Healthy People 2020 Spotlight on Health presents

Improving Diabetes Screening and Referral to Prevention Programs
Today’s Webinar Hosts

- Diabetes Advocacy Alliance
- The U.S. Department of Health and Human Services’ Office of Disease Prevention and Health Promotion
I. Overview of Healthy People Initiative and Introduction of Topic

*Don Wright, MD, MPH, Acting Assistant Secretary for Health, and Director, Office of Disease Prevention and Health Promotion (ODPHP), U.S. Department of Health and Human Services (HHS)*

II. Scope of Diabetes in United States and Key Findings of Diabetes Prevention

*Ed Gregg, PhD, MS, Chief, Epidemiology and Statistics Branch, Division of Diabetes Translation, Centers for Disease Control and Prevention, HHS*
III. USPSTF Abnormal Blood Glucose and Type 2 Diabetes Mellitus Screening Guidelines

Quyen Ngo-Metzger, MD, MPH, United States Preventive Services Task Force Scientific Director, Agency for Healthcare Research and Quality, HHS

IV. Medicare’s New Focus on DPP

Carlye Burd, MS, MPH, Prevention and Population Health, Center for Medicare and Medicaid Innovation, Centers for Medicare and Medicaid Services, HHS
V. Review of New Research on Screening for Diabetes

Ronald T. Ackermann, MD, MPH, Senior Associate Dean for Public Health and Professor of Medicine and Medical Social Sciences at Northwestern University Feinberg School of Medicine

VI. Screening for Diabetes and Pre-diabetes with a Vulnerable Population

Andrea Caracostis, MD, MPH, CEO, Hope Clinic, Houston TX, a federally-qualified Health Center
VII. Live Question and Answer Session

Moderated by Carter Blakey, Deputy Director and Community Strategies Division Director, ODPHP, HHS
Overview of Healthy People Initiative

Don Wright, MD, MPH
Acting 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 **science-based, 10-year national objectives** for improving the health of the Nation

- A **national agenda** that communicates a vision for improving health and achieving health equity

- Identifies **measurable objectives** with **targets** to be achieved by the year 2020

- Requires tracking of **data-driven outcomes** to monitor progress and to motivate, guide, and focus action
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
New Cases of Diagnosed Diabetes Per 1,000 Per Year, Adults 18–84 Years, 1997–2015

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, 2013–2015

NOTES: = 95% confidence interval. *2006-2008 data – HP2020 baseline. Data are for three year average of diagnosed diabetes in the past year 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. Persons of Hispanic origin may be any race. The categories Black and White exclude persons of Hispanic origin. Respondents were asked to select one or more races. Data for the single race categories are for persons who reported only one racial group. Data for Native Hawaiian or other Pacific Islander are not shown because they are statistically unreliable (DSU).

SOURCE: National Health Interview Survey (NHIS), CDC/NCHS.
HP2030 Objective Development and Selection Process

Secretary’s Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030

Public Comment

Federal Interagency Workgroup (FIW)

FIW HP2030 Subgroup
Scope of Diabetes in U.S. and Key Findings of Diabetes Prevention

Ed Gregg, PhD, MS
The Scope of the Diabetes Epidemic and Status of Prevention

Edward Gregg, PhD
Division of Diabetes Translation
Centers for Disease Control and Prevention

Findings and conclusions in this presentation are those of the author and do not necessarily represent those of the Centers for Disease Control and Prevention
Epidemiologic Trends

What Brought Us To The Need for Prevention?

- Doubling of diagnosed prevalence and incidence in 20 years.
- Increasing overweight and obesity.
- Declining levels of physical activity.
- Poor-quality carbohydrates.
- Sugary drinks.
- Increased fast food & portion sizes.
- Diverse socioeconomics.
Trends in Incidence and Prevalence of Diagnosed Diabetes Among Adults Aged 20 to 79, United States, 1980 - 2014
Trends in lifetime risk and years of life lost due to diabetes in the USA, 1985-2011: a modelling study

Edward W Gregg, Xiaohui Zhuo, Yiling J Cheng, Ann L Albright, K M Venkat Narayan, Theodore J Thompson

- Large increased lifetime risk and years spent with diabetes.
- Men now even with women.
- Lifetime risk now > 50% for Latinos and Black women.
- Total years spent with diabetes per 1000 has doubled in men and increased 60% in women.

