


# **Diabetes Care and Education**

## ***Thinking Outside the Box***

**February 3<sup>rd</sup>, 2023**  
**NC Diabetes Advisory Council**

**Presented by: Tammy S. Palumbo RD/LD**  
**BC-ADM, CDCES, MAE**  
**Kintegra Health**  
**[tpalumbo@Kintegra.org](mailto:tpalumbo@Kintegra.org)**



# Objectives:

**Identify ways to:**

- **Expand Services**
  - **Increase Resources for Patients**
  - **Sustain Diabetes Program**
- 



# Kintegra Health

## Mission

Kintegra Health is a community sponsored,  
family-centered provider of health care, health  
education and preventive care services  
**without regard for the ability to pay.**

**76,000 Patients**

**15289 with Diabetes**

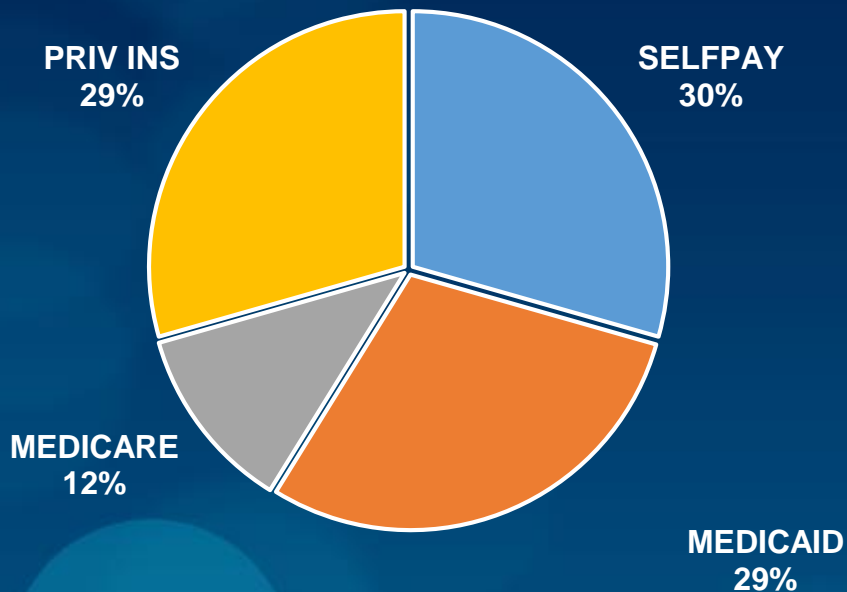
# Federally Qualified Health Center

## FQHC

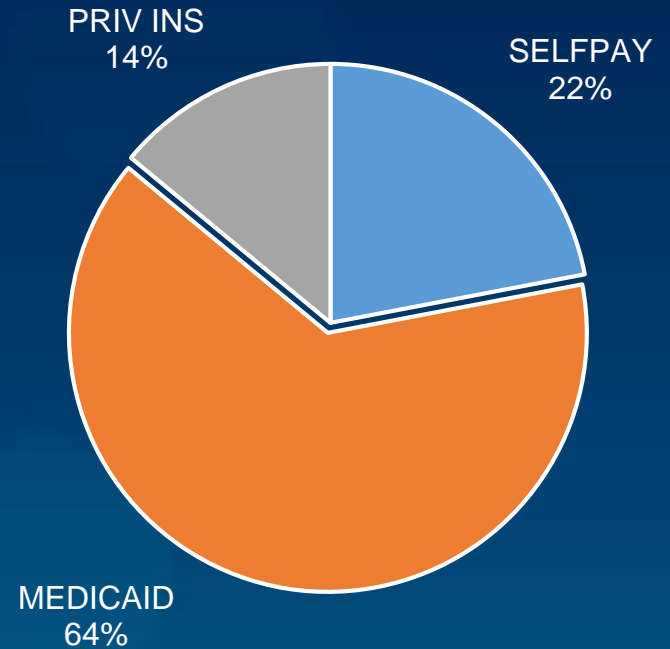
- Federally funded nonprofit health centers or clinics that serve medically underserved areas and populations. Federally qualified health centers provide primary care services regardless of ability to pay. Services are provided on a sliding scale fee based on ability to pay.

