

Promoting Diabetes Prevention Programs and New Payment Options

A Healthy People 2020 Spotlight on Health
Webinar



ODPHP

Office of Disease Prevention
and Health Promotion

Diabetes
Advocacy
Alliance™

Today's Webinar Hosts

Healthy People
2020

- Diabetes Advocacy Alliance
- The U.S. Department of Health and Human Services' Office of Disease Prevention and Health Promotion



Overview of Healthy People Initiative (HP2020) and Introduction of Today's Topic

Don Wright, MD, MPH, Deputy Assistant Secretary for Health and Director, Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services

Overview of the National Diabetes Prevention Program and the Diabetes Prevention Recognition Program, as Medicare Begins Reimbursement

Ann Albright, PhD, RD, Director, Division of Diabetes Translation, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

Overview of the Medicare Diabetes Prevention Program

Carlye Burd, MPH, MS, Team Lead, Diabetes Prevention Program, Division of Health Care Delivery, Preventive and Population Health Care Models Group, Center for Medicare and Medicaid Innovation, Centers for Medicare and Medicaid Services

Coverage for Diabetes Prevention in the Private Sector

Peggy Szczepanski, RDN, Health Promotion Coordinator, Company Focal Point for Healthy Eating and Weight Management, Dow Chemical

**An On-the-Ground
Perspective: Meeting the Needs of
Medicare and Private Insurer
Beneficiaries with Prediabetes**

Heather Hodge, Director for Evidence-Based Health Interventions , YMCA of the USA

**Educating Health Care Professionals
to Drive Participation in Diabetes
Prevention Programs**

Janet Williams, MA, Senior Manager of Physician and Health System Engagement American Medical Association

Question and Answers Session

Ayanna Johnson, Public Health Advisor, Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services

Overview of the Healthy People Initiative

Don Wright, MD, MPH

Deputy Assistant Secretary for Health
Director, Office of Disease Prevention and Health Promotion
U.S. Department of Health and Human Services



What is Healthy People?

- Provides a strategic framework for a **national prevention agenda** that communicates a vision for improving health and achieving health equity
- Identifies science-based, **measurable objectives with targets** to be achieved by the end of the decade
- Requires tracking of **data-driven outcomes** to monitor progress and to motivate, guide, and focus action
- Offers model for international, state, and local **program planning**



Data tool for measuring program performance

Framework for **program planning and development**

Goal setting and **agenda building**

Teaching public health courses

Benchmarks to **compare** state and local data

Way to develop nontraditional **partnerships**

Model for other countries

HealthyPeople.gov: Online Tools & Resources

Healthy People
2020

Objectives and Topic
Area Narratives

DATA2020

National Snapshots

Evidence-based
resources

Infographics

Sharing Library

Midcourse Review

Public comment
database

The screenshot shows the HealthyPeople.gov website with the following elements:

- Navigation:** health.gov, healthfinder.gov, HealthyPeople.gov, Log in, Search HealthyPeople.gov, Go.
- Menu:** Topics & Objectives, Leading Health Indicators, Data Search, Healthy People in Action, Tools & Resources, Webinars & Events, About.
- Hero Section:** "It's National Physical Fitness and Sports Month!" with a photo of a family playing soccer. Text: "Healthy People 2020 aims to improve health and fitness through daily physical activity." Link: "Learn more about the Physical Activity topic area."
- DATA2020 Search:** "This interactive data tool allows users to explore data and technical information related to the Healthy People 2020 objectives. Search Healthy People data."
- Health Disparities:** "A health disparity is a health difference that is closely linked with social, economic, or environmental disadvantage." Link: "View the latest disparities for Leading Health Indicators." Filter: "Browse by Leading Health Indicator".
- LHI Infographics:** "82.4% 2020 TARGET" with icons for physical activity and health services.
- Midcourse Review:** Progress bars for various health indicators: Access to Health Services, Adolescent Health, Asthma, Osteoporosis, and Chronic Back Conditions, Blood Disorders and Blood Safety, Cancer, Chronic Kidney Disease, Dementias, including Alzheimer's Disease.



Office of Disease Prevention
and Health Promotion

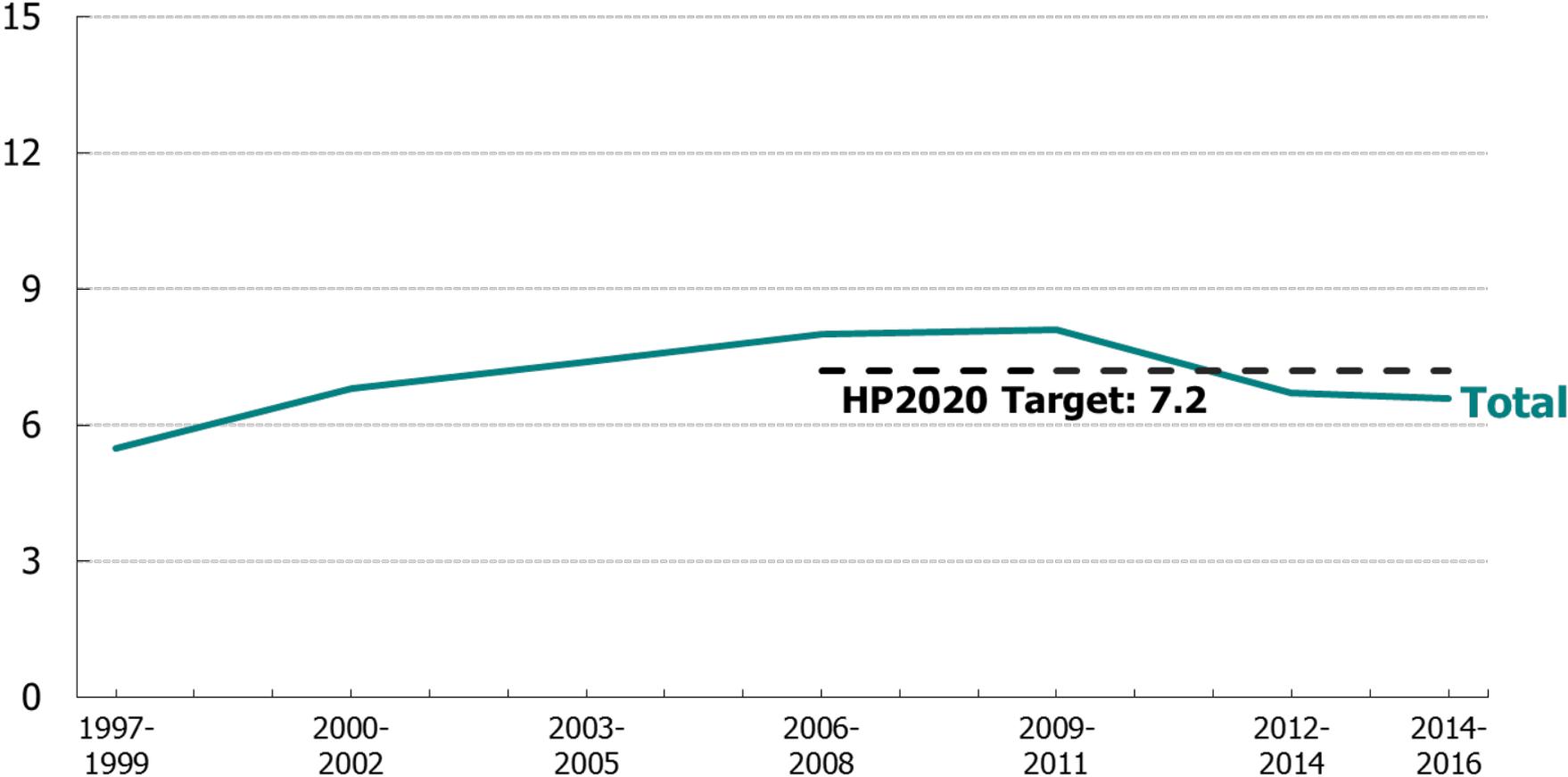


- D-1. Reduce the annual number of new cases of diagnosed diabetes in the population
- D-16. Increase prevention behaviors in persons at high risk for diabetes with prediabetes
 - D-16.1. Increase the proportion of persons at high risk for diabetes with prediabetes who report increasing their levels of physical activity
 - D-16.2. Increase the proportion of persons at high risk for diabetes with prediabetes who report trying to lose weight
 - D-16.3. Increase the proportion of persons at high risk for diabetes with prediabetes who report reducing the amount of fat or calories in their diet

84.1 million adults have prediabetes.

New Cases of Diagnosed Diabetes Per 1,000 Per Year, Adults 18–84 Years, 1997–2016

Rate Per 1,000



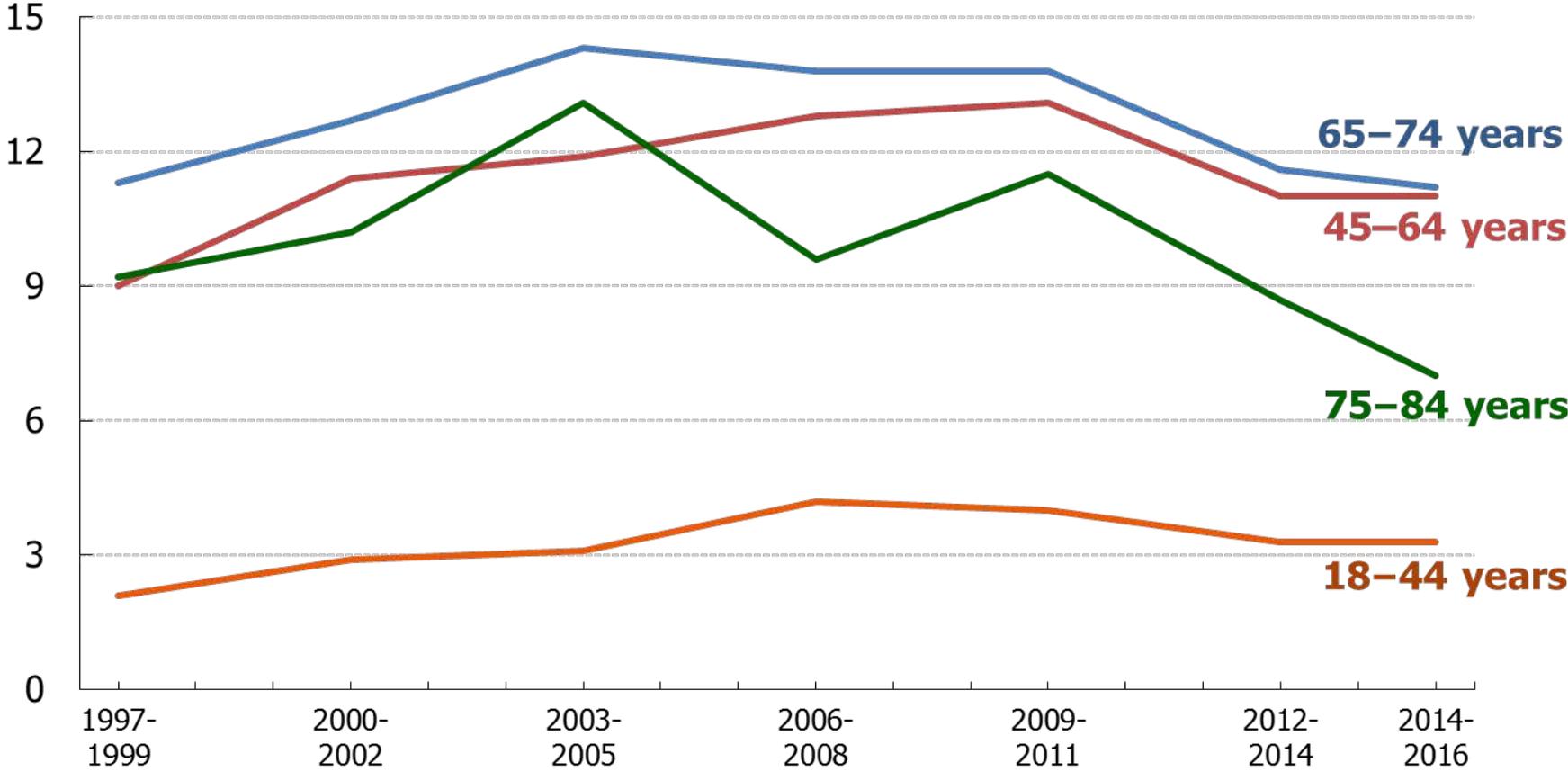
NOTES: Data are for three year estimates of diagnosed diabetes in the past year. Data are for adults aged 18–84 years and are age adjusted to the 2000 standard population. Diagnosed diabetes is defined as self-reported physician diagnosed diabetes. Women who only had diabetes while pregnant and persons with borderline diabetes are excluded.