Gregg et al., *Lancet Diabetes & Endocrinology*, 2014
Incidence Trends: 2002-2012
Type 1 and Type 2 Diabetes

Model Adjusted Incidence Estimates

Type 1 Diabetes (age 0-19 years)

Type 2 Diabetes (age 10-19 years)

SEARCH for Diabetes in Youth Study Group, ADA Scientific Sessions, June 11, 2016.
What does prevention look like in the U.S?
<table>
<thead>
<tr>
<th>Risk Level</th>
<th>Adult Prevalence (%)</th>
<th>10 Years Diabetes Risk (%)</th>
<th>Risk Indicators</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very High</td>
<td>~ 15%</td>
<td>&gt;30</td>
<td>A1c &gt;5.7% FPG&gt;110</td>
<td>Structured Lifestyle Intervention in Community Setting</td>
</tr>
<tr>
<td>High</td>
<td>20%</td>
<td>20 to 30</td>
<td>FPG&gt; 100 NDPP score 9+</td>
<td>Risk Counseling</td>
</tr>
<tr>
<td>Moderate</td>
<td>30%</td>
<td>10 to 20</td>
<td>2+ risk factors</td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>35%</td>
<td>0 to 10</td>
<td>0-1 risk factors</td>
<td>Build Healthy Communities</td>
</tr>
</tbody>
</table>
The National Diabetes Prevention Program: A Public-private partnership to scale the translated model of the DPP.

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 to achieve a greater impact on reducing type 2 diabetes.
The National Diabetes Prevention Program:

- Clinical-community partnership with delivery by lifestyle coaches in community settings.
- Diverse settings (YMCA’s, employers, community settings, virtual delivery)
- Train-the-trainer model by master trainers.
- 16-visit curriculum for small group counseling.
- Training, recognition and registry program by CDC to:
  - Train workforce
  - Ensure standards, quality, and credibility.
  - Drive reimbursement.
- Insurers and self-pays.
1007 CDC-recognized programs across 50 states/territories.

>10,300 coaches (lay people; health professionals) trained.

Serving 85,008 eligible participants.

39 commercial health plans providing some coverage for 2.4M
Characteristics of Participants and 1-year Intervention Response among 9873 participants who completed at least 1 visits.

<table>
<thead>
<tr>
<th>Category</th>
<th>Num</th>
<th>%</th>
<th>Median wt loss</th>
<th>% meet wt. goal</th>
<th>% meet PA goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td>7920</td>
<td>80</td>
<td>3.8</td>
<td>46</td>
<td>52</td>
</tr>
<tr>
<td>Men</td>
<td>1953</td>
<td>20</td>
<td>3.0</td>
<td>35</td>
<td>39</td>
</tr>
<tr>
<td>Age 18-44</td>
<td>1969</td>
<td>20</td>
<td>2.2</td>
<td>28</td>
<td>34</td>
</tr>
<tr>
<td>Age 45-64</td>
<td>5478</td>
<td>55</td>
<td>3.1</td>
<td>35</td>
<td>40</td>
</tr>
<tr>
<td>Age 65+</td>
<td>2426</td>
<td>25</td>
<td>4.1</td>
<td>47</td>
<td>51</td>
</tr>
<tr>
<td>Obese</td>
<td>7121</td>
<td>72</td>
<td>3.1</td>
<td>36</td>
<td>40</td>
</tr>
</tbody>
</table>