# Payor Mix

## MEDICAL AND BEHAVIORAL HEALTH



## DENTAL



# More Info

Follow us!

Kintegra.org

Facebook

Instagram

Twitter

Annual Report 2021:

[Kintegra » Annual Report  
2021](#)



SCAN ME



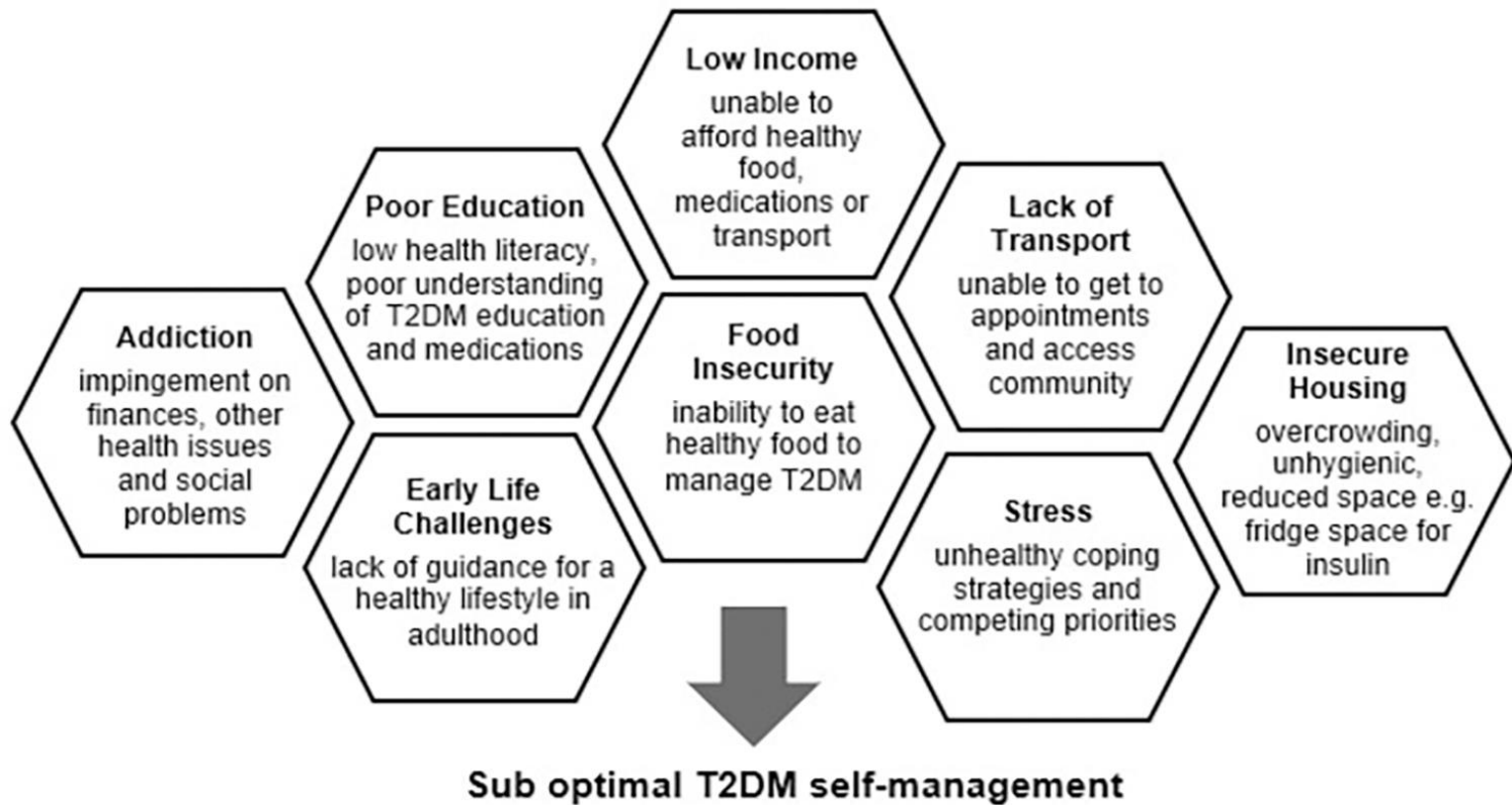
This Photo by Unknown Author is licensed under [CC BY](https://creativecommons.org/licenses/by/4.0/)

