DIABETES SELF-MANAGEMENT EDUCATION AND SUPPORT OPTIMIZATION IN THE LOS ANGELES COUNTY PROJECT REPORT

PREPARED BY
Diabetes Care Partners

ACKNOWLEDGMENT

Diabetes Care Partners and the five selected sites would like to recognize and thank the Los Angeles County Department of Public Health for this opportunity to provide these local DSMES programs in need of technical assistance the support to create new programming and to optimize existing programs to better serve their community.

By ensuring that the infrastructure, resources, and tools necessary are available for these diabetes programs to thrive, we are creating an environment of support for consistent, high-quality education that is tailored to the unique needs of their communities, thereby promoting better patient outcomes, increases patient engagement, and fosters a holistic approach to diabetes care.

We are deeply grateful for this collaboration, underscoring the importance of synergistic partnerships between public health entities and local DSMES programs. Together, we are making strides to advance the diabetes care and education ecosystem one program at a time.

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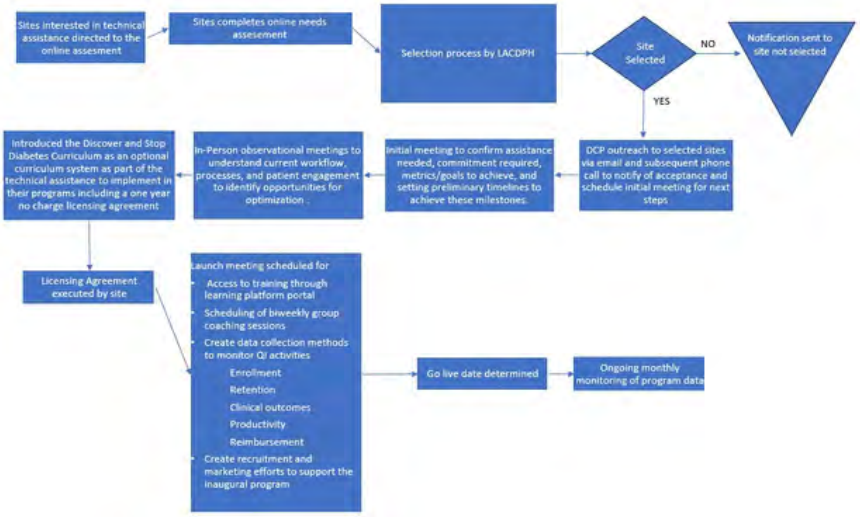
INTRODUCTION

This report offers a comprehensive overview of our technical assistance support offered to five selected DSMES programs in Los Angeles County from May to September 2023. These sites were categorized into two primary practice settings: The hospital and the Clinic setting. This report encompasses site summaries detailing the needs assessment, identified barriers, Technical Assistance rendered, Quality Improvement Outcomes, derived Insights, and Lessons Learned.

Additionally, we present a narrative highlighting the process by which we provided the technical support and common observations and lessons gleaned. Concluding the report with recommendations for improvements to future technical support initiatives.

TECHNICAL ASSISTANCE PROCESS



We have outlined a narrative of the technical support steps and phases accompanied with a process map providing participating sites with a clear illustration of what they can anticipate as we navigate through the subsequent stage of the technical assistance.

Steps and Phases

- The selection criteria were developed in collaboration between LACDPH and Diabetes Care Partners to create an online technical assistance submission portal. Before accepting and initiating technical assistance, participants were required to answer pre-assessment questions regarding their goals and capacity to participate.

- Once the applicants were selected by LACDPH, an initial outreach and assessment confirmation was scheduled by Zoom or in person. This meeting confirmed the specific assistance needed, goals desired to achieve, and metrics needed to monitor progress and laid the preliminary timelines to achieve these milestones.

- We arranged for a minimum of two days for program observation to gain insight into their current workflow, processes, and levels of patient engagement. This approach aimed to pinpoint areas for improvement while also recognizing and reinforcing processes that were already effective and didn't require additional attention.

