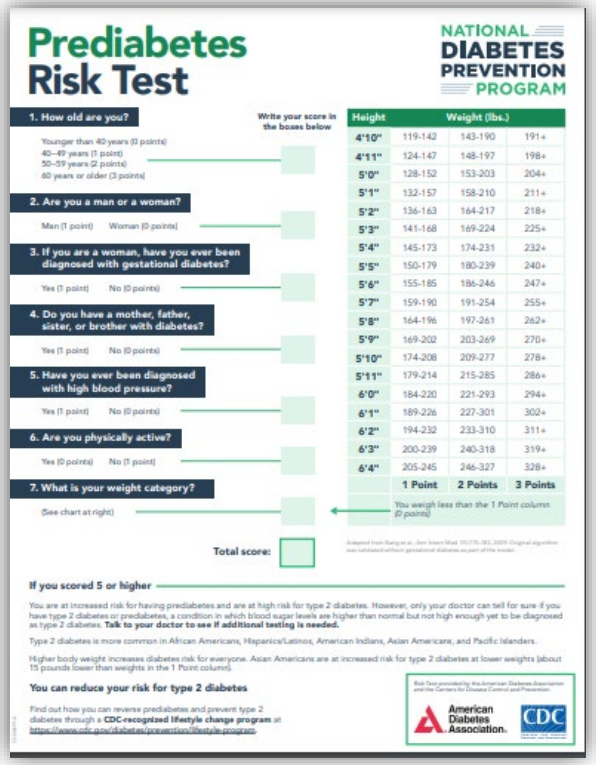
You're also at risk if you are an African American, Hispanic or Latino, American Indian, or Alaska Native person. Some Pacific Islander and Asian American people are also at higher risk.

Adapted from *Diabetes Risk Factors*, by CDC, 2022, *Prediabetes Risk Test*, by ADA & CDC, n.d., and "Standards of Care in Diabetes - 2023," by ElSayed et al., 2023.

ADA Screening Guidelines

- **All adults age 35+ should be tested.**
- Adults of any age who are OVERWEIGHT or OBESE and have one or more additional risk factors.
- People with prediabetes should be tested at least annually.
- Women with a history of gestational diabetes – test at least every three years, lifelong.
- If normal results, repeat at least every three years.

Source: ADA, 2021



Prediabetes Risk Test

NATIONAL DIABETES PREVENTION PROGRAM

1. How old are you? (Write your score in the boxes below)

Younger than 40 years (0 points)
40–49 years (1 point)
50–59 years (2 points)
60 years or older (3 points)

2. Are you a man or a woman?

Man (1 point) Woman (0 points)

3. If you are a woman, have you ever been diagnosed with gestational diabetes?

Yes (1 point) No (0 points)

4. Do you have a mother, father, sister, or brother with diabetes?

Yes (1 point) No (0 points)

5. Have you ever been diagnosed with high blood pressure?

Yes (1 point) No (0 points)

6. Are you physically active?

Yes (0 points) No (1 point)

7. What is your weight category?

(See chart at right)

Height	Weight (lbs.)		
4'10"	119-142	143-190	191+
4'11"	124-147	148-197	198+
5'0"	128-152	153-203	204+
5'1"	132-157	158-210	211+
5'2"	136-163	164-217	218+
5'3"	141-168	169-224	225+
5'4"	145-173	174-231	232+
5'5"	150-179	180-239	240+
5'6"	155-185	186-246	247+
5'7"	159-190	191-254	255+
5'8"	164-196	197-261	262+
5'9"	169-202	203-269	270+
5'10"	174-208	209-277	278+
5'11"	179-214	215-285	286+
6'0"	184-220	221-293	294+
6'1"	189-226	227-301	302+
6'2"	194-232	233-310	311+
6'3"	200-239	240-318	319+
6'4"	205-245	246-327	328+
	1 Point	2 Points	3 Points

You weigh less than the 1 Point column (0 points)

Total score:

If you scored 5 or higher

You are at increased risk for having prediabetes and are at high risk for type 2 diabetes. However, only your doctor can tell for sure if you have type 2 diabetes or prediabetes, a condition in which blood sugar levels are higher than normal but not high enough yet to be diagnosed as type 2 diabetes. **Talk to your doctor to see if additional testing is needed.**

