Diabetes Care Begins with Diabetes Prevention

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Welcome and Introductions

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Objectives

- Review clinical guidelines and evidence related to the identification and management of patients at risk for type 2 diabetes
- Discuss considerations and best practices for implementation of a diabetes prevention strategy at health centers
- Outline the opportunity to participate in a diabetes prevention Learning Series with the AMA

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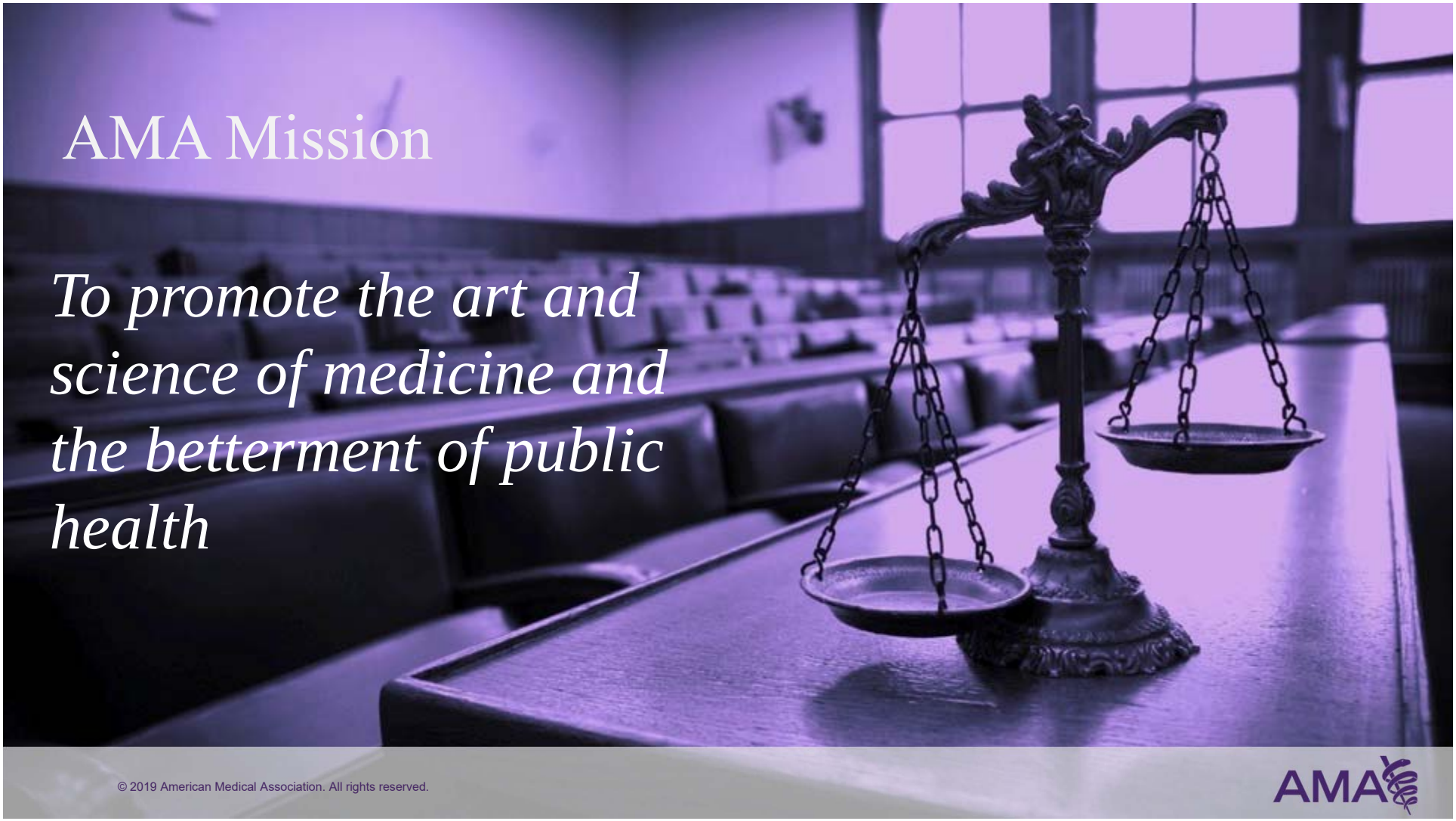

Improving Health Outcomes Strategic Goals

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- 2003 Prediabetes age 55
- 2006 Type 2 Diabetes
- 2016 Retinopathy
- 2020 CKD

Referral Nephrology
Prior authorizations
Ongoing refills
Ongoing labs
Medical complications
Anemia
Osteoporosis
Edema

Preventing type 2 diabetes

Guidelines and Evidence on Diabetes Prevention

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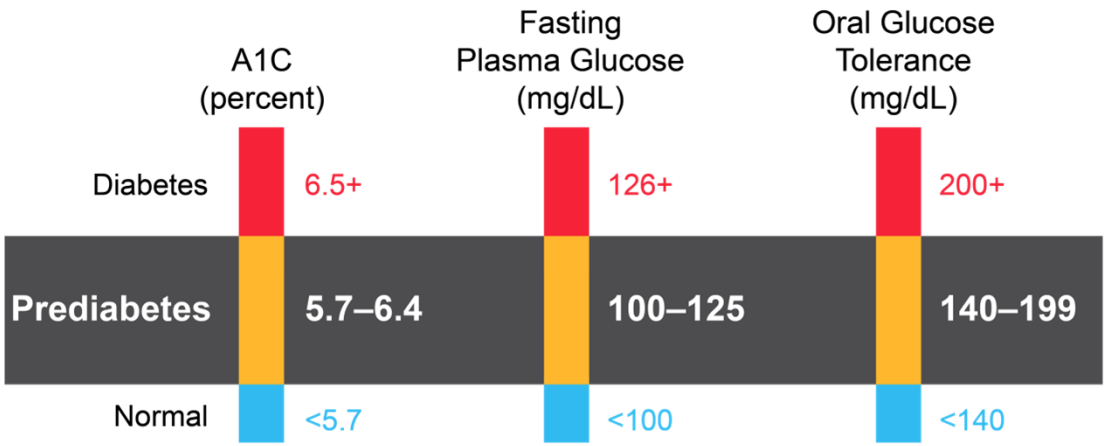
Risk Factors

- Overweight or obese
- Increasing age
- Family history of type 2 diabetes
- Racial/ethnic minorities
- Poor dietary pattern
- Sedentary lifestyle
- Smoking (including passive smoking)
- History of gestational diabetes, hypertension

Prediabetes Diagnostic Values

There are 3 standard test options to identify prediabetes.



ICD10 code:

R73.03

American Diabetes Association. 2.Classification and diagnosis of diabetes: standards of medical care in diabetes -2018. *Diabetes Care.* 2018;41(Suppl 1):S13-S27.

Guidelines/Recommendations/Clinical Resources Related to Diabetes Prevention

Organization	Guidelines
United States Preventive Services Task Force	Abnormal Glucose Screening Recommendation (2015)*
American Diabetes Association	Standards of Medical Care in Diabetes (2019)
American Association of Clinical Endocrinologists/ American College of Endocrinology	Clinical Practice Guideline for Developing a Diabetes Mellitus Comprehensive Care Plan (2015)
	Comprehensive Type 2 Diabetes Management Algorithm (2019)
Community Preventive Services Task Force	Diabetes Prevention and Control: Combined Diet and Physical Activity Promotion Programs to Prevent Type 2 Diabetes Among People at Increased Risk (2015)
National Diabetes Education Program	Guiding Principles for the Care of People With or At Risk for Diabetes (2018)

**in process of being updated*

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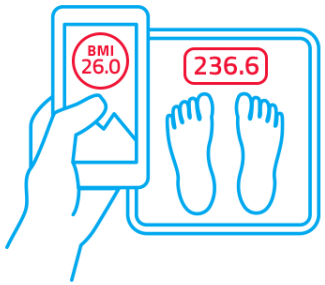
United States Preventive Services Task Force (USPSTF) abnormal glucose screening recommendation



Grade B recommendation

- Screen all adults ages 40-70 AND who have a BMI ≥ 25
  - Consider testing adults at a lower age or BMI if risk factors present
- Screen with a fasting glucose, hemoglobin A1C or oral glucose tolerance test

USPSTF standards suggest testing patients every 3 years.

U.S. Preventive Services Task Force. Final Recommendation Statement: Abnormal Blood Glucose and Type 2 Diabetes Mellitus: Screening. April 2018. https://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/screening-for-abnormal-blood-glucose-and-type-2-diabetes. Accessed March 4, 2019.

