Disclosure to Participants

- Notice of Requirements For Successful Completion
  - Please refer to learning goals and objectives
  - Learners must attend the full activity and complete the evaluation in order to claim continuing education credit/hours
- Conflict of Interest (COI) and Financial Relationship Disclosures:
  - Presenter: Marci Butcher, RD, CDE - No COI/Financial Relationship to disclose
- Non-Endorsement of Products:
  - Accredited status does not imply endorsement by AADE, ANCC, ACPE or CDR of any commercial products displayed in conjunction with this educational activity
- Off-Label Use:
  - Participants will be notified by speakers to any product used for a purpose other than for which it was approved by the Food and Drug Administration.

2017 National AADE Diabetes Educator of the Year!

“Team effort → Team award!”
Celebrating Montana Diabetes Educators and MT Diabetes Program (MT DPHHS)

Increasing Access to DSMES and to the DPP

The Montana Experience: 17 years of expanding DSMES and 10 years of the DPP
Learning Targets

- Describe outcomes and the role of the state diabetes program in improving access to DSMES in MT
- Identify the role of state diabetes program in developing and spreading the DPP
- Describe the outcomes and lessons learned in the Montana DPP
- Describe AADE’s role in spreading and scaling the DPP nationally

CDC chronic disease prevention and health promotion

- 1305 = State public health actions to prevent and control diabetes, heart disease, obesity, & associated risk factors, and promote school health
- 1422 = State public health actions to prevent obesity, diabetes, heart disease, & stroke
  - Complement but not duplicate 1305 activities

Quality Diabetes Education Initiative (MT DPHHS) – late 90’s:

- Diabetes educators not uniformly available in this vast state; concentrated in the ‘urban’ areas
- Little help and support to become a CDE
- Only 2 recognized diabetes education programs
- Numerous other diabetes education programs, but no way of identifying quality or ability to pursue reimbursement

ADA recognized diabetes education programs, Montana, 1999

- ADA Recognized Programs

Collaborating to develop diabetes educators: Mentoring Program

- Self-study program with defined reading materials (tailored to the needs of the individual)
  - Options: basic, intermediate, and advanced
- Pair the learning individual with a CDE-mentor...partnered with MDEN (MT AADE) – coordinate diabetes education “in action” observations/shadowing

Number of CDE’s in Montana 2000 - 2016

- 1995 = 35 (???)
- 2000 = 52*
- 2006 = 77*
- 2008 = 86*
- 2016 = 95*

Statewide increase of 83% from 2000 to 2016

- 30 new CDEs from the mentoring program
- 50% of the CDEs (from the mentoring program) serve in rural communities
- Overall, in 17 years, most new CDEs have come from the mentoring program
Collaborating to develop education programs in Montana...

- Technical support to outpatient sites wanting to develop diabetes education programs
  - Resources, sample curricula
  - On-site visits/technical assistance
- Technical assistance to programs pursuing ADA-recognition and AADE-accreditation

ADA and AADE recognized diabetes education programs, Montana, 2016

ADA Recognized Programs
AADE Accredited Programs

DSME utilization is rising in Montana...?

Source: American Diabetes Association and American Association of Diabetes Educators, 2012-2014

“Pearls...”

- Role of DPHHS: relationship facilitators!
- Peer-mentoring and technical support are effective approaches to build manpower and skills for DSMES and to increase access to quality diabetes education in a rural state.
- Partnering with MDEN has been very beneficial (mutually)
  - Volunteer CDE-mentors
  - CDEs encourage the mentoring program
  - Assisted with recognition workshops
  - Help each other with recognition/education
  - Hold conferences together – helped increase membership and attendance

Challenges/work yet to do:

- American Indian communities
  - Training health professionals
  - Working on program accreditation
  - Training CHRs and diabetes outreach workers
- Reaching the ‘ultra’ rural – telehealth
- Other populations of need – those with disabilities, Medicaid
- Increasing referrals/utilization
- “Lifestyle” programs for those with diagnosed diabetes
- Supporting those with type 1 diabetes
The Montana Diabetes Prevention Program
https://youtu.be/UqNwvdZBYEc

“Man, losing 70 # is like losing a whole 5th grader!”

Diabetes Prevention Program
Findings:
- Diabetes Incidence 58% lower in the lifestyle intervention group
- Lifestyle was effective in all subgroups.

Rolling out the DPP in Montana 2008-2017
Montana Department of Health and Human Services Montana Diabetes Program

Diabetes is common, and prevalence is rising

Only 6.8% of Montana adults without a diagnosis of diabetes reported having pre-diabetes.
According to national study estimates, it’s likely that up to 38% of adults have pre-diabetes.
Frequent Barriers Reported by Primary Care Practitioners to Effective Treatment of Obesity, Montana 2007

<table>
<thead>
<tr>
<th>Lack of patient motivation</th>
<th>Percent (95% CI) who agree:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(N = 430)</td>
</tr>
<tr>
<td>Lack of patient motivation</td>
<td>87% (83-90)</td>
</tr>
<tr>
<td>Lack of clinician time</td>
<td>58% (53-63)</td>
</tr>
<tr>
<td>Lack of reimbursement</td>
<td>55% (50-60)</td>
</tr>
<tr>
<td>Lack of clinician knowledge about treatment</td>
<td>38% (33-43)</td>
</tr>
<tr>
<td>Lack of treatment skills</td>
<td>36% (31-41)</td>
</tr>
<tr>
<td>Lack of support services</td>
<td>61% (56-66)</td>
</tr>
</tbody>
</table>