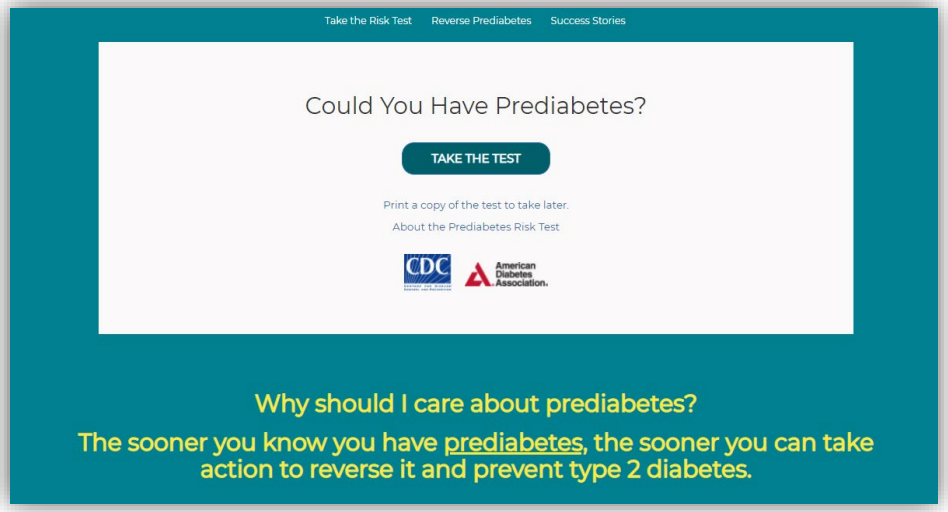
Type 2 diabetes is more common in African Americans, Hispanics/Latinos, American Indians, Asian Americans, and Pacific Islanders.

Higher body weight increases diabetes risk for everyone. Asian Americans are at increased risk for type 2 diabetes at lower weights (about 15 pounds lower than weights in the 1 Point column).

You can reduce your risk for type 2 diabetes

Find out how you can reverse prediabetes and prevent type 2 diabetes through a **CDC-recognized lifestyle change program** at https://www.cdc.gov/diabetes/prevention/lifestyle-program.

American Diabetes Association. CDC



Source: ADA & CDC, n.d.

Access the online test here:
https://www.cdc.gov/prediabetes/takethetest/

The Prediabetes Conversation

Areas to Emphasize	Points to Remember
Use the term “prediabetes.”	Avoid terms such as “borderline diabetes,” “sugar is a little high,” “touch of sugar,” etc.
Ask for questions, concerns, and feelings.	Patients may have different reactions and levels of understanding.
Emphasize the importance of taking action to prevent developing type 2 diabetes.	Talk in terms of an opportunity to address the condition. Don’t tell patients it’s just something “to keep an eye on” or monitor.
Discuss the strong chance to prevent or delay with modest weight loss, being more active, and taking medication as needed.	Be realistic about the challenges of lifestyle change, but communicate confidence and support patient self-efficacy.
Refer to the National Diabetes Prevention Program (National DPP) or other recognized lifestyle change program.	Give patients specific resources, behavioral strategies, support, and follow-up.

Leveraging Data for Outreach and Referral

- Prediabetes ICD-10 code: **R73.03**
- Patients who have a lab test confirmed diagnosis of prediabetes should have the above ICD-10 code added to their medical record.
- Use of a diagnosis code can simplify monitoring individuals with prediabetes for future testing as well as referrals to lifestyle programs.

REFER: National DPP

- Evidence-based
- Cost-effective
- Reduces risk of progression to type 2 diabetes from 58-71%

Source: CDC, 2022

- AmeriHealth Caritas members can attend this program for free

Source: AmeriHealth Caritas, 2022

Source: *NDPP: Working Together to Prevent Type 2 Diabetes*, n.d.

Program Structure

- Classes conducted both in-person and virtually, depending on provider.
- Trained lifestyle coaches help members change their lifestyle by encouraging healthy eating, physical activity and other behavior modifications.
- Program structure: 25 one-hour sessions
  - 16 weekly core sessions
  - 3 bi-weekly sessions
  - Then 6 monthly sessions

Source: CDC, 2022

Qualifications

- To qualify for the National DPP, participants must meet the following criteria:
  - 18 years of age or older
  - Not pregnant
  - Overweight (BMI ≥ 25; BMI ≥ 23 for Asian individuals)
  - Not diagnosed with type 1 diabetes, type 2 diabetes, or ESRD
- And meet **ONE** of the these criteria:
  - Diagnosed within the last year with prediabetes via a qualifying blood test value
  - Previous diagnosis of gestational diabetes
  - Qualifying risk score as determined by the CDC's Prediabetes Risk Test

Source: CDC, 2022

Program Availability in Delaware

- YMCA of Delaware
  - Contracted with multiple insurers
  - Offers in-person and distance learning
  - Available in Spanish & English
  - Ways to refer:
    - Program phone number: **302-572-9622**
    - YMCA website and the Unite US platform

Program Availability in Delaware

- Focus Pharmacy
  - Contracted with multiple insurers
  - Started the first cohort in April 2023
  - Offered in-person only
  - Program phone number: **302-471-3046**
  - Patients can be referred by fax at **302-508-2275**

Program Availability in Delaware

- Beebe Healthcare
  - Contracted with multiple insurers.
  - Started the first cohort in June 2023.
  - Offered in-person only.
  - Program phone number:

