Insights and Lessons Learned Roundtable: Reflecting on Multi-Directional e-Referral Implementation Supporting National Diabetes Prevention Program and Diabetes Self-Management Education Support Services

October 16, 2024

Moderator: Evelyn Gallego

Panelists: Deb Anderson, Shannon Gopaul, Janice Magno, Charlene Wallace

The Diabetes MATCH Initiative: Mobilizing **A**ccess **T**hrough **C**apacity Building & **H**ealth Equity

This content was supported by Cooperative Agreement Number CDC-RFA-DP-23-0021, entitled *A Strategic Approach to Advancing Health Equity for Priority Populations with or at Risk for Diabetes- Subject Matter Expertise, Training, and Technical Assistance*, funded by the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention or the Department of Health and Human Services.

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Meet our Moderator

Evelyn Gallego, MBA, MPH, CPHIMS

Chief Executive Officer and Founder

EMI Advisors

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Session Objectives

- Describe the role of Multi-Directional e-Referrals (MDeR) in improving diabetes care for priority populations and building clinical-community linkages
- Share implementation insights and promising practices from recipient organizations funded by Centers for Disease Control (CDC) cooperative agreement DP23-0020, *A Strategic Approach to Advancing Health Equity for Priority Populations with or at Risk for Diabetes*, and related subject matter experts
- Foster dialogue and knowledge-sharing to maximize the impact of MDeR in diabetes prevention and management

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A Strategic Approach to Advancing Health Equity for Priority Populations With or at Risk for Diabetes CDC-RFA-DP-23-0020

- This notice of funding opportunity (NOFO) seeks to:
  - Decrease risk for type 2 diabetes among adults at high risk
  - Improve self-care practices, quality of care, and early detection of complications among people with diabetes
  - Support implementation of evidence-based, family-centered childhood obesity interventions as a type 2 diabetes risk reduction strategy
  - Strategies are based on interventions grounded in scientific and practice-based evidence

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77 Recipients who fall into one of the below categories:

- **Component A**: Statewide (or DC-wide) reach to eliminate health disparities and achieve health equity for identified priority populations by activating at least six diabetes care and prevention strategies
- **Component B**: Working in high-need counties in partnership with community-based organizations by activating at least four diabetes care and prevention strategies
- **Component C:** (a new approach) Multi-sector partnerships to enroll 10,000 participants in the National Diabetes Prevention Program (DPP) or Medicare DPP

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Strategies by the Number

Strategies 1-4	**1. Increase access to Diabetes Self-Management Education Support (DSMES) and Diabetes Support Programs** 2. Increase Medicaid and employer coverage for DSMES 3. Increase early detection of Chronic Kidney Disease (CKD) and retinopathy 4. Improve team-based care and quality of care for people with diabetes
Strategies 5-7	**5. Increase access to the National DPP Lifestyle Change Program and Medicare DPP Lifestyle Change Program** 6. Increase Medicaid and employer coverage for CDC-recognized lifestyle change programs 7. Increase National DPP sustainability through umbrella hub arrangements
Strategy 8	8. Scale and sustain family-healthy weight programs

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Strategies by the Number

Strategies 9-13

9. Use pharmacy chains and networks to expand DPP/DSMES
10. **Develop multi-directional e-referral to address Social Determinants of Health (SDOH) needs**
11. Design and test innovative payment models with DPP/DSMES/SDOH bundles
12. Improve CHW sustainability in DPP/DSMES
13. Build capacity of the diabetes care workforce around SDOH

These are system-level strategies that support diabetes prevention, diabetes self-management and care, and family health weight programs

