YOUR PATIENTS, A PROVEN PARTNERSHIP

Florida HEALTH
Bay County

Diabetes Services Program

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Why Refer Your Patients for Diabetes Education

When it comes to Diabetes Prevention and Self-Management, education is the key. Studies show that people who are educated in lifestyle change have controlled blood sugars that reduce their complications and improve their quality of life.

Diabetes Self-Management Education

The Florida Department of Health in Bay County's Diabetes Services Program provides certified diabetes educators that are licensed health care professionals, registered nurses and dietitians. These providers specialize in helping people with diabetes understand how to manage their disease. The counseling and support they offer is known as diabetes self-management education.

Certified diabetes educators have a unique skill set and serve as essential support for people with diabetes. Diabetes educators can:

- Increase your practice's efficiency by assuming time-consuming patient training, counseling and follow-up duties.
- Help you meet pay-for-performance and quality improvement goals.
- Track and monitor patient care and progress and provide you with status reports.

While you manage your patients' care, diabetes educators focus on empowering them to manage their diabetes. They teach, coach and guide patients so they understand their diabetes in the context of their personal lives and work with them to set- and meet- behavior change goals to improve their health.

Diabetes Prevention Program

You know the stats. One in three people are at risk for developing type 2 diabetes. You also know that minimal weight loss of five to seven-percent reaps huge health benefits. The Diabetes Prevention Program, DPP, reduces risk for developing Type 2 diabetes by 58-percent. And for people over age 60, DPP has shown to reduce risk by 71%.

Your patients are 15 times more likely to develop Type 2 diabetes if they do nothing, than if they take the DPP class. They are looking to you for health information they can trust. Empower your patients to take charge of their health and learn how to make realistic and achievable lifestyle changes. Refer your patients to DPP where they can learn skills to problem solve, reduce stress, manage weight, and increase exercise.

Why Partner with DOH-Bay Diabetes Services

Diabetes Education Accreditation Program, DEAP

The Florida Department of Health in Bay County's Diabetes Self-Management Education, DSME, program is DEAP, Diabetes Education Accreditation Program, accreditated. It is the only program in the area to achieve this recognition. This accreditation is provided by the American Association of Diabetes Educators.

Diabetes Prevention Program Pending CDC Recognition

Our Diabetes Prevention Program is pending recognition by the CDC. This means our program is delivering results, using the CDC approved curriculum, and has dedicated staff to provide the lifestyle change program. These are just a few of the criteria that we have met to be considered.

Ounce of Prevention Fund Independent Program Audit

The Ounce of Prevention Fund, an outside agency, audited DOH-Bay's Diabetes Services Program. They found that overall patients were satisfied with the education they received. They also found that outcomes of those who participated met or exceeded goals.

The Ounce of Prevention reported that patients in the DSME program met weight loss goals, increased physical activity, and reduced their AICs. The audit also found that participants were satisfied with the information they received. For patients in DPP, they met or exceeded their weight loss goal of five-percent and physical activity goal of 150 minutes per week.

What Our Partners are Saying

"We find the services at the Florida Department of Health in Bay County's Diabetes Services Program to be a valuable asset to utilize for our pregnant women with diabetes," said Dr. Jeffrey Livingston from North Florida Perinatal Associates, Inc.

What Our Patients are Saying

"This class is the best thing a diabetic can do."

"Knowledge is power! I can manage what I eat and know how it's affecting me."

"The course was easy and right to the point. If I can figure it out, anybody can."

Services Offered by DOH-Bay Diabetes Services

Diabetes Self-Management Education

Diabetes Self-Management Education helps your patients know:

- What treatment options they have
- What they can eat
- How they can make sense of their glucose numbers
- What to do if they are sick
- How they can lose weight and be active

Morning and afternoon classes are available.

Medical Nutrition Therapy

Medical Nutrition Therapy, MNT, is for any diagnosis, not just diabetes. If the patient wants to lose weight, decrease blood pressure, or just improve overall health MNT is a good option. MNT can also be disease specific eating disorders, renal impairment, or persons living with diabetes. This includes patients who have several health issues, including diabetes, and need a healthy meal plan that includes recommendations for all of their health concerns. This is also an option for patients who may have attended a DSME class but need additional help with nutrition, meal planning, and carbohydrate counting. Medical Nutrition Therapy is an individual appointment with a Registered Dietitian (RD) who can help patients “put it all together”.