ADA Standards of Medical Care in Diabetes 2019-Diagnosis/Testing

- Test every 3 years if age ≥45 and BMI ≥25 (≥23 for Asian Americans) and one or more risk factors:
  - First degree relative with DM
  - Race/ethnicity
  - History of CVD
  - HTN
  - HDL <35 mg/dL
  - Triglycerides >250mg/dL
  - Women with PCOS
  - Physical inactivity
  - Conditions associated with insulin resistance
- Test women with h/o GDM every 3 years
- Use fasting glucose, A1c, or 2h glucose tolerance

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AACE/ACE guideline

- Very similar to ADA
- Also consider screening those on antipsychotic treatment, chronic glucocorticoids
- Screen every 3 years
- Consider annual screening for those with 2+ risk factors

National Diabetes Education Program
Guiding Principles for the Care of People with or at Risk for Diabetes

Goal: Identify and synthesize areas of general agreement among existing guidelines

Endorsed by:

American Academy of Family Physicians
American Association of Clinical Endocrinologists
American College of Obstetrics and Gynecology
American Geriatrics Society
American Diabetes Association
Obesity Medicine Association
The Endocrine Society
The Obesity Society

Principle 1: Identify People with Undiagnosed Diabetes and Prediabetes

Principle 2: Manage Prediabetes to Prevent or Delay the Onset of Type 2 Diabetes

- Lifestyle intervention with regular activity and dietary change leading to weight loss is the cornerstone of treatment for patients with prediabetes

- Consider referral to:
  - RD/RDN or diabetes educator
  - Structured lifestyle intervention, such as the National Diabetes Prevention Program lifestyle change program

National Diabetes Education Program. Guiding Principles for the Care of People with or at Risk for Diabetes. https://www.niddk.nih.gov/health-information/communication-programs/ndep/health-professionals/guiding-principles-care-people-risk-diabetes. Updated August 2018. Accessed October 24, 2018.

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National Diabetes Prevention Program lifestyle change program

The National DPP lifestyle change program helps participants make sustainable, healthy lifestyle changes and achieve weight loss to lower their risk of developing type 2 diabetes.

Key standard for a program to achieve CDC recognition:

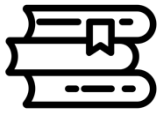
- Minimum average weight loss of 5% within 12 months
- Program maintains compliance with oversight and quality standards

Core curriculum
Participants attend 16 weekly sessions during the first six months.

Follow-up phase
Participants attend one session a month (minimum of 6 sessions).

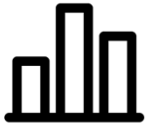
Benefits of the National DPP lifestyle change program

Trained lifestyle coaches facilitate group classes of up to 20 participants



Program curriculum is approved by the CDC.

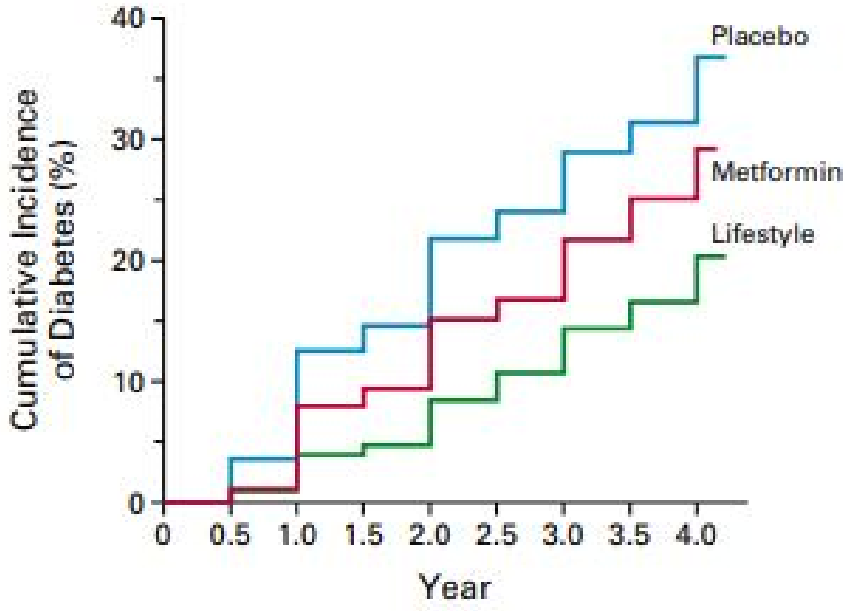
Program emphasizes empowerment through a personal action plan



Program providers are required to follow national standards and submit data on participant outcomes to the CDC.

DPP research study: Historical starting point of evidence of effectiveness

- NIH-funded 3-arm RCT (N=3234) comparing placebo vs. metformin vs. intensive lifestyle counseling[8]
- Lifestyle intervention 3-year follow up **reduced the incidence of type 2 diabetes 58%**, almost twice as effective as metformin at 31%, compared to placebo
- Low calorie, low-fat diet, plus moderate physical activity
- Program goal: 5 - 7% weight loss



Long-term Outcomes: DPPOS Study

Follow-up study of 2,776 (88%) of eligible DPP participants

At 10 years — Incidence of diabetes reduced by **34%** in the lifestyle group compared with the placebo group

At 15 years — Incidence of diabetes reduced by **27%** in the lifestyle group compared with the placebo group

Diabetes Prevention Program Research Group, Knowler WC, Fowler SE, Hamman RF, Christophi CA, Haffman HJ, Brenneman AT, Brown-Friday JO, Goldberg R, Venditti E, Nathan DM. 10-year follow-up of diabetes incidence and weight loss in the Diabetes Prevention Program Outcomes Study. *Lancet.* 2009;14(374):1677-1686

Diabetes Prevention Program Research Group. Long-term effects of lifestyle intervention or metformin on diabetes development and microvascular complications over 15-year follow-up: the Diabetes Prevention Program Outcomes Study. *Lancet Diabetes Endocrinol.* 2015;3(11):866-75

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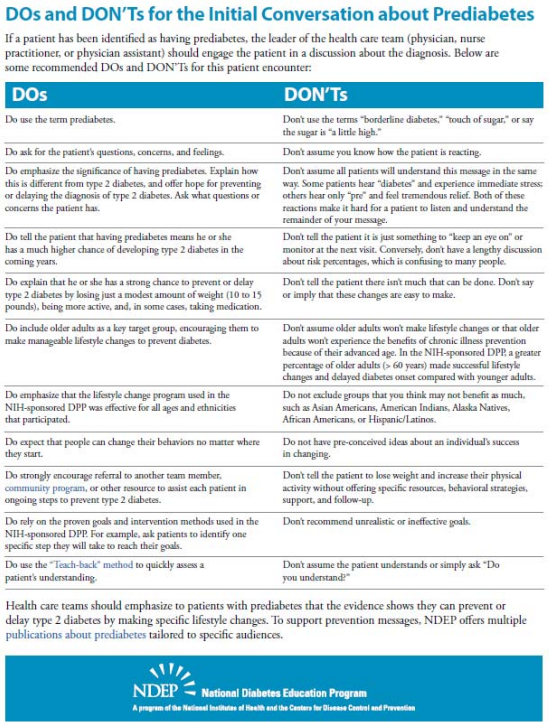
Key Messages for Patients

- *Your blood glucose is higher than normal but not at the level of diabetes. This condition is called prediabetes.*
- *Prediabetes is a serious condition: It poses a high risk of eventually progressing to diabetes and raises your risk of other medical conditions.*
- *Prediabetes is treatable and can be reversible*
  - *The goal is to lose a modest amount of weight (5-7% of body weight) and lead a healthier lifestyle*
  - *A lifestyle change program can support you to do this and help you make lasting healthy behavior changes*



DOs and DON'Ts for the Initial Conversation about Prediabetes

If a patient has been identified as having prediabetes, the leader of the health care team (physician, nurse practitioner, or physician assistant) should engage the patient in a discussion about the diagnosis. Below are some recommended DOs and DON'Ts for this patient encounter:

DOs	DON'Ts
Do use the term prediabetes.	Don't use the terms "borderline diabetes," "touch of sugar," or say the sugar is "a little high."
Do ask for the patient's questions, concerns, and feelings.	Don't assume you know how the patient is reacting.
Do emphasize the significance of having prediabetes. Explain how this is different from type 2 diabetes, and offer hope for preventing or delaying the diagnosis of type 2 diabetes. Ask what questions or concerns the patient has.	Don't assume all patients will understand this message in the same way. Some patients hear "diabetes" and experience immediate stress; others hear only "pre" and feel tremendous relief. Both of these reactions make it hard for a patient to listen and understand the remainder of your message.
Do tell the patient that having prediabetes means he or she has a much higher chance of developing type 2 diabetes in the coming years.	Don't tell the patient it is just something to "keep an eye on" or monitor at the next visit. Conversely, don't have a lengthy discussion about risk percentages, which is confusing to many people.
Do explain that he or she has a strong chance to prevent or delay type 2 diabetes by losing just a modest amount of weight (10 to 15 pounds), being more active, and, in some cases, taking medication.	Don't tell the patient there isn't much that can be done. Don't say or imply that these changes are easy to make.
Do include older adults as a key target group, encouraging them to make manageable lifestyle changes to prevent diabetes.	Don't assume older adults won't make lifestyle changes or that older adults won't experience the benefits of chronic illness prevention because of their advanced age. In the NIH-sponsored DPP, a greater percentage of older adults (> 60 years) made successful lifestyle changes and delayed diabetes onset compared with younger adults.
Do emphasize that the lifestyle change program used in the NIH-sponsored DPP was effective for all ages and ethnicities that participated.	Do not exclude groups that you think may not benefit as much, such as Asian Americans, American Indians, Alaska Natives, African Americans, or Hispanic/Latinos.
Do expect that people can change their behaviors no matter where they start.	Do not have pre-conceived ideas about an individual's success in changing.
Do strongly encourage referral to another team member, community program, or other resource to assist each patient in ongoing steps to prevent type 2 diabetes.	Don't tell the patient to lose weight and increase their physical activity without offering specific resources, behavioral strategies, support, and follow-up.
Do rely on the proven goals and intervention methods used in the NIH-sponsored DPP. For example, ask patients to identify one specific step they will take to reach their goals.	Don't recommend unrealistic or ineffective goals.
Do use the "Teach-back" method to quickly assess a patient's understanding.	Don't assume the patient understands or simply ask "Do you understand?"

