Today’s Webinar Hosts

Office of Disease Prevention and Health Promotion

Diabetes Advocacy Alliance™
Today’s Webinar

• Overview of Healthy People 2020 Objectives for Diabetes and Plans for Healthy People 2030
  o Ayanna Johnson, MSPH, Public Health Advisor, Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services

• Diabetes Prevention: Challenges and Opportunities to Increasing Use of Benefits; Lessons from the Field
  o Heather Hodge, Senior Director for Evidence-Based Health Interventions, YMCA of the USA

• Diabetes Prevention: Challenges and Opportunities to Increasing Use of Benefits; Federal Agency Perspective
  o Ann Albright, PhD, RD, Director, Division of Diabetes Translation, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention

• DSMES: Challenges and Opportunities to Increasing Use of Benefits – Lessons from the Field
  o Ardis A. Reed, MPH, RD, LD, CDE, Health Disparities Diabetes Educator, TMF Health Quality Institute

• Question and Answers
• DSMES is “the ongoing process of facilitating the knowledge, skills, and ability necessary for diabetes self-care, as well as activities that assist a person in implementing and sustaining the behaviors needed to manage his or her condition on an ongoing basis, beyond or outside of formal self-management training.”

• The National Diabetes Prevention Program—or National DPP—was created in 2010 to address the increasing burden of prediabetes and type 2 diabetes in the United States. This national effort created partnerships between public and private organizations to offer evidence-based, cost-effective interventions that help prevent type 2 diabetes in communities across the United States.
Overview of the Healthy People Initiative

Ayanna Johnson, MSPH
Public Health Advisor
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**
Healthy People Evolution: Overarching Goals

1990
- Decrease mortality: infants–adults
- Increase independence among older adults

2000
- Increase span of healthy life
- Reduce health disparities
- Achieve access to preventive services for all

2010
- Increase quality and years of healthy life
- Eliminate health disparities

2020
- Attain high-quality, longer lives free of preventable disease
- Achieve health equity; eliminate disparities
- Create social and physical environments that promote good health
- Promote quality of life, healthy development, healthy behaviors across life stages

226 objectives
319 objectives
1000+ objectives
1200+ objectives
Vision

• A society in which all people can achieve their full potential for health and well-being across the lifespan.

Mission

• To promote, strengthen and evaluate the nation’s efforts to improve the health and well-being of all people.

Overarching Goals

• Attain healthy, thriving lives and well-being, free of preventable disease, disability, injury and premature death.
• Eliminate health disparities, achieve health equity, and attain health literacy to improve the health and well-being of all.
• Create social, physical, and economic environments that promote attaining full potential for health and well-being for all.
• Promote healthy development, healthy behaviors and well-being across all life stages.
• Engage leadership, key constituents, and the public across multiple sectors to take action and design policies that improve the health and well-being of all.
• New cases of diagnosed diabetes in the U.S. decreased by 35 percent since a peak in 2009 – the first sign that efforts to stop the nation’s diabetes epidemic are working

• New cases have declined from 1.7 million new cases per year in 2008 to 1.3 million new cases in 2017
NOTES: Data are for three year average 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.
Poor Glycemic Control, Adults 18 years and Over with Diagnosed Diabetes, 2013-2016

Notes: - is 95% confidence interval. Poor glycemic control is defined as HbA1c greater than 9 percent. Diagnosed diabetes is defined as self-reported physician diagnosed diabetes. Women who only had diabetes while pregnant and persons with borderline diabetes are excluded. Women who were pregnant at the time of the exam are also excluded. The categories Black, and White exclude persons of Hispanic origin. Persons of Hispanic origin may be any race. 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 (other than for age) are age adjusted to the 2000 U.S. standard population. Data by health insurance status is shown for adults ages 18-64. Target does not apply to age groups. 2005-2008* is HP2020 baseline.

SOURCE: National Health and Nutrition Examination Survey (NHANES), CDC/NCHS.
Diabetes Education, Adults with Diagnosed Diabetes, 2017

Notes: - is 95% confidence interval. Data are for adults with diagnosed diabetes who responded that they have ever taken a course or class in diabetes self-management. Diagnosed Diabetes is defined as self reported physician diagnosed diabetes. Women who report that the only time they have been diagnosed with diabetes was during pregnancy (gestational diabetes) are excluded. Persons who report that they have pre-diabetes or borderline diabetes are also excluded. The categories Black, and White exclude persons of Hispanic origin. Persons of Hispanic origin may be any race. 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 are age adjusted to the 2000 U.S. standard population. Data by health insurance status is shown for adults ages 18-64. Data by educational attainment are for adults ages 25 years and older. 2012* is HP2020 baseline.