SOURCE: National Health Interview Survey (NHIS), CDC/NCHS.

Obj. D-1
Decrease desired

New Cases of Diagnosed Diabetes Per 1,000 Per Year, Adults 18–84 Years, 1997–2016

Rate Per 1,000

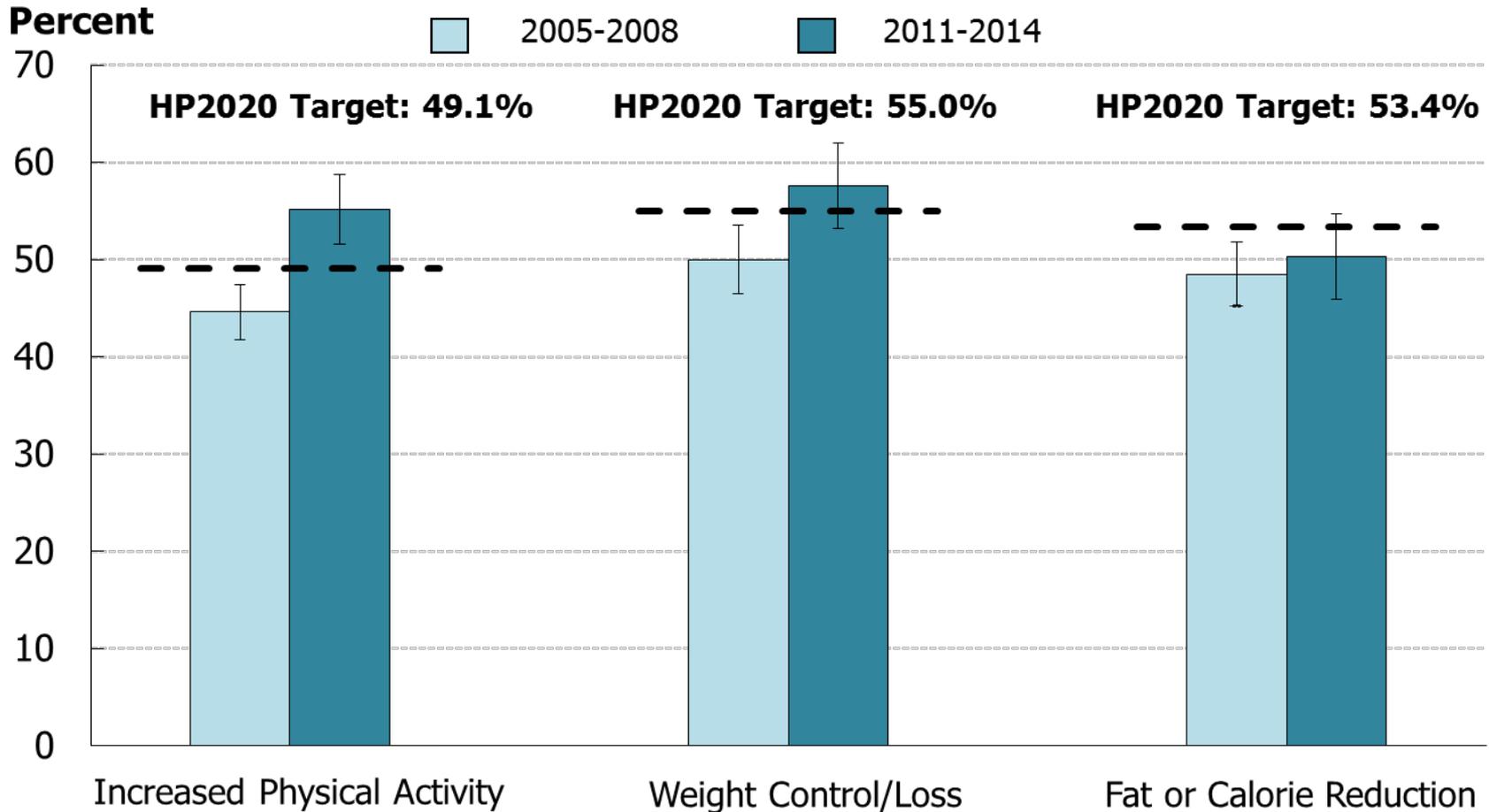


NOTES: Data are for three year estimates of diagnosed diabetes in the past year. Diagnosed diabetes is defined as self-reported physician diagnosed diabetes. Women who only had diabetes while pregnant and persons with borderline diabetes are excluded.

Obj. D-1
Decrease desired

SOURCE: National Health Interview Survey (NHIS), CDC/NCHS.

Prevention Behaviors in Adults at High Risk for Diabetes



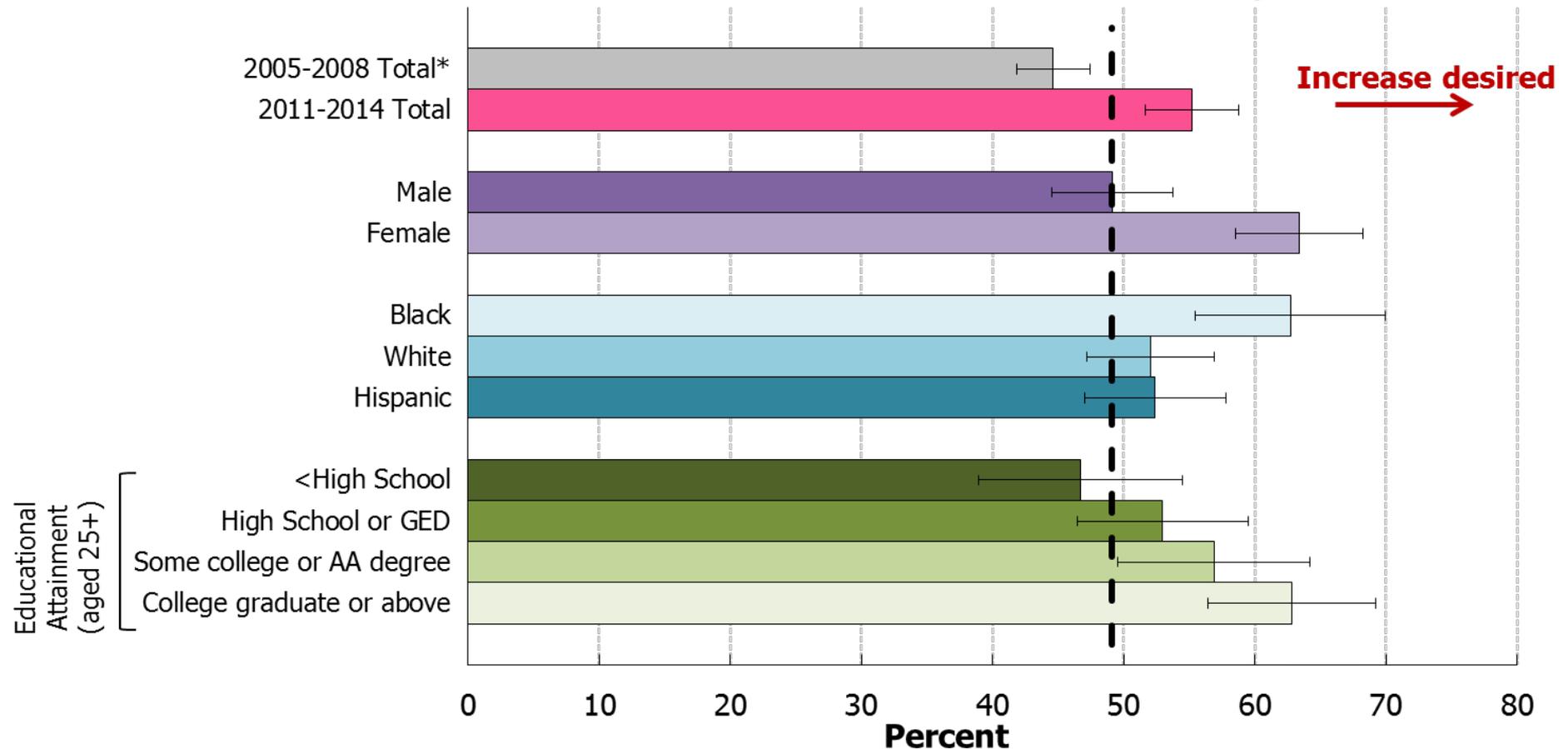
NOTES: I = 95% confidence interval. Data are for adults aged 18 years and over at high risk for diabetes and are age adjusted to the 2000 standard population. Persons are considered at high risk for diabetes if they: did not report diagnosed diabetes and had fasting glucose ≥ 100 and < 126 mg/dL or an HbA1c value $\geq 5.7\%$ to $< 6.5\%$.

SOURCE: National Health and Nutrition Examination Survey (NHANES), CDC/NCHS.

Objs. D-16.1, 16.2, 16.3
Increase desired

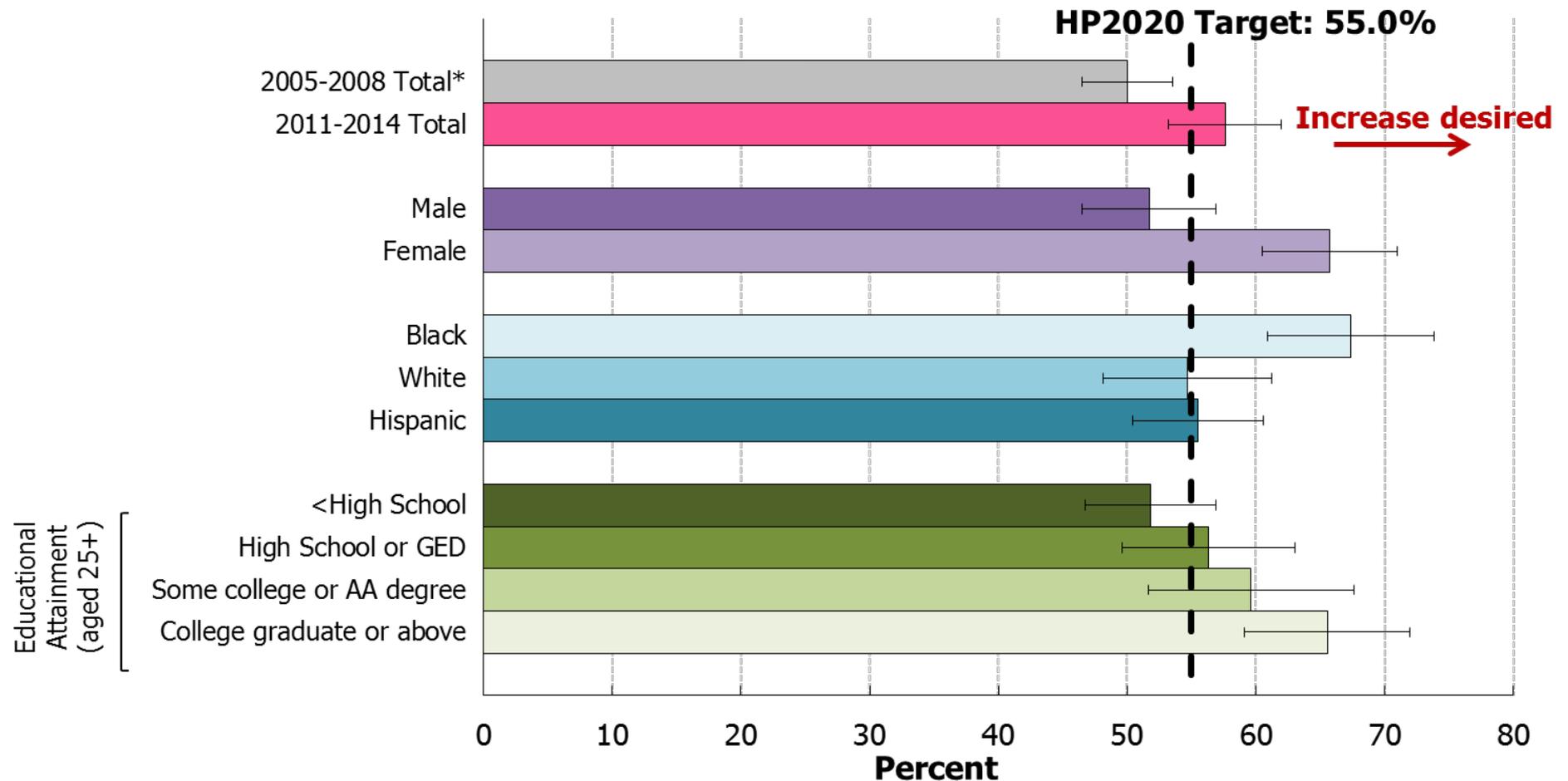
Prevention Behaviors in Adults at High Risk for Diabetes—Increased Physical Activity