TECHNICAL ASSISTANCE PROCESS

- Recognizing that the primary goals of these programs revolved around boosting engagement and retention, we introduced the Discover and Stop Diabetes Curriculum as an optional system that could be integrated into their programs as part of the technical assistance package.

- If the program wished to use the Discover and Stop Diabetes curriculum, a 1 year no charge agreement was sent to the program to receive approval from the organization.

- After receiving the returned agreement, we arranged a launch meeting to introduce the staff to the training platform portal at www.diabetescarepartners.com and initiated the scheduling of training sessions. This phase also included the discussed and implementation of data collection methods. This included the setup for monitoring Quality Improvement (QI) activities, covering aspects such as enrollment, retention, clinical outcomes, productivity, and reimbursement, as well as recruitment and marketing efforts to support the program's launch.

- Following comprehensive staff training and the establishment of marketing and data systems, we set a specific "go-live" date.

- Created a process for ongoing monitoring of program data to make data-driven adjustments to fine-tune the program’s effectiveness and sustainability.

SITE #1
HENRY MAYO NEWHALL HOSPITAL

Site Description

This site is a non-profit hospital based DSMES program serving the community for the past 6 years. It is staffed with 2 part time dietitians, a front office administrator and a department manager.

Needs assessment determined in order of importance.

- ·DSMES Curriculum and system development for inpatient / outpatient program
- Engagement for program participants decreasing No Shows
- Optimizing recruitment and utilization increasing attendance

Technical Assistance Provided

- ·Trained the site on Discover and Stop Diabetes Curriculum for 2 staff dietitians.
- Created mechanism to collect data for enrollment, retention, and clinical outcomes through system EHR.

Quality Improvement Outcomes from Assistance

No outcomes data was able to be collected as the DSMES department was defunded and closed prior to our go live date of the new program.

Insights and Lessons Learned

The DSMES program at Henry Mayo Community Hospital has been the sole resource of diabetes education and support for the Santa Clarita community for the past six years. During this time, it demonstrated substantial value to the affiliated hospital and the patients it served. This value was evident in tangible improvements in reductions of patient A1c levels and decreased hospital readmissions resulting in savings amounting to millions of dollars annually stated by the program director.

However, despite its significant cost-reduction impact, the DSMES program was ultimately defunded before the completion of the technical support due to organizational budget cuts. Unfortunately, this scenario is all too common as healthcare systems often tighten their financial belts by eliminating non-revenue-generating programs such as DSMES and other wellness and preventative initiatives. When asked what could have been done to prevent the program's closure, the program director responded, "We should have focused on achieving financial sustainability years ago." She further emphasized that this proactive approach would have given their DSMES program a better chance of weathering these budget cuts

To sustain operations, many programs rely on non-reimbursement revenue sources, such as foundation grants and in-kind donations. However, as demonstrated in this case, this dependency on non-reimbursement funding may jeopardize their long-term sustainability. The lesson learned here is that establishing reimbursement mechanisms for services provided is crucial for ensuring these programs' sustainability and long-term viability.

SITE #2
TORRANCE MEMORIAL HOSPITAL

Site Description
This site is a non-profit hospital-based ADA-recognized DSMES program serving the South Bay area for over 20 years. The program is staffed with four dietitians, two Registered Nurses, a Program Coordinator, two front office administrators, and a department director.

Needs assessment determined in order of importance.
- Optimizing DSMES staff productivity
- DSMES curriculum and system development for inpatient / outpatient program
- Engagement for program participants decreasing No Shows
- Optimizing recruitment and utilization increasing attendance

Technical Assistance Provided
- Provided marketing strategies to increase referrals from local physicians through two specific tactics to increase the marketing value of the program with referring physicians.