Health care teams should emphasize to patients with prediabetes that the evidence shows they can prevent or delay type 2 diabetes by making specific lifestyle changes. To support prevention messages, NDEP offers multiple publications about prediabetes tailored to specific audiences.

NDEP National Diabetes Education Program
A program of the National Institutes of Health and the Centers for Disease Control and Prevention

National Diabetes Education Program. Guiding Principles for the Care of People with or at Risk for Diabetes. https://www.niddk.nih.gov/health-information/communication-programs/ndep/health-professionals/game-plan-preventing-type-2-diabetes/how-talk-patients-about-prediabetes-diagnosis/dos-donts-initial-conversation-about-prediabetes. Updated August 2018. Accessed March 4, 2019.

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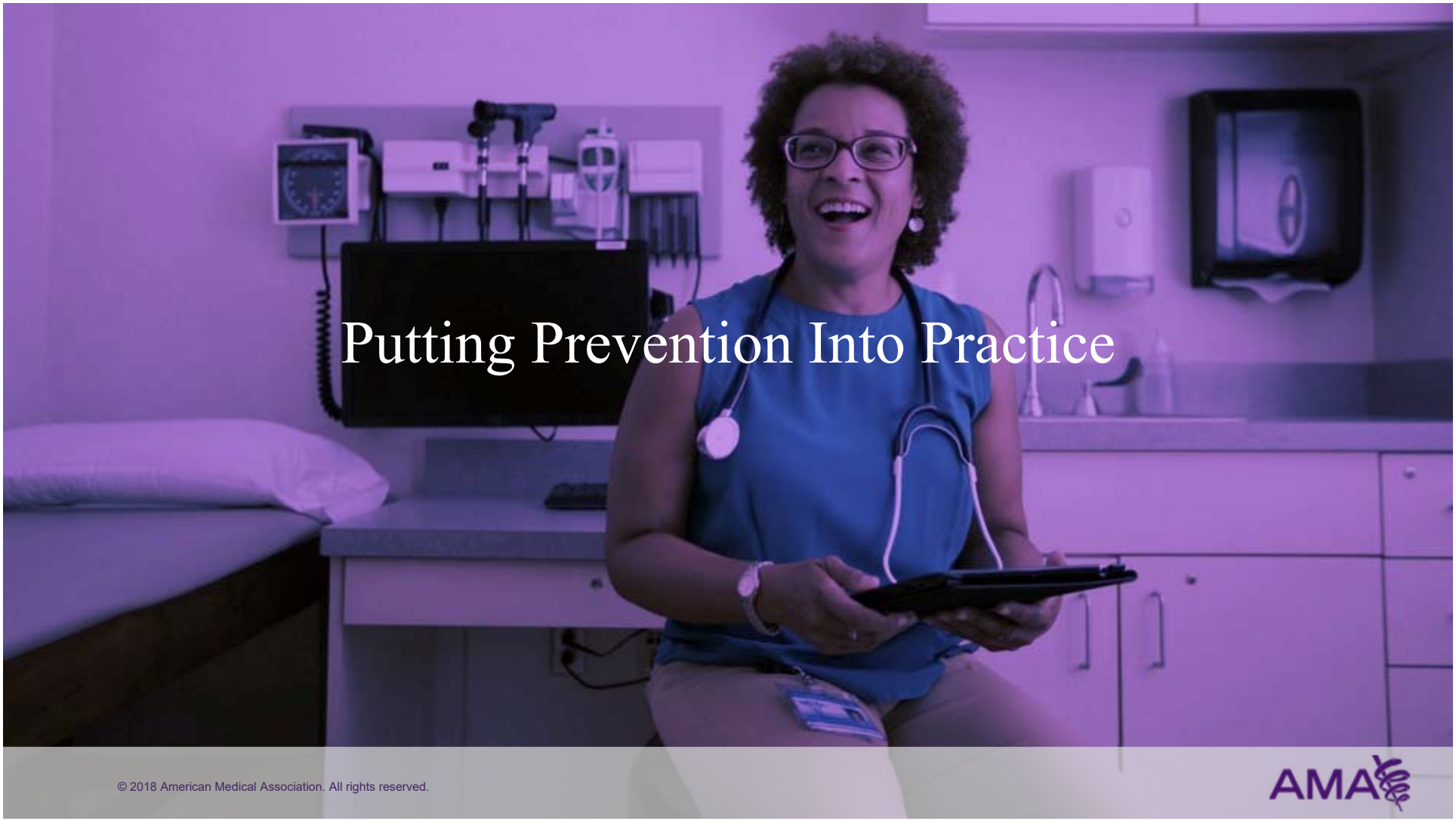


Physicians, care teams and health care organizations play critical roles in **identifying** and **managing** those at risk for type 2 diabetes.

Identify individuals at risk for type 2 diabetes

- ✓ Inform and educate those with prediabetes about their diagnosis

Engage in **shared-decision making** and provide an evidence-based treatment

- ✓ Includes referral to the National DPP lifestyle change program, medical nutrition therapy, and/or prescribing medication

Support individuals in their treatment plan

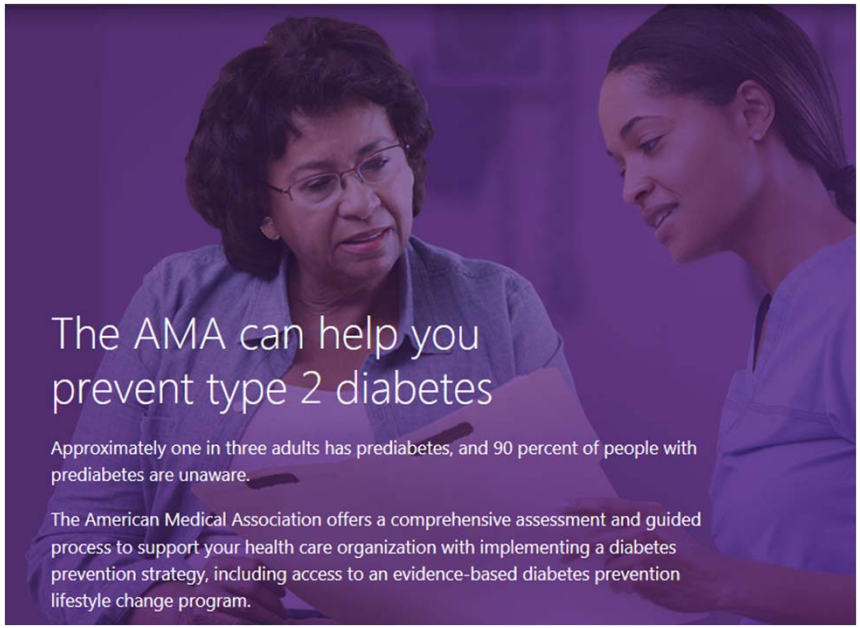
- ✓ Promote self-management and monitor risk

✓ We believe **everyone** with prediabetes should be aware of the condition and be able to take action to reduce their risk of diabetes.

LOGIN

AMA AMERICAN MEDICAL ASSOCIATION

The case for diabetes prevention | Success stories | Tools for the team | Clinical overview | Engage with us



Learn more about diabetes prevention

- Learn how we can help
- Cost-savings calculator
- Tools for the team
- Tools for physicians

Join the Movement to Prevent Type 2 Diabetes.