HP2020 Target: 49.1%



NOTES: ⇐ = 95% confidence interval. *2005-2008 data – HP2020 baseline. Data are for adults aged 18 years and over at high risk for diabetes and are age adjusted to the 2000 standard population. Persons are considered at high risk for diabetes if they: did not report diagnosed diabetes and had fasting glucose ≥ 100 and < 126 mg/dL or an HbA1c value $\geq 5.7\%$ to $< 6.5\%$. The categories black and white include persons who reported only one racial group and exclude persons of Hispanic origin. Persons of Hispanic origin may be any race.

Prevention Behaviors in Adults at High Risk for Diabetes—Weight Control/Loss



NOTES: ⇨ = 95% confidence interval. *2005-2008 data – HP2020 baseline. Data are for adults aged 18 years and over at high risk for diabetes and are age adjusted to the 2000 standard population. Persons are considered at high risk for diabetes if they: did not report diagnosed diabetes and had fasting glucose ≥ 100 and < 126 mg/dL or an HbA1c value $\geq 5.7\%$ to $< 6.5\%$. The categories black and white include persons who reported only one racial group and exclude persons of Hispanic origin. Persons of Hispanic origin may be any race.



The National Diabetes Prevention Program: Overview and Updated National Standards

Ann Albright, PhD, RDN

Director, Division of Diabetes Translation

National Center for Chronic Disease Prevention and Health Promotion

Centers for Disease Control and Prevention

National Diabetes Prevention Program

Largest national effort to mobilize and bring effective lifestyle change programs to communities across the country!

REDUCING THE IMPACT OF DIABETES



Congress authorized CDC to establish the NATIONAL DIABETES PREVENTION PROGRAM (National DPP) —a public-private initiative to offer evidence-based, cost effective interventions in communities across the United States to prevent type 2 diabetes

It brings together:



Research shows structured lifestyle interventions can cut the risk of type 2 diabetes in

HALF

to achieve a greater combined impact on reducing type 2 diabetes



Overview of the National Diabetes Prevention Program

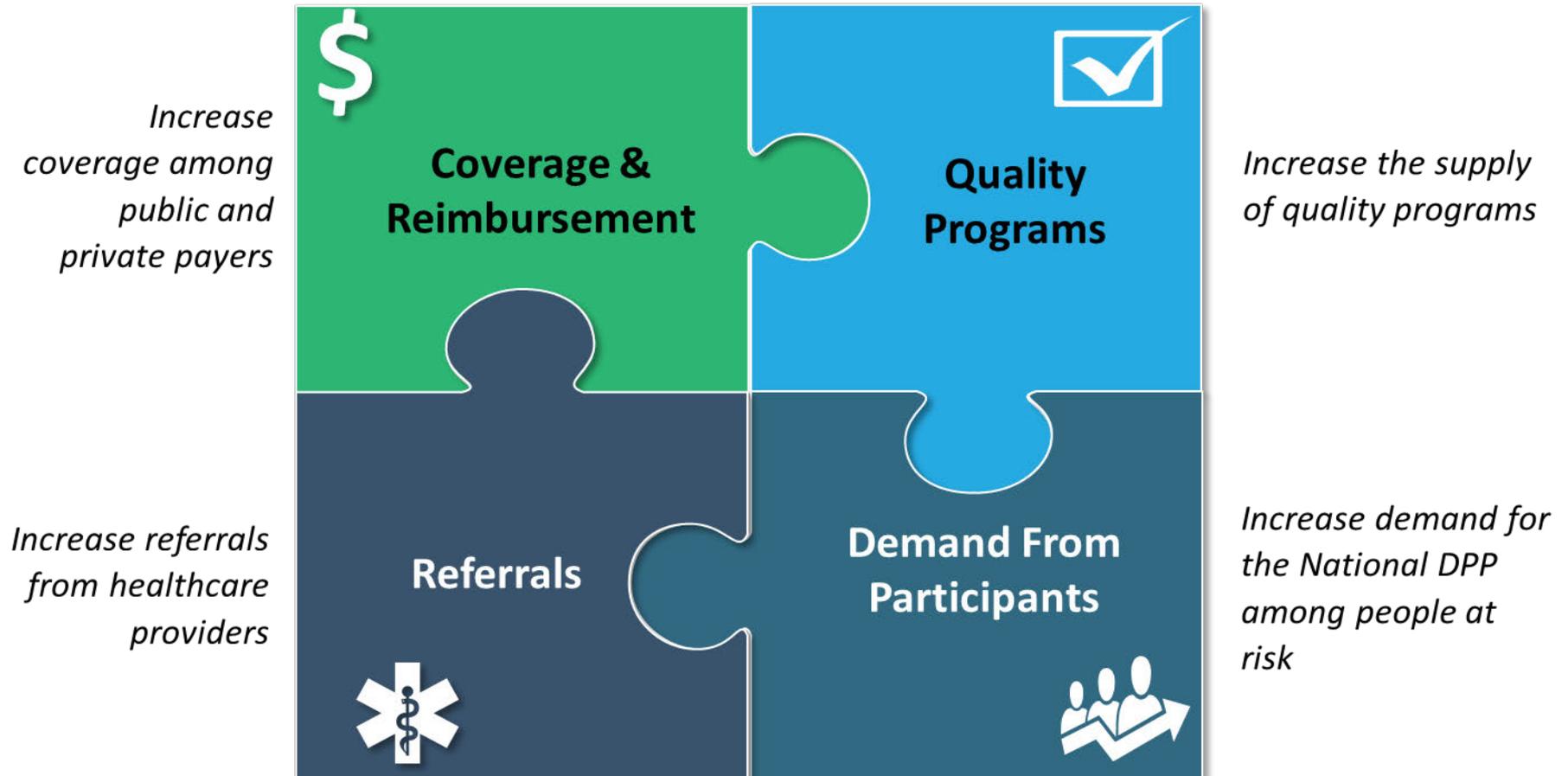
- 1 At the core of the National Diabetes Prevention Program (National DPP) is a CDC-recognized, year-long lifestyle change program that offers participants:



- 2 To successfully implement these lifestyle change programs, the National DPP relies upon a variety of public-private partnerships with community organizations, private and public insurers, employers, health care organizations, faith-based organizations, and government agencies. Together, these organizations work to:



National DPP Strategic Goals

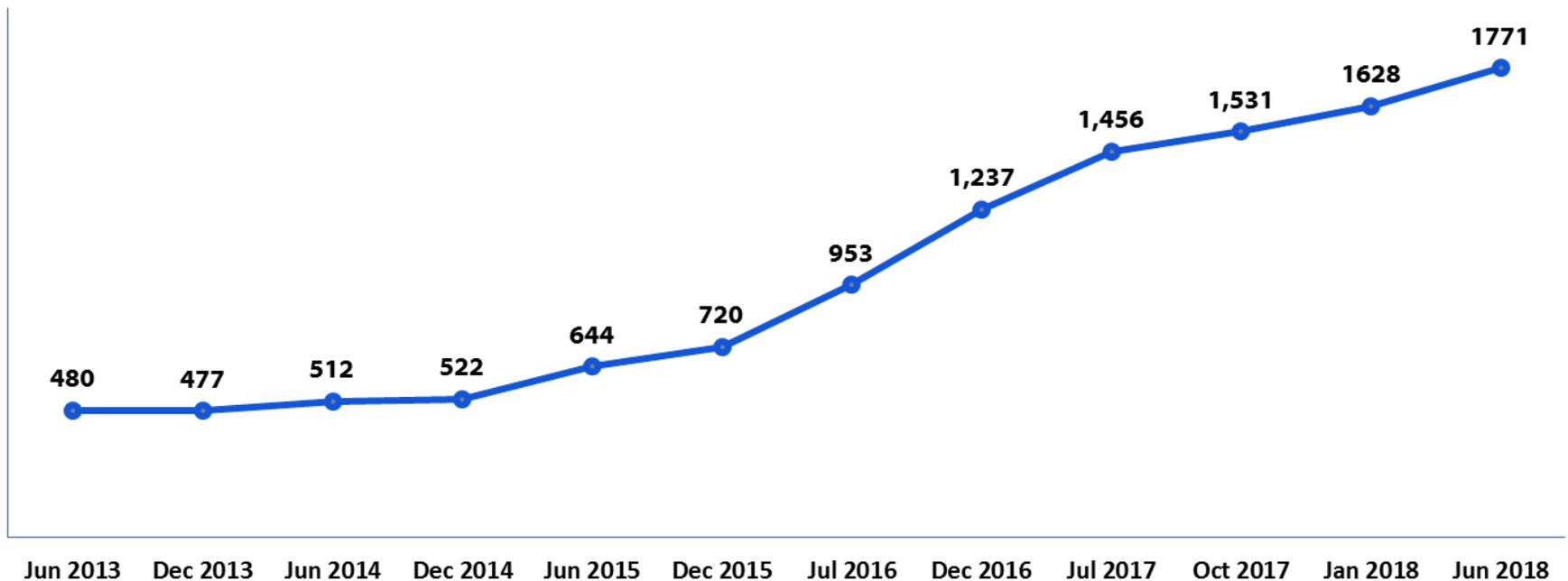


Increase the Supply of Quality Programs



The number of CDC-recognized organizations has increased substantially since the program's inception.

CDC-Recognized Diabetes Prevention Programs Across the U.S.





