ACPM National Diabetes Prevention Program Demonstration Projects

Webinar # 1: Independent Practice Associations
Griffin Hospital + Accent on Health
September 25, 2018
MODERATOR:
Heather Tindall Readhead, MD, MPH
University Health Services (UHS), Primary and Urgent Care
University of California Berkeley

DEMONSTRATION PROJECT GRANTEES
INDEPENDENT PRACTICE ASSOCIATIONS (IPAs):

Griffin Hospital
Victoria Costales, MD, MPH
Program Director of the Internal Medicine/Preventive Medicine Residency and Program and Preventive Medicine Residency Program at Griffin Hospital
Director, Center for Prevention & Lifestyle Management (CPLM)

Accent on Health LLC
Vivian Nnacho Ayuk, PharmD, CDE
Clinical Pharmacist and Diabetes Educator
Author disclosure: No relevant financial affiliations from presenters

The development of this presentation is supported by a five-year cooperative agreement (# 6 NU38OT000130-05-01) between ACPM and the CDC Office of State, Tribal, Local, and Territorial Support (OSTLTS).

The views expressed in this presentation are the authors’ and do not reflect the official policy or position of the CDC or the US government.
• Welcome and Introductions of Speakers
• ACPM Diabetes Prevention Program Demonstration Projects
  • Preventive Medicine Overview
  • ACPM Overview
  • National Diabetes Prevention Program
  • ACPM and CDC Partnership
  • ACPM Diabetes Prevention Program Demonstration Projects
• Grantee Presentations
• Participant Q & A Session
Future Webinars in the Series

Register at: https://www.acpm.org/page/dppwebinars

WEBSINAR 2
Integrated Delivery System
MaineHealth + South Nassau Communities Hospital
October 23, 2018 (12:00–1:30 PM EDT)

REGISTER

WEBSINAR 3
Federally Qualified Health Centers
Christopher Rural Health Corporation + Northeast Missouri Health Council
November 8, 2018 (12:00–1:30pm EDT)

REGISTER
• Explain key components the National Diabetes Prevention Program (National DPP)

• Identify processes for screening, testing, and referring patients with prediabetes to a CDC-recognized diabetes prevention program

• Evaluate screening and referral models and ways to develop, and operationalize these models
National Diabetes Prevention Program
Demonstration Projects

Heather Tindall Readhead, MD, MPH

ACPM Faculty

University Health Services (UHS), Primary and Urgent Care

University of California Berkeley
What is Preventive Medicine?

The Specialty of Preventive Medicine

- One of 24 specialties recognized by the American Board of Medical Specialties
- Only medical specialty that prepares physicians to care for both individuals and populations
- 3-yr postgraduate training program that combines:
  - A 1-year clinical internship
  - 2 years of blended didactic (MPH), clinical and practicum training

Board Certification

- Public Health/General Preventive Medicine
- Occupational Medicine
- Aerospace Medicine
- Clinical Informatics
Vision: ACPM will be the leading professional medical society for advancing preventive medicine, population and public health, and lifestyle medicine.

Mission: ACPM supports efforts to improve the health of individuals and populations through evidence-based health promotion, disease prevention, lifestyle modification, and systems-based approaches to improving health and health care.
ACPM partners with the Center for Disease Control and Prevention (CDCs) Division of Diabetes Translation to increase physician awareness, screening, and referral to the National Diabetes Prevention Program (National DPP).

The CDC-led National DPP is a partnership of public/private organizations working collectively to establish, spread, and sustain an evidence-based lifestyle change program for people with prediabetes to prevent or delay onset of type 2 diabetes.
Demonstration Project Overview

• From 2016 – 2018, ACPM lead and supported 9 demonstration projects funded by the CDC.

• Funding was provided through a competitive process.

• Award: $15,000 (for a 3 month time period).
Demonstration Project Overview

Goals
• To support health care organizations/practices to develop and implement a protocol for screening, testing, and referring patients with prediabetes to a CDC-recognized diabetes prevention program, either through the EHR/EMR or by using another non-electronic approach.

Case Studies
• Grantees have worked with ACPM to document their experiences and lessons learned as case studies to inform and teach providers and health care professionals.
ACPM National DPP Resource Center

- The resource center is provided as a one stop resource to equip physicians and health care professionals to increase awareness, screening and referral within their practice. It contains materials from the CDC, the American Medical Association, YMCA of the USA, Solera Health and other national partners.