    302-645-3100, ext. 70601

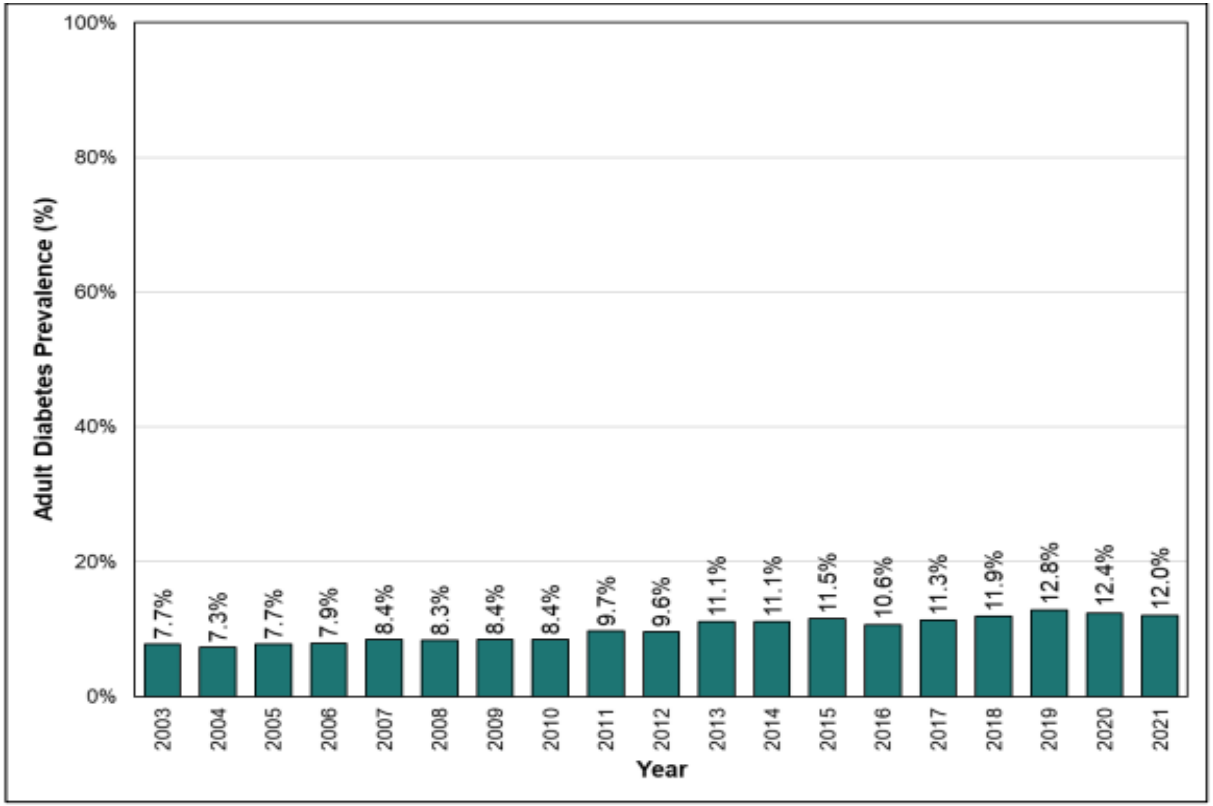
Prediabetes Resources

- CDC's Prediabetes Risk Test
- An Hour a Week
- YMCA National DPP Video

Diabetes and Self-Management

Quality Insights

Diabetes Rates are Stabilizing



Source: Delaware Department of Health and Social Services, Division of Public Health, Behavioral Risk Factor Survey, 2003-2021

