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
AMA Mission

To promote the art and science of medicine and the betterment of public health

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Improving Health Outcomes Strategic Goals

1. No new cases of preventable type 2 diabetes

2. Everyone with hypertension has their blood pressure at goal
Alex

- 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

84 MILLION ADULTS HAVE PREDIABETES

1 IN 3 ADULTS HAS PREDIABETES
9 OF 10 DON'T KNOW IT

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Guidelines and Evidence on Diabetes Prevention
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.

<table>
<thead>
<tr>
<th></th>
<th>A1C (percent)</th>
<th>Fasting Plasma Glucose (mg/dL)</th>
<th>Oral Glucose Tolerance (mg/dL)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>6.5+</td>
<td>126+</td>
<td>200+</td>
</tr>
<tr>
<td>Prediabetes</td>
<td>5.7–6.4</td>
<td>100–125</td>
<td>140–199</td>
</tr>
<tr>
<td>Normal</td>
<td>&lt;5.7</td>
<td>&lt;100</td>
<td>&lt;140</td>
</tr>
</tbody>
</table>

ICD10 code: R73.03
# Guidelines/Recommendations/Clinical Resources Related to Diabetes Prevention

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

*in process of being updated*
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.

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 >250 mg/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
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
Goal: Identify and synthesize areas of general agreement among existing guidelines

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
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
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

- 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


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


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Putting Prevention Into Practice
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.
The AMA can help you prevent type 2 diabetes

Approximately one in three adults has prediabetes, and 90 percent of people with prediabetes are unaware.

The American Medical Association offers a comprehensive assessment and guided process to support your health care organization with implementing a diabetes prevention strategy, including access to an evidence-based diabetes prevention lifestyle change program.

Join the Movement to Prevent Type 2 Diabetes.
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
Select Program Offering

- Internal DPP
- Virtual DPP
- Partner with community organization

Other treatment options
Communication and Messaging

Patient engagement and education tools

Consumer awareness tools

DoIHavePrediabetes.org

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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

**STEP 4**
Evaluate laboratory results and proceed to management protocol

<table>
<thead>
<tr>
<th>Laboratory test</th>
<th>Normal</th>
<th>Prediabetes</th>
<th>Diabetes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemoglobin A1C (%)</td>
<td>&lt;5.7</td>
<td>5.7-6.4</td>
<td>≥6.5</td>
</tr>
<tr>
<td>Fasting plasma glucose (mg/dL)</td>
<td>&lt;100</td>
<td>100-125</td>
<td>≥126</td>
</tr>
<tr>
<td>Oral glucose tolerance test (mg/dL)</td>
<td>&lt;140</td>
<td>140-190</td>
<td>≥200</td>
</tr>
</tbody>
</table>

- If normal, re-screen every three years or as medically appropriate
- If prediabetic diagnosis confirmed, document diagnosis with ICD-10 code R77.03 in EMR and proceed to management protocol (reverse side): inform and educate patient about diagnosis, document in 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
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

<table>
<thead>
<tr>
<th>Core phase (16 weekly sessions)</th>
<th>Session</th>
<th>Date</th>
<th>Attendance (yes/no)</th>
<th>Weight</th>
<th>Reported average physical activity (minutes for the week)</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Week 1</td>
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<td></td>
<td>Week 2</td>
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<td>Week 3</td>
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<td>Week 4</td>
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<td>Week 5</td>
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<td>Week 6</td>
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<td>Week 9</td>
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<td></td>
<td>Week 10</td>
<td></td>
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</tbody>
</table>
Engaging Clinical Care Teams
<table>
<thead>
<tr>
<th>Role of a Clinical Champion(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Input on engagement plan</td>
</tr>
<tr>
<td>Insight on clinical processes</td>
</tr>
<tr>
<td>Raise awareness with other clinicians</td>
</tr>
<tr>
<td>Formal and informal presentations</td>
</tr>
</tbody>
</table>
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
You can find the AMA education resources located here:

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

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
AMA offers customized implementation support for diabetes prevention

- Clinician engagement
- Expertise and resources
- Project planning
- Implementation support

- 1:1
- Digital experience
- Learning series
New AMA digital guide supports a diabetes prevention strategy

• 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

amapreventdiabetes.org
Structured implementation process with tools and resources

<table>
<thead>
<tr>
<th>Task</th>
<th>Jan 2019</th>
<th>Jun 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Task 1: Identify project team</td>
<td>COMPLETE</td>
<td>COMPLETE</td>
</tr>
<tr>
<td>Task 2: Select program offering</td>
<td>COMPLETE</td>
<td>COMPLETE</td>
</tr>
<tr>
<td>Initiate internal lifestyle change program-patients (Task Status)</td>
<td>COMPLETE</td>
<td>COMPLETE</td>
</tr>
<tr>
<td>Task 3: Identify eligible patients (Task Status)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task 4: Communication and messaging (Task Status)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task 5: Establish patient referral process (Complete)</td>
<td>COMPLETE</td>
<td>COMPLETE</td>
</tr>
<tr>
<td>Task 6: Conduct physician engagement (Task Status)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task 7: Set-up feedback loop (Task Status)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task 8: Determine evaluation process (Task Status)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Progress Toward Program Launch
- 54% tasks completed
- 3/9 tasks completed

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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](https://doihaveprediabetes.org) 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.
Insights Into Implementation Strategy: Diabetes Prevention

- Orientation & Overview
- Clinic Processes
- Physician Engagement
- Evaluation & Expansion

4 module learning series
Custom consulting and group support

Success!
What are some of the things you will learn?

**Orientation & Overview**
- Evidence of diabetes prevention
- Expectations
- Set up your dashboard
- Project Team
- Program Offering

**Clinic Processes**
- Patient Identification
- Referral Process
- Patient Communication
- Program Recruitment
- Alternate treatment options

**Physician Engagement**
- Provider/Care Team engagement
- Feedback loop

**Evaluation & Expansion**
- 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
Now is the time to focus on diabetes prevention
If you are interested in learning more or have any questions, contact Siga Vasaitis at siga.vasaitis@ama-assn.org