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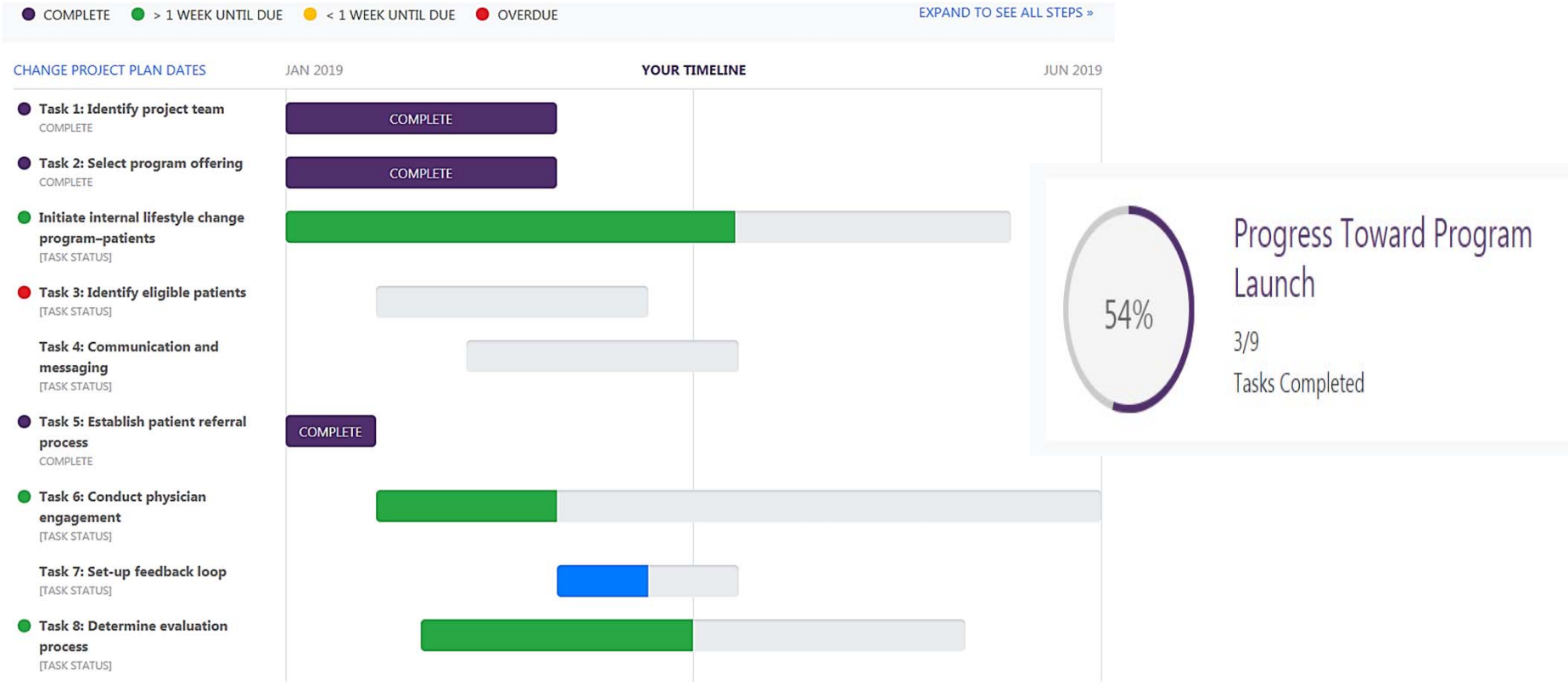
Structured implementation process with tools and resources



Identify Project Team

- Team should:
  - Have diverse make-up, including
    - clinical and administrative representation
    - members who can navigate across business units of the organization
  - Have support/buy-in from system leaders
  - Be responsible for overseeing the planning and organizing of the tasks to implement the initiative

Potential Project Team Members

1. Project Lead
2. Physician Champion
3. Population Health Coordinator/ Physician Practice Manager
4. Health IT Specialist
5. Marketing/ Communication Specialist
6. Financial officers or budget/ procurement managers

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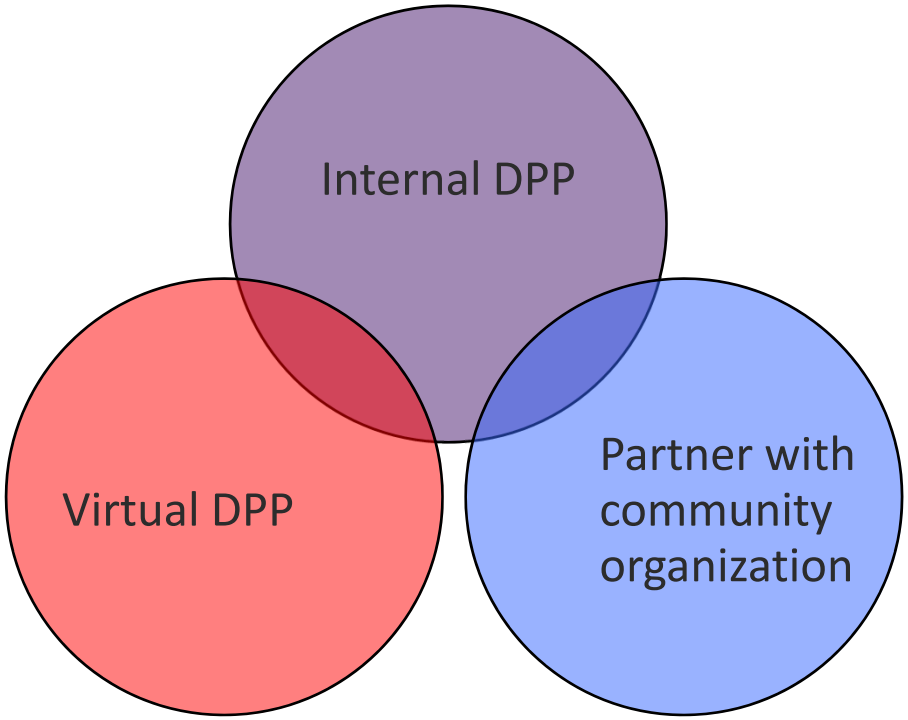
Select Program Offering



Other treatment options

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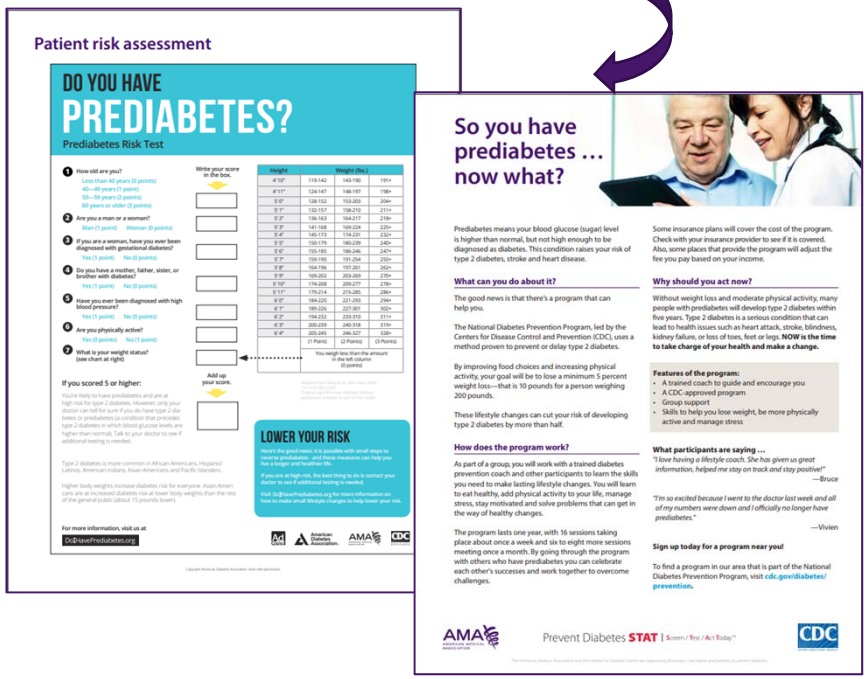
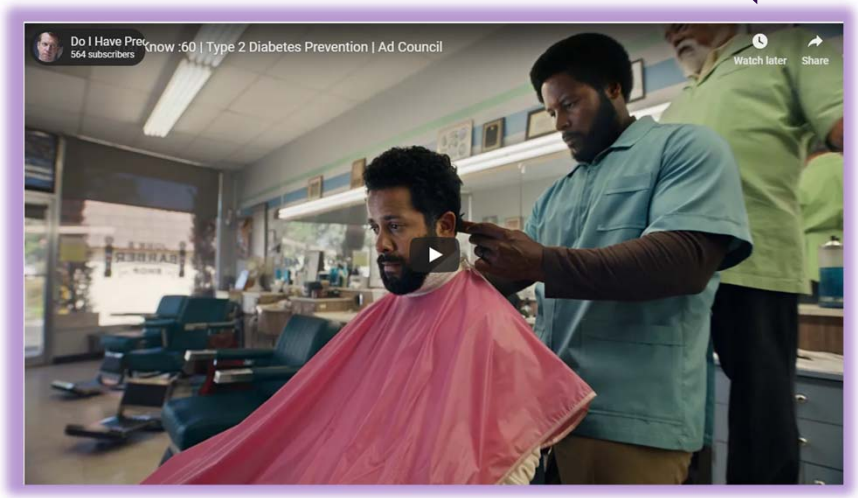
Communication and Messaging