**PANCREAS**  
**CELLS** RESISTANCE **INSULIN**  
METABOLISM **STAGES** ISLETS **MONITOR**  
**GLUCOSE** INJECT **WEIGHT**  
SENSITIVITY CONGENITAL NERVE  
ENDOCRINE WELL **DIABETES** TYPE HEALTHCARE  
ACUTE SYMPTOMS  
**HYPERGLYCEMIA** SUGAR **RESPOND** **COMPLICATIONS**  
KETOACIDOSIS **INSULIN** PANCREAS  
ADULTS INJECT MELLITUS





# Incorporate Social Determinants of Health into Individual Care



# Meet the Patient Where They are At



# Kintegra's Journey

## AADE 7 Self-Care Behaviors:

Healthy Eating \* Being Active \* Monitoring \* Taking Medication  
\* Problem Solving \* Healthy Coping \* Reducing Risks



## Chronic Care Model

### Chronic Care Model – What is it?

It's a framework  
for improving the  
quality of  
diabetes care...  
it has six core  
elements

- Delivery system design
- Self management support
- Decision support
- Clinical information systems
- Community resource
- Health systems

# Build from Experiences



## Hospital Based Diabetes Outpatient Centers

- People want 'diet' Information vs AADE-7

## Inpatient Diabetes Educator

- Frequent Fliers not able to obtain meds or know how to inject or store insulin correctly

## Endocrinology Office CDE, Pump/CGMS Trainer

- Titrating insulin
- Point of Care – A1c
- Benefit of Continuous Glucose Monitoring (CGMS)