ACPM National DPP Advisory Council

- ACPM is fortunate to have 11 preventive medicine physicians that have expertise in the National Diabetes Prevention Program as part of our advisory council. The Advisory Council provides strategic guidance to our demonstration projects and toolkit development.

ACPM Annual Conferences

- Award winners presented findings from their demonstration projects at the Diabetes Prevention Learning Institute at the ACPM Annual Preventive Medicine Conferences in 2017 and 2018.
INTEGRATED HEALTH SYSTEMS
- South Nassau Community Hospital – Oceanside, NY
- Emory Healthcare System – Atlanta, GA
- MaineHealth – Portland, ME

INDEPENDENT PRACTICE / ASSOCIATIONS
- Griffin Faculty Physicians – Derby, CT
- Accent on Health – Washington, DC
- Wheat Ridge Internal Medicine – Wheat Ridge, CO

FEDERALLY QUALIFIED HEALTH CENTERS
- Northeast Missouri Health Council – Kirksville, MO
- Christopher Rural Health Planning Corporation – Mulkeytown, IL
- AltaMed Health Services – Los Angeles, CA
Independent Practice Associations (IPAs)

• Griffin Hospital
• Accent on Health
Victoria C. Costales, MD, MPH
Director, Center for Prevention & Lifestyle Management
Program Director, Internal Medicine/Preventive Medicine
Residency Program, Griffin Hospital
PRESENTATION OUTLINE

1. Background: Griffin Faculty Physicians
2. Demonstration Project
   A. High level Processes
   B. Outcomes/Results
3. Sustainability/Recommendations
4. Key Learnings
GRiffin Faculty Physicians

- Independent Physician Association
- Seven GFP Primary Care Offices serving the lower Naugatuck Valley region in Connecticut
- One office is the Residency Continuity Care Clinic (Ansonia)
- Prediabetes-related Practice elements
  - Referral system to prevention programs in place, within the Electronic Medical Record (EMR)
  - CDC-recognized Diabetes Prevention Program
  - In-house 6-minute HbA1c testing system
- Utilize existing tools and develop/maximize new tools
  - Previsit Planning Form
A. HIGH LEVEL PROCESSES

**Screening**
- Incorporate Prediabetes screening criteria in the Pre-visit Planning Form

**Awareness**
- Train and support Providers/Staff
- Educate and inspire patients and the community

**Testing**
- Test HbA1c during the visit

**Referral**
- Utilize Electronic Medical Record (EMR)

* Goal: Quadruple Aim
B. OUTCOMES/RESULTS

01 Awareness
- Meeting with Providers and Project Team (Admin & Staff representatives)
- Provider/Staff Reference Sheet
- Patient Prediabetes & DPP Information Sessions

02 Screening*
- Combination approach (Previsit Planning Form)

03 Testing*
- Estimate cost of in-house testing depending on patient’s insurance status

04 Referral*
- Facilitate ease of referral through the EMR

*Determine workflow implications
MEETING WITH PROVIDERS

Outcomes: Provider/Staff Awareness

 Presented the project
 Solicited feedback

Concerns/Observations:
 Financial burden of testing on patients
 Variation in provider knowledge:
   ICD codes to use for screening
   Frequency of testing covered by insurance

January 2018 Provider Meeting
**Outcomes:**

**Provider/Staff Awareness**

**REFERENCE SHEET FOR STAFF/PROVIDERS**

- Created to orient staff and providers to the demonstration project
- Created to address provider and staff concerns

---

**Background on the Diabetes Prevention Program (DPP)**

- Griffin offers a CDC-recognized Diabetes Prevention Program (DPP) for all patients with prediabetes
- The DPP is a lifestyle change program comprised of one-hour weekly sessions for 6 months followed by 1-2x per month support group meetings for another 6 months (See reverse page for topics covered at the DPP).
- Program Fee: $0
- The DPP is designed to help patients reduce their body weight by 5-7% and increase physical activity to 150 minutes per week
- Evidence: Compared to taking metformin 850 mg twice a day, the DPP lifestyle program reduced new cases of diabetes by 56% and by 71% among patients over 60 years old