CDC Recognition: Overview

Recognition involves...

assuring quality by developing and maintaining a registry of organizations recognized (by CDC's Diabetes Prevention Recognition Program) for their ability to deliver effective type 2 diabetes lifestyle interventions

Key Activities



Quality Standards

- DPRP Standards and Operating Procedures
- Updated every 3 years



Registry of Organizations

- Online registry and program locator map



Data Systems

- Data analysis and reporting
- Feedback/technical assistance for CDC-recognized organizations

New Application Data Elements

- **4 Delivery Modes with one application per delivery mode required:**
 1. In-person (delivery is 100% in-person)
 2. Online (delivery is 100% online)
 3. Distance learning (new):
 - Delivered 100% by trained Lifestyle Coaches via remote classroom or telehealth (i.e., conference call or Skype) where the Lifestyle Coach is present in one location and participants are calling or video-conferencing in from another location.
 4. Combination (new):
 - Delivered as a combination of any of the previously defined delivery modes for all participants by trained Lifestyle Coaches

Participant Eligibility Changes

□ **BMI thresholds:**

- Non-Asian: BMI of greater than or equal to 25 kg/m²
- Asian-American: BMI of greater than or equal to 23 kg/m²

□ **Blood test eligibility:**

- A minimum of 35% of all participants in a cohort must be eligible for the lifestyle change program based on either a blood test indicating prediabetes or a history of GDM; 65% may come in on a risk test
- 100% of Medicare Diabetes Prevention Program participants must come in on a blood test

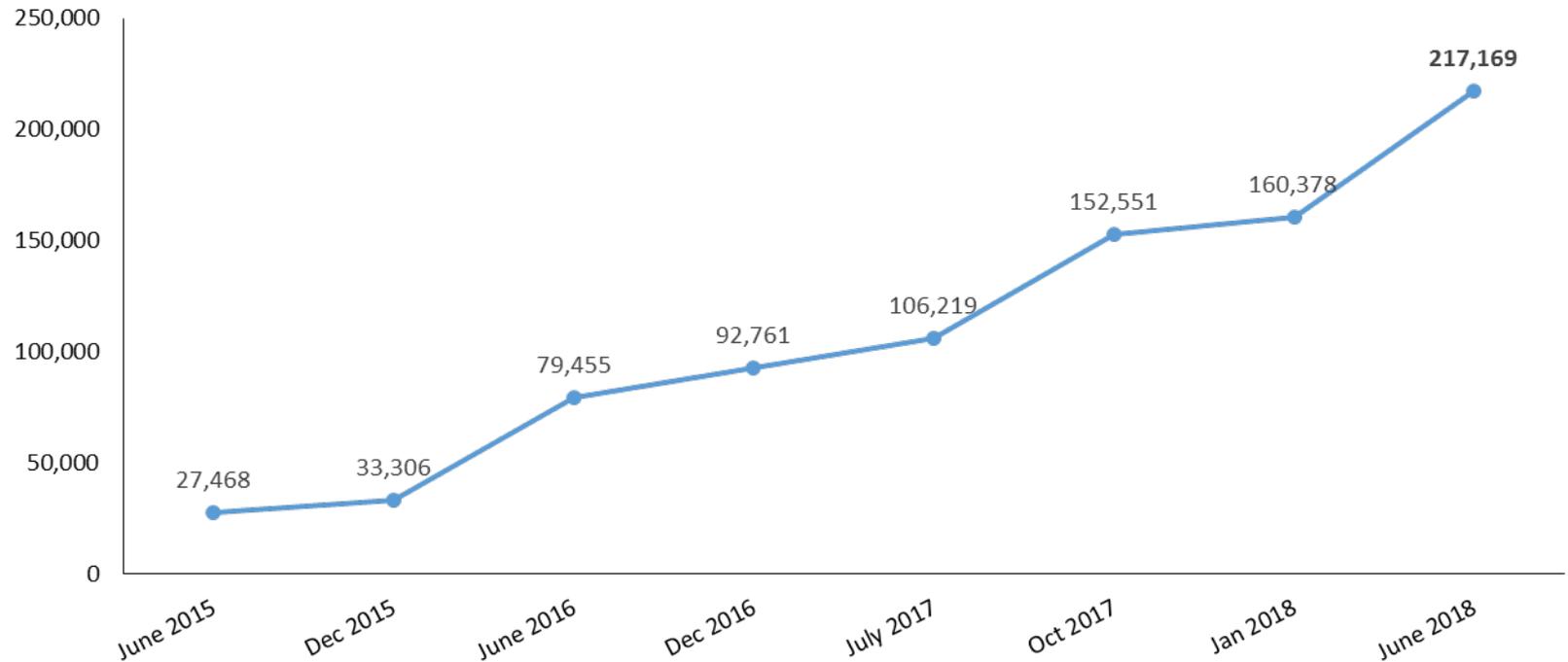
Data Submission Timeline and Evaluation

- ❑ **Data submission now occurs every 6 months; organizations will receive progress/evaluation reports accordingly**
- ❑ **Numerators and denominators for evaluation toward Preliminary and Full recognition have been liberalized to help organizations serving all populations succeed**
- ❑ **Six new data elements collected for more thorough evaluation:**
 1. **Enrollment source (how a participant was referred to the program)**
 2. **Payer type (reimbursement source)**
 3. **Education (proxy for socioeconomic status)**
 4. **Delivery mode (per session to account for how make-up sessions are delivered and to track combination modes)**
 5. **Session ID (tracks session number by first 6 months, second 6 months, and for on-going maintenance sessions delivered in Year 2 by MDPP suppliers)**
 6. **Session type (denotes if a session is core, core maintenance, ongoing maintenance, or make-up)**

Increase Demand for the Program Among People at Risk



Cumulative Number of Individuals Enrolled in the National DPP¹



160,378 individuals have enrolled in the National DPP as of June 4, 2018¹

1. CDC Diabetes Prevention Recognition Program

Award-Winning Prediabetes Awareness Campaign

Ad Council, AMA, ADA, CDC



So is taking a one-minute
prediabetes risk test.

Puppies –
A Perfect Way to Spend a Minute

Hedgehogs on Vacation –
A Perfect Way to Spend a Minute

DoIHavePrediabetes.org



That's all it takes to
know where you stand.

Increase Referrals from Health Care Providers

CDC works with numerous partners to help identify and refer at-risk individuals to CDC-recognized diabetes prevention programs. Examples include:



American College of
Preventive Medicine

American College of Preventive Medicine

Partnership with the ACPM to increase health care provider screening/testing/referrals through training, developing local champions, and testing and evaluating approaches in the field.



American Medical Association

Partnership with AMA to increase health care provider screening/testing/referrals by engaging and activating state medical societies.

Y-USA

Partnership with the Y-USA to explore bi-directional e-referral models for use by health care systems and CDC-recognized diabetes prevention programs to screen and refer people at high risk for type 2 diabetes (retrospectively or at point of contact).

State Grantees

Partnership with state health departments to work with local health care organizations to develop referral protocols/policies/systems.



Increase Program Coverage & Reimbursement



Many public and private insurers are offering the National DPP lifestyle change program as a covered benefit.



Commercial Insurers

Many commercial health plans provide some coverage for the National DPP. Examples include:

- AmeriHealth Caritas
- Anthem
- BCBS Florida
- BS California
- BCBS Louisiana
- Denver Health
- Managed Care: Medicaid, Medicare, Public Employees
- Emblem Health: NY
- GEHA
- Highmark
- Humana
- Kaiser: CO & GA
- LA Care: Medicaid
- MVP's Medicare Advantage
- Priority Health: MI
- United Health Care: National, State, Local, Private, and Public Employees

Medicare payment began April 1, 2018



State Coverage

Over 3 million public employees/dependents in the following 17 states have the National DPP as a covered benefit:

- Colorado
- Delaware
- Kentucky
- Louisiana
- Maine
- Maryland (partial payment)
- Minnesota
- Tennessee
- New Hampshire
- New York
- Rhode Island
- Vermont
- Washington
- Oregon (Educators)
- California
- Texas
- Connecticut (DoT)

*The following states have approved coverage for **Medicaid** beneficiaries:*

- Minnesota
- Montana
- Vermont
- New Jersey (in 2018)
- California (in 2018)

For More Information

www.cdc.gov/diabetes/prevention

**National DPP Customer Service Center going live
in July**



Like us on
Facebook

<https://www.facebook.com/CDCDiabetes/>



Follow us on
twitter

<https://twitter.com/CDCDiabetes>



MEDICARE DIABETES PREVENTION PROGRAM Expanded Model

Carlye Burd, MS, MPH

Program Lead, Medicare Diabetes Prevention Program

Center for Medicare and Medicaid Innovation (CMMI)

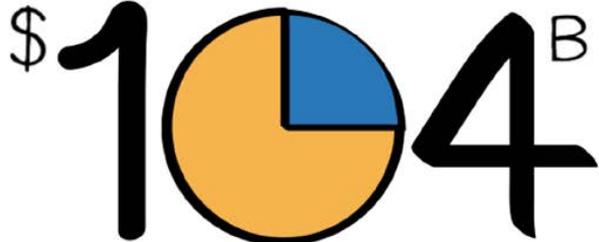
*Centers for Medicare and Medicaid Services (CMS)
June 13, 2018*

The Problem

25%

Americans 65 and older with type 2 diabetes

Care for these individuals costs Medicare about **\$104^B** each year, and is growing

A large graphic of the number '104' with a dollar sign to its left and a superscript 'B' to its right. The '0' is a pie chart with a blue slice representing 25% of the total area, and an orange slice representing the remaining 75%. The '1' and '4' are solid black.

The Solution: The Medicare Diabetes Prevention Program (MDPP)

Medicare pays organizations, called MDPP suppliers, to furnish a group-based intervention to at-risk Medicare beneficiaries, using a CDC-approved National Diabetes Prevention Program curriculum.



Up to 2 years of sessions delivered to groups of eligible beneficiaries

As a Medicare preventive service, there are no out-of-pocket costs



DIET



PHYSICAL ACTIVITY



WEIGHT LOSS

Coaches furnish MDPP services on behalf of MDPP suppliers

MDPP suppliers' primary goal is to help Medicare beneficiaries achieve at least 5% weight loss

Intra-Agency Coordination

CMS and CDC each have unique roles and responsibilities with respect to MDPP services.



Payment, Enrollment, and Oversight Arm

MDPP suppliers receive payment from CMS and must meet and remain compliant with requirements established by Medicare



Quality Assurance Arm

MDPP suppliers must maintain CDC recognition and follow CDC quality standards, including use of a CDC-approved curriculum

Beneficiary Eligibility Criteria

Specific criteria determine Medicare beneficiary eligibility throughout the MDPP services period



Beneficiary Eligibility Requirements

Medicare beneficiaries are eligible for MDPP services if they meet the following criteria:

- Enrolled in Original Medicare (Part B) or Medicare Advantage (Part C)
- Body Mass Index (BMI) of at least 25 (23 if self-identified as Asian) on the date of the first core session
- Meet 1 of 3 blood test requirements within the 12 months prior to attending the first core session:
 1. A hemoglobin A1c test with a value between 5.7% and 6.4%, or
 2. A fasting plasma glucose of 110-125 mg/dL, or
 3. A 2-hour plasma glucose of 140-199 mg/dL (oral glucose tolerance test)
- No previous diagnosis of diabetes prior to the date of the first core session (with exception of gestational diabetes)
- Do not have end-stage renal disease (ESRD)
- Has not previously received MDPP services

A Glance at What is Covered

The first year of MDPP core services includes six months of weekly core sessions followed by six months of monthly maintenance sessions; the second year is contingent upon beneficiary performance and consists of monthly maintenance sessions.



- Follows a CDC-approved curriculum
 - No beneficiary copay
 - No referral required

* The ongoing maintenance sessions are unique to the MDPP services and not required for CDC recognition.

Better Outcomes, Higher Incentives

The healthier beneficiaries become, the more suppliers earn.

Payments are made based on beneficiary attendance *and* beneficiary weight loss

<i>Year 1 Payment Scenarios*</i>		
Attendance	Weight Loss (WL)	Payment
1 Core Session	N/A	\$25
4 Core Sessions	Without 5% WL	\$75
4 Core Sessions	With 5% WL	\$235
Full (9 Core, 4 Core Maintenance)	5% WL in mos. 10 – 12	\$400
Full (9 Core, 4 Core Maintenance)	5% WL (mos. 0 – 6) & maintains WL in mos. 7-12	\$445

**Note: in Year 2, suppliers can also receive up to 4 payments of \$50 (total potential of \$200) per beneficiary, assuming ongoing maintenance session attendance and maintenance of 5% weight loss; the maximum payment per beneficiary is \$670 over 2 years*

Becoming an MDPP Supplier

Organizations must meet key requirements and complete an application to become MDPP suppliers.

