North Carolina's Guide to Prevention and Management of Diabetes 3rd Edition

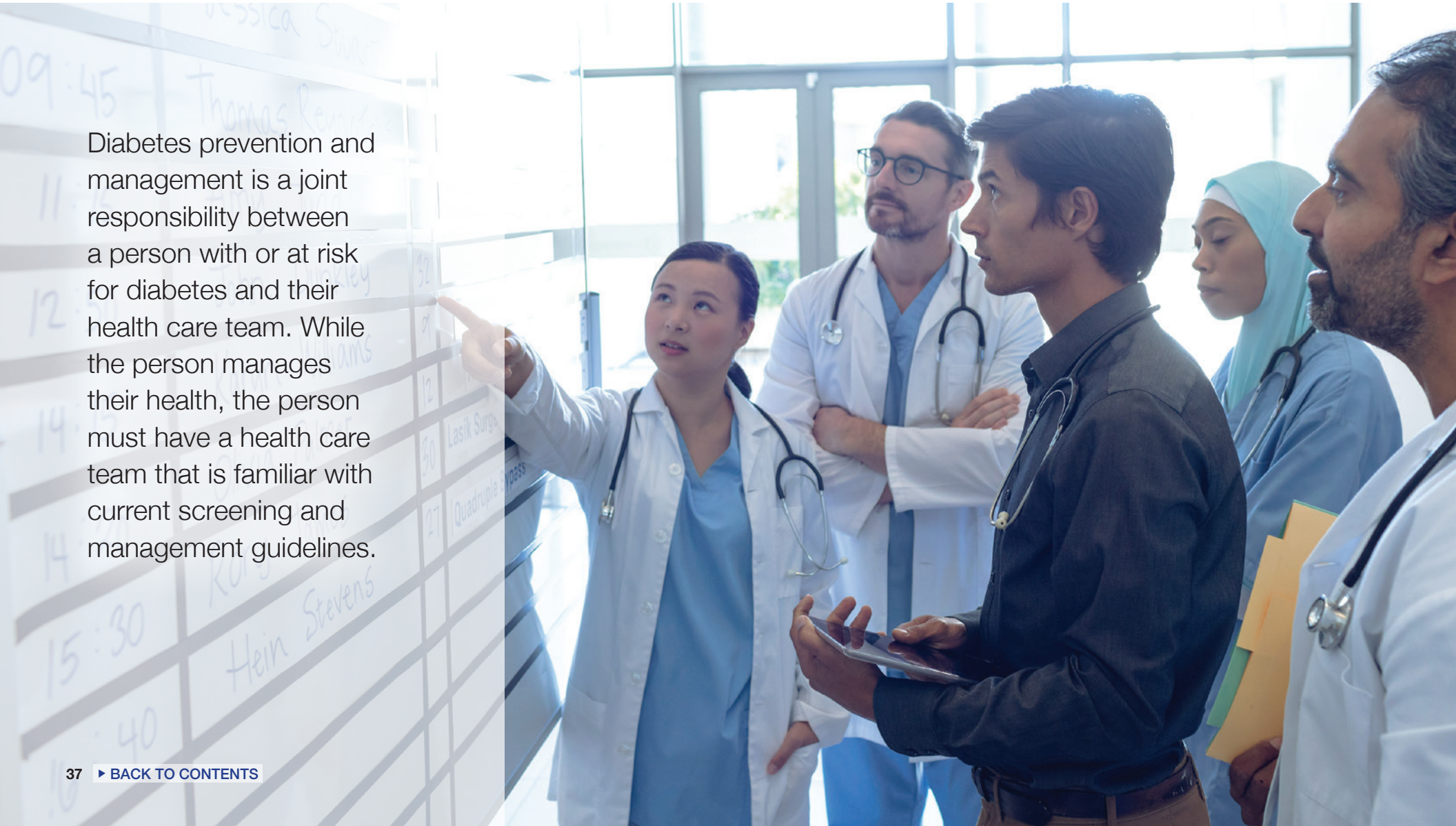
North Carolina Diabetes Advisory Council

What Can Health Care Providers Do?

MANAGE WEIGHT | LIVE TOBACCO FREE | PARTICIPATE IN LIFESTYLE CHANGE PROGRAMS
PARTICIPATE IN DIABETES EDUCATION | ENGAGE IN TREATMENT PLAN | GET ADEQUATE SLEEP

What Can Health Care Providers and Insurers Do?

Diabetes prevention and management is a joint responsibility between a person with or at risk for diabetes and their health care team. While the person manages their health, the person must have a health care team that is familiar with current screening and management guidelines.