**Goals of the Diabetes Prevention Program Demonstration Project**

- Identify all patients at risk for diabetes through a standardized process, which maximizes patient identification and minimizes provider time assessing a patient’s need for diabetes screening
- For patients with identified with prediabetes (HbA1c 5.7-6.4%), providers discuss referral to our free CDC-recognized, effective Diabetes Prevention Program (DPP)

**Criteria for Screening (Pre-visit Planning (PVP) form will identify patients at risk for diabetes)**

- 45 years old OR BMI greater than 25 (Asians American BMI 23 or greater) AND one or more of the following:
  - First-degree relative with Diabetes (Athena-family history DM)
  - High Risk Ethnicity (African American, Latino/Hispanic, Alaskan Native, Asian American, Pacific Islander)
  - Females with history of gestational diabetes
  - History of heart disease
  - Diagnosis of Hypertension
  - HDL cholesterol less than 35mg/dl and/or Triglycerides level greater 250mg/dl
  - Females with Polycystic Ovarian Syndrome (PCOS)

**Process**

- For patients that need prediabetes screening: If the above criteria for screening is met, a line will populate on the PVP to do a screening Hba1c, indicating type of insurance of the patient and reminder of what ICD-10 code to use ([Insurance type]; Use “Screen for diabetes”: ICD-10 code Z13.1)
- Providers and staff can refer to this sheet for patient co-pay information and DPP topics (reverse page)
- Testing Frequency: Screening will only flag once per calendar year
- During the huddle, the PVP will be reviewed with the PCP and MA, patients identified for screening will be discussed
- MA will complete the Hba1c on identified patients (In-house HbA1c procedure code 83036QW)
- PCPs will review the results; for patients with HbA1c 5.7-6.4%, PCPs discuss DPP referral
- DPP referral: Search for “CPLM” or “prediabetes” in the diagnoses & orders section
- For patients with HbA1c between 5.7-6.4 before the visit: PVP will flag “Has HbA1c in the prediabetes range, discuss referral to the DPP” (MA to remind the PCP)

**Patient Insurance Type and Co-Pay**

<table>
<thead>
<tr>
<th>Insurance Type</th>
<th>Co-Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>$0</td>
</tr>
<tr>
<td>Medicaid</td>
<td>$0</td>
</tr>
<tr>
<td>Cigna</td>
<td>$15.52</td>
</tr>
<tr>
<td>CT Care</td>
<td>$0</td>
</tr>
<tr>
<td>Aetna</td>
<td>$8.75-$15.00</td>
</tr>
<tr>
<td>United Health</td>
<td>$36 out pocket on any lab, once met no cost</td>
</tr>
</tbody>
</table>
Outcomes: Provider/Staff Awareness

Curriculum for CDC-Recognized Diabetes Prevention Lifestyle Change Programs

Topics Covered in First 6 Months
Welcome to the Program
Be a Fat and Calorie Detective
Three Ways to Eat Less Fat and Fewer Calories
Heathy Eating
Move Those Muscles
Being Active - A way of life
Tip the Calorie Balance
Take Charge of What's Around You
Problem Solving
Four Keys to Healthy Eating Out
Talk Back to Negative Thoughts
The Slippery Slope of Lifestyle Change
Jump Start Your Activity Plan
Make Social Cues Work for You
You Can Manage Stress
Ways to Stay Motivated

Topics Covered in the Second 6 months
Fats - Saturated, Unsaturated, and Trans Fat
Food Preparation and Recipe Modification
Healthy Eating - Taking it One Meal at a Time
Healthy Eating with Variety and Balance
More Volume, Fewer Calories
Staying on Top of Physical Activity
Stepping up to Physical Activity
Balance Your Thoughts for Long-Term Maintenance
Handling Holidays, Vacations, and Special Events
Preparing for Relapse
Stress and Time Management
Heart Health
A Closer Look at Type 2 Diabetes
Looking Back and Looking Forward
INCREASING PATIENT AWARENESS OF PREDIABETES AND THE DPP

PERSONALIZED NEWSLETTER FROM PCP

Dear Sarah,

Did you get enough sleep last night? It's a question we ask and answer all the time, and often have a lot to say about. May is Better Sleep Month, so it's a good time to look at your sleep habits, and make simple changes in your lifestyle to help improve your sleep habits.