**Rebranded Diabetes**  
**Department**

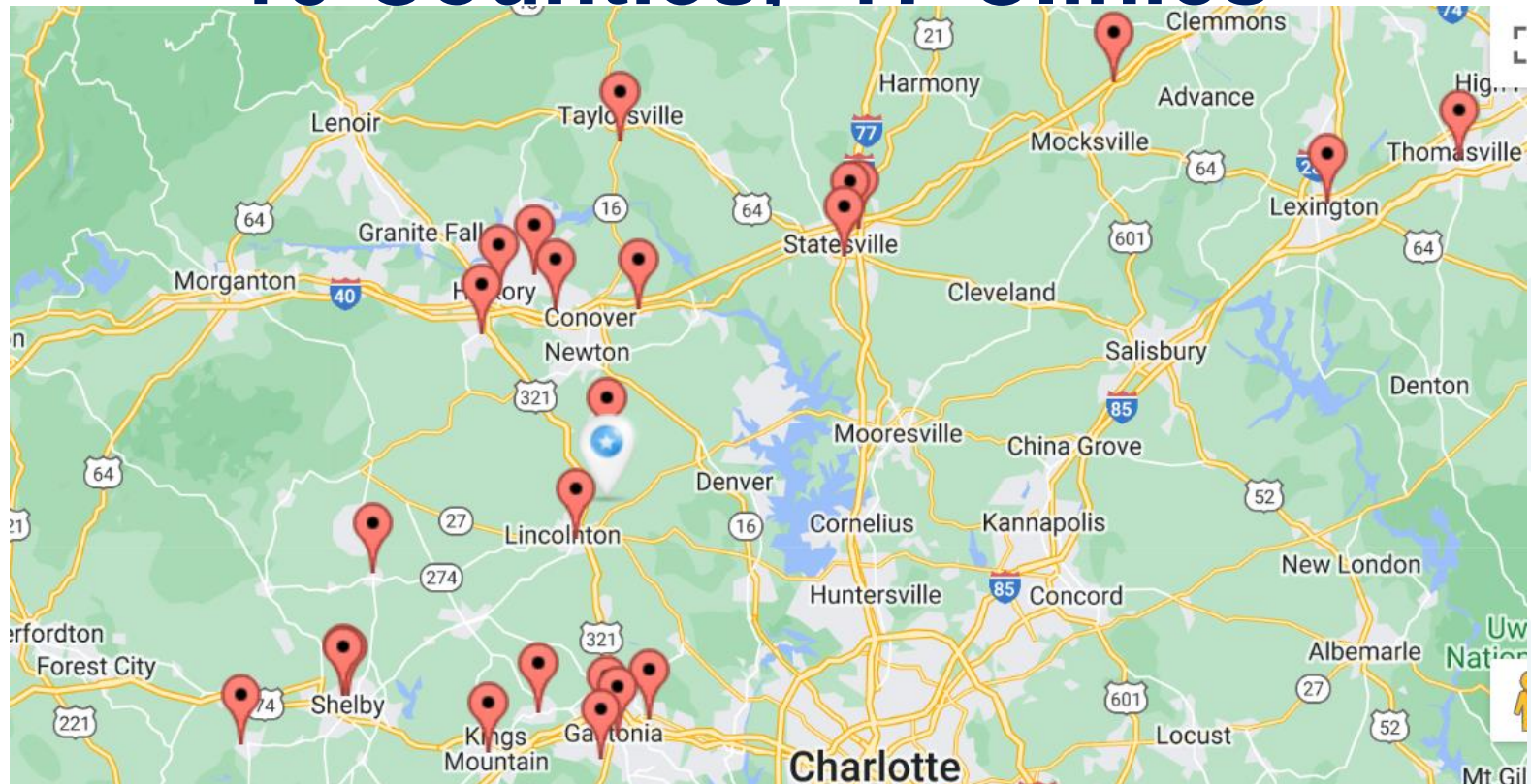
*to*

**Chronic Illness Patient  
Education**



# Chronic Illness Patient Education

## Serving 10 Counties, 17 Clinics



# **Chronic Illness Patient Education** **TEAM**

## **ADA Recognized Program**

**3 Team Members (*Currently hiring a RD/LD,  
CDCES*)**

***Offices in Corporate Building Gastonia***



# Diabetes Program Navigator

- Gatekeeper
- *Started with a Grant*
- Processes referrals including Free ENDO Clinic
- Review Services offered for diabetes related health inequities/social determinant of health:
  - Medication Assistance Program (MAP's)
  - NC Super SNAP (*\$40 extra for fruits/vegetables via EBT card at Food Lion*)
- Medicare Enrollment (SHIIP)
- Transportation
- Phlebotomist – for ENDO Clinic
- Process Continuous Glucose Monitor Scripts for Insured



# Provider: CDCES – RD/LD

- **Diabetes Self Management Training (DSMT)**
  - *Group – free, Individual -\$*
- **Medical Nutrition Therapy (MNT)**
  - *Group – free, Individual -\$*
- **Weight Management**
  - *Group – free, Individual -\$*
- **Grocery Store Tours - free**
- **Community**
  - FIT Squad
  - RAM's Kitchen



# Provider: BC-ADM, CDCES – RD/LD

- **High Risk DM Management**
  - Works under Medical Director Protocols for Insulin Titration, Bolus Correction Scale, Point of Care A1 –
  - Frequent Visits for glucose management \$
- **ENDO Clinic - FREE**
  - See initial referrals to ENDO Clinic and between visits with Endocrinologist
  - Continuous Glucose Monitoring (CGMS)
  - Commercial, Medicaid/Medicare CGMS Training  
-\$
- **CaroMont Community Program** Discharged patients with dx of DM and self pay
  - Goal: lower A1c to 8 or less

# Patient Resources Point of Care



# How We Support Our Clinics



# Clinic Glucomete r

- **GlucoCard Expression**
- Patient walks out of clinic with meter.
- Free Bulk Meters for Clinic
- Able to provide 50ct strips \$6
- (340B pricing)
- English / Spanish
- Large Display
- Audio