From *The Impact of Diabetes in Delaware, 2023*

Costs of Diabetes

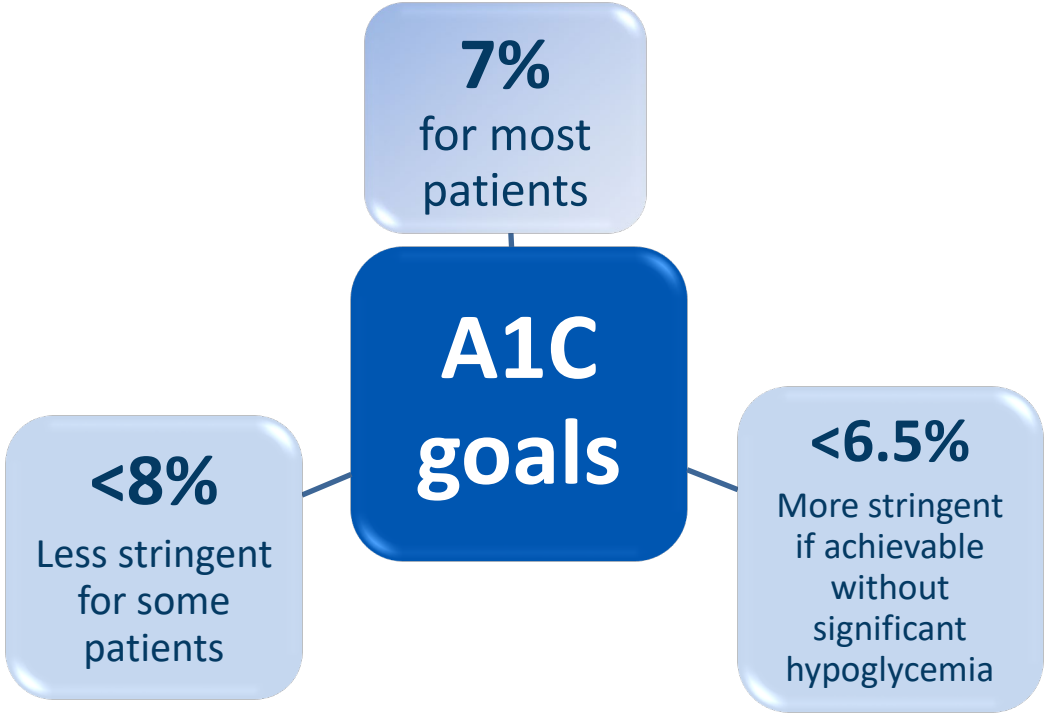
- **$327 billion** in U.S.
- **$1.1 billion** in DE
- **$818 million** in direct medical expenses
- **8th** leading cause of death in Delaware

Source: DHSS, 2021

Source: American Diabetes Association, 2017

A1C:
Educate
Collaborate
Monitor

Test Frequency	Patient Status
Twice/year	Meeting targets; stable control
Quarterly	Changes in therapy
Quarterly	Not meeting targets



Source: ADA, 2022

Standards of Care in Diabetes 2024

- Recommendations:
  - All people with diabetes should participate in diabetes self-management education and support to facilitate understanding and mastery of their disease state.
  - The program should be person-centered and can be held in individual or group settings.
  - The program should address individual barriers.

Source: ADA, 2024

Referrals

- Diabetes Self-Management Education and Support (DSMES)
- Diabetes Self-Management Training (DSMT)
- Covered by AmeriHealth Caritas but does require a provider referral

Source: National Association of Chronic Disease Directors, 2019

New Castle DSMES Locations

- ChristianaCare - Living with Diabetes
  - In person & virtual options
  - Program phone number: **302-508-3983**
  - Program website

Kent DSMES Locations

- Bayhealth - Diabetes and You
  - Program options are available both in-person and virtually
  - Spanish translation available
  - Program phone number: **302-208-6218**
  - Program website

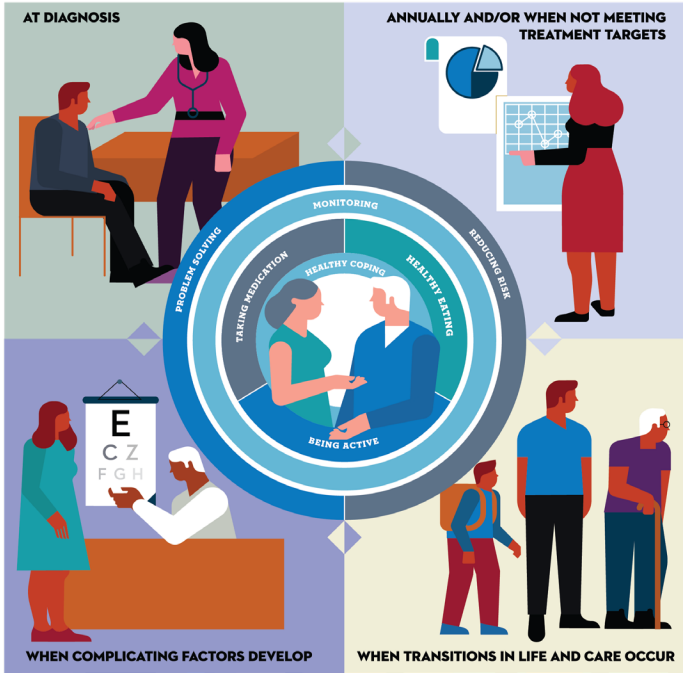
Sussex DSMES Locations

- Beebe Healthcare - Diabetes Management and Medical Nutrition Therapy (available in-person only)
  - Program phone number: **302-335-6631**
  - Program website
- I&O Diabetes Consultants
  - Program phone number: **302-514-1991**
  - Program website
- TidalHealth Nanticoke - Diabetes Connection
  - Program available in-person only
  - Program phone number: **302-517-1239**
  - Program website

When to Refer to DSMES

- All new diagnoses
- Self-care and management
- Medication, nutrition, etc.