Sleep plays a bigger role in our daily lives than we often think, and if you're like me, you probably wish you had the time to get more of it. If you're struggling with sleep issues, The Sleep Wellness Center at Griffin Hospital may be able to help.

On May 13 we also celebrate Mother's Day, and it's a great time to remind all the moms in your life to put their health first and be sure to get an annual physical or wellness exam. Moms (and women) are often the health "coordinators" of the family, but also often forget to make their own health a priority.

This month, I have tips on how to make sleep a priority, as well as a quiz to assess if you have a sleep disorder. I'll also tell you how you can support the health of all the moms and women in your life.

I look forward to seeing you soon!

- Dr. Elizabeth Arbia

To schedule an annual exam, or general appointment call 1-800-382-0903
Griffin Faculty Physicians Shelton
UPCOMING EVENTS

JOIN THE GRIFFIN TEAM FOR THE 2018 GREATER NEW HAVEN HEART WALK!

Griffin Hospital will once again sponsor and participate in the American Heart Association’s Greater New Haven Heart Walk on Saturday May 5. We hope you can join us for this fun, healthy event!

CLICK HERE for more information or to join the Griffin Hospital team!

COME FIND OUT IF YOU'RE AT RISK FOR PRE-DIABETES

You are invited to a Prediabetes Information Session called "Are you and your loved ones at risk for Diabetes?"

Dr. Victoria Costales, Internal Medicine/Preventive Medicine physician who specializes in Lifestyle Medicine, Mary Swansiger, Diabetes Nurse Educator and two community members who are Program graduates will speak about prediabetes and our free CDC-recognized Diabetes Prevention Program.

Light refreshments will be served.

CLICK HERE for our free risk assessment sheet which you can fill out in advance and discuss with our staff.
84 MILLION AMERICANS HAVE PREDIABETES. DO YOU?

1. How old are you?
   - Less than 40 years (0 points)
   - 40—49 years (1 point)
   - 50—59 years (2 points)
   - 60 years or older (3 points)

2. Are you a man or a woman?
   - Man (1 point)
   - Woman (0 points)

3. If you are a woman, have you ever been diagnosed with gestational diabetes?
   - Yes (1 point)
   - No (0 points)

4. Do you have a mother, father, sister, or brother with diabetes?
   - Yes (1 point)
   - No (0 points)

5. Have you ever been diagnosed with high blood pressure?
   - Yes (1 point)
   - No (0 points)

6. Are you physically active?
   - Yes (0 points)
   - No (1 point)

7. What is your weight status? (see chart at right)

If you scored 5 or higher:
You’re likely to have prediabetes and are at high risk for type 2 diabetes. However, only your doctor can tell for sure if you do have type 2 diabetes or prediabetes (a condition that precedes type 2 diabetes in which blood glucose levels are higher than normal). Talk to your doctor to see if additional testing is needed.

Type 2 diabetes is more common in African Americans, Hispanic/Latinos, American Indians, Asian Americans and Pacific Islanders.

Higher body weights increase diabetes risk for everyone. Asian Americans are at increased diabetes risk at lower body weights than the rest of the general public (about 15 pounds lower).

LOWER YOUR RISK
Here’s the good news: it is possible with small steps to reverse prediabetes—and these measures can help you live a longer and healthier life.

If you are at high risk, the best thing to do is contact your doctor to see if additional testing is needed.

Visit DoIHavePrediabetes.org for more information on how to make small lifestyle changes to help lower your risk.

For more information, visit us at DoIHavePrediabetes.org
Outcomes: Patient Awareness

INCREASING PATIENT AWARENESS OF PRE-DIABETES AND THE DPP

TARGETED EMAIL BLAST
OUTCOMES: Patient Awareness

INCREASING PATIENT AWARENESS OF PREDIABETES AND THE DPP
PREDIABETES INFORMATION SESSION

PREDIABETES & THE DIABETES PREVENTION PROGRAM
PREDIABETES INFO SESSION
MAY 2018

Victoria C. Costales, MD, MPH
Director, Center for Prevention & Lifestyle Management
Program Director, Internal Medicine/Preventive Medicine Residency Program