Unpublished Analyses, 2016
## Proportion of Non-diabetic Adults Meeting Key Healthy Targets for Diabetes Risk Reduction, NHANES 2007-2012

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th>Women</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vegetables</td>
<td>26</td>
<td>27</td>
<td>27</td>
</tr>
<tr>
<td>Dairy</td>
<td>18</td>
<td>9</td>
<td>13</td>
</tr>
<tr>
<td>Whole Grains</td>
<td>29</td>
<td>23</td>
<td>26</td>
</tr>
<tr>
<td>Added Sugars</td>
<td>26</td>
<td>27</td>
<td>26</td>
</tr>
<tr>
<td>Saturated Fats</td>
<td>42</td>
<td>45</td>
<td>43</td>
</tr>
<tr>
<td>Leisure-Time Phys Activity</td>
<td>40</td>
<td>32</td>
<td>36</td>
</tr>
</tbody>
</table>

Unpublished Analyses, 2015
Summary and Challenges Ahead

- Despite encouraging recent trends in diabetes incidence, prevalence remains 60% higher than the early 1990s and the future burden is ominous.

- Multi-tiered efforts to prevent diabetes are needed for both high risk individuals and the overall population.

- Key challenges ahead include:
  - Program availability, engagement, participation and reimbursement for high risk people.
  - Finding and implementing approaches to change the levels of risk factors for the overall population.
U.S. Preventive Services Task Force
Abnormal Blood Glucose Screening

February 21, 2017

Quyen Ngo-Metzger, MD, MPH
Scientific Director
The U.S. Preventive Services Task Force…

- Makes recommendations on clinical preventive services to primary care clinicians for use in a primary care setting

  - The USPSTF scope for clinical preventive services include:
    - screening tests
    - counseling
    - preventive medications

  - Services are offered in or referred from the primary care setting

  - Recommendations apply to adults & children with no obvious signs or symptoms
Overview - USPSTF

● Makes recommendations based on rigorous review of existing peer-reviewed evidence
  ► Does not conduct the research studies, but reviews & assesses the research
  ► Evaluates benefits & harms of each service based on factors such as age & sex
  ► Makes population-based recommendations for primary care clinicians

► Is an independent panel of non-Federal experts in prevention & evidenced-based medicine
A group health plan and a health insurance issuer offering group or individual health insurance coverage shall provide coverage for and shall not impose any cost sharing requirements for

- Evidence-based items or services that have a rating of ‘A’ or ‘B’ in the current recommendations of the United States Preventive Services Task Force.
Abnormal Blood Glucose and Type 2 Diabetes Mellitus

<table>
<thead>
<tr>
<th>Population</th>
<th>Recommendation</th>
<th>Grade (What's This?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults aged 40 to 70 years who are overweight or obese</td>
<td>The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.</td>
<td>B</td>
</tr>
</tbody>
</table>

This recommendation applies to adults aged 40 to 70 years who are seen in primary care settings and do not have obvious symptoms of diabetes. Persons who have a family history of diabetes, have a history of gestational diabetes or polycystic ovarian syndrome, or are members of certain racial/ethnic groups (that is, African Americans, American Indians or Alaskan Natives, Asian Americans, Hispanics or Latinos, or Native Hawaiians or Pacific Islanders) may be at increased risk for diabetes at a younger age or at a lower body mass index. Clinicians should consider screening earlier in persons with 1 or more of these characteristics.
Populations to Screen

- Ages 40 to 70 who are overweight or obese

- Clinicians should consider screening earlier in patients with one or more of these characteristics:
  - a family history of diabetes
  - a history of gestational diabetes
  - polycystic ovarian syndrome
  - members of certain racial/ethnic groups (African Americans, American Indians/Alaskan Natives, Asian Americans, Hispanics/Latinos, or Native Hawaiians/Pacific Islanders) may be at increased risk of developing diabetes at a younger age or at lower BMI levels
“…adequate evidence that intensive behavioral counseling interventions for persons at increased risk for CVD have moderate benefits in lowering CVD risk. Populations… include persons who are obese or overweight and have hypertension, hyperlipidemia or dyslipidemia, and/or IFG or IGT. Benefits of behavioral interventions include reductions in blood pressure, glucose and lipid levels, decreased obesity and increased physical activity.”