Health Care Providers

Health care providers encompass a broad range of professionals with general and specialized expertise in diabetes and its complications. This includes physicians, physician assistants, advanced practice nurses, pharmacists, podiatrists, ophthalmologists, optometrists, dentists, audiologists, registered dietitian nutritionists, nurses, diabetes care and education specialists, behavioral health and mental health providers, among others. These providers play a crucial role in counseling individuals at risk for diabetes on strategies to prevent or delay the onset of the disease and its complications. They also diagnose diabetes and collaborate with patients to manage their condition through lifestyle and behavioral changes, medication, and other therapies.

Moreover, health care providers are uniquely positioned to refer individuals with diabetes to recognized Diabetes Self-Management Education and Support (DSMES) services. While the term "health care provider" is often associated with physicians, physician assistants, and advanced practice nurses, many other professionals are essential to diabetes care. This includes case managers, care coordinators, physical and occupational therapists, trainers, and exercise physiologists. Additionally, community pharmacists and community health workers have developed unique and valuable roles in supporting individuals with diabetes.

Community Pharmacists play a unique and vital role in the care of people with diabetes. With greater accessibility and frequent interactions, they often see patients more regularly than other health care providers, fostering strong collaborative relationships. Community pharmacists are instrumental in managing medication therapy, providing crucial safety checks for medications prescribed by multiple providers, and offering guidance on over-the-counter treatments. They also serve as valuable resources for information on available and affordable therapies for diabetes management.

Increasingly, community pharmacists are incorporating Diabetes Self-Management Education and Support (DSMES) services into their practices. The involvement of pharmacists in DSMES programs has led to significant improvements in medication adherence and persistence among participants, further enhancing the overall management of diabetes.[114,115]

Community Health Care Workers (CHWs) are typically lay health care workers who provide vital assistance to people with diabetes, their families, and the broader community through education and support services. Working within their own communities, CHWs share linguistic, cultural, economic, and social characteristics with those they serve, which fosters trust and respect. This connection enables CHWs to build strong relationships and serve as essential links between the community and the health care system.[116]

CHWs provide support, education, and resources related to health crises, prevention, ongoing care, and transitions of care. Their role is crucial in improving the overall health of underserved communities, reducing health disparities, and advancing health equity. Research has shown that individuals who receive interventions from CHWs experience better glycemic and lipid management, along with reduced health care utilization.[117] Moreover, economic evidence suggests that CHW interventions are cost-effective.[118]

Recognizing the value of CHWs, health care teams are increasingly incorporating them as integral members of diabetes care teams. The Community Preventive Services Task Force (CPSTF) initiated interventions in 2017 that engaged CHWs to help patients manage their diabetes. These interventions demonstrated improvements in patients' glucose and lipid management, as well as reductions in health care usage. The interventions included education, support, and coaching on glucose monitoring, medication adherence, healthy nutrition, physical activity, and weight management.

For further information, the **NC Community Health Worker Initiative** provides valuable resources. If your community does not have a CHW, the Centers for Disease Control and Prevention (CDC) offers a **CHW Toolkit** to help establish such programs

Challenges Faced by Health Care Providers

North Carolina has made significant progress in expanding the availability of health care providers across its diverse geography and communities. Nationally recognized programs such as Area Health Education Centers (AHEC), the state health department, and federally qualified health centers, along with the state's commitment to professional health education through its esteemed institutions, have all played crucial roles. Additionally, the focus on developing physician assistants and advanced practice nurses has enhanced the quality of health care available to diverse populations.

Despite these advancements, challenges remain. Underserved communities and disparities continue to be significant issues, as detailed in the section on Social Determinants of Health and Health Equity (p. 26). Health care providers also face obstacles related to adequate reimbursement for services and the need for ongoing education to keep pace with new technologies, including telehealth. Furthermore, the rapid pace of clinical developments necessitates quicker adaptation to new, proven therapeutic advances.

Therapeutic Inertia: Despite advancements in technologies and therapies, nearly half of all people with diabetes in the United States continue to have blood sugar levels that exceed target goals.[119] Therapeutic inertia—defined as the delay or failure to set appropriate treatment targets and progress treatments to achieve desired outcomes—remains a significant barrier to effective diabetes management. This issue can hinder the adoption of new, proven advances in diabetes care, including monitoring techniques, medications, and delivery methods.

To address therapeutic inertia, health care providers need to stay updated with the latest therapeutic options and emerging evidence about their effectiveness. Collaborative approaches, such as team-based care models, can be effective in overcoming this barrier.[120]

Table 5: Understanding and Overcoming Therapeutic Inertia[121]

Did you know?	How health care providers and insurers can overcome therapeutic inertia:
In the last 20 years despite more technology, more education and more drug therapies the average A1C for a person with diabetes has not changed. The number of people with an A1C over 9% has actually increased.	Refer your first patient (or additional people) with prediabetes to a DPP program.
Treatment intensification is significantly behind recommendations.	Stay up to date on emerging effective strategies—read and attend professional continuous education opportunities.
Only 5% of people recently diagnosed with diabetes on Medicare are using DSMES services.	Consider being an early adopter for new therapies that interest you or those you treat and gain experience sooner than later to share with those you treat.
There is a significant gap in what people say they are willing to do and what physicians believe people are willing to do to reduce A1C.	Get involved in community, professional and other organizations whose mission is to reduce the burden of diabetes.
Within one year of a diagnosis of diabetes, less than 50% of people are still taking the prescribed medication.	Partner with a Diabetes Care and Education Specialist to help bring emerging and effective therapies and technology into your practice or to those you treat.