Mary E. Swansiger, BSN, MPH, CDE
Diabetes Nurse Educator
Valley Outreach Coordinator
Dept. of Outreach and Parish Nursing
INCREASING PATIENT AWARENESS OF PREDIABETES AND THE DPP
PREDIABETES INFORMATION SESSION

Goals:
1. Connect prediabetes/diabetes to lifestyle change
2. Inspire and empower patients to make lifestyle changes
3. Demystify the DPP
   - Effectiveness
   - Components
4. Present narratives

PRESENTATION OUTLINE
- Prediabetes/Diabetes and Lifestyle Change
- Diabetes Prevention Program: Lifestyle Change Program
- Program Graduates’ Testimonials
- Q and A
WELCOME ON BEHALF OF YOUR PRIMARY CARE PROVIDERS
Symptoms of diabetes

- Always tired
- Always hungry
- Sexual problems
- Always thirsty
- Numbness or tingling in hands or feet
- Frequent urination
- Systemic weight loss
- Wounds that won’t heal
- Blurry vision
- Vaginal infections

If you have some of the above symptoms, you are recommended to talk to your Doctor.

Symptoms can mimic other conditions
86 million American adults — more than 1 out of 3 — have prediabetes

• 15%-30% will develop diabetes in 5 years

people with prediabetes don’t know they have it

What is Prediabetes?

<table>
<thead>
<tr>
<th>Fasting Plasma Glucose</th>
<th>2-hour Plasma Glucose On OGTT</th>
<th>Hemoglobin A1C</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diabetes Mellitus</strong></td>
<td><strong>Prediabetes Impaired Glucose Tolerance</strong></td>
<td><strong>Prediabetes</strong></td>
</tr>
<tr>
<td>126 mg/dL</td>
<td>200 mg/dL</td>
<td>6.5%</td>
</tr>
<tr>
<td>100 mg/dL</td>
<td>140 mg/dL</td>
<td>5.7%</td>
</tr>
</tbody>
</table>

**Normal**

Any abnormality must be repeated and confirmed on a separate day.

The diagnosis of diabetes can also be made based on unequivocal symptoms and a random glucose >200 mg/dL.

Effect of Insulin on Glucose Uptake

1. Insulin binds to the insulin receptor.
2. Phosphorylation of the insulin receptor.
3. Recruitment of the insulin receptor tyrosine kinase (IR/TK) to the cytoplasmic tail of the insulin receptor.
4. Translocation of GLUT4-containing vesicles to the plasma membrane.
5. Glucose transport into the cell.
THERE IS GOOD NEWS: LIFESTYLE CHANGE WORKS

If you have prediabetes, losing weight by:

- EATING HEALTHY
- BEING MORE ACTIVE

can cut your risk of getting type 2 diabetes in half

The lifestyle change program that is part of the CDC-led National Diabetes Prevention Program is proven to help prevent or delay type 2 diabetes. It is based on research that showed:

- Weight loss of 5 to 7% of body weight achieved by reducing calories and increasing physical activity to at least 150 minutes per week resulted in a 58% lower incidence of type 2 diabetes.
- For people 60 and older, the program reduced the incidence of type 2 diabetes by 71%.
- After 10 years, lifestyle change program participants had a 34% lower incidence of type 2 diabetes.

THERE IS GOOD NEWS: LIFESTYLE CHANGE WORKS

THE CHANGES YOU MAKE FOR YOURSELF CAN IMPACT YOUR LOVED ONES

TYPE 2 DIABETES & YOUTH

What you can do

Rates of type 2 diabetes in youth are increasing; so are obesity rates. Diabetes risk can run in families, but so can healthy lifestyle habits:

- Limit high-calorie food.
- Make physical activity fun.
Prevent T2 Goals

Prevent T2 is a yearlong program. It's designed for people with prediabetes. It's also for people who are at high risk for type 2 diabetes and want to lower their risk.