- Related or unrelated to diabetes
- Recommend specialty referrals



Source: ADCES, 2020 DSMES Consensus Report

- Problem solving for dynamic needs
- Overcoming therapeutic inertia

- Addressing evolving health and life situations

Potential Benefits from DSMES

- Enhances self-efficacy and empowerment
- Increases healthy coping
- Decreases diabetes-related distress
- Promotes lifestyle behaviors including healthful meal planning and engagement in regular physical activity
- Improves quality of life
- Reduces all-cause mortality
- Lowers A1C
- No negative side effects

Adapted from *2020 DSMES Consensus Report* [PowerPoint Presentation], by Association of Diabetes Care & Education Specialists, 2020.

Diabetes Resources

- Delaware Diabetes Coalition Website
- Diabetes Self-Management Program
- Dining with Diabetes
- Improve Your Diabetes with Education
- Phone Apps to Help You Better Manage Your Diabetes
- The Delaware Emergency Medical Diabetes Fund

Diabetes Resources (cont.)

- New Castle County Health Care Resources
- Kent County Health Care Resources
- Sussex County Health Care Resources

Diabetes and Social Determinants of Health

Quality Insights

Social Determinants of Health (SDOH)

"In diabetes, understanding and mitigating the impact of SDOH are priorities due to disease prevalence, economic costs, and disproportionate population burden."

Source: Hill-Briggs et al., 2021

Diabetes Risk Breakdown

Race		
White	11.8%	Diabetes prevalence for Black Delawareans is significantly higher than for White Delawareans.
Black	17.5%	
Hispanic	10.6%	
Education		
< High School	20.0%	Diabetes prevalence for adults with less than a high school education is significantly higher than for those who are college graduates.
High School or GED	14.1%	
Some Post-High School	12.5%	
College Graduate	9.0%	
Household Income		
< $15,000	21.1%	Diabetes prevalence for adults with a household income of less than $15,000 is significantly higher than for those with a household income of $50,000 or more.
$15,000 - $24,999	15.0%	
$25,000 - $34,999	13.1%	
$35,000 - $49,999	15.5%	
≥ $50,000	10.2%	

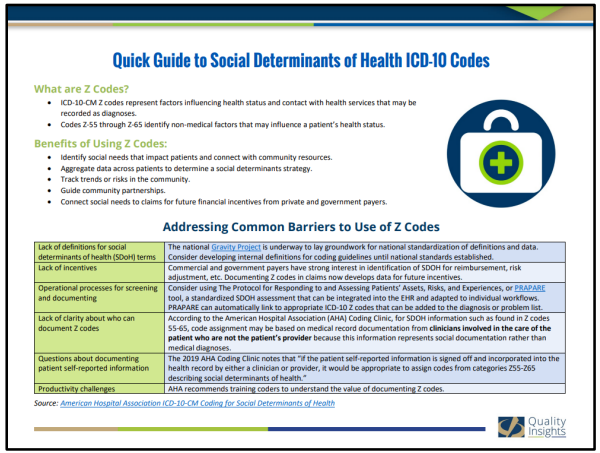
Source: DHSS, 2021

2024 Physician Fee Schedule Final Rule

- The Centers for Medicare and Medicaid Services (CMS) 2024 Final Ruling announced new provider HCPCS codes effective January 1, 2024.
- As of the above date, providers who perform SDOH screening in their Medicare population will be able to bill Medicare Part B for the screening using:
  - G0136 is “Administration of a standardized, evidence-based Social Determinants of Health Risk Assessment, 5-15 minutes, not more often than every 6 months.”

Source: CMS, 2023.

Capture Data with ICD-10 Z Codes



Quick Guide to Social Determinants of Health ICD-10 Codes

What are Z Codes?

- ICD-10-CM Z codes represent factors influencing health status and contact with health services that may be recorded as diagnoses.
- Codes Z-55 through Z-65 identify non-medical factors that may influence a patient's health status.

Benefits of Using Z Codes:

- Identify social needs that impact patients and connect with community resources.
- Aggregate data across patients to determine a social determinants strategy.
- Track trends or risks in the community.
- Guide community partnerships.
- Connect social needs to claims for future financial incentives from private and government payers.

Addressing Common Barriers to Use of Z Codes

Lack of definitions for social determinants of health (SDoH) terms	The national Gravity Project is underway to lay groundwork for national standardization of definitions and data. Consider developing internal definitions for coding guidelines until national standards established.
Lack of incentives	Commercial and government payers have strong interest in identification of SDOH for reimbursement, risk adjustment, etc. Documenting Z codes in claims now develops data for future incentives.
Operational processes for screening and documenting	Consider using The Protocol for Responding to and Assessing Patients' Assets, Risks, and Experiences, or PRAPARE tool, a standardized SDOH assessment that can be integrated into the EHR and adapted to individual workflows. PRAPARE can automatically link to appropriate ICD-10 Z codes that can be added to the diagnosis or problem list.
Lack of clarity about who can document Z codes	According to the American Hospital Association (AHA) Coding Clinic, for SDOH information such as found in Z codes 55-65, code assignment may be based on medical record documentation from **clinicians involved in the care of the patient who are not the patient's provider** because this information represents social documentation rather than medical diagnoses.
Questions about documenting patient self-reported information	The 2019 AHA Coding Clinic notes that "if the patient self-reported information is signed off and incorporated into the health record by either a clinician or provider, it would be appropriate to assign codes from categories Z55-Z65 describing social determinants of health."
Productivity challenges	AHA recommends training coders to understand the value of documenting Z codes.