**ONLY  
GLUCOMETER**

# Clinic Toolbox

**Provide injection training for Medical Assistants with annual review.**

**Supply Clinics with Toolbox that contain:**

- Sample pens/pen needles
- Sample syringe/vials
- Injection pillow
- Sample Glucose tablets

**Provide injection and medication training for Behavior Health Providers**



# Patient Education Material

Located on 'STAFF  
CONNECT'

English / Spanish

- Insulin Pen Injection Training
- Vial / Syringe Injection Training
- General Diabetes Information



# Target Education

Current  
Re-Think Your Drink  
Upcoming  
Foot Care

Available on  
**STAFF CONNECT**  
*English /Spanish*



## Drink Plenty



- Zero-calorie water
- Tea/Coffee without sugar
- Low-fat (1%) or fat-free milk, plain
- Minneapolis tap water

## Drink Occasionally



- Diet drinks
- Reduced-fat (2%) milk, plain
- 100% fruit or vegetable juice

## Drink Rarely



- Soft drinks (e.g. soda pop)
- Sports and energy drinks
- Fruit drinks or punches
- Whole or flavored milk drinks
- Other sweetened drinks



**reTHINK**  
**your drink!**  
every sip counts.



This project is supported by the Minneapolis Health Department with Statewide Health Improvement Partnership funding, Minnesota Department of Health.



# Behavioral Health Providers (BHP)

- **Integrated into Clinics**
- Available to Providers to step into visit for brief intro to Diabetes, injection training
- Available to CDE, BC-ADM to step into visit or refer to address Diabetes Distress, Fear of Injections, Mental or Family Barriers



[This Photo](#) by Unknown Author is licensed under [CC BY-SA-NC](#)

# **Diabetes Education 101 for the Behavioral Health Professional**

- **Target Audience**

- This program is intended for **mental health providers who treat current patients with or who are at-risk for diabetes.**

- **Learning Objectives**

- At the end of this activity, the attendees should be able to:
- Describe major challenges of living with diabetes that may be the focus of mental health treatment
- Apply general knowledge of diabetes to mental health care of people with diabetes
- Discuss potential roles of mental health professionals in the care of people with diabetes
- Integrate supportive terminology to interactions with people with diabetes and with other healthcare professionals

**FREE - American Diabetes Association**

# **Behavioral Health in Diabetes** **Care**

- **Overview:**
- This is a 7-module online learning program, includes a discussion forum once program is complete.
  
- **Target Audience:**
- •Certified Diabetes Care and Education Specialists (CDCES)/Master/Certified Health Education Specialist (MCHES)
- **Social Workers with experience working with people with diabetes**
- Other members of the diabetes care team
  
- **CE Credit:**
- 5.25 credit hours.

**FREE – American Diabetes Association**



# Endocrinology Clinic - ENDO



[This Photo](#) by Unknown Author is licensed under [CC BY-SA-NC](#)