By the end of the first six months, your goal is to:
- Lose at least 5 to 7 percent of your starting weight
- Get at least 150 minutes of physical activity each week

By the end of the second six months, your goal is to:
- Keep off the weight you've lost
- Keep working toward your goal weight, if you haven't reached it
- Lose more weight if you wish
- Keep getting at least 150 minutes of activity each week

Losing weight can:
- Prevent or delay type 2 diabetes
- Ease sleep problems, arthritis, and depression
- Lower your blood pressure and cholesterol level
- Make you feel better about yourself

Getting more active can:
- Prevent or delay type 2 diabetes
- Give you more energy
- Help you sleep better
- Improve your memory, balance, and flexibility
- Lift your mood
- Lower your blood pressure and cholesterol
- Lower your risk of heart attack and stroke
- Lower your stress level
- Strengthen your muscles and bones

• Diabetes Educator describing the DPP components
COMBINATION APPROACH
~ RETROSPECTIVE + POINT-OF-CARE

Outcomes: Prediabetes Screening

COMBINATION APPROACH

UTILIZING OUR PRACTICE TOOL: PREVISIT PLANNING FORM

*Web-based previsit planning form
COMBINATION APPROACH

UTILIZING OUR PRACTICE TOOL: PREVISIT PLANNING FORM

*Web-based previsit planning form
Outcomes: Testing

REFERENCE SHEET FOR STAFF/PROVIDERS

- Determine cost for patients depending on insurance status
- Utilize in-house HbA1c system

Features

- Only 1 μL of whole blood needed for HbA1c testing
- Results in 6 minutes
- No sample or reagent preparation needed allowing for simple and efficient operation
- Kit includes 10 reagent cartridges, 11-capillary holders, 1-calibration card, and 2-package inserts

More ...

<table>
<thead>
<tr>
<th>Patient Insurance Type and Co-Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare: $0</td>
</tr>
<tr>
<td>Medicaid: $0</td>
</tr>
<tr>
<td>Cigna: $15.52</td>
</tr>
<tr>
<td>CT Care: $0</td>
</tr>
<tr>
<td>Aetna: $8.75-$15.00</td>
</tr>
<tr>
<td>United Health Care: $36 out pocket on any lab, once met no cost</td>
</tr>
</tbody>
</table>
Outcomes: Referral

REFERRALS
VIA THE ELECTRONIC MEDICAL RECORD (EMR)

- PCP referral through Diagnoses & Orders EMR section
- Staff empowered to send a case to diabetes nurse educator for a referral/one-on-one discussion
### 3. SUSTAINABILITY AND RECOMMENDATIONS

<table>
<thead>
<tr>
<th>01</th>
<th>Awareness</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Newsletters and email blasts: Twice per year campaigns</td>
<td></td>
</tr>
<tr>
<td>• Prediabetes info sessions: powerful way for participant buy-in and empowerment (multidisciplinary: MD &amp; RN/CDE; on behalf of the PCP; use CDC/ADA tools)</td>
<td></td>
</tr>
<tr>
<td>• Regular Meetings to promote provider, admin and staff buy-in</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>02</th>
<th>Screening*</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Combination approach (Previsit Planning Form)</td>
<td></td>
</tr>
<tr>
<td>• Trust building with providers/staff: Iterative process ensuring accuracy of PVP (i.e. correct patients are flagged) with periodic audits and working closely with staff and consultants</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>03</th>
<th>Testing</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Up to date database of testing costs (depends on insurer) – reassures staff, provider and patients</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>04</th>
<th>Referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Facilitate ease of referral through the EMR</td>
<td></td>
</tr>
<tr>
<td>• &quot;Warm handoff&quot;: CPLM Intake Coordinator (in other settings: the DPP facilitator)</td>
<td></td>
</tr>
<tr>
<td>• Involving all providers in the system (resident continuity care clinic; Resident outpatient binders)</td>
<td></td>
</tr>
</tbody>
</table>
4. KEY LEARNINGS

Create/promote a collaborative process
- Empower all (patients, PCP/staff, admin) stakeholders in the process (listen, iterate from feedback, monitor/evaluate)
- Use/maximize existing tools

Demystify DPP/showcase power of lifestyle change
- Tandem of Provider, diabetes educator, and program graduates is effective
- Narratives are powerful
- Emphasize patient self-management & empowerment

Facilitate ease of referral/joining the DPP
- Incorporate DPP referral within the EMR
- Warm Handoff: Identify point persons of contact (for patients, providers)

Planning to hold at least two sessions per year

Continuing with team meetings/listening sessions and focus group interviews, and iterating to improve the process

