# Living Well with Diabetes Education Program

## Operational & Implementation Considerations

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## INTRODUCTION

In 2025, the Northwest Regional Telehealth Resource Center (NRTRC) recognized that there are significant gaps in the availability and accessibility of diabetes education that aligns with the **American Diabetes Association (ADA) Standards of Care**. These gaps disproportionately affect people with limited access to accredited or reimbursed programs that are delivered by credentialed individuals. The ADA recommends "offering diabetes self-management education and support (DSMES) **via telehealth and/or digital interventions as needed** to meet individual preferences, address barriers to access, and improve satisfaction". For the ADA's the full set DSMES-related recommendations see Appendix A - ADA Recommendations (below) from the Standards of Care in Diabetes 2025.

To help address these gaps, the NRTRC developed a comprehensive set of slides designed as a starting point for healthcare organizations or individuals to customize, brand, and use to deliver diabetes education to **nonpregnant adults with type 2 diabetes**. These materials are intended to be delivered by trained, supervised staff in situations where an accredited diabetes self-management education and support (DSMES) program is not available.

"Not available" may include circumstances such as:

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- Lack of insurance coverage or specifically coverage of diabetes education
- Out-of-pocket costs
- Geographic inaccessibility - too far away, lack of transportation
- Inconvenient scheduling - inability to get time away from work or other commitments
- Limited access to or inability to participate in telehealth
- Fear or anxiety about navigating the healthcare system or working with someone “new”

By recruiting and training staff, this diabetes education program helps bridge this gap and empowers adults with type 2 diabetes to strengthen their knowledge, build their self-confidence and efficacy, and manage their condition effectively.

If you do not already have the slide set, you can access it here: **NRTRC’s Living Well with Diabetes Education Program slides.**

If you experience any issues accessing or downloading the slides - or if you have feedback or suggested corrections - please contact us at info@NRTRC.org.

Resource: Implementing and Evaluating Diabetes Self-Management Education and Support (DSMES) Programs for Underserved Populations/Communities - A Practice-Based Guide. CDC. 2019. May be helpful for leadership and administration.

The following are important considerations for operations and implementation.

# COMMUNICATION WITH STAFF

- “We’re doing this!” Make sure everyone is aware of implementation of the new option for referring patients in need of diabetes education. Be explicit about why the change is happening and what outcomes are expected outcomes (e.g., decrease percentage of people with uncontrolled diabetes, improve knowledge and self-management for people with diabetes).
- Share specific information with those involved in related processes, including
  - Referring patients
  - Scheduling
  - Identifying eligible participants
  - Documenting in the EHR
  - Collecting and reporting data
  - Supervising or training the diabetes educator(s)
- Engage frontline staff - proactively solicit feedback, concerns, and questions from staff. This helps identify potential unintended consequences early and mitigates “change fatigue” by making staff feel heard and involved.
- Consider a process map for the ideal state as a way to communicate the changes and clarify who will do what, when, and how.
- Clarify how training of staff will happen and who and how supervision will happen.

- Consider identifying a champion who can help with communication.
- Consider developing a RACI chart to clearly define:
  - **R**esponsible: Who is doing the work?
  - **A**ccountable: Who is ultimately answerable for the outcome?
  - **C**onsulted: Who needs to give input?
  - **I**nformed: Who needs to be kept up to date?

## DOCUMENTATION

Documentation should be part the patient chart for each diabetes education session. However, providers should weigh in on what documentation they want or need to see. They typically do not want the full notes of the diabetes educator. They may just want to know:

- What was discussed?
- What is the plan or care plan?
- What are the self-management goals and targets?
- Whether education was provided or declined. If declined, make sure it is documented in the patient chart and why (e.g., no time, changed their mind, not interested).
- When will the patient follow up with the educator?

We strongly recommend making the required documentation standard rather than allowing each provider to have their own specific requirements for documentation.

Will educators have access to the electronic health record for pre-visit planning, chart review, and documentation? If yes, is there a template, charting macro, smart documentation tool, etc.?

## BACKUP PLAN FOR EDUCATORS

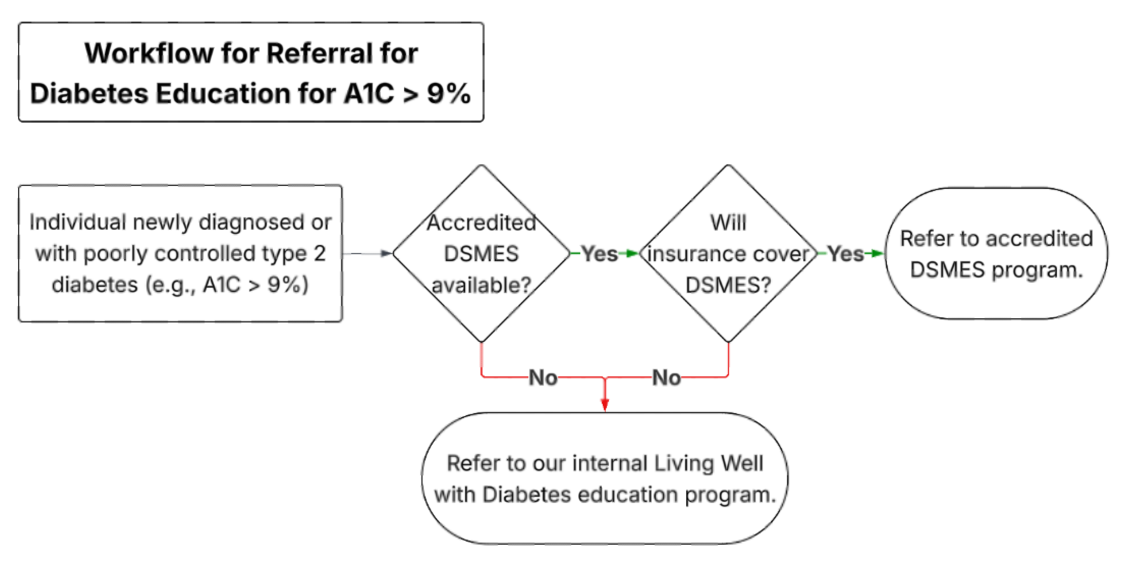
- What is the plan for situations where the educator is not comfortable or does not feel they have the requisite knowledge base or skills to answer a question, provide guidance, or address a patient issue?
- Educators should have a “go to” person or people for these scenarios, which will invariably arise. A few examples include mental or physical health concerns, issues with obtaining medications (cost, transportation, etc.), or health-related social needs (e.g., food insecurity, unhoused).