“Studies that specifically treat persons who have IFG or IGT with intensive lifestyle interventions… consistently show a moderate benefit in reducing progression to diabetes. Lifestyle interventions have greater effects… than metformin or other medications.”
Behavioral Interventions

- Behavioral interventions that impact cardiovascular disease risk and delay or avoid progression of glucose abnormalities to type 2 diabetes

- Combine counseling on a healthful diet and physical activity; with intensive and multiple contacts over extended periods
Diabetes Prevention Intervention

- Goals included a 7% weight loss and 150 min of weekly activity
- Intervention components included:
  1. Lifestyle coaches
  2. Frequent contact with participants
  3. 16-session structured curriculum
  4. Supervised physical activity sessions
  5. Flexible maintenance phase including restarts
  6. Network of training, feedback, and clinical support
Healthy Lifestyle Trials for CV Prevention

- 16 trials (n=4,623) in persons primarily with dyslipidemia
  - Tot Cholesterol (TC): 233-282 mg/dL, LDL: 156-200 mg/dL in persons not on lipid-lowering medications

- 13 trials (n=4,512) in persons primarily with HTN
  - BP: 127-162 / 71-96 mmHg on anti-HTN (~145/90 in persons not on anti-HTN)
  - Only 3 trials in persons not yet on medications

- 13 trials (n=5,791) in persons primarily with IFG/IGT
  - Fasting glucose (FBG): 101-111 mg/dL in persons not on metformin

- 22 trials (n=14,269) in persons with mixed CVD RF
  - TC: 191-258 mg/dL; LDL: 112-178 mg/dL; BP: 125-155/ 77-91 mmHg; FBG: 93-148 mg/dL
● Because overweight and obesity, physical inactivity, abnormal lipid levels, high blood pressure, and smoking are all modifiable risk factors for cardiovascular events, the USPSTF recommends screening and appropriate interventions for all these conditions (www.uspreventiveservicestaskforce.org)
Behavioral Interventions

- Although intensive interventions may not be practical in some primary care settings, patients may be referred from primary care to community-based programs for these interventions.
The evidence is insufficient to conclude that pharmacologic interventions have the same multifactorial benefits (e.g. weight loss, lower levels of glucose, blood pressure, and lipids) as behavioral interventions.
USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a BMI of >30 kg/m² or higher to intensive, multicomponent behavioral interventions. (B grade)

Includes 12 to 26 individual or group sessions a year, provided by primary care clinicians or specialists (including nutritionists).
USPSTF recommends offering or referring adults who are overweight or obese and have additional cardiovascular (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention. (B Grade)

Benefits of healthy lifestyle and weight loss include decreased blood pressure, cholesterol, and blood glucose levels.
Thank you for your interest

www.USPreventiveServicesTaskForce.org
Medicare’s New Focus on DPP

Carlye Burd, MS, MPH
Medicare Diabetes Prevention Program Expansion

Carlye Burd, MPH, MS

Medicare Diabetes Prevention Program (MDPP) Expansion

Center for Medicare and Medicaid Innovation

February 21, 2017
Disclaimer

This presentation was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

This presentation was prepared as a service to the public and is not intended to grant rights or impose obligations. This presentation may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations, and other interpretive materials for a full and accurate statement of their contents.
Today’s Agenda

- Context
- Overview of MDPP
- Question and Answer
How we got here

<table>
<thead>
<tr>
<th>Problem</th>
<th>DPP Model Test</th>
<th>MDPP Model Expansion</th>
</tr>
</thead>
<tbody>
<tr>
<td>25% of Americans 65 or older have type 2 diabetes</td>
<td>CDC NDPP &amp; Y-USA Feb. 2013 – Jan. 2015 7,800 beneficiaries</td>
<td>2016 Expansion Announced First Rule Published</td>
</tr>
<tr>
<td>Diabetes care for 65+ population costs $104 billion annually, and growing.</td>
<td>Results: 83% participants ≥ 4 sessions Average weight loss of 9 lbs</td>
<td>2018 Medicare Diabetes Prevention Program Expansion Go Live</td>
</tr>
</tbody>
</table>
What is the MDPP Benefit?