Diabetes and Pregnancy Consultation

This option is for patients who are struggling to manage their diabetes while they are pregnant. It provides them information about how diabetes impacts their pregnancy, how to have a safe pregnancy and deliver a healthy baby. This is also beneficial to women who have been recently diagnosed with gestational diabetes. RDs/CDEs cover topics such as an overview of gestational diabetes, blood glucose monitoring, nutrition counseling, insulin instruction and post-pregnancy care. This service includes gestational as well as high-risk OB clients.

Insulin Pump Training/Management

A CDE trained and experienced in insulin pump management conducts individual consultation sessions with physician referred participants to cover basic and advanced insulin pump training.

Services Offered by DOH-Bay Diabetes Services

Living Well with Diabetes

Living Well with Diabetes is for patients who have completed the DSME. This class offers continued support and accountability for their new healthy lifestyle.

Type 2 Diabetes Support Group

Our Type 2 Diabetes Support Group is facilitated by RN/RD/CDE staff. It offers discussions on diabetes related topics chosen by support group members. This option is free and open to the public. Meetings are on the first Wednesday of the month from 4:00 - 5:00 p.m. at DOH-Bay.

Individual Consultations

Individual consultations are available for patients requiring more in depth education. This includes topics such as pregnancy and diabetes, Type 1 diabetes, insulin pump education and management, continuous glucose monitors (CGM), pre-pregnancy planning for diabetes, or individuals that learn better in a one on one environment.

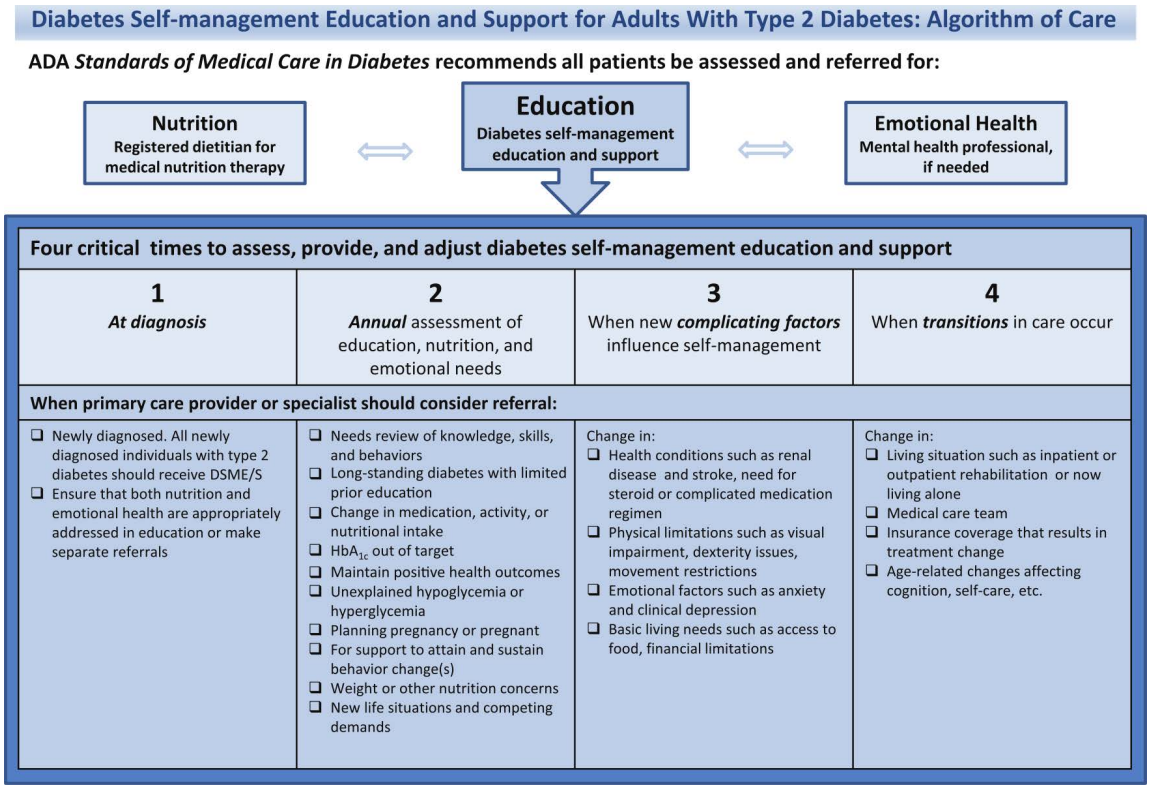
Diabetes Prevention Program

DPP is for patients who are at risk for developing Type 2 diabetes based on a risk factors test (enclosed), who have been diagnosed with pre-diabetes or have a history of gestational diabetes. This may include patients who are; overweight, have a family history of diabetes, or who have had a baby weighing more than nine pounds at birth. Type 2 diabetes can be delayed or prevented in people with pre-diabetes through this effective lifestyle program. DPP is great option for women who are in the family planning stage and may be at risk. As you know, reducing their weight and increasing physical activity will help them have a healthier pregnancy and baby.