    - #1 To consistently remind patients that they are the best marketing tool for the program. If the program added value to their lives, they were asked to inform the referring doctor about their experience at the center. A proposed slide was added to their current PowerPoint presentation to standardize this strategy.

    - #2 To further emphasize and incorporate this marketing strategy, the center prepared blank note cards for each patient session for willing patients to write a thank you note to their doctor regarding their experience at the diabetes education center. This allowed the patient to express their appreciation to their health provider while genuinely endorsing the program.

Quality Improvement Outcomes from Assistance
Due to the time limitation of the technical assistance ending in September, we were unable to gathering outcomes data for this report from the marketing assistance efforts. We will be working with this site beyond the grant term to complete marketing implementation and to monitor awareness and marketing outcomes to present data to the LACPHD in the future.

SITE #2
TORRANCE MEMORIAL HOSPITAL

Insights and Lessons Learned

The Torrance Memorial DSMES program is a highly regarded and long-standing diabetes education resource within the South Bay community. Over the years, management has tracked DSMES program performance metrics closely. However, recent challenges have emerged in the data, including low program enrollment/attendance and an increase in no-shows, which have impacted productivity metrics and raised concerns about achieving departmental goals.

The program administrator noted that the current curriculum leaned heavily towards data presentation and felt it needed more patient engagement. Upon program observation, this deficiency was identified as a possible contributor to the higher rate of no-shows and program completion.

However, upon further examination and consideration to adopt the new curriculum to increase engagement and retention, the site stated that a significant barrier to implementing a new curriculum was the risk of the inevitable decrease in productivity during the initial training and implementation. Instead, the site focused on optimizing productivity through modifications in the charting process as the primary driver for productivity improvement. Thus, the technical assistance focused on charting processes and marketing efforts to increase referrals from physician practices.

This decision reflects the realization that critical metrics must align with the goal of these technical assistance efforts and the lesson learned that not all organizations are immediately prepared to embrace changes in curriculum pedagogy as it can have challenges to program culture and internal key performance indicators such as the one faced by this site.

SITE #3
EAST VALLEY COMMUNITY HEALTH CENTER

Site Description

This site is a non-profit FQHC serving the San Gabriel Valley for more than 20 years. No DSMES program existed before the technical assistance. The diabetes management team is staffed with five dietitians, an administrator, a Department Nursing Director, and a Qi director.

Needs assessment determined in order of importance.

- DSMES curriculum and system development for outpatient program
- Engagement for program participants decreasing No Shows
- Optimizing recruitment and utilization increasing attendance

Technical Assistance Provided

- Trained the site on the Discover and Stop Diabetes Curriculum to 5 dietitians, with two more to be trained by October 2023
- Assistance to initiate DSMES in 2 organization facilities and a third by October 2023
- We have assisted in creating data collection management processes working with their QI and IT departments.
- Created a patient recruitment flier with their internal marketing department that aligned with the culture and goals of the program. (Exhibit A)
- Presentation created for PCP team (Exhibit B)

Quality Improvement Outcomes from Assistance

- Engagement outcomes are represented by attendance- 74% of patients attended at least two sessions and 68% completed the program.
- The program achieved a decrease of -2.31% in A1c for those who completed the program, from an average A1c of 10.22% to a post-A1c Average of 7.91%.
- A decrease of 5.30% was the most significant patient decrease observed in the first cohorts of the newly established program.
- 90.5% of patients who completed two or more sessions had a decreased A1c.
- 75% of high-risk members decreased their A1c below 9.0 after completing the program

Insights and Lessons Learned

While creating and scaling the EVCHC DSMES program to its current six programs a-month schedule across 3 locations, one reoccurring discipline and valuable lesson learned was the "start small and build up" approach. This method enabled us to start with one program and methodically assess elements like process flow, timing, incentives, data systems, inter-departmental communication, marketing, and referral management. We then implemented and tested these approaches, optimizing what worked and adjusting what didn't within EVCHC's specific systems and workflow.