- CDC-approved DPP curriculum
- 12 month Core Benefit
- Maintenance Sessions
- Additional Preventive Service

- Minimum of 16 core sessions
- First 6 months
- Monthly maintenance sessions
- Second 6 months

AFTER 1st YEAR: monthly maintenance sessions IF patient achieves & maintains minimum weight loss
Who can participate in MDPP?

- **Eligibility:**
  - Part B beneficiaries
  - >25 BMI (>23 for Asians)
  - Lab test results demonstrate high blood glucose levels
  - No history of T1 or T2 Diabetes

- **Coverage**
  - Once per lifetime per beneficiary
  - 12 month benefit regardless of weight loss
  - Ongoing maintenance sessions only available if beneficiary has achieved maintenance of weight loss

- **No referral required**
Who can provide MDPP services?

- **Eligibility:** Organizations must obtain CDC recognition to provide MDPP services
- **Enrollment**
  - Organizations will enroll in Medicare as *MDPP suppliers*
  - Expected to begin following rulemaking in 2017
- **Existing Medicare Providers:** required to adhere to the same enrollment requirements
QUESTIONS?

For more information…

- Sign up for updates about this expanded model, by subscribing to the Medicare Diabetes Prevention Program listserv
- Please send questions about the CDC Recognition Process and Standards to dprpAsk@cdc.gov
Review of New Research on Screening for Diabetes

Ronald T. Ackermann, MD, MPH
Diabetes Prevention: Evidence & Practical Approaches for Screening & DPP Engagement

Ronald T. Ackermann, MD, MPH
Professor of Medicine
Northwestern University Feinberg School of Medicine
The Prediabetes Screening Waterfall

100,000 Primary Care Patients

Screening

Inform/Activate

83,000 undergo opportunistic screening\(^1\)

Linkage/Access to DPP

32,370 have PDM\(^1,2\)

Only 11% made aware;\(^3\) how many linked?

Engagement/Participation in DPP

40-60% attend\(^4\)

Lifestyle Change

30-35% have 5% weight loss\(^4\)

Diabetes Prevention

58% new T2D\(^5\)

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5 Hamman RF, et al. 2006 Diabetes Care 29:2102–2107
Outcomes Desired by Patients

- Diabetes patients perceive intensive diabetes management to reduce their HRQL by 22%\(^1\) (similar to angina)
- Adults who perceive they are at high risk for T2D express a willingness to pay >\$1000 per year for interventions like DPP\(^2\)
- Treating 100 high risk adults (age 50) for 3 years with the DPP...
  - Prevents 15 new cases of Type 2 Diabetes\(^3\)
  - Prevents 162 missed work days\(^4\)
  - Avoids the need for any BP or Chol pills in 11 people\(^5\)
  - Avoids $91,400 in other healthcare costs\(^6\)
  - Adds the equivalent of 20 perfect years of health\(^7\)

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1 Huang ES, et al. Diabetes Care 2007;30:2478-83
4 DPP Research Group. Diabetes Care. 2003 Sep;26(9):2693-4
5 Ratner, et al. 2005 Diabetes Care 28 (4), pp. 888-894
Attitudes & Barriers of Clinical Providers

● Attitudes expressed by primary care providers
  – Knowing that a patient has prediabetes can be “positive” – enable action
  – Advice to patients can be framed as a chance to avoid diabetes; avoid medications
  – Lifestyle changes are preferred over medications for diabetes prevention
  – It is unrealistic for patients to make lifestyle changes without access to programs
  – Patients cannot maintain motivation; usually regain weight