# Dr. Richard Kleinmann - Volunteer

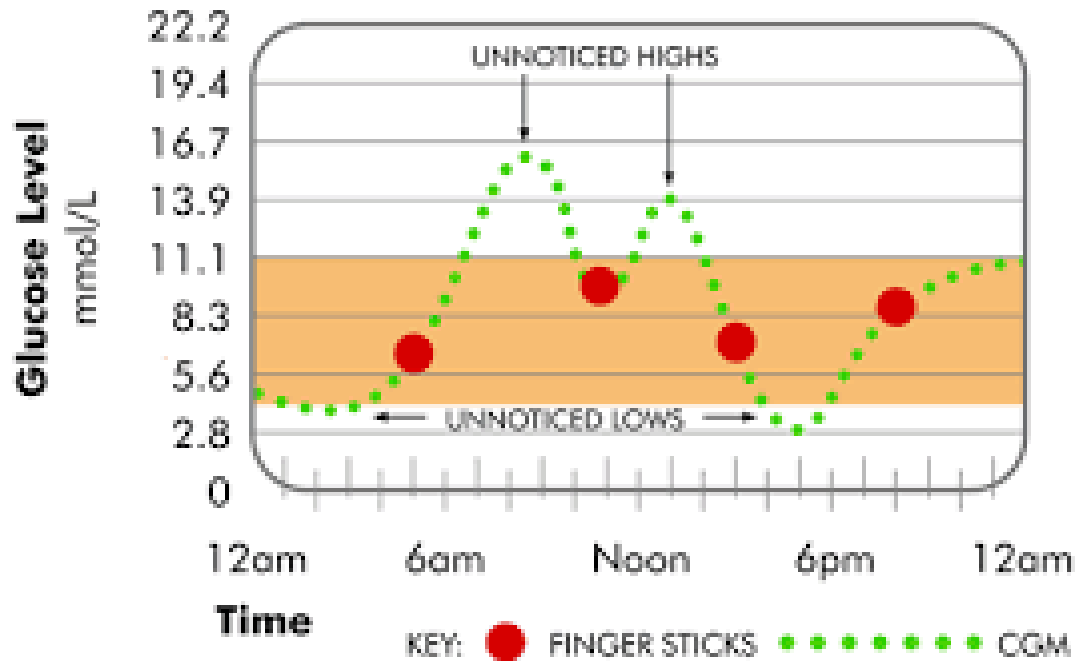
*Specializes in Endocrinology, Diabetes & Metabolism*

- 1<sup>st</sup> & 3<sup>rd</sup> Tuesday/Month, 8am – 2pm
- Common Referrals: Diabetes, Thyroid
- Functions as Consultant
- Initiates Prescriptions (PCP to complete refills)
- Order labs, Calls Patients with Results
- Performs Biopsies
- Requests Continuous Glucose Monitors
- Refers to BC-ADM for follow up between his visits
- Available for Phone Consults for Providers, CDE, BC-ADM
- Can only see Self-Pay Patients – *NO CHARGE*

# More Than Replacing Finger Sticks



# Why Invest in Continuous Glucose Monitoring?



# Continuous Glucose Monitoring System (CGMS)

- Low Alert Alarms
- High Alert Alarms
- Blood Sugar Rise, Fall Arrows
- Great for Those Fearful of Lows
- Ease of Testing
- Data can be shared with others
- Comprehensive Data





# Paper Blood Sugar Log Sheets

Day	Breakfast		Lunch		Dinner		Bedtime	
	Pre Post	Carbs Insulin	Pre Post	Carbs Insulin	Pre Post	Carbs Insulin	Carbs Insulin	
M	78	5/1	26/20	1	178	3/1	70	1
T	96	5/1	112 196	1	145	8	102	1
W	82	5/1	130 183	1	94	9/1	183	1
T	126	4/1	103	1	99	8/1	95	1
F	102	5/1	57	1	183	8/1		1

# CGMS Glucose Data

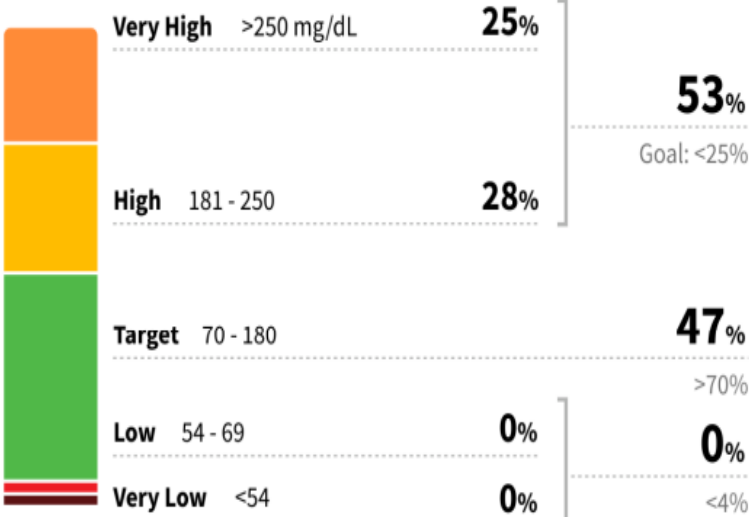
## Glucose Pattern Insights

Generated: 01/28/2023 Page: 1 of 1

Selected Dates: Jan 15 - Jan 28, 2023 (14 Days)