Source: American Hospital Association ICD-10-CM Coding for Social Determinants of Health

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Download the Quick Guide to SDOH ICD-10 Codes from Quality Insights.

- Codes Z-55 through Z-65 identify non-medical factors that may influence a patient's health status.
- Identify social needs that impact patients and connect with community resources.
- Aggregate data across patients to determine a social determinants strategy.
- Guide community partnerships.

Assessing and Addressing SDOH

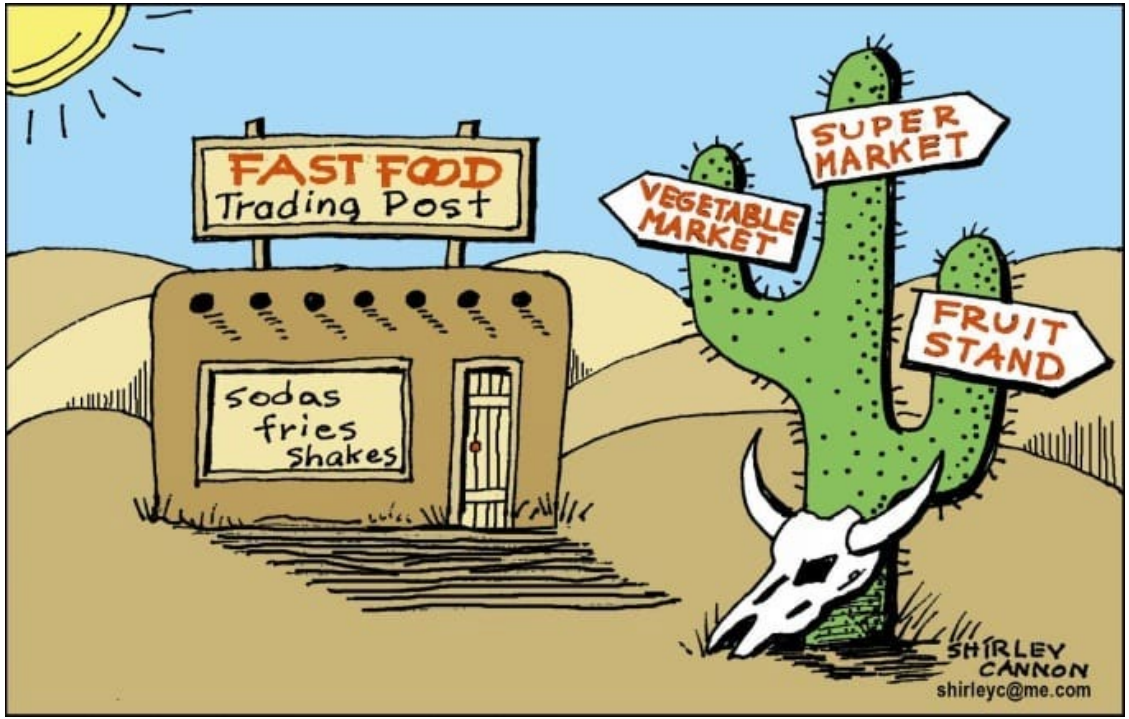
Health-Related Social Needs Screening

NOWPOW

Drivers of Health Inequities

Source: [Healthy People](), 2022

Diet and Diabetes



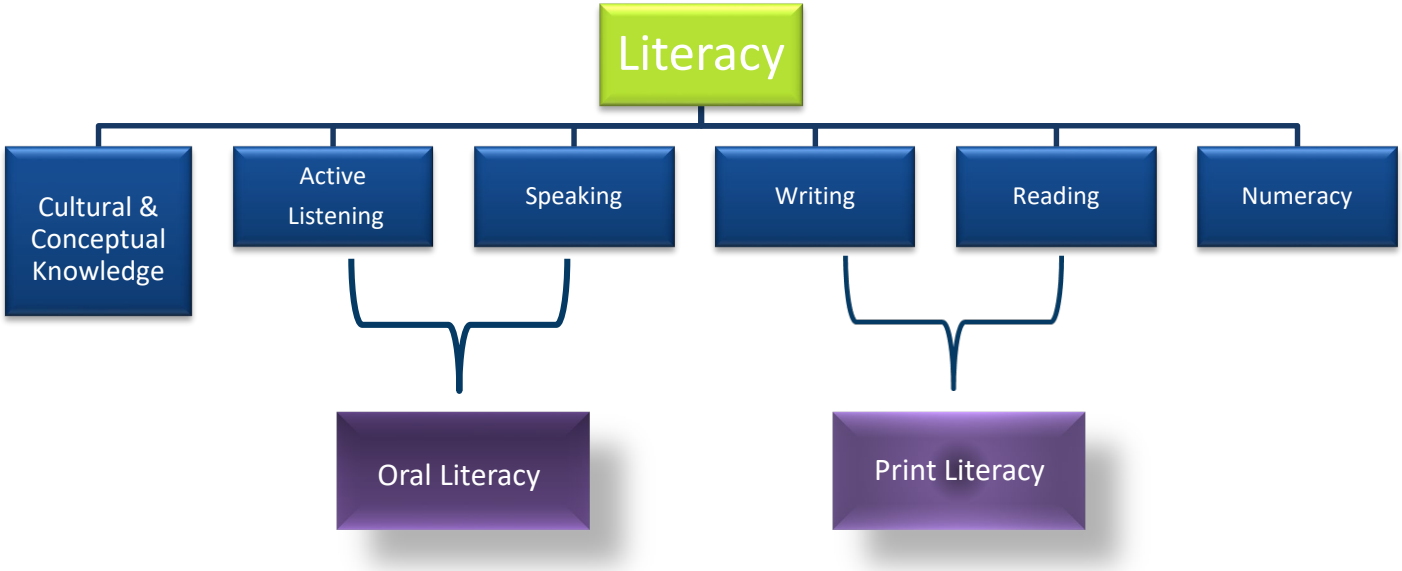
Source: [Foodbank of Southeastern Virginia and the Eastern Shore](), 2023

Drivers of Health Inequities

Source: Healthy People, 2022

General Literacy

The Bridge to Health Literacy



Source: Adapted from the National Academy of Sciences, 2004

Health Literacy: Prevalence & Impact

- Limited health literacy is very common, and mental illness commonly co-occurs.
- Low health literacy is highly stigmatized.
- Individuals with low health literacy have more encounters with the health care systems compared to those with proficient health literacy.