SOURCE: Behavioral Risk Factor Surveillance System (BRFSS), CDC/NCCDPHP
Prevention Behaviors in Adults at High Risk for Diabetes

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

**Obj. D-16.1, 16.2, 16.3**
Increase desired
REDEFINE YOUR HEALTH
TRANSFORM YOUR LIFE

DIABETES PREVENTION: CHALLENGES AND OPPORTUNITIES TO INCREASING USE OF BENEFITS; LESSONS FROM THE FIELD

June 20, 2019
GOAL:
Maximize the revenue brought in from third party payers to increase the likelihood of sustainability, remove cost as a barrier to consumers and organizations delivering the DPP, all while ensuring the delivery of services with a high quality, customized approach to the payors along with their members that yields positive outcomes.
WHERE TO START

1) Understand the motivation behind payor demands related to customer service

2) Employ standardized messaging and service for members that is aligned with best practices

3) Understand and apply best practices for program management/delivery that maximize revenue

4) Monitor your outcomes: enrollment, retention, and revenue

5) From the get-go, plan to diversify your revenue sources
IN PRACTICE - MOTIVATION

Understand the motivation behind payor demand related to customer service

- Communicate service standards – be realistic and follow-through
- Be careful about what you promise, it’s better to over-deliver
- Highly competitive market for health plans, especially Medicare Advantage
- How you take care of their members could impact things like Star Ratings which Medicare Advantage plans are required to share in all Marketing Materials
IN PRACTICE – PAYOR MEMBER SUPPORT

Employ standardized messaging and service members that is aligned with best practices

- Communicate service standards – be realistic and follow-through
- Call backs must be made within 48 hours on business days
- Ensure ample time for enrollment calls (may take a minimum of 30 minutes for calls)
- Always ask for them to have the insurance card they take to the doctor’s office with them for the call or when you meet them in person
- Be prepared for many questions
- Must ensure program qualifications, may be stricter than CDC’s Diabetes Prevention Recognition Program standards depending on the payor
IN PRACTICE – DELIVER QUALITY

Understand and apply best practices for program management/delivery that maximize outcomes and revenue

- Be prepared for lots of questions

- Understand the difference in needs between working age participants and retirees when it comes to program strategies like food tracking, use of online tracking tools, email, etc.

- Build relationships with other community-based organization service providers for support with needs outside of the scope of the program, such as food pantries and transportation service

- Plan for how you will ensure sustained participation and weight loss for the program year or year two (if applicable)
IF YOU BUILD IT...

Enrollment may be lower than you anticipated. Coverage ≠ enrollment

Work with the health plan to determine how they will also promote the program:

- Online – benefit portal or DPP websites
- Print – brochures, newspaper, etc.
- Health care provider – physician network engagement
- Onsite – consider offering to support employers directly through lunch and learns, testing events, health fairs
RECRUITMENT PARTNERS

It takes a village:

• Health plans and employers
• Health care systems and physicians
• Senior centers
• Community organizations
• Faith-based organizations
• Media and marketing
• Friends and family
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
DELIVERING OUTCOMES AT SCALE:
YMCA’S DPP

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

By The Numbers (as of 4/30/19)

<table>
<thead>
<tr>
<th>Measurement</th>
<th>Number</th>
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<tbody>
<tr>
<td>Participants attending at least one session</td>
<td>65,132</td>
</tr>
<tr>
<td>Completer’s average year-end weight loss</td>
<td>5.5%</td>
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<tr>
<td>Average physical activity minutes per week</td>
<td>162.7</td>
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<tr>
<td>Y associations delivering program</td>
<td>244</td>
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<tr>
<td>States where the program is available</td>
<td>40</td>
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<tr>
<td>Total active program sites</td>
<td>1,134</td>
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<tr>
<td>Low income participants*</td>
<td>18.3%</td>
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</tbody>
</table>

*Participants at or below Federal Poverty Guidelines
THANK YOU

Heather Hodge, M.Ed.
Senior Director, Evidence-based Health Interventions
YMCA of the USA
101 N. Wacker Drive
Chicago, IL 60606
heather.hodge@ymca.net
National Diabetes Prevention Program
Challenges and Opportunities to Increase Use of Benefits
Federal Agency Perspective

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

National effort to mobilize and bring effective lifestyle change programs to communities across the country
National DPP Strategic Goals

- **Coverage & Reimbursement**: Increase coverage among public and private payers
- **Quality Programs**: Increase the supply of quality programs
- **Referrals**: Increase referrals from healthcare providers
- **Demand From Participants**: Increase demand for the National DPP among people at risk
DDT Cooperative Agreement Investments

1705, 1815, and 1817 are cooperative agreements focused on scaling and sustaining the National DPP. All have required strategies to work toward public and private payer and employer coverage.