Time CGM Active: **88%**

### Time in Ranges



### Glucose Statistics

Average Glucose

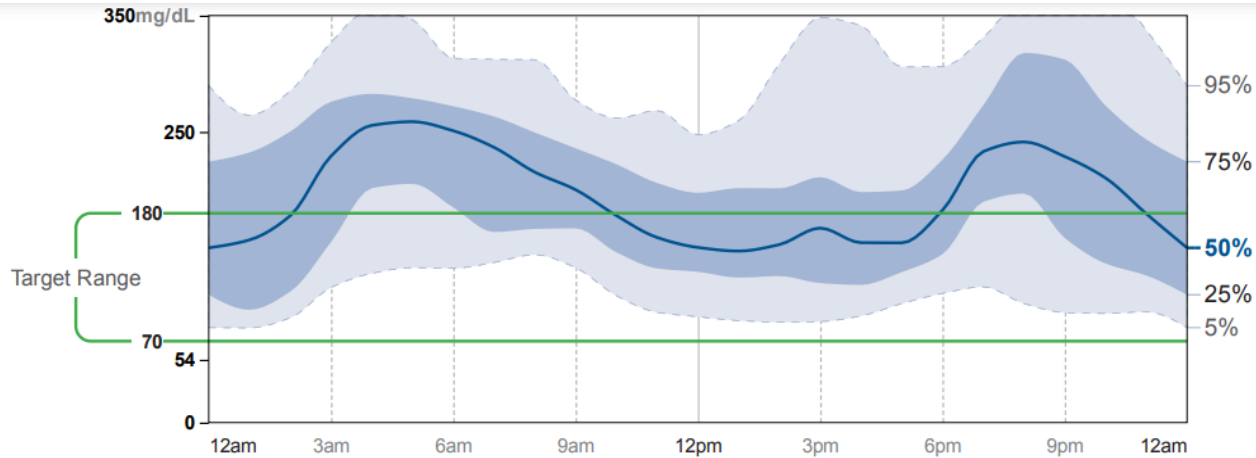
**196** mg/dL Goal:  $\leq 154$  mg/dL

Glucose Management Indicator (GMI)

Approximate A1C level based on average CGM glucose level.

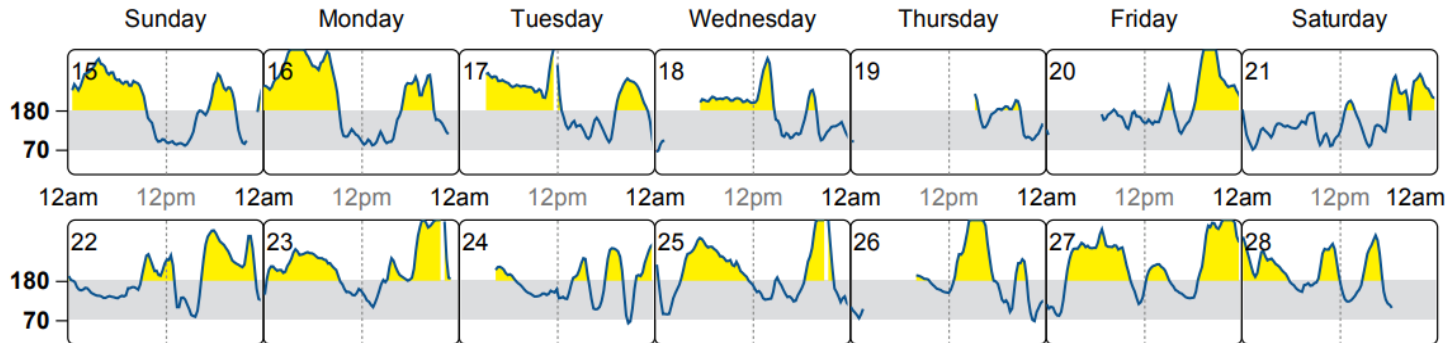
**8.0%** Goal:  $\leq 7.0\%$

# CGMS Patterns and Daily Data



## DAILY GLUCOSE PROFILES

Each daily profile represents a midnight to midnight period with the date displayed in the upper left corner.