1. Gain CDC Recognition



- Organizations must have **either CDC full or preliminary recognition**
- Visit the [CDC website](#) to learn more about gaining recognition

2. Enroll as an MDPP supplier

- Enroll using the online [PECOS application](#) or the [CMS-20134 form](#)



3. Furnish MDPP Services

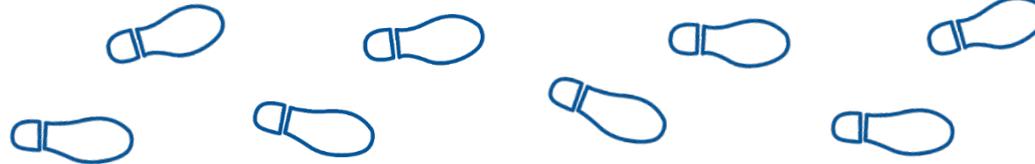
- MDPP services must be **furnished to eligible MDPP beneficiaries** by an enrolled MDPP supplier



4. Submit Claims to Medicare



- Suppliers will submit claims to their **Medicare Administrative Contractor (MAC)**, or when applicable, submit encounter data to a **Medicare Advantage organization**



How You Can Help Make MDPP a Success

Take action now!

CDC Recognized DPP Organizations:

- Check your recognition status (Full or Preliminary)
- If recognized, enroll now through PECOS

Diabetes Prevention Stakeholders:

- Encourage organizations to work toward CDC recognition
- Help educate organizations on CMS enrollment and billing processes using MDPP resources
- Work with providers to increase awareness and referrals

Clinicians:

- Become familiar with beneficiary eligibility criteria and coverage
- Educate patients on prediabetes and encourage participation in MDPP
- Get to know your local DPPs: https://nccd.cdc.gov/DDT_DPRP/Registry.aspx

Subscribe to receive MDPP updates at [go.cms.gov/mdpp](https://www.go.cms.gov/mdpp)

More Resources



Ready to become a CDC-recognized National DPP delivery organization?

Head to the [National DPP Website](#)



Ready to enroll as an MDPP supplier?

Once recognized by CDC (either full or preliminary status), enroll online through the Provider Enrollment Chain and Ownership System (PECOS) [here](#). Review the enrollment application [here](#)



Want to access supplier support resources?

Head to the [MDPP Website](#)



Want to find out which organizations are eligible to become MDPP suppliers?

Head to [CDC's National DPP Registry](#), and look for “Full” or “Preliminary” recognition organizations



Other ways to stay updated or ask questions

Sign up for our listserv at [MDPP Website](#), email us at mdpp@cms.hhs.gov, call the MDPP Help Desk at 1-877-906-4940



— National Diabetes Prevention Program (NDPP) @ Dow

US Implementation Overview

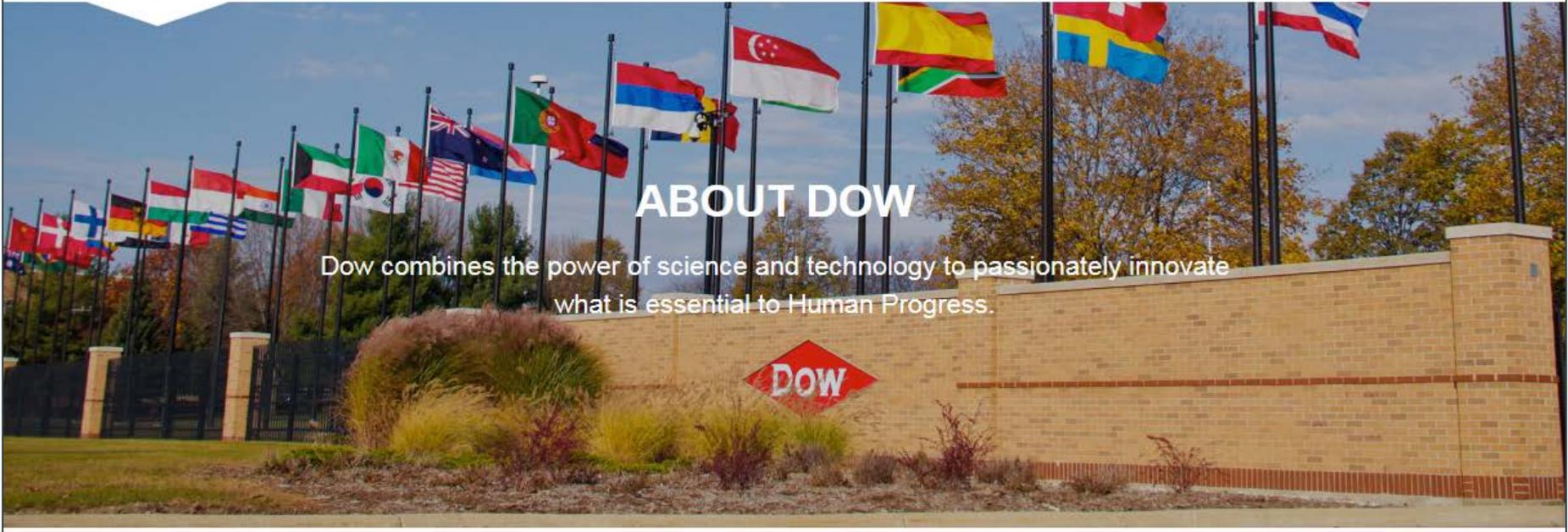
Szczepanski

About Dow



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 [United States](#) 



Health Matters @ Dow

Total Worker Health™



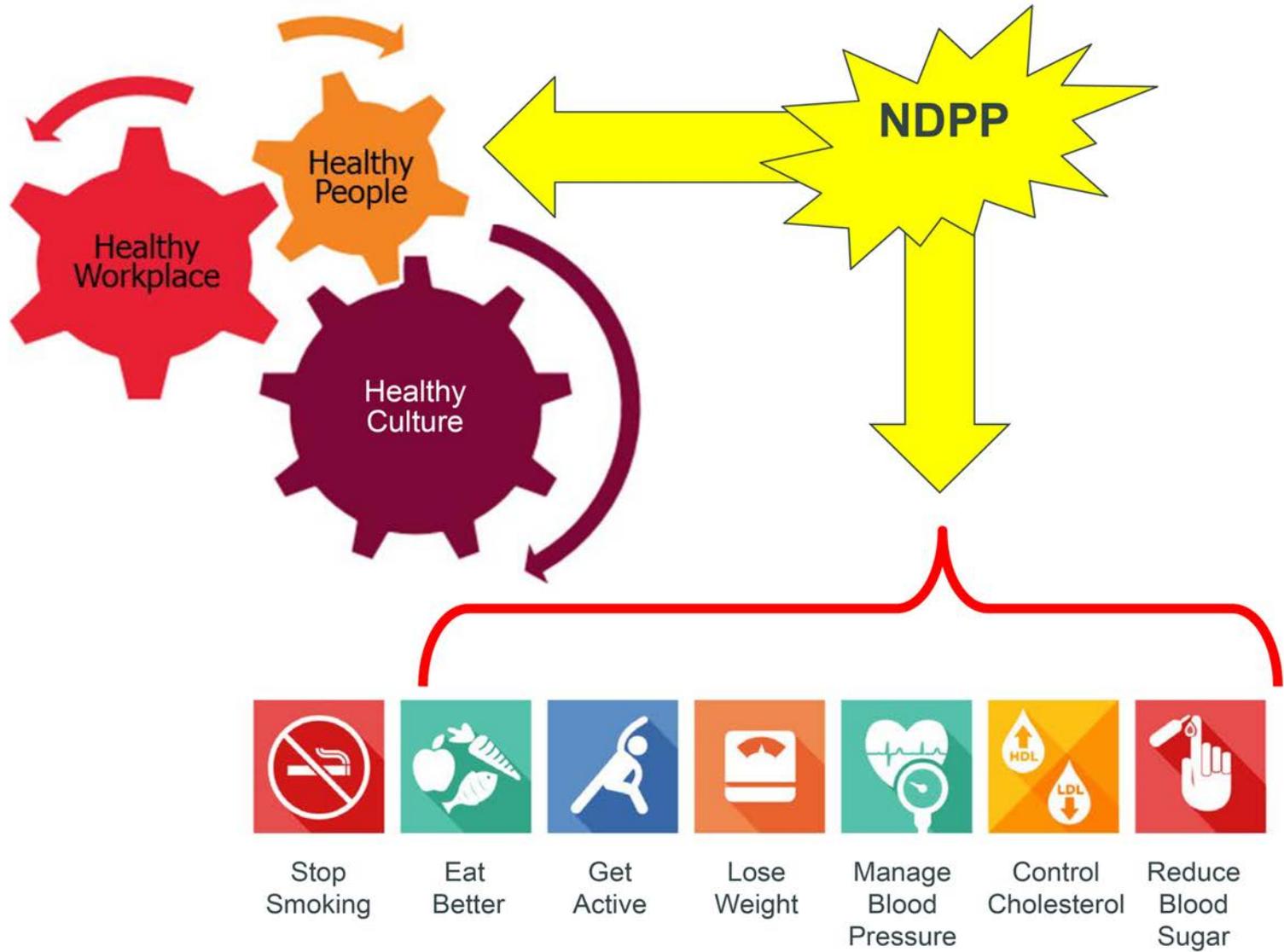
Total Worker Health™ is a strategy integrating occupational safety and health protection with health promotion to prevent worker injury and illness and to advance health and well-being.

Our Vision is that Dow people are healthier, happier and more productive as a result of our Total Worker Health (TWH) initiative. By fostering the health of our people, we improve their quality of lives and create value for Dow.

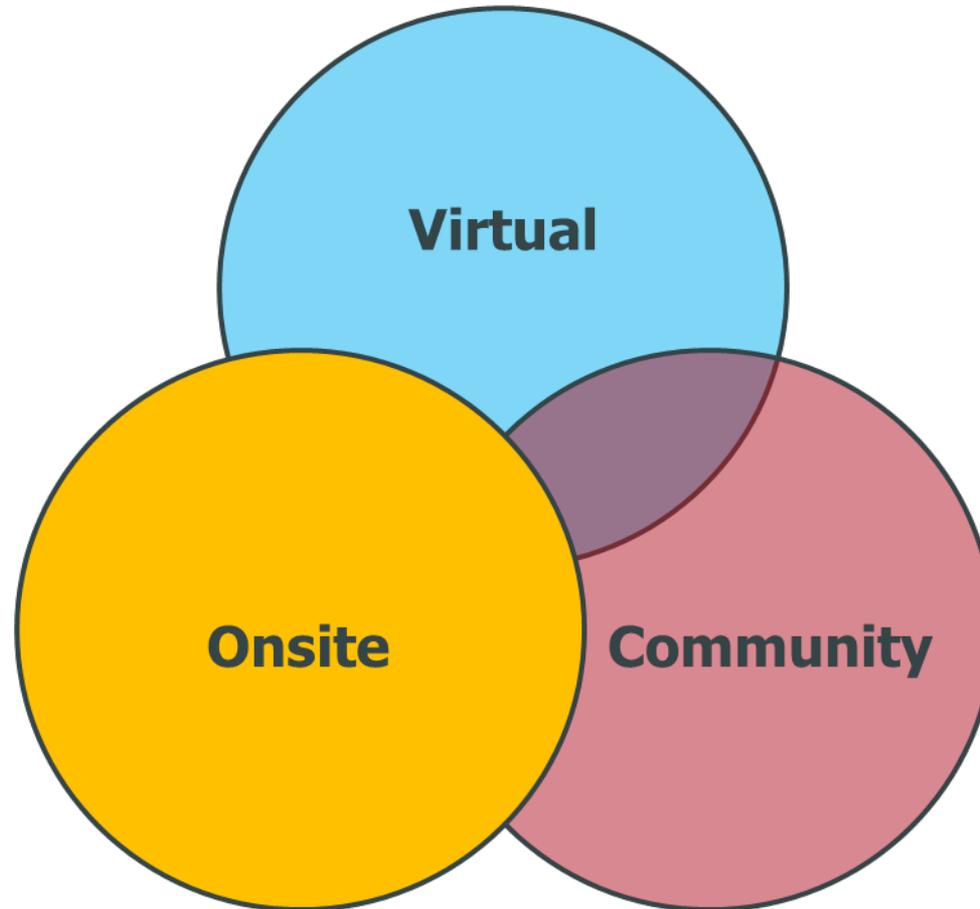
By 2025, Dow will have Total Worker Health (TWH) implementation that comprehensively controls workplace health risks, protects workers, and optimizes the health of Dow people.