The importance of partnership: Alone we can do so little; together we can do so much. – Helen Keller
THANK YOU VERY MUCH

Victoria C. Costales, MD, MPH
vcostales@griffinhealth.org
Incorporating Pre-Diabetes Screening into Independent Practice: Accent on Health Case Study

Vivian Nnacho Ayuk, PharmD, CDE
AGENDA

• District of Columbia Demographic Overview
• Project Implementation
• Outcomes
• Challenges and Recommendations
DISTRICT OF COLUMBIA
Demographic Overview

47.7%  Black/African American
44.6%  White
7.7%  (Asian, Latino, American Indian, other)

All Wards Are Not Created Equal

Data Provided by: DC Action for Children, US Census Bureau, and Greater Greater Washington
WARDS 7 AND 8

Highest Poverty Rates
Ward 7 (27.7%)
Ward 8 (36.8%)

Predominantly Black (90%)

Highest rates of Diabetes and Obesity

Food Deserts

Limited Access to Healthcare

One Hospital
Retrospective Review (6 Months)

**EMR Review***
- BMI
- A1c
- Check Insurance Coverage
- Flag at Risk Patients

**Contact Patients**
- Mail patient letters
- Contact patients via telephone to enroll in DPP or to schedule office visits

**Follow Up**
- Provide patient with phone number for DPP Provider
- Follow up with patients and DPP

*6 months*
Project Implementation
(Office Visits)

**Sign In**
- Pre-Diabetes Questionnaire
- Check Insurance Coverage
- BMI
- Check Lab for A1C
- Flag system as needed

**See Provider**
- Discuss Pre-Diabetes Results
- Discuss benefits of DPP
- Sign Referral Form
- Provide patient with health literature

**Check Out**
- Provide patient with DPP contact information
- Follow up with patient and DPP Provider
Retrospective Chart Review

806 Electronic Patient Records Reviewed

89 Patients Identified with Pre-Diabetes

Letters mailed to patients, followed by phone call

High percentage of patients with incomplete diagnostic criteria

BMI > 24

>98% had medical Insurance
Results
Patient Identification

128
Patients Diagnosed with Pre-Diabetes

39 Identified during routine office visits

89 Identified through retrospective study
• Limited access to CDC recognized Diabetes Prevention Programs
  • No programs offering classes except YMCA (YMCA program $425/participant – cash only)
  • Transportation

• Insurance Coverage
  • Only 2 claims were paid
  • Billing Department unfamiliar with how to code Pre-Diabetes Screening

• Medical Records and Tracking
  • Current EMR not designed to support Pre-Diabetes screening
  • No reliable way to track provider and support staff compliance
RECOMMENDATIONS

STAFF

• Make Diabetes Pre-screen testing a practice priority

• Follow up with patients – Remind them of the benefits of signing up for the Diabetes Prevention Program

• Keep ADA toolkit (Good Starting Point)
RECOMMENDATIONS
INCREASE ACCESS TO DPP

• Demand that local health departments fill the gap in care (temporarily)
• Assist current programs – help them achieve full recognition and begin billing for services
• Provide local grants to cover the cost of offering Diabetes Prevention Programs for the first year
• Make DPP a covered service for all Medicare and Medicaid recipients
RECOMMENDATIONS
INCREASE ACCESS TO DPP

• Provide promotional and referral assistance to existing programs
  • Online referral and enrollment platform for providers and patients
  • Coordination of resources between various agencies and local community organizations
• Revise Reimbursement Guide
  • Keep it simple
  • 1 or 2 CPT codes only
SUSTAINABILITY AND NEXT STEPS

• DOH Grant Approval for Diabetes Prevention Programs

• Webinars on MDPP and how it will work in DC

• Full recognition for DPP programs to increase access

• Explore partnership opportunities
  • Medicaid MCOs and Private insurances
“If you want to go fast
Go Alone
If you want to go far
Go Together”
REFERENCES


- Photos licensed by Adobe Stock and Vecteezy.
Thank you

VIVIAN NNACHO AYUK, PharmD, CDE

vayuk@flexcarepharmacy.com
Q & A Session
Thank you

CME Evaluation and MOC information will be emailed shortly
More information visit:
www.acpm.org/page/dpp
https://www.acpm.org/page/dppresources