● Commonly reported barriers
  – Insufficient time to provide education and counseling during routine encounters
  – Limited availability / access to effective support programs
  – Lack of provider reimbursement for counseling and interventions
  – Patient costs to access lifestyle change programs
Convergence in Health Care

Many Patients Wanting to Avoid T2D

Blood Test
Inform
Set Goals
Link to DPP

Health Systems & Communities Aligning to Make DPP Accessible & Affordable
Clinical Process Flow for Diabetes Prevention

**Clinical Processes**
- Document Risk Factors
- Diabetes Screening Test (Z13.1)
- Document PreDM Diagnosis (R73.XX)
- Brief Advice
- DPP Referral

**Community Processes**
- Engage
- Access Resources
- Behavior Change
- Ongoing Support

**Linkage Processes**
- Feedback

**Annual Retesting “TS”**
Practical Considerations for Screening

- A1c can be done non-fasting
- Consider adding plasma glucose to any fasting lipid profile order
- Attach the ICD-10 code Z13.1
- If high risk, include prediabetes (R73.XX) on the patient problem list
- Create a letter or electronic message template to inform patients of results
  - Prediabetes is not the same as T2D
  - On average, ¼ to ½ of people with PDM will develop T2D in 10 years
  - Just small amounts of weight loss and exercise can help normalize blood glucose and prevent more than half of people from developing T2D
  - ...transition to advice....
Evidence-based Brief Behavioral Support

- Help patients set a goal they can achieve/control
  - Endpoint
    - Weight loss of 6 to 12 lbs in 12 weeks (1/2 to 1 pound per week)
    - Can set a new goal when they reach it
  - Immediate
    - Weigh self every day for 7 days and write down number in log book
    - 3 day food diary
- Follow-up (Accountability)
  - 1-2 weeks
    - Decide on way she will submit weight records and food log
    - Ask her to identify foods she might eat less often/differently to decrease diet intake by 300 kcal/d
    - Ask when/how she could move for 40 more minutes every day
    - Reaffirm daily weighing and weight loss goal
    - Link to a DPP / other ILI support programs available to them in community
  - 4-6 weeks
    - Have her return or contact to troubleshoot if not at least 3 lbs of weight loss
Screening for Diabetes and Pre-diabetes with a Vulnerable Population

Andrea Caracostis, MD, MPH
Diabetes Control
Creating a Community Coalition

Andrea Caracostis, MD, MPH
Chief Executive Officer
Asian American Health Coalition/HOPE Clinic
Our Mission: “to provide quality health care without any prejudice to all people of greater Houston, in a culturally and linguistically competent manner.”

Our Vision: “A healthy community with quality, affordable health care for all.”
Asian American Health Coalition dba HOPE Clinic

● In 1994, the Asian American Health Coalition (AAHC) was formed to reduce health disparities in the Asian American Community.
● HOPE Clinic was established by AAHC in 2002
● 2005 Hurricane Katrina victims received HOPE Clinic’s assistance
● In 2007, HOPE Clinic moved to its current location
● Today, HOPE Clinic is an FQHC operating six days a week, in 3 sites
Our Staff 2016
Patient Diversity

- Hispanic/Latino: 32%
- Vietnamese: 14%
- Chinese: 14%
- African-American: 14%
- White: 8%
- African Islander: 4%
- Unknown: 1%
- Korean: 2%
- Other Asian: 3%
The Need for Services