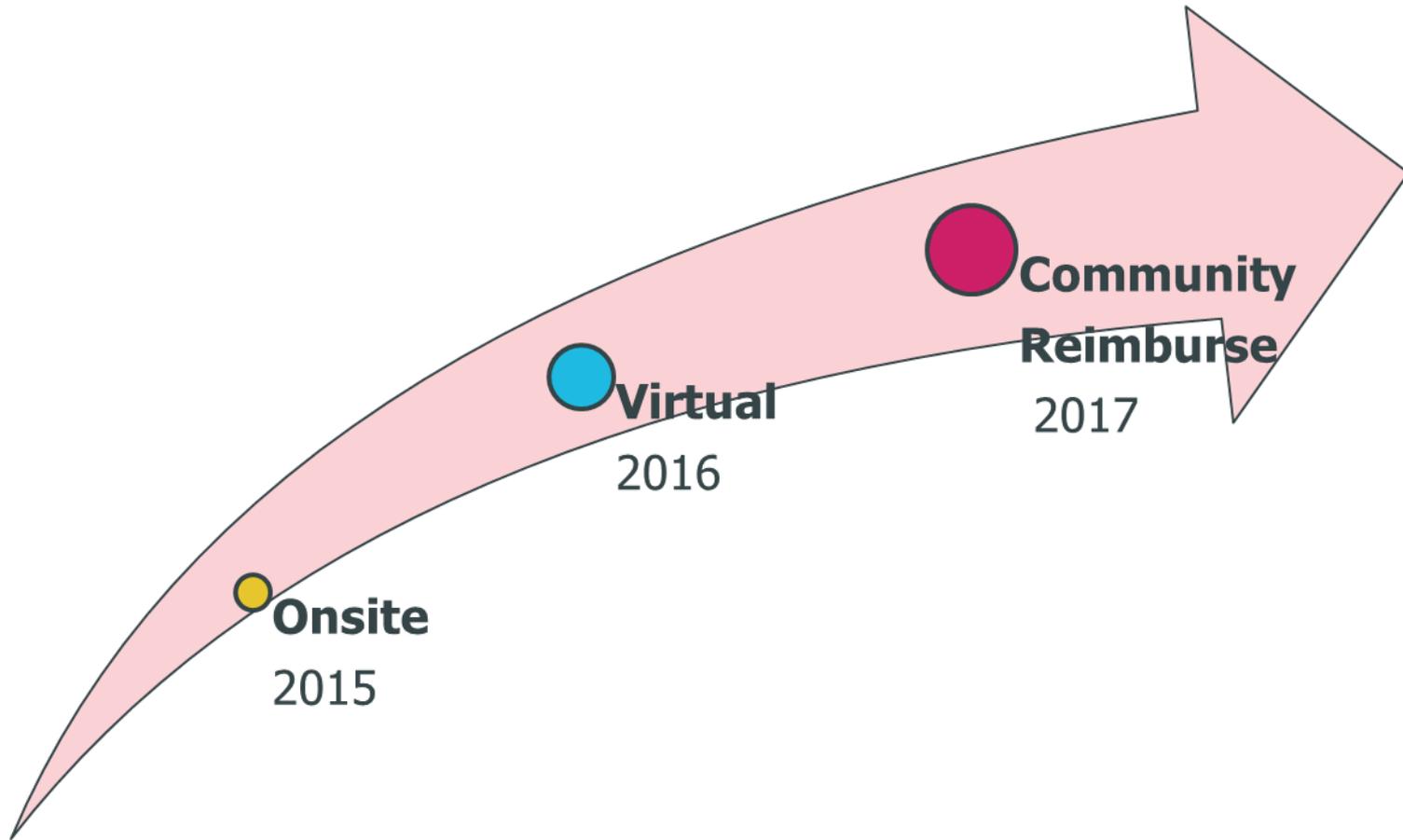
Impactful Solutions



Dow's US DPP Strategy



Implementation Journey



Experience with On Site Model

- Launched April 2015
- Collaborative Effort
 - Grant
 - 3 trained Lifestyle Coaches
 - 1 internal Master Trainer for onsite program sustainability
- To date
 - 12 on site classes at 2 sites
 - Midland, MI
 - Lake Jackson, TX
- 2019
 - On site classes at 4 locations
 - Midland, MI
 - Lake Jackson, TX
 - Houston, TX
 - Collegeville, PA



Experience with **Virtual Model**

- Launched April, 2016
 - US
- Collaborative effort
- To date
 - >4,200 participants



omada

Measuring Success

CDC Recognition Standards!

Overall Outcomes:

- 51% of participants completing 9+ lessons lost $\geq 5\%$ initial body weight

Implementation Learning's

Solid company commitment to health

Steering Team – oversight & coordination

- HR/HS Leadership
- HS Business Office
- Communications/Public Affairs

Invest time in selecting Lifestyle Coaches

Systems integration

- EMR, existing processes

Trainings – Internal Staff and Stakeholders

Integrated, Ongoing Communication Plan

- Executive Leadership, implementation staff, Workforce, Dependents,



FOR YOUTH DEVELOPMENT®
FOR HEALTHY LIVING
FOR SOCIAL RESPONSIBILITY

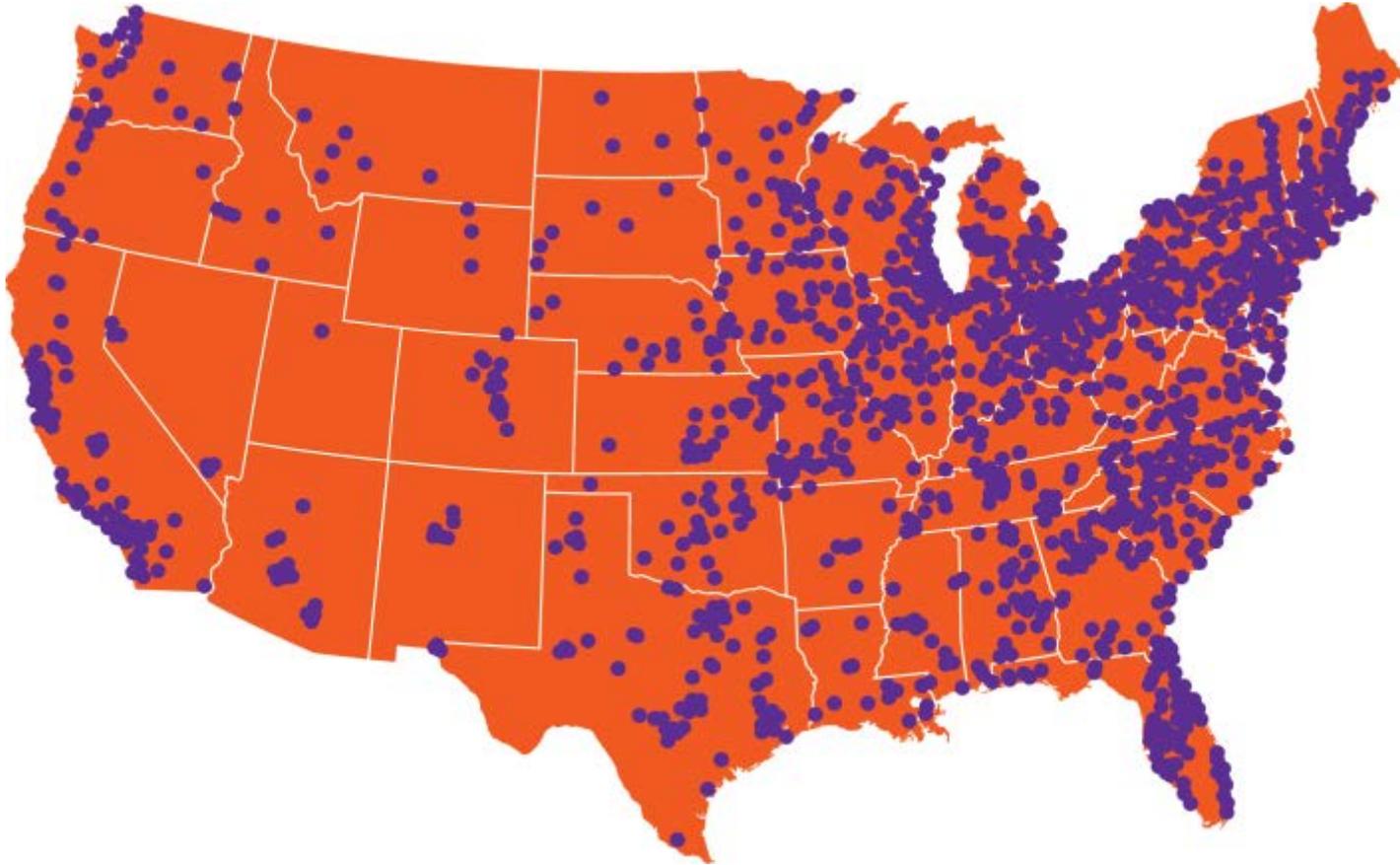
REDEFINE YOUR HEALTH TRANSFORM YOUR LIFE

IMPROVING HEALTH
THROUGH THE Y'S
NATIONAL NETWORK OF
COMMUNITY- BASED
PROGRAMS

JUNE 13, 2018



THE Y: ASSOCIATIONS & BRANCHES



OUR REACH

FACTS

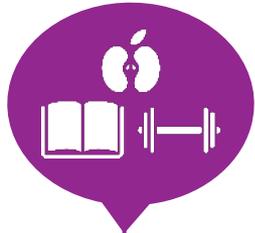
YMCAs
2,700

YMCAs IN COMMUNITIES
WHERE HOUSEHOLD INCOME IS
BELOW THE NATIONAL AVERAGE
58%

COMMUNITIES SERVED
10,000

STATES
50 plus
District of Columbia
and Puerto Rico

A BRIEF HISTORY



The YMCA first began work with insurance companies for coverage of the DPP

2010



Secretary of Health and Human Services announces certified health improvement and Medicare cost savings with intent to expand the DPP

2016



Prep for the Medicare Diabetes Prevention Program

2018



2005

DPP translated into the community by the IU School of Medicine and the YMCA of Greater Indianapolis



2012

CMMI Medicare project began



2017

Implementation of an electronic medical record within the Y network to facilitate referrals and revenue cycle management



DELIVERING OUTCOMES AT SCALE:

YMCA'S DPP



By The Numbers

(as of 4/30/18)

Participants attending at least one session	60,064
Completer's average year-end weight loss	5.5%
Average physical activity minutes per week	162.5
Y associations delivering program	214
States where the program is available	42
Total active program sites	1,134
Low income participants*	21.9%

THE PROGRAM IS:

- Group-based and led by a trained Lifestyle Coach
- A year-long program: 25 sessions*
- Open to all community members; YMCA membership is not required
- A Centers for Disease Control and Prevention (CDC) - approved curriculum

RECRUITMENT PARTNERS

It takes a village:

- Health care systems and physicians
- Senior centers
- Community organizations
- Health plans and employers
- Faith-based organizations
- Media and marketing
- Friends and family



CAPTURE AND USE THE DATA

Examples of the types of data collected

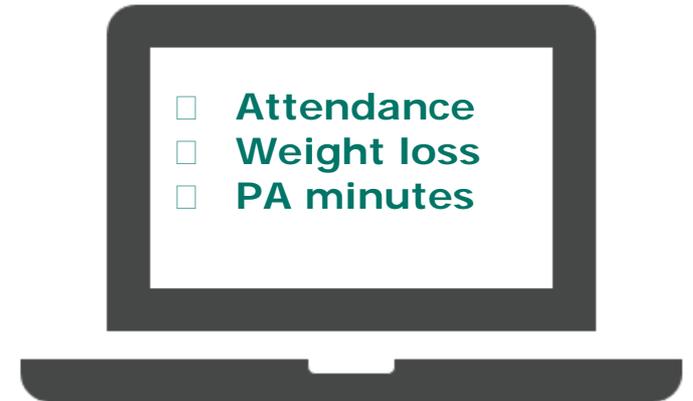
Program:

- Impact and improved health
- Demographics and qualification
- Self-report and observed

Process:

- Uptake and Reach
- Self-report and observed

Learning agendas – social isolation



ENGAGEMENT

CONSUMER ENGAGEMENT MATERIALS

Consumer brochure, flyer, poster

Consumer pull-up banner

Direct payor brochure

E-mail and mailing templates

Employer brochure

Health plan brochure

Facebook cover image

Newsletter event flyer

Physician brochure

Pocket folder

Promo button

Promo magnet

Web banner



Can you measure a healthy life? Sure, you can—by the cup, the ounce, and the block.

