July 2025 Diabetes Prevention and Management Community of Practice (DPM CoP)

Kickoff & Mapping the Referral Landscape

DC Health Chronic Disease Division & April B. Reese, MPH, CHES (NACDD)

Date: July 22, 2025

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Agenda

- Welcome/Introductions
- Ice Breaker
- Updated DPM CoP Curriculum
- Identifying and Mapping Referral Pathways
- DSMES Referral Network Toolkit Resource
- Q&A

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Ice Breaker: Would You Rather!

Would you rather have to calculate carbs for every single meal, or only eat the same five foods forever?

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Diabetes Prevention and Management Community of Practice (July 2025- June 2026)

Goal, Objectives, Curriculum

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About Us: The Diabetes Prevention and Management Community of Practice

- DC Health's Diabetes Prevention and Management Community of Practice (DPM CoP) convenes key stakeholders across clinical, community, and pharmacy settings to **expand access, visibility, and sustainability of high-quality diabetes prevention and management services** in Washington, DC (the District).
- The DPM CoP serves as a collaborative learning environment to **share best practices, overcome implementation barriers, and foster innovation across the diabetes care continuum** with the goal of improving diabetes health outcomes.

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DPM CoP Strategies

- Facilitate cross-sector collaboration and communication
- Promote adoption of best practices in diabetes care
- Center community voices and lived experiences
- Support sustainable programs and interventions
- Track and improve health outcomes through data-sharing

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July 2025 to June 2026 DPM CoP Goal and Objectives

Goal: Increase the **availability and visibility** of DSMES/DSMS services in high-need areas.

Objectives:

1. Support the launch, growth, and sustainability of DSMES/DSMS programs across **clinical and community settings**.
2. Build **pharmacy-based capacity** to deliver **culturally responsive** DSMES/DSMS services and engage **hard-to-reach populations**.
3. Build case for **Medicaid coverage** for DSMES and **build billing capacity.**
4. Foster **peer learning, technical assistance, and collaboration** across a multi-sector network of providers and partners.

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DPM CoP Curriculum- 6 Sessions

- Building Referral Pathways

Month	Session Title	Speakers
July 2025	DPM CoP Kickoff & Mapping the Referral Landscape	April Reese (NACDD)
September 2025	Building Strong Referral Networks & Leveraging EHR	

- Increasing Cultural Competency

Month	Session Title	Speakers
November 2025 (in-person)	Increasing Program Appropriateness and Feasibility	
January 2026	Implementing peer-led SMRC Programs	

- Billing and Building Capability

Month	Session Title	Speakers
March 2026	Reimbursement 101 for DSMES Programs	
May 2026	Data Tracking for Referral and Billing Improvements	

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A 7 Step Guide to Identifying and Mapping Referral Pathways

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Learning Objective:

1. Equip program implementers with a clear, step-by-step process to identify, map, and strengthen referral pathways that improve DSMES and DPP enrollment

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Step 1: Define Your Goal

Create a Goal Statement:

- Identify how people with or at risk for diabetes move through the system (from screening, to referral, to enrollment in your program) and how you can make it easier and more consistent, including LinkU as a pathway.

Goal Statement Example: "Create a clear, documented pathway for how people are referred to our DSMES program from clinics, hospitals, and community partners in Ward 8."