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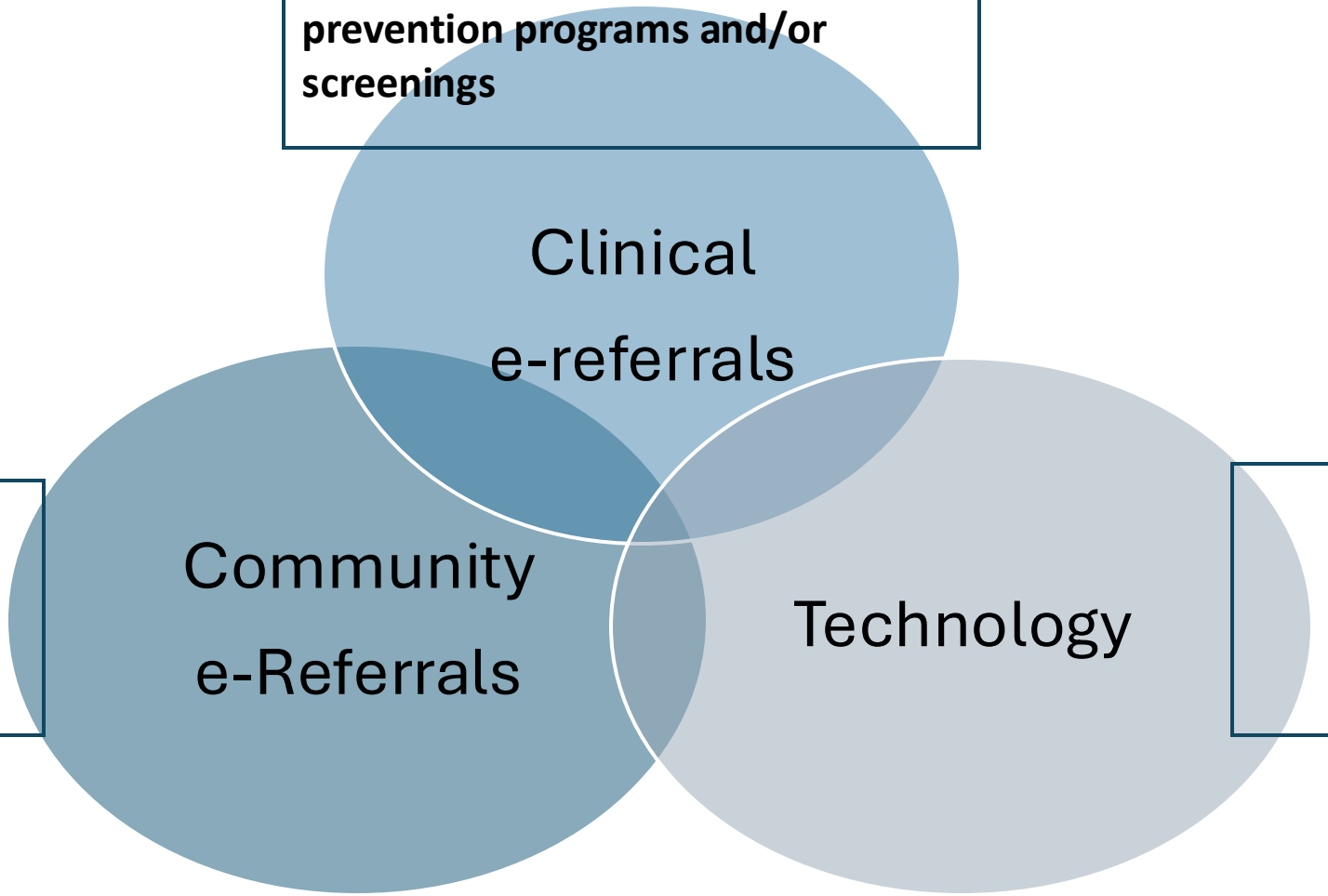
Intent of Strategy 10: Connect Health and Social Care

Connect patient to evidence-based prevention programs and/or screenings



Navigate community resources

Closed loop e-referral system; Connect health care and social care

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Meet our Panelists

Charlene Wallace, *Vice President, Diabetes Prevention*	**Deb Anderson,** *Health IT Consultant*	**Janice Magno,** *Executive Director, Community Healthcare Strategic Partnerships*	**Shannon Gopaul,** *Chronic Disease Division Chief*
American Diabetes Association	Wyoming 211, Inc.	NYC Department of Health and Mental Hygiene	District of Columbia Department of Health
The ADA developed a collective impact network of partners to contribute to the health, behavior, policies, systems, and environments related to the National DPP. Additional focus is on the creation of infrastructure to support MDeR implementation in health and social care, insurers and employers to increase enrollment.	Wyoming 211 established CommuniCare, a CIE, that supports partners in accessing a single longitudinal client record to share relevant information and closed-loop referrals. Current work is being done to expand the CIE reach to include state and regional chronic disease prevention and management programs.	Advancing Care and Equity for Diabetes Prevention and Management (ACED) focuses on 22 neighborhoods in NYC that aims to increase community and clinical collaborations that support prevention and management of diabetes, including clinical interventions, SDOH screenings and referrals.	DC Health is working with the region's Health Information Exchange, CRISP, to integrate LinkUDMV, an MDeR tool focused on health and social needs services. They are focused on training providers, facilitating increased uptake of the tool in hospitals and clinics, while ensuring that underserved populations receive timely and coordinated support.

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Let's Stay in Touch

Charlene Wallace, *Vice President, Diabetes Prevention*	**Deb Anderson,** *Health IT Consultant*	**Janice Magno,** *Executive Director, Community Healthcare Strategic Partnerships*	**Shannon Gopaul,** *Chronic Disease Division Chief*
American Diabetes Association	Wyoming 211, Inc.	NYC Department of Health and Mental Hygiene	District of Columbia Department of Health
Cwallace@diabetes.org	Danderson@wyoming211.org	Jmagno@health.nyc.gov	Shannon.gopaul@dc.gov

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Thank you!

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