Patient engagement and education tools



Consumer awareness tools



DoIHavePrediabetes.org

Identify eligible patients

Prediabetes identification

STEP 1

Determine eligible population for screening

- Exclude individuals < 18 yrs
- Exclude people with diabetes (problem list diagnosis or laboratory evidence)
- Exclude currently pregnant women

STEP 2

Determine if there has been a screening laboratory test for abnormal glucose

- If no, proceed to Step 3
- If yes, proceed to Step 4

STEP 3

Proceed with relevant screening option

A. General adult population

- Determine if patient meets USPSTF criteria for laboratory test
- Optional: Determine if patient meets ADA criteria for laboratory test
- Optional: Consider administering **doihaveprediabetes.org** risk test to assess patient risk
- If laboratory test was not performed in the last three years, order HbA1c, **or** fasting plasma glucose, **or** 2hr glucose tolerance test

B. History of prediabetes diagnosis

- Order HbA1c, or fasting plasma glucose, **or** 2hr glucose tolerance test

C. History of gestational diabetes

- If laboratory test not performed within the last three years, order HbA1c, **or** fasting plasma glucose, **or** 2hr glucose tolerance test
- **Note:** Individuals with a history of GDM (and an elevated BMI) are eligible to participate in a National DPP lifestyle change program regardless of current laboratory results

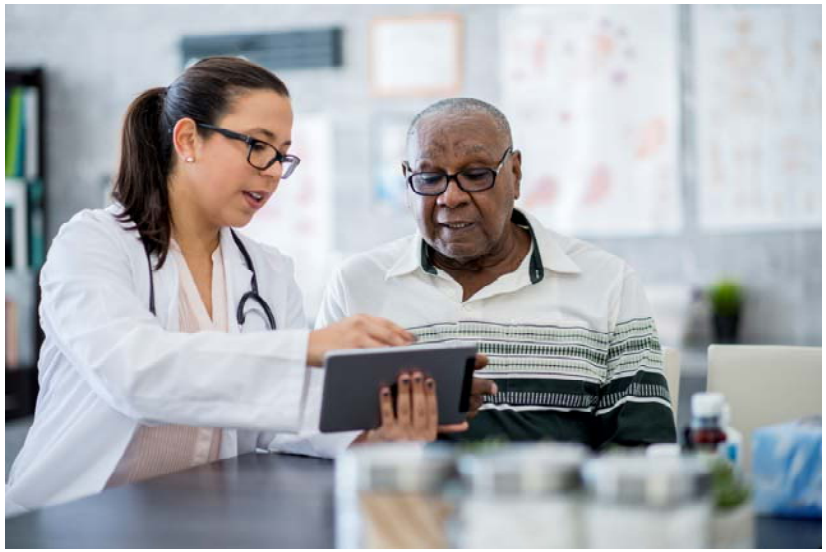
STEP 4

Evaluate laboratory results and proceed to management protocol

Laboratory test	Normal	Prediabetes	Diabetes
Hemoglobin A1C (%)	< 5.7	5.7–6.4	≥ 6.5
Fasting plasma glucose (mg/dL)	< 100	100–125	≥ 126
Oral glucose tolerance test (mg/dL)	< 140	140–199	≥ 200

- If normal, rescreen every three years or as medically appropriate
- If prediabetes diagnosis confirmed, document diagnosis with ICD-10 code R73.03 in EHR and proceed to management protocol (reverse side); inform and educate patient about diagnosis, document in the chart and proceed to management protocol
- If diabetes diagnosis confirmed, document diagnosis and treat

Establish patient referral process and set-up feedback loop



- Establish patient referral process
- Request that the DPP provide reports on patient progress
- Appropriate clinical follow-up

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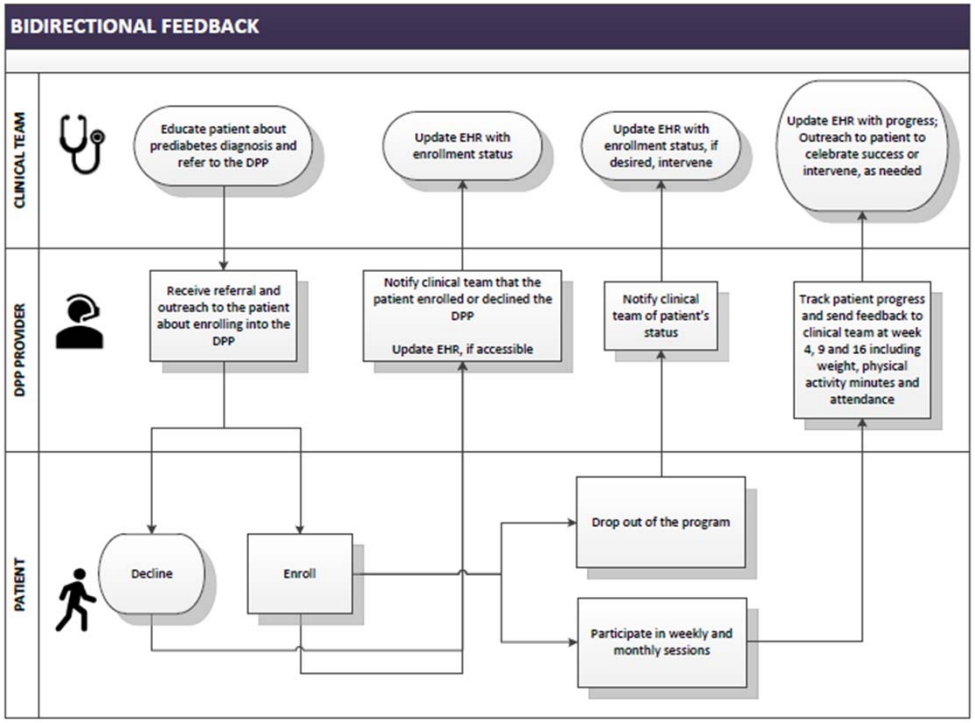
Clinical Feedback

- Enrolled
- Declined
- Dropped Out
- Progress (monthly/end of core/end of maintenance)



Progress Report Templates

National DPP lifestyle change program: **Initial contact** report

Date: [DD/MM/YYYY]

Re: [INSERT PATIENT's NAME]
DOB: [INSERT PATIENT's DOB]

Dear Dr. [INSERT PHYSICIAN's NAME],

Thank you for referring [INSERT PATIENT's NAME] to the [INSERT NAME OF LIFESTYLE CHANGE PROGRAM PROVIDER] National DPP lifestyle change program. Below is the patient's enrollment status based upon your referral:

- ❑ Enrolled
  Enrollment date: [INSERT DATE (DD/MM/YYYY)]
- ❑ Declined Enrollment
- ❑ Could not be reached
- ❑ Not eligible to enroll in the program

[INSERT NAME OF NATIONAL DPP LIFESTYLE CHANGE PROGRAM]
[INSERT LIFESTYLE COACH'S NAME]
[INSERT LIFESTYLE COACH'S EMAIL]
[INSERT LIFESTYLE COACH'S PHONE NUMBER]

National DPP lifestyle change program: Participant progress report

Date: [DD/MM/YYYY]

Re: [INSERT PATIENT's NAME]
DOB: [INSERT PATIENT's DOB]

Dear Dr. [INSERT PHYSICIAN's NAME],

Thank you for referring [INSERT PATIENT's NAME] to the [INSERT NAME OF LIFESTYLE CHANGE PROGRAM PROVIDER] lifestyle change program. Below is a summary of your patient's progress in achieving the goals of the program.

*Weekly progress on back

*If the patient has dropped out of the program, please indicate which week the patient dropped out

Core phase (16 weekly sessions)				
Session	**Date**	**Attendance (yes/no)**	**Weight**	**Reported average physical activity (minutes for the week)**
Week 1				
Week 2				
Week 3				
Week 4				
Week 5				
Week 6				
Week 7				
Week 8				
Week 9				
Week 10				

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Engaging Clinical Care Teams

Role of a Clinical Champion(s)

- Input on engagement plan
- Insight on clinical processes
- Raise awareness with other clinicians
- Formal and informal presentations

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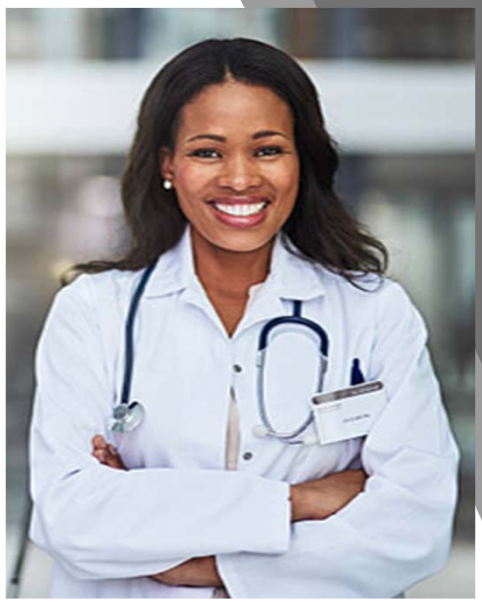
Clear call to action

Be clear on what the clinician role is!