## WORKFLOW CONSIDERATIONS

- How will patients be referred for diabetes education? We recommend an “opt out” approach (with guidelines endorsed by clinical staff). For example, the educator could conduct pre-visit chart reviews or “scrubs”. For any patient that has an A1C ≥ 9% (for example) the educator would ensure that when the patient checks in, reception staff will schedule the patient with the educator unless there is a note in the chart from the provider to opt out their patient (e.g., patient is on hospice).

- Does the health maintenance / preventive/chronic care modules include "Diabetes Education" as a trackable item, with due/complete dates?
- Who will schedule patients with the diabetes educator - reception staff, educator, someone else?
- Will the organization use orders or referrals in the EHR to track who has been referred to diabetes education? Once that education has been provided, or the patient declines, or no shows repeatedly, etc, who will close the referral?
- Is there an opportunity to run reports of all patients with type 2 diabetes (T2D) with A1C ≥ 9% who have not received diabetes education in the past 12 months? Staff could then call those patients to schedule with the diabetes educator.
- Does the educator's note need to be routed for supervision, cosignature, provider review or other reason?
- What tools and patient handouts should be used and will they be stored in the EHR?

### Sample Workflow for Referrals



# HIPAA PRIVACY AND SECURITY TRAINING

All educators should receive HIPAA privacy and security training regardless of whether the organization that hires the educator is a covered entity.

# QUALITY IMPROVEMENT & QUALITY ASSURANCE

### Quality Improvement (QI)

- We strongly recommend including data from the delivery of the diabetes education program. For example, do patients who receive diabetes education lower their A1C, BMI, blood pressure, urgent or emergent care, and/or LDL? What percent who are "due" for diabetes education receive it? And if not receiving it, why not? For pre-visit planning, how often do we have missed opportunities (that is, the patient came for a provider visit, and we did not identify and address the need for diabetes education)?
- What reports are needed and are they readily available from the EHR or other source?
- Do we have a QI team or person who can take this on?
- To track those who have received diabetes education, consider using Z codes, although that may not always track to the date provided.
  - Z71.89 (Other specified counseling)
  - Z71.3 (Dietary counseling and surveillance)
  - Z71.2 (Diabetes education)

### Quality Assurance (QA)

How can we ensure that every person with diabetes has a high quality diabetes education experience?

There are essentially two ways.

1. Provide adequate supervision and system of feedback, the latter of which is an essential component of building skill, learning, and growing.
2. Develop a system of feedback from patients. It doesn't have to be long. What went well? What didn't go so well? What can we do better next time?

## REIMBURSEMENT

If an organization opts to use these materials to deliver diabetes education, there is not a pathway for payment or reimbursement if the content is delivered by trained and supervised staff that are not licensed or credentialed/certified.

However, there are alternative options healthcare organizations can explore to fund or support this work.

- Programs that focus on outcomes rather than specific services may support lay educator-delivered DSMES, including but not limited to Accountable Care Organizations (ACOs), Medicaid Managed Care Organizations (MCOs), CMS Innovation Models (e.g., Chronic Care Management, Enhanced Primary Care). These models may allow funding for education efforts that contribute to better A1C control, reduced admissions, etc., even if they're not traditionally billable.
- Grants or state chronic disease programs often support diabetes education by lay educators.
- Community health worker (CHW) programs are often used to deliver diabetes education; some states allow Medicaid reimbursement for CHWs delivering health education under supervision.

## APPENDIX A - DSMES-RELATED RECOMMENDATIONS FROM THE ADA STANDARDS OF CARE IN DIABETES 2025

- 5.1 **All people with diabetes should be advised to participate in** developmentally and culturally appropriate diabetes self-management education and support (DSMES) to facilitate informed decision-making, self-care behaviors, problem-solving, and active collaboration with the health care team. A
- 5.2 Provide DSMES at diagnosis, annually and/or when not meeting treatment goals, when complicating factors develop (e.g., medical, functional, and psychosocial), and when transitions in life and care occur. E
- 5.3 Routinely assess clinical outcomes, health status, and well-being as key goals of DSMES. C
- 5.4 Screen for behavioral health concerns at the same critical times as evaluating the need for DSMES and refer to a qualified behavioral health professional if indicated to increase engagement in DSMES. E
- 5.5 DSMES should be culturally appropriate and responsive to individual preferences, needs, and values and may be offered in group or individual settings. A Such education and support **should be documented and made available to members of the entire diabetes care team**. E
- 5.6 Consider **offering DSMES via telehealth and/or digital interventions** as needed to meet individual preferences, address barriers to access, and improve satisfaction. B
- 5.7 DSMES can improve outcomes and reduce costs, so reimbursement by third-party payors is recommended. B
- 5.8 Identify and address barriers to DSMES that exist at the payor, health system, clinic, health care professional, and individual levels. E
- 5.9 Screen for and include social determinants of health in guiding design and delivery of DSMES C with the ultimate goal of health equity across all populations.