1705

*Scaling the National DPP in Underserved Areas*: Funds 10 national organizations to scale the National DPP in underserved areas with a focus on priority populations including Medicare, men, racial/ethnic minority groups and people with physical or visual impairments.

1815

*Improving the Health of Americans through Prevention and Management of Diabetes, Heart Disease and Stroke*: Funds all 50 states & D.C. to support state investments in implementing and evaluating evidence-based strategies to prevent and manage cardiovascular disease (CVD) and diabetes in high-burden populations/communities, contributing to improved health outcomes.

1817

*Innovative State and Local Public Health Strategies to Prevent and Manage Diabetes, Heart Disease, and Stroke*: Funds 22 state health departments, 5 large city/county health departments and 2 consortia of city/county health departments to support the design, testing, and evaluation of novel approaches to address evidence-based strategies aimed at reducing risks, complications, and barriers to prevention and control of diabetes and cardiovascular disease (CVD) in high-burden populations.
Goal: All-Payer Coverage

- Working with all public and private payers and employers to eliminate cost barriers for participants and sustain program delivery organizations long-term

### Private Sector
- Self Insured Employers
- Health Plans

### Public Sector: State/Local
- State/Public Employee Benefit Plans

### Public Sector: Federal
- CMS: Medicare & Medicaid
Commercial Insurance Plan Coverage

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

- AmeriHealth Caritas
- Anthem
- BCBS Florida
- BS California
- BCBS Louisiana
- Cigna
- Denver Health Managed Care
- Emblem Health: NY

- GEHA
- Highmark
- Humana
- Kaiser: CO & GA
- LA Care
- MVP Medicare Advantage
- Priority Health: MI
- United Health Group
National DPP Coverage for Public Employees

Over 3.8 million public employees and dependents in 20 states have the National DPP lifestyle change program as a covered benefit.

States with Coverage for State/Public Employees

- California
- Colorado
- Connecticut (DoT)
- Delaware
- Georgia (Kaiser members)
- Hawaii
- Indiana
- Kentucky
- Louisiana
- Maine
- Maryland (partial payment)
- Minnesota
- New Hampshire
- New York
- Oregon (educators/local government)
- Rhode Island
- Tennessee
- Texas
- Vermont
- Washington

Demonstrations ongoing in North Dakota, Pennsylvania, South Dakota, and Utah.
Medicaid Coverage

**Goal:** Achieve sustainable coverage of the National DPP lifestyle change program for Medicaid beneficiaries

**Result:** Remove cost barriers and reduce diabetes health-related disparities for high-risk/burden populations

**Approach**

- **Work with State Health Departments** - Funded health departments in all states and DC to partner with Medicaid sister agencies to make the case for coverage
  - 9 states have full or partial coverage through Medicaid authorities, demonstrations, or pilots

- **Work with Managed Care Organizations (MCOs)** - Funded a comprehensive demonstration project in 2 states with a focus on implementation and uptake

**Resources**

- National DPP Coverage Toolkit: [https://coveragetoolkit.org](https://coveragetoolkit.org)
- Virtual Learning Collaborative with 20 States
National DPP Coverage for Medicaid Beneficiaries

8 states have approved Medicaid coverage for the National DPP lifestyle change program

- California
- Maryland
- Minnesota
- Montana
- New Jersey
- New York
- Oregon
- Vermont

States with Medicaid Coverage

Demonstration projects ongoing in Pennsylvania
Medicare Diabetes Prevention Program

**Problem**
- 25% of Americans 65 years and older are living with type 2 diabetes, which negatively impacts health outcomes.
- Care for older Americans (65+ years) with diabetes costs Medicare $104 billion annually, and is growing.

**Medicare Implementation**
- DPP model test with Y-USA 7,800 beneficiaries.
- Rulemaking to expand coverage to beneficiaries & establish MDPP supplier type.