- Identify patients at risk for type 2 diabetes
- Engage in shared-decision making with patients on treatment options and refer eligible patients to a DPP lifestyle change program
- Monitor patient progress and risk

Clinical care team engagement methods

- Presentations at existing provider meetings
- Academic detailing
- Formal Grand Rounds presentations
- CME offerings

Physician and care team engagement Presentation tips

One of the most important aspects of creating a successful National Diabetes Prevention Program lifestyle change program is engaging physicians and care team members. Following your prediabetes general awareness campaign, you should hold events targeted for specific care team members to create deeper awareness, engagement and education on your organization's diabetes prevention initiative. Potential events are webinars, lunch and learns and in-person presentations. You can supplement these events with the additional CME resources available from the American Medical Association.

We have listed several "tips" below to assist in coordinating successful in-person physician and care team presentations.

1. Coordinating the presentation logistics

☐ **Schedule the presentation during an existing meeting**

To secure good attendance, it's ideal if this presentation is scheduled during an existing meeting.

- It will be more valuable to get 15 minutes on the agenda for an existing meeting that has great attendance, than it will be to schedule a separate meeting where you may be offered a greater amount of time where attendance cannot be guaranteed.
- Location of the meeting should also be consistent with where the existing meeting is held (on site, easy to get to).

☐ **Healthy food options**

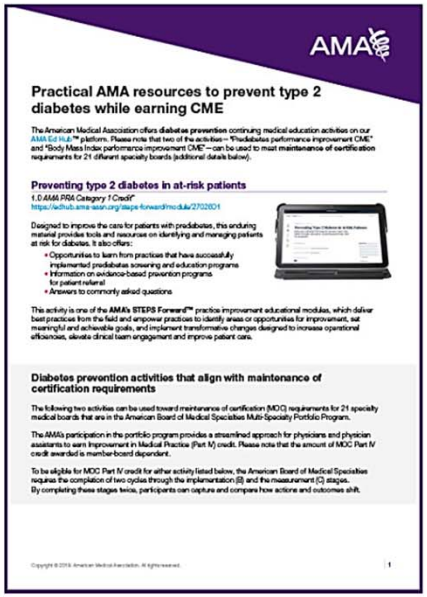
If ordering food for the meeting, select healthy food options consistent with the message to prevent type 2 diabetes.

☐ **If the meeting is for one group only (i.e., a physician meeting), consider extending an invitation to the entire care team and other key stakeholders. Potential invitees are:**

- Primary care practice physicians, NPs and PAs
- Residents
- Residency program directors
- Physician liaisons
- Nurses
- Practice managers
- Care coordinators
- IT/informatics support

You can find the AMA education resources located here:

Tools for the Team: Tools and Resources
https://amapreventdiabetes.org/tools-resources



Practical AMA resources to prevent type 2 diabetes while earning CME

The American Medical Association offers **diabetes prevention** continuing medical education activities on our AMA Ed Hub™ platform. Please note that two of the activities—"Prediabetes performance improvement CME" and "Body Mass Index performance improvement CME"—can be used to meet maintenance of certification requirements for 21 different specialty boards (additional details below).

Preventing type 2 diabetes in at-risk patients

1.0 *AMA PRA Category 1 Credit™*

https://edhub.ama-assn.org/steps-forward/module/2702601

Designed to improve the care for patients with prediabetes, this enduring material provides tools and resources on identifying and managing patients at risk for diabetes. It also offers:

- Opportunities to learn from practices that have successfully implemented prediabetes screening and education programs
- Information on evidence-based prevention programs for patient referral
- Answers to commonly asked questions

This activity is one of the **AMA's STEPS Forward™** practice improvement educational modules, which deliver best practices from the field and empower practices to identify areas or opportunities for improvement, set meaningful and achievable goals, and implement transformative changes designed to increase operational efficiencies, elevate clinical team engagement and improve patient care.

Diabetes prevention activities that align with maintenance of certification requirements

The following two activities can be used toward maintenance of certification (MOC) requirements for 21 specialty medical boards that are in the American Board of Medical Specialties Multi-Specialty Portfolio Program.

The AMA's participation in the portfolio program provides a streamlined approach for physicians and physician assistants to earn Improvement in Medical Practice (Part IV) credit. Please note that the amount of MOC Part IV credit awarded is member-board dependent.

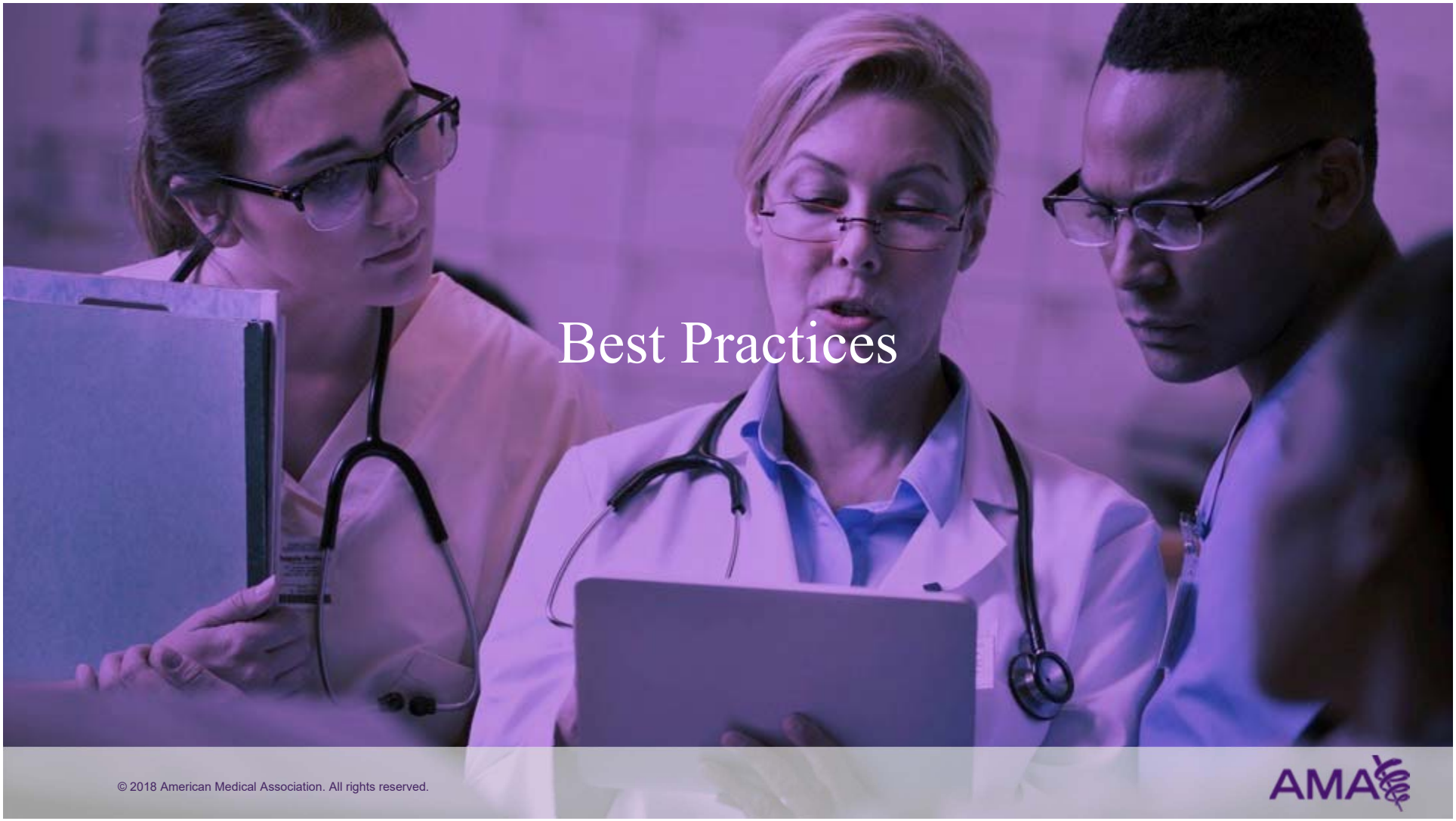
To be eligible for MOC Part IV credit for either activity listed below, the American Board of Medical Specialties requires the completion of two cycles through the implementation (I) and the measurement (C) stages. By completing these stages twice, participants can capture and compare how actions and outcomes shift.

1

Diabetes Prevention CME Offerings

This resource outlines the Continuing Medical Education (CME) activities on diabetes prevention available through the AMA's education platform, Ed Hub™.