# Free Style Libre 2



# How to Obtain CGMS for Insured

## Medicare/Medicaid

- Must be taking 3 injections a day
- Must order the reader
- Medicaid needs Prior Authorization
- Free Style Libre OR Dexcom
- Reimbursed for Training \$

## Commercial

- Depends on Insurance company regarding # of injections.
- Do not have to order reader
- Requires Prior Authorization
- Free Style Libre or Dexcom
- Reimbursed for Training \$

# CGMS for Self Pay

- No coverage for either Free Style Libre 2 or Dexcom
- For Patient Assistance Card - call Free Style Libre

## Kintegra ENDO

- *Grant Funded*
- Kintegra ENDO Clinic Patient
- Appointment scheduled 4-6 weeks for download and receive new sensors
- Requirements:
  - Multiple Daily Injections, Hx of DKA, Hx of Hypoglycemia, Fear of lows, Frequent Hospitalization


# What We Have Learned

- Value is based on more than reimbursement.
- Train and utilize other staff: *Chronic Care Managers, Community Resource Advocates (CRA's)*. That way everyone is speaking the same language and message.
- ENDO Clinic – Providers need reminder that Dr. Kleinmann does not take over care of the patient's diabetes.
- Primary Care Providers not quick to embrace CGMS. Not downloading data. ***Opportunity for training***
- Use of CGMS for ENDO Patients, is it the CGMS or frequent follow up attributing to improvement? ***Potential study***
- Advocate for patients at every resource juncture.

# Summary

- Expand Services – Chronic Care Model
- Increase resources for Patients – Grants, Public Relations
- Sustain Diabetes Program - Increase Program Value

## Tools

- Draw on your past experiences
  - Increase your skill set
  - Build a multidisciplinary support team
  - Advocate for patients as every resource juncture
  - Do not be afraid to ask. The worst thing you could hear is no!
- 





# DSMES

# TOOLKIT

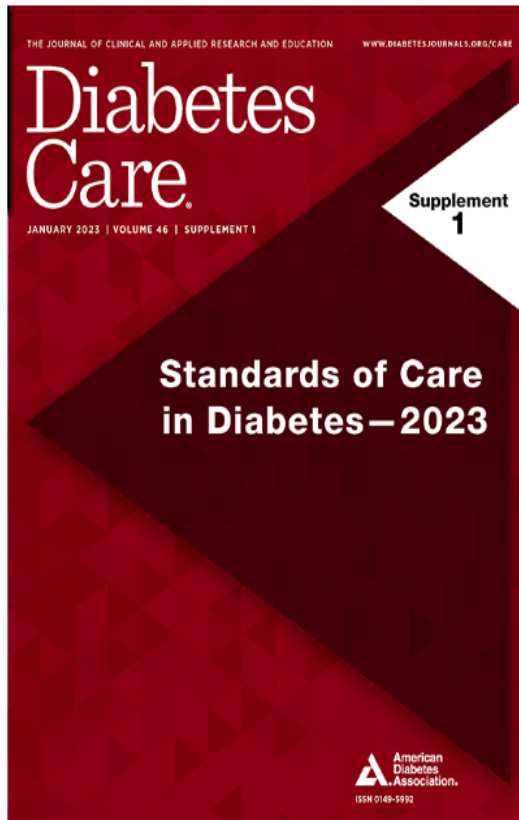


Centers for Disease Control and Prevention

CDC 24/7: Saving Lives, Protecting People™

<https://www.cdc.gov/diabetes/dsmes-toolkit/index.html>

# American Diabetes Association



**Standards of Care in Diabetes**

**Abridged Standards of Care for Primary Care Providers**

**Standards of Care App**

<https://professional.diabetes.org/>