SITE #3
EAST VALLEY COMMUNITY HEALTH CENTER

To effectively scale, we introduced vital support at specific growth stages. Throughout, the team asked, "Who should join the team for the next phase?" This led us to involve IT, operations, mental health, case management, and pharmacy departments to tackle process issues and care gaps. While this approach was highly effective, it necessitated detailed project management, rigorous data oversight, and robust communication across the organization. Most importantly, upper management's steadfast commitment to the "go slow to go fast" strategy was crucial for success.

A noteworthy recurring challenge revolved around employee retention. The initial educators who had undergone training before the program's commencement resigned from the organization; this challenge of high turnover in staff can cause significant disruption to the program and, in extreme cases, effectively shut down a program for long periods or even for good. This underscores the critical importance of having a standardized program rather than one that is loosely assembled, as program structure is the cornerstone of sustainability. Additionally, this situation presented a training challenge. To enable sites to maintain consistency and expand their reach, establishing a standardized training program in which new educators can effectively be trained is essential as it serves as the program's foundation.

SITE #4
HARBOR COMMUNITY HEALTH CENTERS

Site Description
This site is a non-profit FQHC clinic servicing the community for more than 20 years. No DSMES program existed before the technical assistance. The current program is a physician-run individual appointment-based model for high-risk diabetes members of the center. The newly created diabetes team is staffed with two medical Assistants, a CHW, a nurse practitioner, a Primary Care Physician, and a per-diem pharmacist, all led by the QI director.

Needs assessment determined in order of importance.

- DSMES Curriculum and system development for inpatient programs create a standardized and sustainable program that would endure administration and provider turnover.
- Engagement for program participants decreasing no-shows.
- Optimizing recruitment and utilization, increasing attendance

Technical Assistance Provided

- We are currently in the training phase of technical support as the agreement was approved late September. We are currently in the process of creating a data collection management process and a recruitment strategy working with their QI director and newly formed team.

Insights and Lessons Learned
While we have yet to get data for this site, our discussions have set the stage for the organization to establish a robust foundation. This commitment is evident in the leadership's decision to form an Interdisciplinary team to advance this initiative. We plan to collaborate with this site post-grant to finalize program implementation and track quality outcomes. We aim to provide data to the LACPHD in the upcoming period.

During the initial assessment, it was determined that the site had an existing program years before that was physician-directed. This program had been in operation for several years and was instrumental in serving the community's healthcare needs. However, the physician associated with the program decided to leave the practice, which led to the discontinuation of the program, leaving a void in diabetes education services offered to patients for many years.

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SITE #4
HARBOR COMMUNITY HEALTH CENTERS

This scenario served as a valuable lesson for the site and us all, highlighting the inherent vulnerability of programs heavily reliant on a single individual. It underscored the importance of transitioning from a model where the program existed within one person's domain to one that is integrated into the organization's processes to achieve sustainability through a shift towards a systematic approach.

The key to this transformation lay in assembling a multidisciplinary team that includes physicians, medical assistants, CHWs, pharmacists, and mental health workers who could provide the necessary expertise and support to ensure the program's continued operation. By distributing responsibility and fostering collaboration among various healthcare professionals, the site aimed to reduce its reliance on any single individual and create a resilient program that could withstand personnel changes and transitions and ultimately serve the patient better. This strategic shift enhanced the program's stability and ensured that it could adapt and thrive within the ever-evolving landscape of healthcare delivery.

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SITE #5
WHITE MEMORIAL ADVENTIST HOSPITAL

Site Description

This site is a non-profit hospital-based ADA-recognized DSMES program serving the Los Angeles area for more than 20 years. It is staffed with two dietitians, two registered nurses, two front office administrators, a para-professional educator, and a department director.

Needs assessment determined in order of importance.