If you're 65 or older, you're at risk for type 2 diabetes. The good news is that you can make small, measurable changes that can reduce your risk and help you live a happier, healthier life.

CHANGE IS TOUGH—WE CAN HELP
Let's face it, if change were easy, we'd all do it. You've spent years developing habits that you can't expect to change overnight. It's tough. We can help.

The YMCA's Diabetes Prevention Program gives you the skills you need and the support you deserve to make lasting healthy lifestyle changes.

* Asian individuals with type 2 diabetes are at a higher risk of complications. Individuals who have a first-degree family member with type 2 diabetes are also at a higher risk of developing type 2 diabetes. The CDC and the National Council on Aging (NCOA) have made a commitment to collaborate with the national YMCA affiliates to support a national movement to increase awareness and take measures to prevent diabetes.



84 million Americans age 20 and older have prediabetes—more than 1 in 3—but only 10% of people know they have it. Without weight loss and moderate physical activity, 15% to 30% of people with prediabetes will develop type 2 diabetes within 5 years. Physicians like you know the toll this disease takes on individuals, families and even communities.

CONNECT PATIENTS TO BETTER HEALTH

Patients look to you—their trusted health care provider—for information on promoting health and preventing chronic diseases.

After assessing your patients' risk for type 2 diabetes and testing for prediabetes, you can feel confident that referring them to the YMCA's Diabetes Prevention Program may reduce their chances of developing type 2 diabetes and provide them tools for living happier and healthier lives.

BLOOD GLUCOSE TESTS	PREDIABETES ZONE	DIABETES
FASTING PLASMA GLUCOSE TEST	100 to 125	126 or higher
A1C TEST	5.7% to 6.4%	6.5% or higher

- Eat for a balanced lifestyle
- 150 minutes of moderate physical activity each week
- A regular walking plan with support and motivation
- Diabetes focus on healthy eating, light physical activity and stress management
- Use resources and tools to help you stay on track

COSTS OF DIABETES	AMERICAN OUT-OF-POCKET MEDICAL COST OF DIABETES (ESTIMATE)	AMERICAN OUT-OF-POCKET MEDICAL COST OF DIABETES (ESTIMATE)	
	\$3,673	\$9,202	\$17,762*

THE EFFORT TO BECOME MDPP SUPPLIERS



Progress made to date...

- Requirements of suppliers
- 9+ Ys with submitted applications
- 40+ Ys in the supplier application process
- Implementation planning and recruitment preparation

CONNECTING PEOPLE: YMCA OF DELAWARE

LIFESTYLE COACHES



CINDY BEAVER – 1 year

“Medicare paying for the program made them feel like someone cared. When the doctor writes a note that says you have prediabetes,

it’s a real call to action. But saying eat less and move more isn’t enough because they’ve been hearing that for years. They need a set program like ours and the fact that the doctor is saying, “This is free,” gives them no excuse not to go.”

MARY BRUNO – 3 years



“I’m at a time now where I have more of an interest connecting with seniors. They all seem to be so concerned with their readings (blood results) and their doctors telling them they would become diabetic. So, in their mind, the result is, ‘I’m going to become diabetic.’ Then we present this and show them that it doesn’t have to happen. We can attack this in a different way. We can learn to live a healthier lifestyle, feel better about ourselves, get moving, and hopefully prevent this from happening.”

MEET EDNA, 68

A close friend led Edna to the YMCA. “When my doctor told me I was borderline diabetic, I was nervous. I knew I didn’t want to have diabetes. I was talking to my friend in Virginia and she asked if I tried the DPP program at the Y.” Edna was excited to get started but the timing of the classes made it a challenge for her to join. “I talked with the Y and they said they could hold an earlier class but there needed to be at least eight people in it.” Not only did Edna persuade seven other Medicare eligible participants to sign-up for the program, she also convinced her local senior center to provide a space to hold their classes. “I was happy to introduce this program to other seniors. My husband is diabetic and we spend hundreds of dollars each month on just one medication. Oftentimes seniors will have to sacrifice their health needs for the basic life needs. I am retired and without the grant funding, it would have been hard. When I went back to the doctor, my A1c went down 5 points. I couldn’t believe it. With the encouragement of Medicare, this program is saving lives.”



QUALITY FAMILY PHYSICIANS

As a medical home it is essential that Quality Family Physicians (QFP) is able to provide its patients with prediabetes a comprehensive, coordinated solution that is safe, effective, and easily accessible.

Prior to collaborating with the Y, the physicians with QFP had limited resources for supporting their patients with prediabetes. Once QFP began referring its patients with prediabetes to the Y, they were pleasantly surprised by the patients’ response. The patients were losing weight, they were excited about their classes, and they were motivated to see the program through to the end. They were bonding, supporting and encouraging one another. They strengthened a community that began in their doctors’ office.



COMMUNITY INTEGRATED HEALTH

Evidence-based Interventions

Ys are discovering, developing, and disseminating research-tested, high-fidelity health interventions to improve health.

Capacity Building

Y-USA is engaging Ys from the earliest stages to ensure they have the staff, competencies, and relationships necessary to implement evidence-based programs.

Compliance

Y-USA is helping YMCAs and other community-based organizations comply with privacy laws and health care regulations.

Compliance

Evidence-based Interventions

Capacity Building

Health Equity

Health Equity

Y-USA infuses principles of equity into services to ensure everyone has the opportunity to live their healthiest lives, and that underserved populations have access to health-promoting resources.

THE YMCA'S
MODEL OF
COMMUNITY
INTEGRATED
HEALTH

Shared Spaces

Shared Physical Spaces

Ys are exploring the value of shared spaces with health practices, rehab and cancer centers, primary care within Y facilities, retail programming space with health care systems, clinical facilities at camps, and other health services.

Healthier Community Initiative

Healthier Communities Initiative

Across 247 communities, Ys have used a collective impact model to implement policy, system, and environmental changes so that healthy choices are the easy choices for all. Building on this knowledge, Y-USA's Talent and Knowledge Management department is testing new and advanced models of collaboration over the next three years.

Community Health Navigation

Community Health Navigation

Ys help individuals develop the relationships necessary to manage health by conducting home visits, spreading awareness of recommended preventive services, and helping connect people to health care exchanges and marketplaces.

THE Y'S PIPELINE OF EVIDENCE-BASED HEALTH INTERVENTIONS

DISCOVERY

Efficacy

Validation

DEVELOPMENT

Translation

Scaling

DISSEMINATION

Dissemination

Diabetes Prevention – YMCA's Diabetes Prevention Program

Falls Prevention – Enhance®Fitness, Moving For Better Balance

Arthritis Self-Management – Enhance®Fitness

Cancer Survivorship - LIVESTRONG at the YMCA

Hypertension control – Blood Pressure Self-Monitoring

Childhood Obesity Intervention – Healthy Weight and Your Child

Brain Health

Parkinson's

Tobacco Cessation



THANK YOU

Heather Hodge, M.Ed.

Senior Director, Evidence-based Health Interventions

YMCA of the USA

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Bending the Diabetes Curve through Clinical Practice Change

Janet Williams, MA
Senior Program Manager, Improving Health Outcomes

AMA Improving Health Outcomes Initiatives



Identify individuals with prediabetes and actively manage them to reduce risk of type 2 diabetes



84 million with prediabetes



Achieve blood pressure control rates of 70% or higher for all populations



103 million with hypertension

Primary Care Crisis

Without intervention, depending on where an individual is on the prediabetes spectrum:

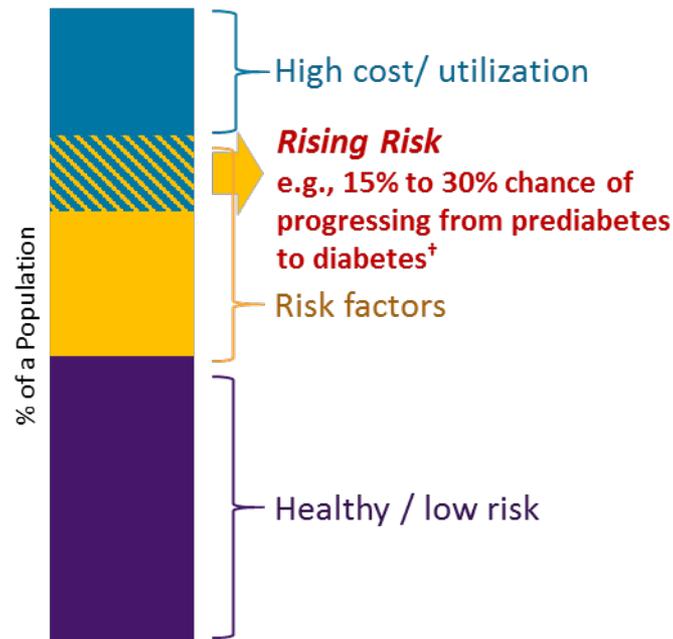


The population with prediabetes is heterogeneous and those at the higher end of the prediabetes spectrum have a higher risk of developing type 2 diabetes.

<http://www.cdc.gov/diabetes/pubs/statsreport14/prediabetes-infographic.pdf>

Prevention = Better Health Outcomes

Move Beyond Keeping the Healthy Well



AMA Assists with Diabetes Prevention Strategy



Prevent
Diabetes
STAT
Screen / Test / Act Today™

Personalized
Consulting and Plans

Implementation
Support and Evaluation

Practice Facilitation and
Clinical Resources

Patient Engagement
and Awareness Tools

*All services provided
are free of cost*

The National Diabetes Prevention Program



PHYSICAL ACTIVITY, 150
MINUTES/WEEK



HEALTHY EATING



STRESS MANAGEMENT &
BEHAVIOR MODIFICATION

Year-long in-person or online lifestyle change program

FIRST 6 MONTHS
weekly curriculum



NEXT 6 MONTHS
meet once/twice a month for
maintenance

Examples of AMA working with health systems on prevention of type 2 diabetes

Trinity Health

Leveraging community benefit dollars and clinical practice goals for system-wide implementation

- Require ministries to allocate community benefit dollars for DPP
- Establishes prediabetes screening and referral goal



Henry Ford Macomb Hospital, AMA Partner on Prediabetes Patient Registry

September 07, 2017

DETROIT – Henry Ford Macomb Hospital, in partnership with the American Medical Association (AMA), is piloting a patient registry that could become a national model for enrolling patients with prediabetes into evidence-based diabetes prevention programs and reducing their risk of developing type 2 diabetes.