**Impact**
- Promotes healthier behaviors for eligible Medicare beneficiaries at risk for type 2 diabetes.
- Decreases Medicare costs associated with diabetes.

Quick Facts

- Online resource to support Medicaid, Medicare Advantage, and commercial health plans that are considering covering or implementing the National DPP lifestyle change program
- Covers topics such as contracting, delivery options, coding & billing, data & reporting
- Developed by the National Association of Chronic Disease Directors (NACDD), Leavitt Partners, and the Centers for Disease Control and Prevention (CDC)
- Includes special sections on how to obtain Medicaid coverage and draw down federal funds
AMA National DPP Employer Toolkit
https://preventdiabetesstat.org/employers-and-insurers.html
Large Employer Market Landscape

The large employer market presents an opportunity for scaling the National DPP lifestyle change program given its reach, influence and interest in employee health.

1. They reach many Americans.
   - 63.1 million Americans are employed by employers with 500+ employees... that’s 52.2% of the American workforce.¹
     • There is no standard definition of a large employer.
     • Employer sizes are generally determined either by 1) revenue or 2) # of employees.

2. They have substantial influence over their health plans.
   - Large self insured employers are the direct decision makers in their health plans.
     • The larger the employer, the more likely they are to be self-insured.
     • Most large employers offer health benefits: 99% of employers with 200+ employees offer health benefits to their employees.²
     • Many large employers are fully or partially self-insured: 79% of covered workers in firms with 200+ employees are in a full or partially self-funded plan.³
     • Large employers that are not self insured still maintain significant influence over the items covered by their health plans.

3. They have a vested interest in employee health.
   - Diabetes costs employers and is highly prevalent.
     • Diabetes is associated with high healthcare costs and lost revenue through absenteeism, impaired productivity, etc.
     • Preventing type 2 diabetes is more cost effective than treating it, making a clear business case for prevention.
     • 6.3% of full-time workers have diabetes; 9.1% of part-time workers have diabetes.⁴
     • $20.4 billion is the annual cost of diabetes for employers due to absenteeism.⁴
Coverage Trifecta

- Employers that cover the program tend to meet the following criteria: they have program champions, a way to pay for the program, and a mechanism to deliver/administer the program.

**Delivery/Administration**

**Description**
- Employers covering the program are typically interested in delivering the program themselves or through a vendor. Successful rollouts of the program have a pre-planned strategy for program recruitment and enrollment.

**Barriers to Delivery/Administration**
- Low or limited National DPP lifestyle change program options (i.e. program supply to reach all employees)

**Program Champion**

**Description**
- A program champion or sponsor can assist in ensuring the program moves towards becoming a covered benefit. Since decision making within an employer is fragmented, an individual who is committed to seeing the program through to coverage is key.

**Barriers to a Program Champion**
- Lacking awareness of or education about the National DPP lifestyle change program, and prevention in general, across the organization

**Payment for Program**

**Description**
- A funding mechanism may be necessary to deliver the program (i.e. through a health benefit or wellness perk). Employers would need to identify a source of funding and budget for the program in order to deliver it.

**Barriers to Payment for Program**
- Lack of perceived return on investment (ROI) complicated by high turnover rates among certain employers
National DPP Coverage Workshops

**Objective:** In partnership with state health departments, convene commercial payers and employers to:

- Learn the benefits, outcomes, and member-engagement advantages of covering the National DPP lifestyle change program
- Assess readiness and outline key steps for program implementation

<table>
<thead>
<tr>
<th>States (2018 - 2019):</th>
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<tbody>
<tr>
<td>Massachusetts (3/15/18)</td>
<td>Utah (5/1/19)</td>
</tr>
<tr>
<td>Iowa (4/20/18)</td>
<td>Texas (5/17/19)</td>
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<tr>
<td>Pennsylvania (6/27/18)</td>
<td></td>
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<tr>
<td>Kentucky (9/13/18)</td>
<td></td>
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<tr>
<td>Hawaii (4/17/19)</td>
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**Upcoming:**

- Nebraska (October 2019)
- Missouri (November 2019)
1815 Employer Coverage Learning Collaborative
(A CDC-National Association of Chronic Disease Directors Partnership)