- DSMES curriculum and system development for inpatient/outpatient program
- Engagement for program participants decreasing no shows
- Optimizing recruitment and utilization increasing attendance
- Telehealth implementation for sister sites in Montebello

Technical Assistance Provided

- We are currently in the agreement submission phase to leadership for approval, which has been temporarily delayed due to the organization's attention to reopening a sister hospital in Montebello. We will be working with this site beyond the project term to complete program implementation and to monitor quality outcomes from the ongoing assistance to present data to the LACPHD in the future.

Insights and Lessons Learned

Due to delays in leadership approval this site is at the beginning of the technical assistance process. We will work with this site beyond the project term to complete program implementation. Thus, we will report any insight from the ongoing assistance to present to the LACPHD.

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IMPORTANT OBSERVATIONS

A consistent theme across all sites was the absence of standardization in both processes and curriculum. This lack of standardization hindered organizations from conducting data-driven analyses and making necessary adjustments to their programs for optimal program delivery. In all cases, processes needed to be first identified and re-built with pathways for more accessible data collection in mind. One site recruited and tasked their IT department to create a customized data mapping in their clinical tools to track enrollment, attendance, and clinical markers specifically for enrolled members. When in place, this critical component of the process made it easier for educators to track individual patient progress while providing the management team with real-time aggregate data for more precise decision-making.

Regarding curriculum standardization, sites tended to develop their own curriculum and materials over time, creating an assortment of materials from different sources that had no aligned focus and consistency. The common issue observed with this practice was the need for intentional patient-centered materials that promoted learning over information instruction. This transition in curriculum pedagogy was noted to pose a more significant challenge for well-established programs. Shifting from a didactic approach, where participants typically played a passive, impersonal role and lectures served as the primary teaching method, to a more active process involving interaction and discussion to engage learners in the educational process and an understanding that diabetes self-care cannot be taught like history but it must be learned, proved to be more difficult for some sites. This hesitancy to make this shift is not uncommon, as we understand and realize that change is difficult for programs that have done it a certain way for many years. Still, in order to provide a patient-focused program, the process and system must also be aligned with a patient-centered approach.

A recurring topic of discussion during the assessment and planning phases of this technical support initiative revolved around the issue of financial sustainability. Both clinic and hospital-based sites highlighted the importance of viability as a significant metric, but hospital-based programs were less focused on reimbursement and more concerned about productivity metrics. These programs were primarily tracking staff productivity as the key performance metric, as directed by their leadership, but were not tasked with understanding the profit and loss (P&L) statement of their program.

It's understood that productivity serves as a benchmark for comparing departments within a larger organization. However, what we have consistently observed, especially during this project with the closure of one of our participating sites, is that DSMES departments are not secure, as they are typically not considered revenue-generating units. In most cases, they are regarded as community service expenses and appear as loss items on the P&L statement. Unfortunately, when organizations face tough times and need to downsize, DSMES departments are often the first to be affected.

Due to the nature of hospital-based programs and their position within larger hospital settings, reimbursement, and billing issues are usually beyond their control or influence. Our recommendation to these sites was to actively seek information on billing associated with DSMES and collaborate with their finance department to explore reimbursement opportunities for their services if they were not already doing so. Another strategy discussed to enhance both productivity and the P&L of their program was to offer more group programming. The reimbursement model for group programs tends to yield a higher return on revenue and places greater emphasis on productivity while taking advantage of the benefits of group support dynamics .

While both types of programs shared concerns about sustainability, new clinic-based programs demonstrated a greater willingness to design their programs with a focus on financial stability and sustainability through reimbursement considerations by utilizing non-traditional staff, such as Medical Assistants (MAs) and Community Health Workers (CHWs) and pharmacists, for program design and implementation. In contrast, hospital-based programs did not prioritize this perspective regarding program development. This approach may challenge their future growth, sustainability, and program expansion as reimbursement models shift to managed care payment models, and traditional CDCES, nurse, and dietitian providers may be less utilized for traditional DSMES services and more for their specialized skills in the DSMES ecosystem.