Download



Best Practices for Implementing Diabetes Prevention

- Approach as a quality improvement, interdisciplinary initiative
- Raise awareness through multiple channels
- Automate processes and integrate into existing workflows
- Develop communication pathways between project team, clinicians, community organizations and leadership

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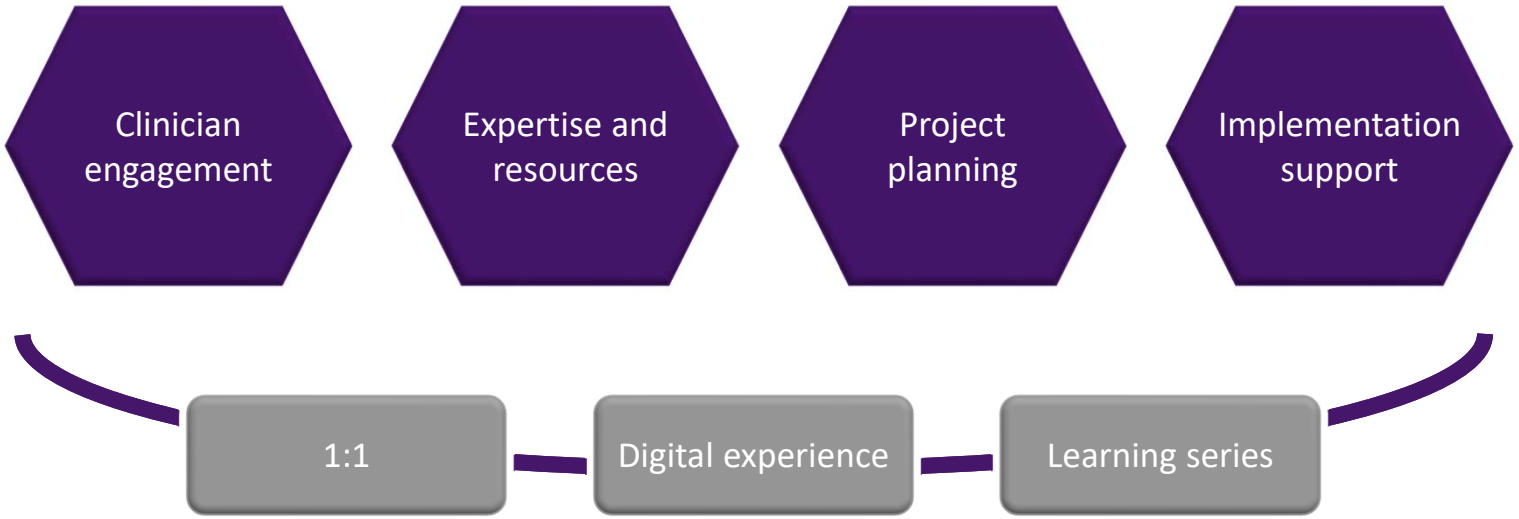
AMA Support

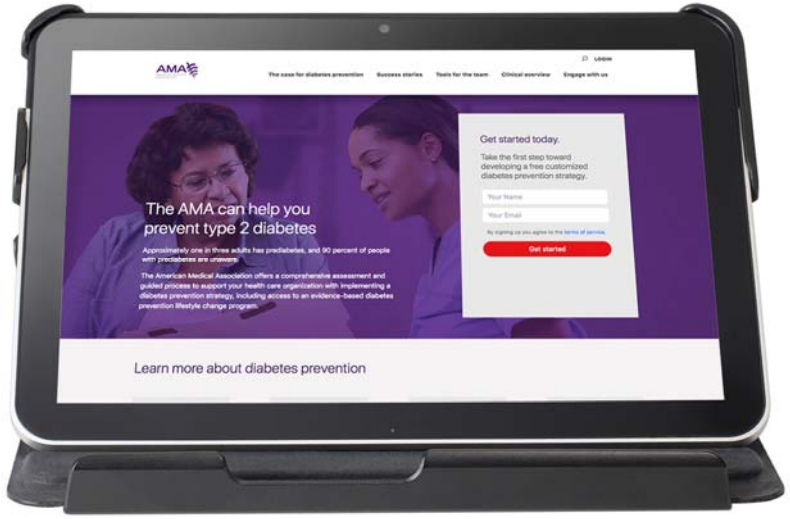
AMA | MEMBERSHIP MOVES MEDICINE.

AMA offers customized implementation support for diabetes prevention



AMA | MEMBERSHIP MOVES MEDICINE

New AMA digital guide supports a diabetes prevention strategy



amapreventdiabetes.org

- Guided implementation journey with focused tools on topics such as clinician engagement, patient communications, and feedback loop
- Dedicated content for clinical care teams
- Clean, simple user interface
- Personalized project plan and dashboard
- Mechanisms to get help—webinars, newsletters, FAQs and service support

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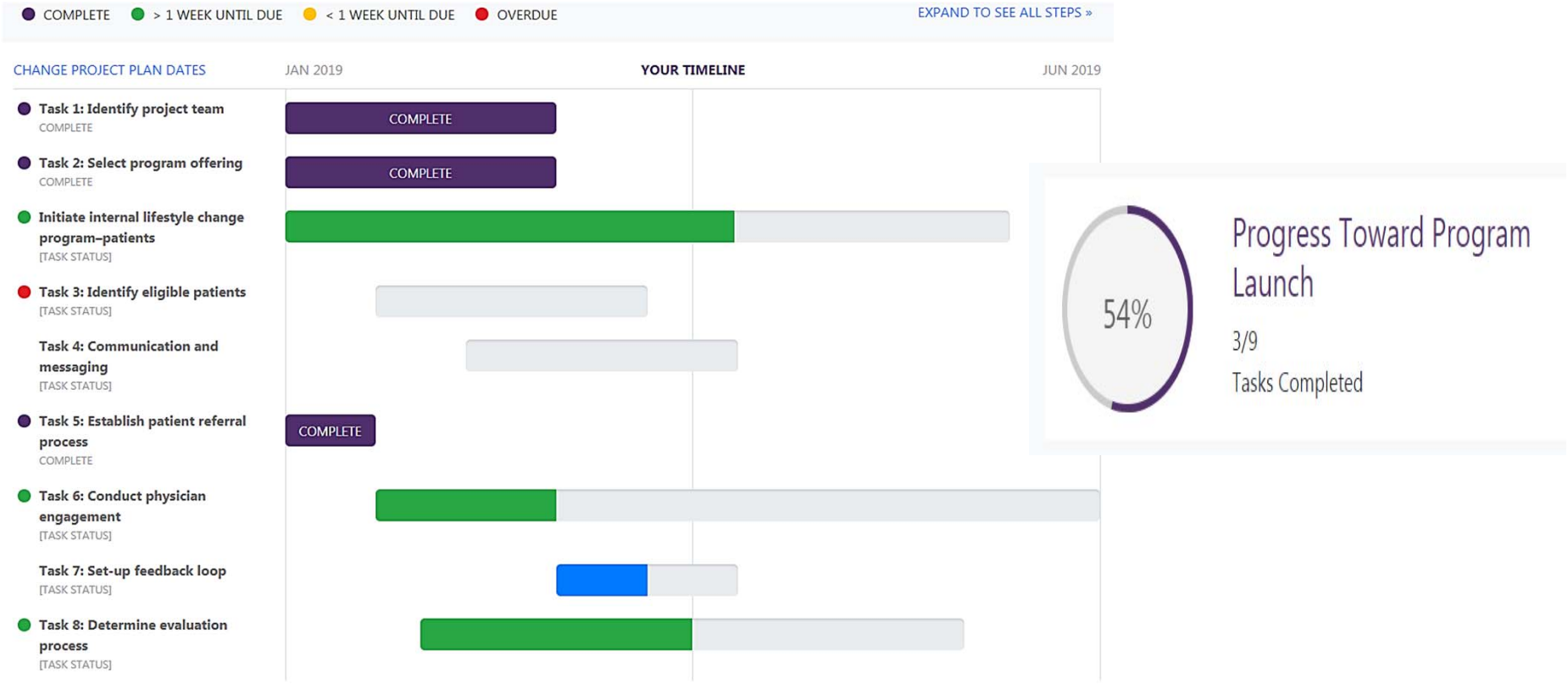
Structured implementation process with tools and resources



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STEP 1

Point of Care or Care Management.

Approach 1: The Point of Care (PoC) approach occurs during your patient's routine office visit. This provides your practice with the ability to engage with your patients face to face, and refer to a course of treatment while your patient is in the office. Should you choose this approach, the following steps will help you to select the time at which physicians will identify patients with a potential risk of prediabetes, as well as integrate the process into your workflow.

Step 1: Identify which PoC option would meet the needs of your practice.

- Option A: During pre-visit planning.
  Identify your patient's risk of prediabetes prior to their office visit.