Worksite Wellness

As part of our commitment to a Healthy Bay County, the Diabetes Services Program supports organizations seeking to create a healthy workplace. We provide rapid point of care biometrics onsite and individual health counseling for employees identified at risk for chronic disease such as diabetes, heart disease, and stroke. Counseling also includes information on tobacco cessation class.

When to Refer Your Patients to DSME



A list of recognized and accredited DSME programs in your area can be found on the ADA and AADE websites:
ADA: http://professional2.diabetes.org/erp_zip_search.aspx
AADE: http://www.diabeteseducator.org/ProfessionalResouces/accred?Programs.html#Florida

People with Type 2 diabetes should be referred to a DSME class that is either accredited by the American Association of Diabetes Educators (AADE) or recognized by the American Diabetes Association (ADA) at diagnosis, annually, when new complicating factors influence self-management and when new transitions in care occur.

Any test used to diagnose diabetes requires confirmation with a second measurement unless clear symptoms of diabetes exist. The following chart provides the blood test levels for diagnosis of prediabetes and diagnosis of diabetes for non-pregnant adults:

Diagnostic Test	Normal	Prediabetes	Diabetes
HgbA1c (%)	<5.7	5.7-6.4	≥ 6.5
Fasting plasma glucose	<100	100-125	≥ 126
Oral glucose tolerance test	<140	140-199	≥ 200

Normal	Prediabetes	Diabetes
• Encourage patient to maintain a healthy lifestyle. • Continue with exam/consult. Retest within three years of last negative test.	• Refer patient to Diabetes Prevention Program. (Does not qualify for DSME) • Consider retesting annually to check for diabetes onset.	• Confirm diagnosis; retest if necessary. • Counsel patient on diabetes diagnosis. • Initiate DSME therapy referral.

*Adapted from Diabetes Self-Management Education and Support in Type 2 Diabetes, A Joint Position Statement of the American Diabetes Association, the American Association of Diabetes Educators, and the Academy of Nutrition and Dietetics, Powers et al, 2015.

When to Refer Your Patients to DPP

If the patient is age 40-70, is obese or overweight and does not have diabetes, proceed to the blood test

If the patient is age ≥ 18 and does not have diabetes, nor meet the criteria above, provide self-screening test, and if self-screening test reveals high risk, proceed to next step

Review medical record to determine if BMI>25* (>23 if Asian) or history of GDM**

NO

Patient does not currently meet program eligibility requirements

YES

Determine if a HgbA1c, FPG or OGTT was performed in the past 12 months

NO

Order one of the tests below:

- Hemoglobin A1c (HgbA1c)
- Fasting plasma glucose (FPG)
- Oral glucose tolerance test (OGTT)

RESULTS

YES

Diagnostic test	Normal	Prediabetes	Diabetes
HgbA1c (%)	<5.7	5.7 – 6.4	≥ 6.5
Fasting plasma glucose (mg/dL)	<100	100 - 125	≥ 126
Oral glucose tolerance test (mg/dL)	<140	140 – 199	≥ 200

Encourage patient to maintain a healthy lifestyle

Continue with exam/consult. Retest within three years of last negative test

- Refer patient to Diabetes Prevention Program, provide program brochure
- Consider retesting annually to check for diabetes onset

- Confirm diagnosis; retest if necessary
- Counsel patient on diabetes diagnosis
- Initiate DSME therapy referral

Adapted from: Preventing Type 2 Diabetes-A guide to refer your patients with prediabetes to an evidence-based diabetes prevention program

When to Refer Your Patients to DPP

Physicians and other health care providers may use this process, in addition to their independent judgement, when referring to a diabetes prevention program. You may make copies of patient resources provided by DOH-Bay County in advance of patient visits, so your office can have them available in the waiting room or during consult.

Measure:

Step 1: During check in: If age ≥18 and patient does not have diabetes, give him/her the "CDC Prediabetes Screening Test" or American Diabetes Association "Diabetes Risk Test". After patient completes the test and returns it, insert completed test in the paper chart or note risk score in the electronic medical record (EMR). Screening test can also be mailed to patient along with other pre-visit materials.