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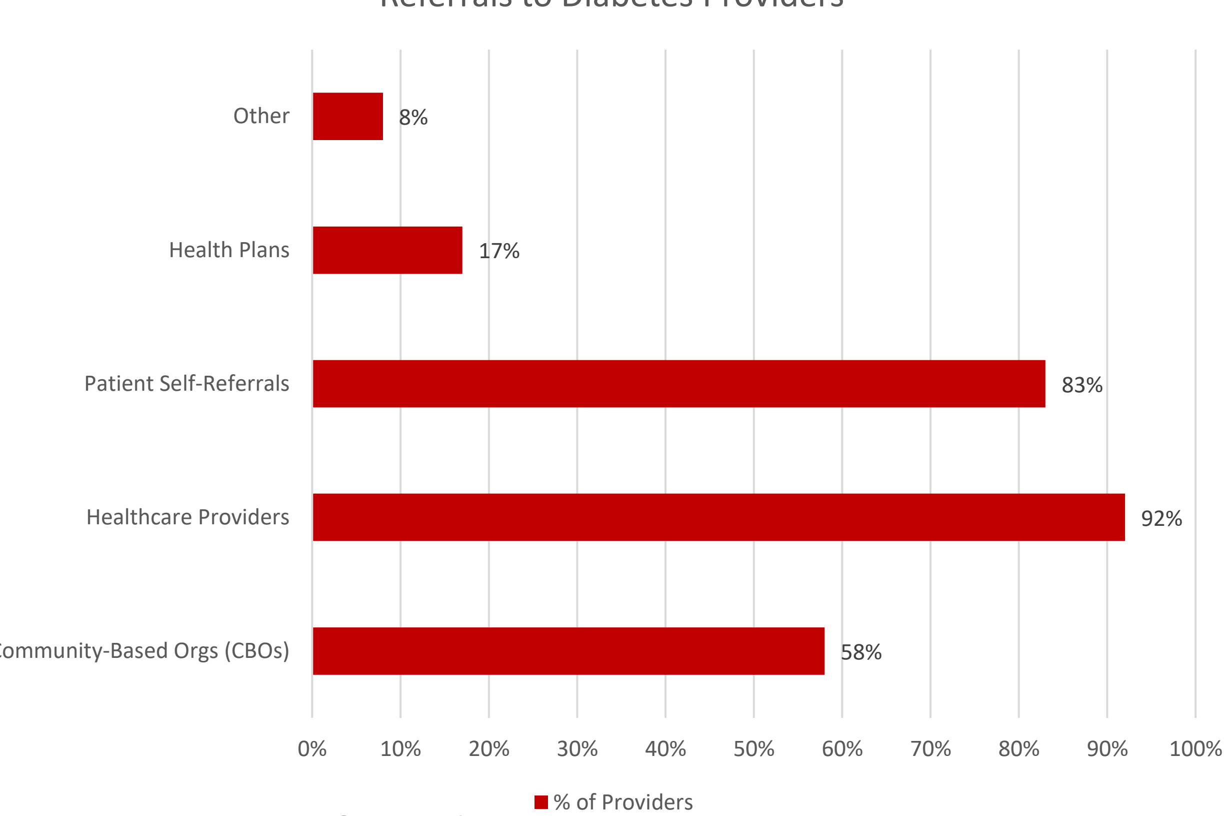
Step 2: Make a List of Referral Sources

Identify all the Places that Currently Refer Clients to Your DSMES or DPP Program

- Federally Qualified Health Centers (FQHCs)
- Primary Care Practices
- Endocrinologists
- Hospitals
- Pharmacies
- Faith-based Organizations
- Senior Centers
- WIC Programs
- MCOs



Tip: Take note of who is missing from your current referral sources

Source: Diabetes Landscape Assessment (2024)

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Step 3: Interview Referral Partners

Ask Current Referral Partners How They Identify People, What Referral Process They Use and What Barriers They Face.

You can use a simple interview script like this:

- How do you identify someone who might benefit from DSMES?
- How do you currently refer? (ex. fax, email, phone call, LinkU)
- What would make it easier to refer patients?
- Are you interested in feedback on your referred patients?

Tools: You can use Google Forms or record responses in a shared Excel sheet

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Step 4: Map the Current Referral Pathway

Turn Your Interview Notes Into a Simple Flowchart on the Referral Process (including gaps and delays)

An example of a map may look like this:

- Patient screened at FQHC (A1c>9%)
- Provider mentions DSMES but does not refer directly
- Patient goes home with no follow up
- No clinician or self referral takes place

Tools: Paper/pen or tools like PowerPoint

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Step 5: Identify Gaps and Opportunities

Review Your Map(s) and Find:

- Where the process breaks down
- Where people get lost or delayed
- Where technology like LinkU can help
- Where better communication or feedback is needed

Tools: Highlighters (red, yellow, green). Use color-coding to highlight breakdowns (red), areas that need improvement (yellow), and parts that are working well (green)

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Step 6: Design an Improved Pathway (Incorporating LinkU)

Work with Partners to Create a Better Process for Referring and Enrolling Participants.

The process may include:

- Ensure that your program is claimed in LinkU and that there is an organizational workflow to accept, process and close referrals. (Request TA from DC Health if necessary)
- Confirm that the provider is using LinkU (Refer to DC Health for TA support if necessary)
- Connect with patient
- Have a follow up reminder system for patients

Tools: PowerPoint or Canva for final map

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Step 7: Engage New Referral Partners

🔎 Identify the Right Person

- Don't assume the doctor is your best contact
- Find out who handles education/referrals in the office
- Tailor your message to the person whose job you're making easier

📣 Expand Where You Show Up

- Go beyond doctors and connect with:
  - **Pharmacists** who manage frequent diabetes patient interactions
  - **Community organizations** (e.g., food banks, housing nonprofits, faith groups) that serve your priority populations
  - **Social workers and nursing home directors** who influence referral decisions

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Step 7 Contd.: Consider Increasing Community Presence

- Participate in community health fairs to identify community resources, provide resources, and market DSMES programs.
- Present an in-service at a DC Health Heart Disease and Stroke Learning Collaborative Meeting.

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Building and Strengthening Your Referral Network | DSMES Toolkit

April B. Reese, MPH, CHES

National Association of Chronic Disease Directors

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