Health Resources & Services Administration
CDC-Health Literacy
Taylor, D.M., Fraser, S.D.S., Bradley, J.A., Bradely, C., Draper, H., Metcalfem W., … Roderick, P.J. (2017). A systematic review of the prevalence and associations of limited health literacy in CKD. *Clin J Am Soc Nephrol*, *12*(7), 1070-1084. doi:10.2215/CJN.12921216

Potential Indicators of Low Health Literacy

1. Frequently missed appointments.
2. Incomplete registration forms.
3. Non-adherence with medication therapy.
4. Unable to name medications, or explain purpose or dosing.

Source: Agency for Healthcare Research and Quality, *Health literacy: Hidden barriers and practical strategies*, 2017

Potential Indicators of Low Health Literacy

5. Identifies pills by looking at them, not reading the label.
6. Unable to give coherent, sequential history.
7. Ask fewer questions.
8. Lack of follow-through on tests or referrals.

Source: Agency for Healthcare Research and Quality, *Health literacy: Hidden barriers and practical strategies*, 2017

Health Literacy and Diabetes

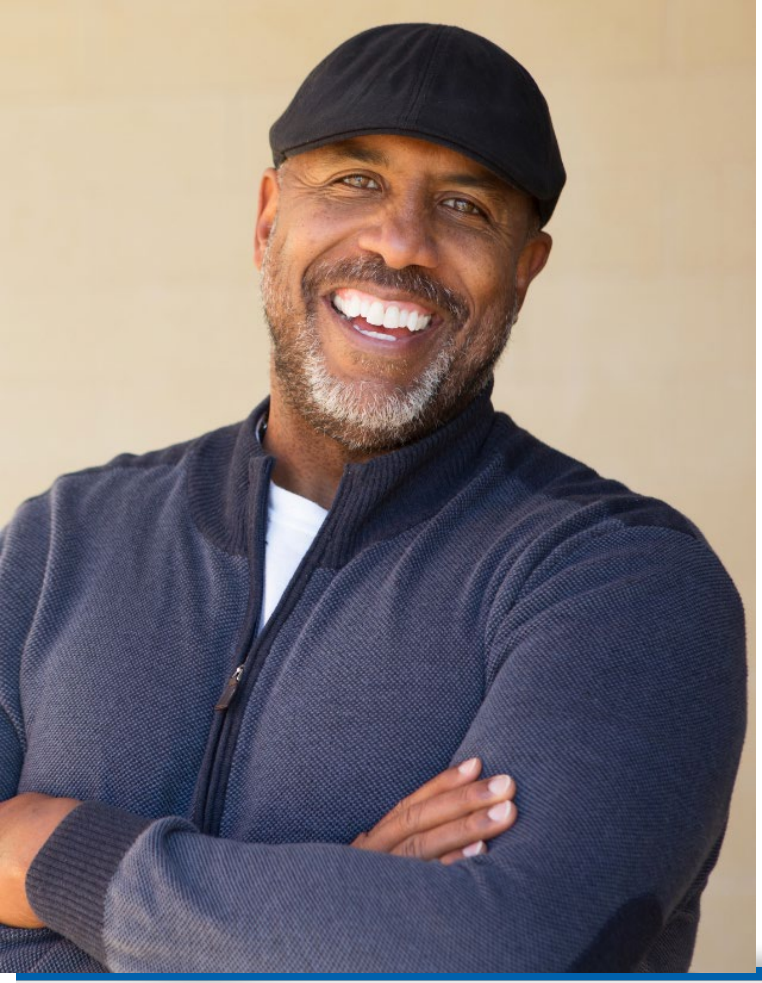
- Among people with type 2 diabetes, inadequate health literacy is independently associated with:
  - Worse glycemic control
  - Higher rates of retinopathy
  - Lower self-rated health