<table>
<thead>
<tr>
<th>Year</th>
<th>Visits</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>9,459</td>
<td>7,365</td>
</tr>
<tr>
<td>2011</td>
<td>13,039</td>
<td>4,124</td>
</tr>
<tr>
<td>2012</td>
<td>23,539</td>
<td>5,692</td>
</tr>
<tr>
<td>2013</td>
<td>31,921</td>
<td>7,452</td>
</tr>
<tr>
<td>2014</td>
<td>44,834</td>
<td>9,274</td>
</tr>
<tr>
<td>2015</td>
<td>54,756</td>
<td>11,212</td>
</tr>
<tr>
<td>2016</td>
<td>59,200</td>
<td>14,150</td>
</tr>
</tbody>
</table>
Discovering Diabetes

- Asians are more likely to develop the disease even at a lower BMI
- Nearly 50% of adult men in Asian countries smoke regularly
- White rice and other refined grains a a large proportion of daily energy intake
- Lack of education within the AAPI
- Asian population is diverse, no data on differences within populations.
Diabetes control over time

Prevalence 6% to 5%
The Stakeholders
(Some of) Our partners

- American Cancer Society – Houston
- American College of Acupuncture Medicine
- Asian American Family Services
- Asian Cancer Council
- Asian Senior Coalition
- Baylor College of Medicine
- Asian Pacific American Medical Students
- Office of Outreach and Health Disparities
- PAMSA
- Boat People SOS
- Burmese American Association of Texas
- Chinese Community Center
- City of Houston – Health Dept.
- **Cities Changing Diabetes**
  - Filipino Cancer Network of America/Houston
  - Filipino Doctors & Nurses Assoc.
  - Gateway to Care
  - Herald Cancer Assoc. – Houston
  - Harris Health
  - Harris County Public Health Services
  - Houston Korean Nurses Assoc
  - Shifa Foundation Clinic
  - Ibn Sina Foundation Clinic
- Indian American Cancer Network
- Light & Salt Assoc.
- M.D. Anderson Cancer Center:
  - Center for Research on Minority Health
  - Dept. of Health Disparities Research
- Polynesian Culture Assoc. – Houston
- Rose, The
- Sam Houston State Univ. – Sociology Dept.
- Taiwanese Heritage Society
- Texas Children's Hospital:
  - Texas Liver Coalition
  - Texas Woman’s University
- U.H. College of Pharmacy
- U.T. School of Biomedical Informatics
- U.T. School of Public Health
- University of Houston School of Optometry
- University of Houston School of Social Work
- Vietnamese Cultural and Science Association
- Vietnamese American Medical Assoc.
- VN Teamwork
- India House
- ADA
Diabetes on problem list

- About 600 diabetes patients at Hope per year
- About 5% of total patients
- 50% are on some kind of medication
- 25% attend nutritional consultation
The Process

Evaluate Data around patient care

Screen A1c and Treat

Educate

Nutritionist

Community Work
Integrated Care

- Integrating Diabetes care into the primary practice
  - Greater reach and impact
  - Demystifies diabetes
  - Cost savings
  - Greater compliance
  - Collecting data that includes social determinants of health
  - Patient centered medicine
Program Development Logic

Understand disease burden across cultures

Established clinical protocols and standing orders from screening to scheduling

Defined financial sustainability of the program for a long term impact
The Future

- Create enhanced awareness
- Participate in community activities
- Increase screening
- Increase nutritional consultation
- Collaborate with research institutions and community organizations
- Group visit model as an alternative of care
Thank You!
Question and Answer Session

Carter Blakey, Deputy Director and Community Strategies Division Director, ODPHP, HHS
Questions?

If you have any questions you would like to pose to the presenters, please type it into the Q&A window to the right. We will address as many questions as we can in the time allotted.
Join us on **Tuesday, February 28** at 12:30 p.m. ET for a Progress Review webinar featuring 2 Healthy People 2020 topic areas:

- Arthritis, Osteoporosis, and Chronic Back Conditions
- Heart Disease and Stroke

Register at [www.healthypeople.gov](http://www.healthypeople.gov)
Learn more about the Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2030 and Healthy People 2030 development

https://www.healthypeople.gov/2020/about/history-development/healthy-people-2030-advisory-committee
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.
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