Henry Ford Macomb, part of the Henry Ford Health System, is currently evaluating the registry for its effectiveness for screening, testing and referring patients diagnosed with prediabetes to a diabetes prevention program. The hospital developed specific clinical protocols before creating the registry using tools available in its Epic electronic medical record.

"We're delighted to be working in partnership with the American Medical Association on this pilot project," says Henry Ford Macomb President and CEO Barbara Roseman. "Our team has designed a user-friendly, efficient registry that has the potential to be a valuable tool for addressing the rising prevalence of prediabetes in Michigan and across the country."

Henry Ford Health System

Using the EMR to Operationalize Diabetes Prevention

- Utilize Epic turbocharger to establish ongoing patient identification



Loma Linda University Health program aims to prevent prediabetes from becoming type 2 diabetes

By Joanne Proeber July 8, 2017

Trinity Health

Hospitals & Facilities Find a Physician Programs & Services

About Us

Mission, Core Values and Vision

Our Mission

Physicians praise online diabetes prevention program: "Finally"

JAN 31, 2017

Timothy M. Smith
Senior Staff Writer
AMA Wire

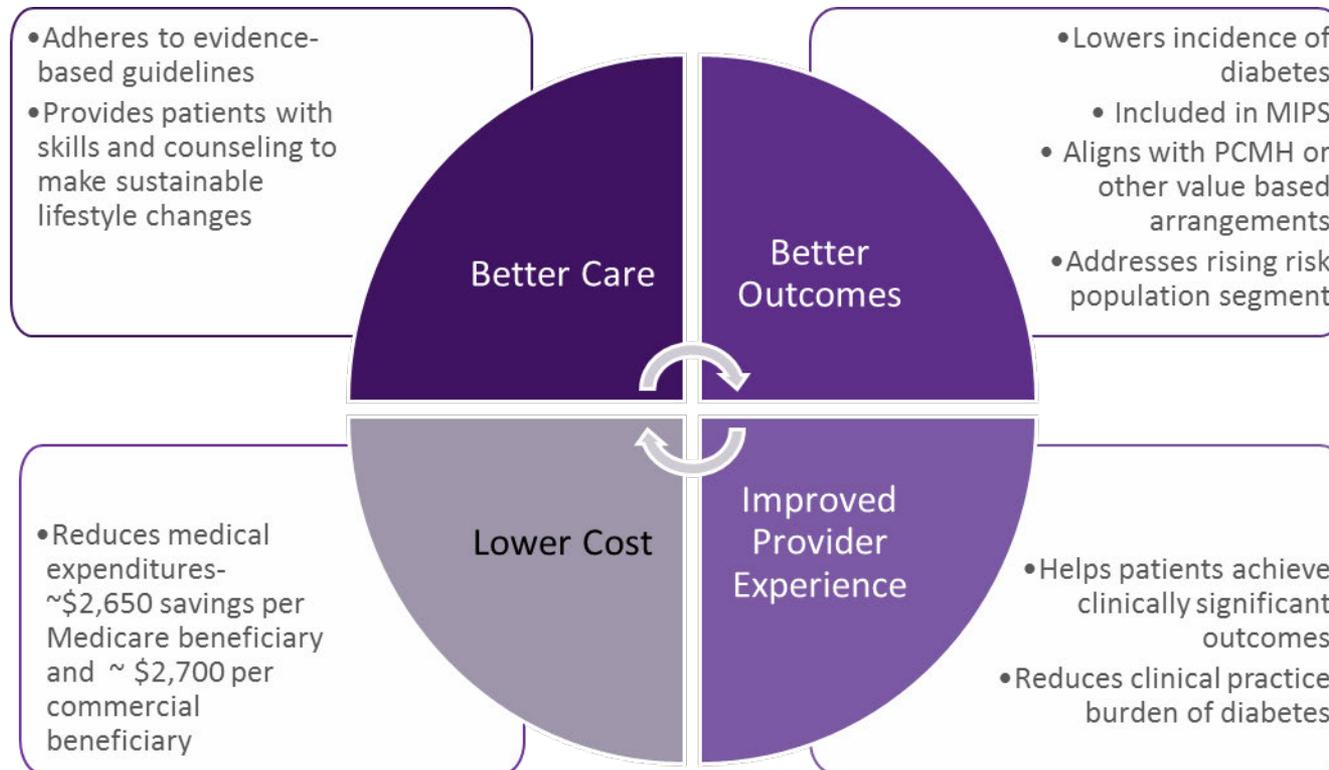
Care teams have been stymied for years in their attempts to get upstream diabetes. In large part because of a lack of tools that work with patients' full lives. It's time to plan to reimagine health care by launching a one-year pilot online diabetes prevention program (ODPP) which enables patients to part

Intermountain

Offering multiple DPP modalities and looking at roles of care team members

- Moving upstream in the diabetes role of care team members, including care managers
- Offer in-person and online, patient and physician choice
- Initial partnership to integrate virtual DPP (Omada) into health care system setting

Diabetes Prevention Leads to Improved Health



Type 2 diabetes prevention requires team-based approach



Create patient awareness and engage with physicians



Identify patients at risk and screen for prediabetes



Discuss treatment options with patients and document



Refer eligible patients with prediabetes to an evidence-based lifestyle change program (National DPP LCP) or other treatment



Create bi-directional flow of information and follow up regularly

Lessons learned from implementations in clinical practice

1. Build referrals as **clinical practice change**
2. Identify a **physician champion** AND an implementation manager
3. Overcome local **barriers**
 1. **Coverage**
 2. **Feedback loop**
 3. **Share outcomes**
4. Create **incentives**



For More Information contact:
janet.williams@ama-assn.org

Questions and Answers

Ayanna Johnson, MSPH



Questions?

If you have any questions that you would like to pose to the presenters, please type it in to the Q&A window to the right. We will address as many questions as we can in the time allotted.



- The event will focus on keeping Americans healthy as they transition into older adulthood and maximizing the health of older adults through prevention strategies and more.
- The 2018 Healthy Aging Summit goals are to:
 - Explore the science on healthy aging
 - Identify knowledge gaps
 - Promote prevention
 - Support people aging in place and in their community
- Conference tracks include:
 1. Social and Community Context
 2. Maximizing Quality of Life
 3. Health and Health Care
 4. Neighborhood and Built Environment
- Register now at www.2018HealthyAgingSummit.org



Co-hosts: Office of Disease Prevention and Health Promotion (ODPHP), the Office on Women's Health (OWH), and the American College of Preventive Medicine (ACPM)

Next Meeting: Tuesday, July 10, 2018

Time: 1:00 – 4:00 pm Eastern Time

Location: Online via webinar

Cost: Free

Purpose: The Committee will continue its deliberations regarding:

- The nation's health promotion and disease prevention objectives for 2030
- Setting of targets for a more focused set of measurable, nationally representative objectives
- The roles of health promotion, health and well-being, systems science, health equity, health literacy, summary measures, law and policy in Healthy People 2030.

Register at [HealthyPeople.gov](https://www.healthypeople.gov)



HealthyPeople.gov Tools and Resources

DEVELOPING
HealthyPeople
2030

The screenshot shows the HealthyPeople.gov website interface. At the top left is the 'HealthyPeople.gov' logo and the 'Healthy People 2020' logo. To the right is a search bar with the text 'Search HealthyPeople.gov' and a 'Go' button. Below the search bar is a navigation menu with tabs for 'Topics & Objectives', 'Leading Health Indicators', 'Data Search', 'Healthy People in Action', 'Tools & Resources', 'Webinars & Events', and 'About'. The main content area features a large image of two women, one in a white lab coat, looking at a tablet. To the right of the image is a dark blue box with white text: 'Register for a Spotlight on Health Webinar', 'We're teaming up with the Diabetes Advocacy Alliance on February 21 to talk about improving diabetes screening and referral to prevention programs.', and 'Join us.' with an external link icon. Below this are two promotional cards. The first card, titled 'DATA2020 Search', features a magnifying glass icon and describes an interactive data tool. The second card, titled 'Midcourse Review: Interactive Infographics', features a 'New' badge and describes interactive infographics for tracking progress.



Office of Disease Prevention
and Health Promotion



Diabetes Advocacy Alliance Screening Tools & Resources

DEVELOPING
HealthyPeople
2030



HOME CONTACT US

About Us | Policy Priorities | Advocacy Activities | Media | Resources and Advocacy Tools

LATEST NEWS

DAA submits comments to CMS on Medicare Diabetes Prevention Program guidance
[Read More](#)

DAA releases two infographics on new diabetes screening guideline
[Read More](#)

Our mission is to unite and align key diabetes stakeholders and the larger diabetes community around key diabetes-related policy and legislative efforts in order to elevate diabetes on the national agenda.

MEMBER PROFILE

Academy of Nutrition and Dietetics
The Academy of Nutrition and Dietetics

The Diabetes Advocacy Alliance™ is working to increase awareness of, and action on, the diabetes epidemic among legislators and policymakers. We are a diverse group of patient advocacy organizations, professional societies, trade associations and corporations, sharing a common goal to defeat diabetes. Explore our site to learn more about what's on the front burner in our interactions

More of your patients are now eligible for free diabetes screening and prevention programs.

The US Preventive Services Task Force (USPSTF) has updated its screening recommendation, and now, for the first time, recommends screening for prediabetes and referral to diabetes prevention programs, in addition to screening for undiagnosed diabetes.

Patients with these characteristics are now eligible for a screening with no cost-sharing:

- Age 40 to 70 years old, and are overweight or obese.
- OR
- Have 1 or more of these characteristics (regardless of age or weight):
 - Overweight or obese
 - A history of gestational diabetes or polycystic ovarian syndrome
 - Family history of diabetes
 - African American, Hispanic/Latino, American Indian, or Asian American or Pacific Islander

Through screening, we can identify...

- Prediabetes**: Be referred to free diabetes prevention programs
- Diabetes**: Begin diabetes treatment

Knowing is better, so that your patients can...

Through this new USPSTF guideline, millions more adults are now eligible for prediabetes and diabetes screening.

People Eligible for Screening Through USPSTF

Year	People Eligible (millions)
2008	61 million
2015	170 million

Beginning in 2017
Private health plans are required to cover screening for prediabetes and diabetes at no cost to patients. In addition, insurers will be required to cover diabetes prevention programs at no cost to patients because the guideline states that clinicians should offer or refer patients with prediabetes to intensive behavioral counseling interventions to promote a healthful diet and physical activity.

Beginning in 2018
Medicare will begin covering diabetes prevention programs for eligible beneficiaries at risk for type 2 diabetes starting January 1, 2018.

Key Takeaway
When combined and fully implemented, the new USPSTF guideline and Medicare DPP coverage will result in most Americans having insurance coverage for diabetes screening and prevention programs at no cost.

Visit us at www.diabetesadvocacyalliance.org.
Download our infographics and additional information on screening and diabetes prevention at www.diabetesadvocacyalliance.org/screening.html.



Office of Disease Prevention and Health Promotion



A library of stories highlight ways organizations across the country are implementing Healthy People 2020

Stories from the Field

Want to know what others are doing to improve the health of their communities? Explore our *Stories from the Field* to see how communities across the Nation are implementing Healthy People 2020. You can also [share your story!](#)

Explore the map below or filter to view stories by the related topic area or Leading Health Indicator.

Sort By: Viewing 80 results

Topic Area	Organization Name	Organization Type	Date Posted	Program State
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Filter By: Show LHI Only [Reset Filters](#) [Update](#)

Healthy People 2020 in Action

- Who's Leading the Leading Health Indicators? series
- Stories from the Field

Healthy People in Action
<http://www.healthypeople.gov/2020/healthy-people-in-action/Stories-from-the-Field>

JOIN THE HEALTHY PEOPLE LISTSERV & CONSORTIUM



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YOUTUBE ODPHP (search "healthy people")