Source: Protheroe et al., 2017

- Better patient understanding is needed for improved self-management and outcomes

Health Literacy Resources

- Health Literacy Roadmap
- Rapid Estimate of Adult Literacy
- Tips for Developing Materials



Case Scenario

- Patient KB
  - Black male – age 47
  - Chief complaint/reason for visit:
    - Poorly controlled type 2 diabetes
    - Last A1c: 10.2%
  - Medical history:
    - Obesity
    - Type 2 diabetes (diagnosed 5+ years ago)
    - Elevated cholesterol
    - Chronic kidney disease, stage 3

Patient History

- Family history
  - Myocardial infarction on both sides
  - Diabetes mellitus, type 2 on both sides

- Social history
  - Married, three children ages 7-14
  - 4-year college degree
  - Works in an office, mostly sedentary lifestyle
  - Coaches son's basketball team
  - Family does take out 3-4 times a week due to schedule

Plan: Educate and Refer

- Acknowledge the patient's recent changes and barriers to success.
- Discuss the DSMES program with patient.
- Convey to the patient the need for the program to prevent potential complications and discuss program benefits.

Key Takeaways

- Patients with prediabetes should be referred to the National DPP to lower their risk of developing Type 2 diabetes.
- Patients with diabetes should be referred to self-management programs.
- SDOH and health literacy can have a big impact on a patient's ability to control their diabetes effectively.

Questions/Comments?

Quality Insights

None of the planners for this educational activity have relevant financial relationship(s) to disclose with ineligible companies whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

AmeriHealth Caritas Delaware

Quality Insights

MSD Medical Society of Delaware

Claiming CME Credit

Evidence-Based Opportunities to Improve Diabetes & Prediabetes Control and Prevention - Event Date: 5.15.24

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  Note… you can save site as a favorite, bookmark or Google
- **Claim Your Credit:** Activity Code – Type in U O Q C I U
  Note… You will receive a new Activity Code for each sessi
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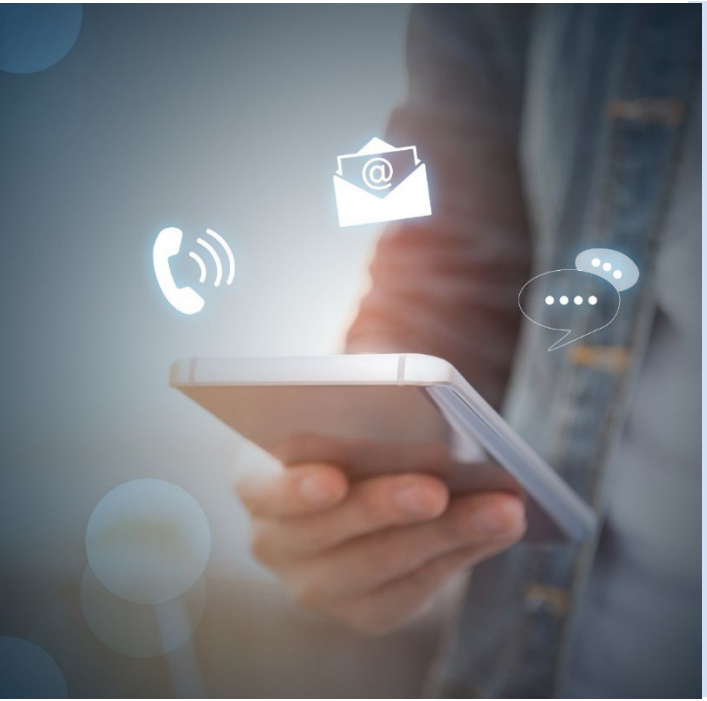
- **Confirm Attendance:** Complete Survey

Please ensure that you disable browser extensions or add-ons to ensure any third-party firewall that was set up on your device/network lets you through to the site.

Resources – AmeriHealth

- Care Coordination Staff
- DE Member Handbook and DE Provider Manual
- DE Health Literacy Brochure

Contact Quality Insights



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www.qualityinsights.org/stateservices

Social Media:

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