  Below is a list of potential workflows:

  - Send the doihaveprediabetes.org risk test to your patient prior to the clinic visit. This can be done via postal service mailing, email or a posting to the patient portal. Based on the evaluation of the completed risk test, the care team can insert the results into your patient's chart.
  - Use the EHR to pull a list of patients who have a visit scheduled within a certain time frame (within the next month, for example) and meet criteria for abnormal glucose screening (per evidence-based guidelines i.e. USPSTF or ADA guidelines). Once the patient has been identified, a flag can be placed on the patient's record to obtain a laboratory test for prediabetes at their scheduled visit. Leverage the AMA EHR Quick Tips document to assist.

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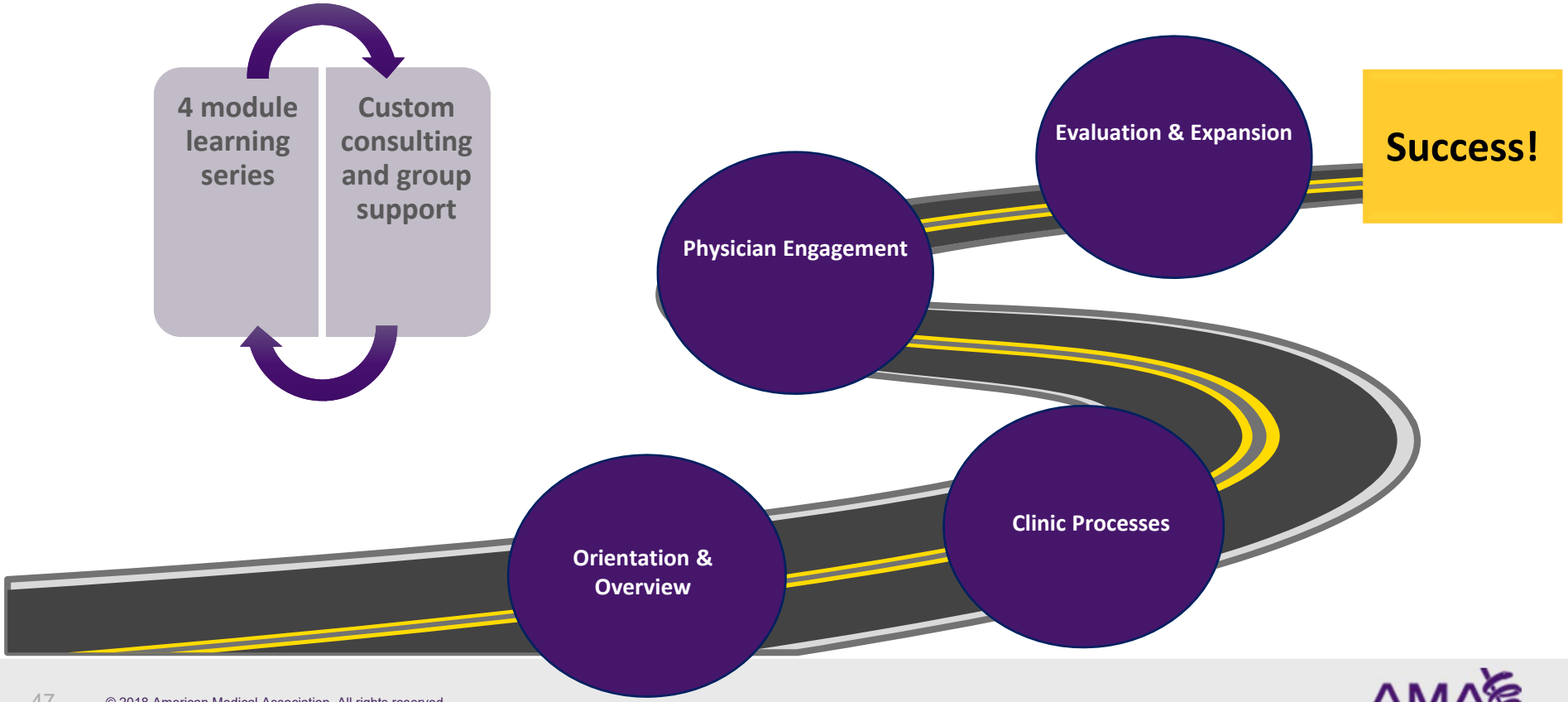
Insights Into Implementation Strategy: Diabetes Prevention



What are some of the things you will learn?

Orientation & Overview	Clinic Processes	Physician Engagement	Evaluation & Expansion
• Evidence of diabetes prevention • Expectations • Set up your dashboard • Project Team • Program Offering	• Patient Identification • Referral Process • Patient Communication • Program Recruitment • Alternate treatment options	• Provider/Care Team engagement • Feedback loop	• Evaluation process • Best practices • Sustainability and expansion

Benefits of the learning series

A comprehensive program to guide implementation of clinical practice change

Engage directly with American Medical Association subject matter experts

Access to tools and resources to support implementation

Gain from experiences of other participating health care organizations

No cost

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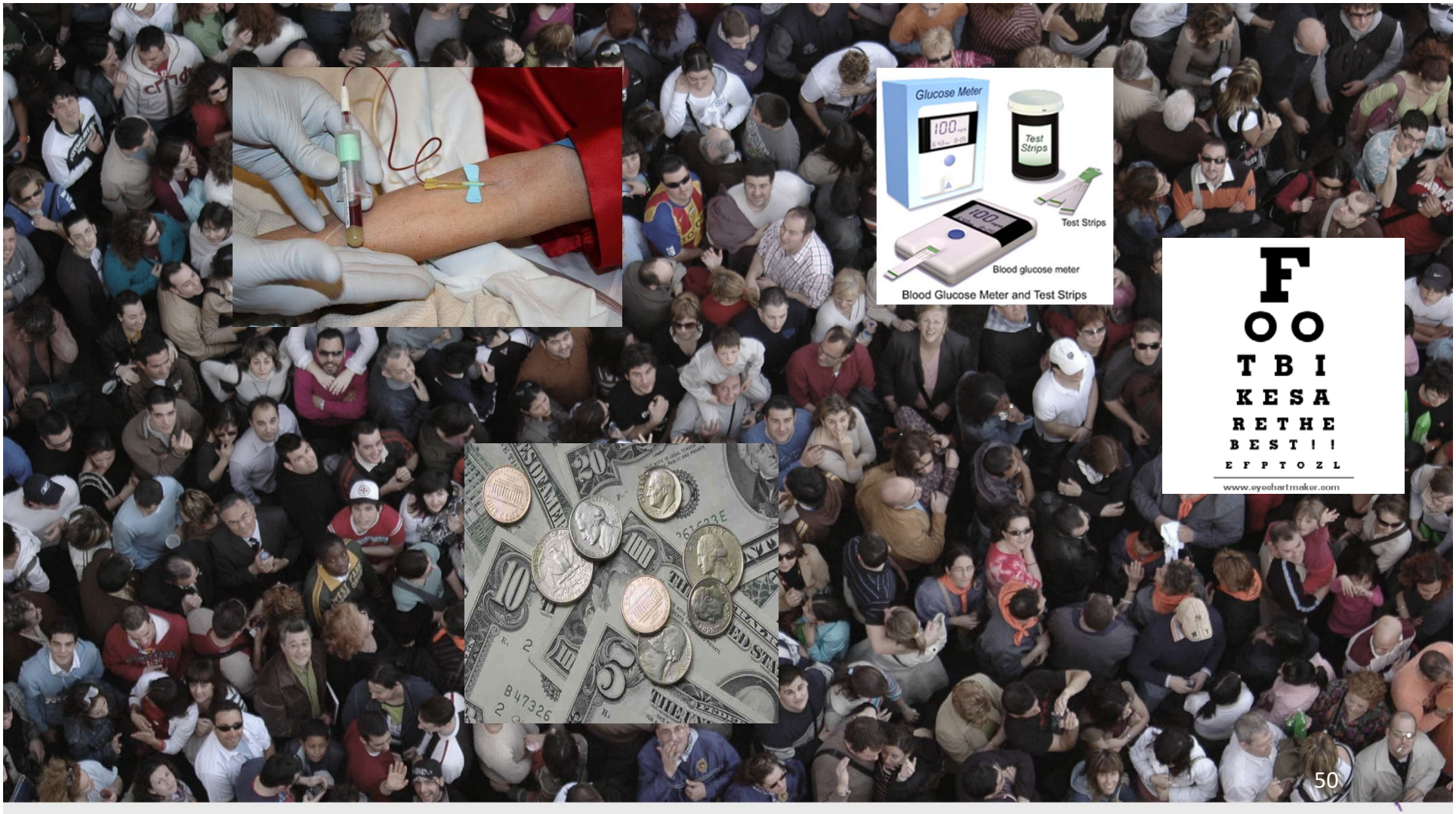
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Test Strips
Blood glucose meter
Blood Glucose Meter and Test Strips
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Now is the time to focus on diabetes prevention

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If you are interested in learning more or have any questions, contact Siga Vasaitis at siga.vasaitis@ama-assn.org