Another notable difference between these two program categories was their inclination toward pursuing recognition from organizations like the ADA (American Diabetes Association) or ADCES (Association of Diabetes Care & Education Specialists). Largely operating in highly regulated environments, hospital programs were more likely to design their programs with recognition in mind. For instance, two of the three hospital programs in this assistance were already ADA-recognized. In contrast, clinic-based programs generally regarded recognition as a "nice to have" rather than a necessity. This was primarily due to the administrative burden and the nominal financial benefits driven by the managed care environment, which did not require recognition as a prerequisite for reimbursement. Instead, financial reimbursement models such as PPS (Prospective Payment System) rates, capitation, and reimbursement for non-physician providers were the drivers for the future financial sustainability of these programs in the clinic setting.

The deficiency in marketing skills was a notable challenge for these diabetes programs. Many of these programs focus on feature-based messaging rather than the more effective benefit-led messaging. It's crucial to emphasize that this isn't a shortcoming on the part of the programs. The truth is the intricacies of marketing, and the craft of persuasive messaging are not components typically covered in standard nursing or dietitian training. Yet, for a diabetes program to be truly successful and sustainable, integrating effective marketing strategies is indispensable. Bridging this skill gap is not just about attracting more patients but about communicating the genuine value and impact of the program in a way that resonates and motivates. While some programs had access to marketing departments within their organization, many were left to create their own with inconsistent results. Leveraging technical support initiatives such as this provided guidance and a better understanding of crafting a message to effectively increase referrals.

On a closing note . Many sites emphasized that, without this opportunity offered by the LA County Public Health Department, they might not have taken the initial steps to develop or enhance their DSMES programs. Besides its valuable technical support, the LA County Public Health technical assistance program played a crucial role in giving each site's department the necessary endorsement to propose the initiative and request essential resources from their organizational leadership.

One site even expressed that this assistance program empowered their department to make significant progress with increased momentum. They particularly valued the project management assistance, acknowledging that their team was already stretched thin with additional responsibilities beyond Diabetes Self-Management Education and Support (DSMES) and would not have been able to tackle this project on their own.

FUTURE IMPROVEMENTS

One of the notable challenges encountered in this project was the variability in timelines. The pace at which each organization progressed through the different phases of technical assistance was influenced by their internal schedules, availability for meetings (in-person or via Zoom), and the allocation of team resources dedicated to advancing the project. Another significant factor impacting the project's timeline was the internal approval processes within the participating sites. Some organizations required multiple layers of approval, including departmental, legal, and C-suite approvals, which introduced delays to the technical assistance process. While we acknowledge that factors like internal timelines and approval processes are beyond our control, it may be worthwhile to consider process adjustments. For instance, providing the licensing agreement at the introduction phase would give us a jump start on the approval process, saving time as we proceed forward. Additionally, a more targeted selection process could identify organizations that are less prone to multiple layers of approval, thereby streamlining our overall process for greater efficiency.

Understanding the pivotal role that the Los Angeles County Department of Public Health annual survey plays in the department's strategic planning and the difficulties we face in obtaining responses, we propose a recommendation to require sites to submit the Los Angeles County Diabetes programming survey annually as a precondition for acceptance for technical assistance. This mandatory submission would ensure more evaluations are received to better provide an accurate picture of our county's diabetes care environment and the progress seen through these assistance initiatives.

A concluding recommendation to enhance the assistance program is to understand its future purpose, who we should specifically target, and align efforts accordingly clearly with that purpose. We suggest that it is to increase access to DSMES programs in the Los Angeles County. While assisting existing programs in optimizing their sustainability is valuable, it might be a more effective allocation of resources to prioritize access to programs that currently do not exist, as this could potentially create the most significant impact on the diabetes community as a whole.