**States selected to participate:**
- Delaware, Georgia, Illinois, Louisiana, North Carolina, and Rhode Island

**Goals:**
- Increase the number of employers covering the National DPP lifestyle change program
- Develop a replicable step-by-step model for state/employer engagement for scaling the National DPP
- Create employer case studies and success stories that can be used to work with employers in all 50 states

**2019 Key Activities:**
- State training series
- Employer recruitment and commitment (2 per state)
- Plan and design employer benefit
Perspectives from the Field in Diabetes

Ardis A. Reed, MPH, RD, LD, CDE
Health Disparities Team
June 20, 2019
Ardis A. Reed
MPH, RD, LD, CDE

- Part of the writing group that revised the current Competencies for Diabetes Educators and the 2017 National Standards for Diabetes Self-Management Education and Support (DSMES)
- Lead DSMES Trainer for Cities Changing Diabetes - Faith and Diabetes work group
Bird’s Eye View

- Providers And Clinicians
- Health Care Systems
- Population with Diabetes
- Population Health
- Nonprofits and Community Outreach
Providers and Clinicians

Lack of understanding of what Diabetes Self-Management Education and Support (DSMES) is all about

Providers who feel they should be managing the diabetes and not the client, so no referrals to DSMES

Forms, forms, forms...

Do not see value of DSMES
Many clinicians are wearing too many hats to focus on developing certified diabetes centers

Lack of sharing Quality Outcome reports; too many silos, especially in big institutions

Lots of confusion on reimbursement rules

Poor marketing skills to promote DSMES services in many places
Population Health

- More focus on social determinants of health and diabetes distress (behavioral health)
- Inconsistent funding streams to support DSMES services
- Learning collaborative across counties and states
- Collaboration of funding opportunities
Nonprofit and Community Outreach

- Need capacity-building skills
- Need standard data demographic collection
- Need to better understand about the importance of data collection for their sustainability
- Need more funding opportunities and less confusion between different agency rules
Innovative Community Approaches

- Community Employers
- County and City Health Departments
- Academic Institutions
- Faith Ministries
- Health Care Systems
- Nonprofits

Population with Diabetes
Two Community Approaches

**Everyone with Diabetes Counts (EDC)** - A Centers for Medicare & Medicaid Services (CMS) national initiative that is focused on improving access to diabetes care, management and education, working with community nonprofit organizations, health care systems and provider offices.

**Cities Changing Diabetes (CCD)** - A global initiative to reduce the prevalence of diabetes in urban settings around the world through urban community efforts to address the urban infrastructure and access to diabetes resources, community engagement and education.

Faith and Diabetes Initiative - City of Houston
The Model for Both Initiatives

- Train the Trainer to engage community organizations to provide community-based DSMES
  - Provide peer-to-peer workshops
- Evidence-based DSMES curriculum
  - Participatory techniques
  - Adult learning theory
  - Focused on behavioral goal skill development
- Partners range from houses of faith to health system community outreach departments
# Current Reach

## EDC

Reach since August 2014
- Texas, Oklahoma, Arkansas, Missouri, and Puerto Rico

- Total Reach = **27,215**
- Medicare Reach = **13,094**

- Six-week workshop = **2,447**

## CCD

Reach since January 2018
- **1st** cohort - 13 houses of faith, 25 peer educators
- **2nd** cohort - 11 houses of faith, 22 peer educators

- Total Reach = **216**
- Medicare Reach = **105**
Community-Based Needs

EDC

Needs:
- Capacity building
- Data collection skills
- Sustainable funding
- Program development skills
- Peer commitment
- Marketing skills

CCD

Needs:
- Strengthen health ministry structure
- Peer commitment
- Space/time on calendars
- Marketing skills
- Coordination skills
Barriers for People with Diabetes

- Copays
- Access to all populations
- Health literacy
- Medications and supplies
Person with Diabetes

- Wants a quality of life
- Wants to learn
- Needs support
- Understands the how and why
- Wants access
- Wants access to care
- Wants to take care of themselves
Thank You

ardis.reed@tmf.org

TMF Health Quality Institute
Health Disparities Team
Austin, Texas
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.
Date: Wednesday, June 26, 2019

Time: 12:00 – 4:00 pm Eastern Time

Location: Online via webinar

Cost: Free

Purpose: The Committee will:

- Deliberate and prioritize its recommendations for implementing the disease prevention and health promotion goals and objectives for the nation
- Develop recommendations regarding graphics for communicating key Healthy People 2030 elements.

Register at HealthyPeople.gov
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”)