Step 2: During rooming/vitals: Calculate the patient's body mass index (BMI). Most EMRs can calculate the BMI automatically. Review the patient's diabetes risk score and if elevated (>5 on ADA test of >9 on CDC test), flag for possible referral to DPP.

Step 3: During exam/consult: Follow the "Point-of-Care Prediabetes Identification Algorithm" to determine if patient has prediabetes. Patients who are at risk based on the quiz should be screened with one of the following tests: Hemoglobin A1c (HbA1C or A1C), Fasting Plasma Glucose, or Oral Glucose Tolerance Test.

If the blood results do not indicate prediabetes: encourage the patient to maintain healthy lifestyle choices. Continue with exam/consult.

Act

A. If the patient screens positive for prediabetes and has BMI <25* (<23 if Asian):

- Introduce the topic of prediabetes by briefly explaining what it is and its relation to diabetes. Review the patient's personal risk factors.
- Emphasize the importance of prevention, including healthy eating, increased physical activity, and the elimination of risky drinking and tobacco use (Visit the National Diabetes Education Program's GAME PLAN to Prevent Type 2 Diabetes for additional patient resources).

B. If the patient screens positive for prediabetes and has BMI >25* (>23 if Asian):

- Follow the steps in "A" above, discuss the value of participating in a diabetes prevention program, and determine the patient's willingness to let you refer him/her to a program.
- If the patient agrees, complete and send the referral form to FDOH-Bay County or another community-based or online diabetes prevention program, depending on patient preference. Programs can be found at https://nccd.cdc.gov/DDT_DPRP/Programs.aspx.
- If patient declines, offer him/her a program handout and re-evaluate risk factors next clinic visit.

When to Refer Your Patients to DPP

Step 4: Referral to diabetes prevention program: DOH-Bay County's Diabetes Prevention Programs is configured to receive referrals via conventional fax. Complete the referral form and submit to 850-462-6200.

Partner

Step 5: Follow up with patient: DOH-Bay County will advise you when your patient has completed the program or declines participation. At the next clinic visit ask patient about progress and encourage continued participation in the program.

* These BMI levels reflect eligibility for the National DPP as noted in the CDC Diabetes Prevention Recognition Program Standards and Operating Procures. The American Diabetes Association (ADA) encourages screening for diabetes at a BMI of > 23 for Asian Americans and > 25 for non-Asian Americans and some programs may use the ADA screening criteria for program eligibility.
** History of GDM = eligibility for diabetes prevention program

Adapted from Preventing Type 2 Diabetes: A guide to refer your patients

Diabetes Services Referral Process

1. Thank you for referring your patient to DOH-Bay County's Diabetes Services Program for Diabetes Self-Management Education (DSME) or National Diabetes Prevention Program. Your clients are important to us and we want to ensure they receive quality care in a timely manner. Please review the following steps to make this process efficient and effective.

2. The medical provider should complete the Diabetes Services Program referral form. Please ensure the form is completed in entirety and your information and the patient's information is clearly written. Please fax the completed referral form to 850-462-6200. DOH-Bay County is HIPAA compliant and referrals are received by secured fax process.

3. The form is reviewed for completeness by the DSP intake RN or her designee. If incomplete, the intake RN (or designee) calls the HCP office and requests the missing information be sent within 5 business days. If information is not received after 5 days, a second call to that office will be made and the referral form will be placed in a hold file for 30 days. If information is still not received after 30 days, the referral form will be placed in the incomplete forms folder and held for one year.

4. When a completed form is received, the referred client will be contacted within 3 business days to schedule an appointment. DSP will make 3 attempts within 10 business days to contact the client. If DSP is unable to contact the client, a letter will be sent to the referring HCP advising them of the inability to contact their patient. If the client was contacted and refused an appointment, a letter will be sent to the HCP advising them of the refusal.

5. Once scheduled for an appointment, DSP will mail the client a welcome letter, the date and time of their appointment, a health questionnaire and a pre-test. The client is asked to complete the questionnaire and pre-test and bring them to the first appointment.

6. DSP faxes the referring HCP a copy of the referral form with the client's appointment date and time documented at the bottom of the form. If the client cancels or is a no show, the referring HCP will be notified via fax or mail.

7. Once the client has completed the DSME Program, DSP Staff will fax a follow-up report to the referring medical provider