Promoting Diabetes Prevention Programs and New Payment Options

A Healthy People 2020 Spotlight on Health Webinar
Today’s Webinar Hosts

• 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 Sczepanski, RDN, Health Promotion Coordinator, Company Focal Point for Healthy Eating and Weight Management, Dow Chemical
Today’s Webinar

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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**
Uses of Healthy People

- **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
Healthy People 2020 Diabetes Objectives

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

Rate Per 1,000

15
12
9
6
3
0

1997-1999
2000-2002
2003-2005
2006-2008
2009-2011
2012-2014
2014-2016

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.

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 ≥5.7% to <6.5%.

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

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

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

It brings together:
- Employers
- Health Care Organizations
- Private Insurers
- Faith-Based Organizations
- Community Organizations
- Government Agencies

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:

   - A trained lifestyle coach
   - CDC-approved curriculum
   - Group support over the course of a year

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:

   - Build a workforce that can implement the lifestyle change program effectively
   - Ensure quality and standardized reporting
   - Deliver the lifestyle change program through organizations nationwide
   - Increase referrals to and participation in the lifestyle change program

National DPP Strategic Goals

- Increase coverage among public and private payers
- Increase referrals from healthcare providers
- Increase the supply of quality programs
- Increase demand for the National DPP among people at risk
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.

1: CDC Diabetes Prevention Recognition Program
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 DPP

160,378 individuals have enrolled in the National DPP as of June 4, 2018

1. CDC Diabetes Prevention Recognition Program
Award-Winning Prediabetes Awareness Campaign
Ad Council, AMA, ADA, CDC

Puppies –
A Perfect Way to Spend a Minute

So is taking a one-minute prediabetes risk test.

Hedgehogs on Vacation –
A Perfect Way to Spend a Minute

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

DoIHavePrediabetes.org
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**
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.

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

**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).
## 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

### 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)

Medicare payment began April 1, 2018
For More Information

www.cdc.gov/diabetes/prevention

National DPP Customer Service Center going live in July

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

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 $104B each year, and is growing
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

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.

<table>
<thead>
<tr>
<th>MDPP Core Services</th>
<th>Ongoing Maintenance Sessions*</th>
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<tr>
<td>Months 1-6 (Core Sessions) and Months 7-12 (Core Maintenance)</td>
<td>Months 13-24</td>
</tr>
<tr>
<td>• All MDPP beneficiaries are eligible for 12 months of core services</td>
<td>• Beneficiaries must meet weight loss and attendance goals to be eligible</td>
</tr>
</tbody>
</table>

• 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.

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

*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](https://nccd.cdc.gov/DDT_DPRP/Registry.aspx)

*Subscribe to receive MDPP updates at [go.cms.gov/mdpp](http://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

Sczepanski
About Dow

ABOUT DOW

Dow combines the power of science and technology to passionately innovate what is essential to Human Progress.
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

Healthy Workplace → Healthy People → Healthy Culture → NDPP

- Stop Smoking
- Eat Better
- Get Active
- Lose Weight
- Manage Blood Pressure
- Control Cholesterol
- Reduce Blood Sugar
Dow’s US DPP Strategy

Virtual

Onsite

Community
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
Measuring Success

CDC Recognition Standards!

Overall Outcomes:

• 51% of participants completing 9+ lessons lost > 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,
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

- YMCA's
- Communities

YMCA's

- 2,700

States

- 50 plus

Communities Served

- 10,000

District of Columbia and Puerto Rico

58%
A BRIEF HISTORY

2005
DPP translated into the community by the IU School of Medicine and the YMCA of Greater Indianapolis

2010
The YMCA first began work with insurance companies for coverage of the DPP

2012
CMMI Medicare project began

2016
Secretary of Health and Human Services announces certified health improvement and Medicare cost savings with intent to expand the DPP

2017
Implementation of an electronic medical record within the Y network to facilitate referrals and revenue cycle management

2018
Prep for the Medicare Diabetes Prevention Program
**DELIVERING OUTCOMES AT SCALE:**

**YMCA’S DPP**

- 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

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**THE PROGRAM IS:**

<table>
<thead>
<tr>
<th><strong>By The Numbers</strong> (as of 4/30/18)</th>
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<tbody>
<tr>
<td>Participants attending at least one session</td>
</tr>
<tr>
<td>Completer’s average year-end weight loss</td>
</tr>
<tr>
<td>Average physical activity minutes per week</td>
</tr>
<tr>
<td>Y associations delivering program</td>
</tr>
<tr>
<td>States where the program is available</td>
</tr>
<tr>
<td>Total active program sites</td>
</tr>
<tr>
<td>Low income participants*</td>
</tr>
</tbody>
</table>

*Participants at or below Federal Poverty Guidelines
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
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.

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

**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.

**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.

**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.

**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**
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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Chicago, IL 60606
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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:

15% - 30% of people with prediabetes1

within 5 years

Type 2 Diabetes

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.

Prevention = Better Health Outcomes

Move Beyond Keeping the Healthy Well

- **High cost/ utilization**
- **Rising Risk**
  - e.g., 15% to 30% chance of progressing from prediabetes to diabetes
- **Risk factors**
- **Healthy / low risk**
AMA Assists with Diabetes Prevention Strategy

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
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 Health System**
*Using the EMR to Operationalize Diabetes Prevention*

- Utilize Epic turbocharger to establish ongoing patient identification

**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

**Better Care**
- Adheres to evidence-based guidelines
- Provides patients with skills and counseling to make sustainable lifestyle changes

**Better Outcomes**
- Lowers incidence of diabetes
- Included in MIPS
- Aligns with PCMH or other value based arrangements
- Addresses rising risk population segment

**Lower Cost**
- Reduces medical expenditures:
  ~$2,650 savings per Medicare beneficiary
  ~$2,700 per commercial beneficiary

**Improved Provider Experience**
- Helps patients achieve clinically significant outcomes
- Reduces clinical practice burden of diabetes
Type 2 diabetes prevention requires a 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.
2018 Healthy Aging Summit

• 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:
  o Explore the science on healthy aging
  o Identify knowledge gaps
  o Promote prevention
  o 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
HealthyPeople.gov
Tools and Resources

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.

Join us.

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.

Midcourse Review: Interactive Infographics
Check out our interactive infographics to track the Nation’s progress toward Healthy People 2020 targets.
A library of stories highlight ways organizations across the country are implementing Healthy People 2020.

Healthy People in Action
JOIN THE HEALTHY PEOPLE LISTSERV & CONSORTIUM

WEB  healthypeople.gov
EMAIL  healthypeople@hhs.gov
TWITTER  @gohealthypeople
YOUTUBE  ODPHP (search “healthy people”)

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