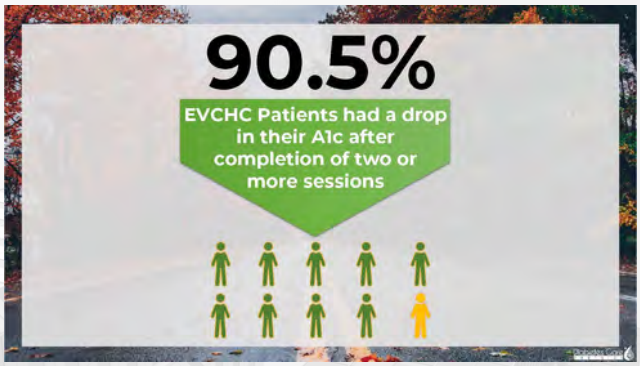
EXHIBIT A


DIABETES ALERT
DON'T GIVE UP THE FOODS YOU LOVE
We'll show you how.
WHAT YOU WILL LEARN
Discover how to eat the foods you love while improving A1c
Discover how to reduce your medications
Discover how to loss weight naturally without dieting
This program will help you become your expert in your diabetes so you can enjoy the people and things you love for a lifetime.
CALL TO ENROLL IN
Our New Diabetes Education Program
909-632-1224
NO COST TO ENROLL
RECIEVE A FREE GIFT AFTER COMPLETING 3 SESSIONS
EastValley
COMMUNITY HEALTH CENTER

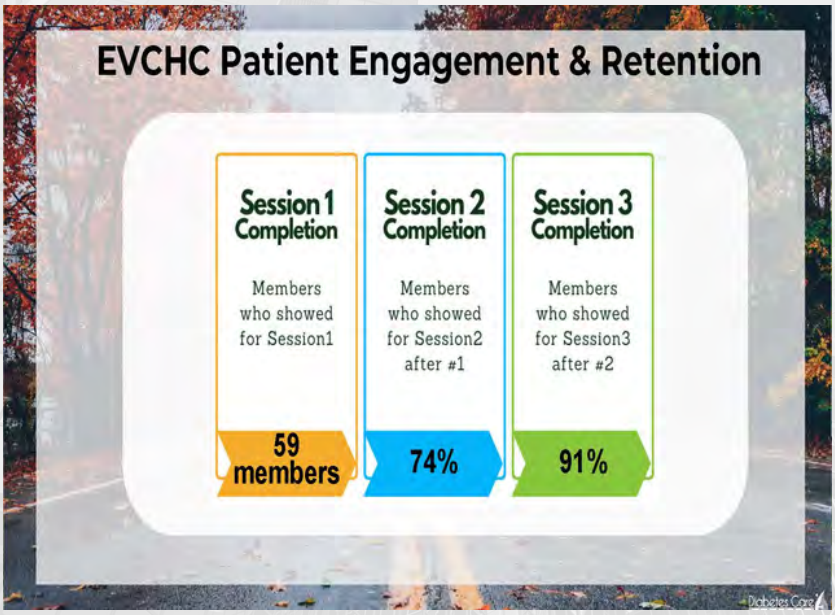
EXHIBIT B


Pre Program Baseline
Average A1c (10.22%)
Significant A1c Reduction for members enrolled in the program
-2.31%
Decrease in A1c
Post Program Average A1c (7.91%)
Patients that have completed at least 2 or more out of the 3 sessions and have a post A1c on record N=21 members


75%
of high risk members >9.0 A1c dropped A1c below 9.0 after completion of the program


90.5%
EVCHC Patients had a drop in their A1c after completion of two or more sessions


Pre Program Baseline
Average A1c (11.40%)
Largest A1c drop for EVCHC's member after completing the program
-5.30%
Decrease in A1c
Post Program Average A1c (6.1%)


EVCHC Patient Engagement & Retention
Session 1 Completion
Members who showed for Session1
59 members
Session 2 Completion
Members who showed for Session2 after #1
74%
Session 3 Completion
Members who showed for Session3 after #2
91%