Health Care Insurers ("Payers") also have multiple roles to play including:

For their insured members:

- Reimbursing individuals with diabetes or their health care providers for covered services such as direct primary and specialty care, medications, equipment, and Diabetes Prevention Programs
- Establishing their own plan specific policy for what are and are not covered services

Participation with government, employers and advocacy groups:

- More broadly shaping reimbursement policy for what are covered services across North Carolina

Over the past decade in North Carolina, insured individuals have seen expanded coverage for services, including insulin, medications, glucometers, testing supplies, vaccines, and participation in diabetes prevention programs, particularly for those at high risk. However, this coverage remains incomplete and is not universally available.

Recently several reimbursement issues driving policy deliberations in the state for broader coverage include:

- Universal reimbursement of Diabetes Prevention Programs
- Managed Medicaid
- Telehealth technology reimbursement
- Group medical or clinical visits
- Better reimbursement and coverage for DSMES and diabetes supplies, hearing aids, orthotics, reimbursement for pharmacists for DSMES

Need for better reimbursement for telehealth services not only in rural areas with reduced health care access has been particularly emphasized across the state—urban, suburban and rural—due to the COVID-19 pandemic. Telehealth can provide a wide range of clinical and educational services including indirect care and diabetes prevention.

Additional ways health care insurers and providers can work together around policy change are included in Table 6.

Table 6: Activities for Health Care Providers and Insurers

Diabetes Primary Prevention

To help manage weight and/or participate in regular physical activity

1. Advocate for walkable communities.
2. Refer people to evidence-based weight loss programs including those offered through diabetes prevention programs, or North Carolina's **Eat Smart, Move More, Weigh Less** or a registered dietitian nutritionist for weight management.
3. Engage barbers and hair stylists as community ambassadors of diabetes prevention and management, supported by community grants, partnerships with insurers and health care system, community health workers.[122]

To help live tobacco free

1. Refer people to the **Quitline.**
2. Support programs like **Live Vape Free** to help educate on the dangers of vaping.

To promote adequate sleep

1. Ask people about the quantity and quality of their sleep and advise accordingly (i.e. sleep studies to diagnose sleep apnea).

Diabetes Prevention for People at High Risk

To help participation in diabetes prevention programs

1. Refer people to diabetes prevention programs and build the referral into the electronic health record (may require A1C level with definite glucose metrics required).
2. Train community resource providers of diabetes prevention programs on how to provide feedback on program participation to health care providers.

Diabetes Management and Prevention of Complications

To help participation in individual and/or group Diabetes Self-Management Education and Support (DSMES) services

1. Establish a professional relationship with hospital transition coordinators to ensure knowledge of local DSMES services and develop integration of these services into discharge paperwork.
2. Partner with a sponsoring agency to become an expansion site to deliver DSMES services, either in person or via telemedicine.
3. Refer people with diabetes to recognized DSMES services and build the referrals into the electronic health record.
4. Consider the incorporation of a Diabetes Care and Education Specialist in the primary care office without the addition of a copay or separate visit for the person with diabetes.
5. Partner with local DSMES service providers, such as local pharmacies, podiatrists, ophthalmologists/optometrists, dentists, and audiologists.[123]
6. Ensure that DPP and DSMES are covered benefits for all and waive co-pays/out of pocket deductibles.
7. Partner with CHWs in the communities to provide support, ongoing education, resources, and a link between providers and persons with prediabetes or diabetes.

To help with monitoring diabetes treatment for individual and population health

1. Develop standing orders for screening for diabetes.
2. Follow the United States Preventive Services Task Force screening recommendations and build it into the practice electronic health record.
3. Use plain language in communication with people with diabetes about diagnosis and plan of care. Consider health literacy and numeracy needs.
4. Follow clinical guidelines for diabetes care.
5. Encourage clinical decision support systems.
6. Work with Area Health Education Centers to improve continuing education about diabetes care.
7. Work with pharmacists to ensure that patients are taking the least expensive drugs that are appropriate for their condition, as well as simplification of medication plans to help reduce medication (pill) burden.
8. Follow clinical guidelines for post-partum screening of women who have had gestational diabetes.
9. Consider participating in the American Medical Group Association's Together 2 Goal program to ensure best practices.
10. Incorporate the use of technology in individualized treatment plans, including remote monitoring and real-time or flash continuous glucose monitoring.
11. Support the use of reimbursement of Telehealth for virtual clinical care and education.

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