Capacity of DSME programs to provide lifestyle services to persons at high risk for diabetes:

- 93% of urban programs and 71% of rural programs provide lifestyle services to persons at high risk for diabetes (pre-diabetes, IGT, IFG)
- The majority of urban programs provide these services in both group and individual settings
- 70% of rural programs provide these services in an individual setting only
- The majority of both urban and rural programs charge patients and insurers for these services
- 84% of urban programs and 60% of rural programs indicated that they have capacity to provide lifestyle services to additional patients at high risk for diabetes

How did we start? DPP Delivery in Montana:

- Received funding from legislature (2007) to implement DPP in 4 Montana communities...put out a RFP
- All 4 original sites were ‘housed’ in recognized/accredited DSME programs... “No brainer! Diabetes educators are experts in facilitating behavior change.” Also good connections w/ referring providers
- Adapted for group-based implementation and telehealth delivery to rural/frontier areas; sites continue to be added with ongoing funding
- Reimbursement by Montana Medicaid (starting 2012) for Medicaid beneficiaries - CMS grant ended Sept 2016
- Working to get DPP as a covered benefit by various payors – state employee insurance program pilot

Montana DPHHS Role:

- Build and support the prevention system – provide ‘structure’
- Fund sites across Montana to deliver the intervention
- Coordinate training and provide ongoing technical assistance to lifestyle coaches
- Facilitate networking and mentoring between lifestyle coaches (Build relationships similar to Montana’s peer-mentoring program for diabetes educators = success!)

Montana DPHHS Role (cont):

- Provide a database and evaluation tool
- Collect and analyze data
- Conduct program evaluation
- Disseminate results through presentations, published reports, and peer-reviewed articles
- Work with partners to get DPP covered as a benefit by payors

Montana DPP sites, 2017
**I. Key Lessons: 2008-2010**

- Group Intensive Lifestyle Intervention delivered by health professional lifestyle coaches could achieve the same outcomes as the DPP Intensive 16 week core.
- Health Professional Lifestyle Coaches – CDEs, Cardiac Rehab, Dietitians, Exercise Physiologists, Physical Therapists, with a two-day initial training session, could deliver the program in a variety of settings.
- Programs could recruit appropriate referrals working with Primary Care Physicians in the community using criteria that address comprehensive cardiometabolic risk and readiness to change.
- Programs could monitor individual/group behavioral and weight changes along with changes in BP, FBS/A1c, lipid profiles using a simple electronic registry to track participation and outcomes and facilitate communication with referring physicians.

**Montana Diabetes and CV Prevention Program: Features of the Registry**

- Track individual and group participation and outcomes
- Track key cardiometabolic risk factors from baseline through core and post-core
- Generate individual and group reports at each site along with pre-programmed letters to referring physicians at baseline and follow-up
- Programmed in commonly available software to facilitate data entry and use at each site
- Easy submission to state DCP for data analysis and feedback

**II. Key Lessons 2011-2014**

- Group size from 8 to 34 had no impact on weight loss.
- Participants 65+ years old attended more sessions and were more likely to achieve the weight loss goals compared to participants <65.
- Third Party Reimbursement could be obtained with licensed health professionals as lifestyle coaches.
- Participants with social risk factors benefited from participation but did not achieve the same levels of participation and outcomes as others. Monetary incentives for Medicaid participants improved participation but did not improve weight loss.
- Disabled participants achieved preventive benefits from DPP participation but needed simplified nutrition tools and exercise options to meet their needs.
Weight Loss and Group Size 2011*

Two Factors Independently Associated with 7% Weight Loss:
1. Frequency of self-monitoring of fat intake
2. Achievement of the physical activity goal

Harwell, Prim Care Diabetes 2011; 5: 125-129

Effectiveness of an Adapted Diabetes Prevention Program
Lifestyle Intervention in Older and Younger Adults
Montana DPP Core 2008-2012

Participants aged 65 and older were significantly more likely to:
- attend more sessions, self-monitor their fat intake, and
- achieve the physical activity and weight loss goals than those younger than 65.

Older and younger participants experienced significant improvements in CVD-related risk factors.

Diabetes is a Common and Costly for Medicaid:
- Diabetes is one of the top ten prevalent and costliest conditions among adults in Medicaid based on administrative claims data
- Medicaid Health and Chronic Disease Survey:
  - Telephone survey of a random sample of adults aged 18-64 enrolled in Medicaid (Conducted in 2010, 2011, and 2012)
  - Prevalence of CVD and CVD-related risk factors was significantly higher than the general adult population aged 18-64
- CMS grant (5 years): Medicaid Incentives for the Prevention of Chronic Disease – reimburses for DPP delivered to Medicaid clients

What Have We learned about Medicaid Recipients and the DPP ?
1. Medicaid participants benefit but are less likely to achieve weight loss goals.
2. Specific challenges include recruitment, transportation, social factors affecting retention and ability to monitor regularly.
3. Modest monetary incentives increased participation rates but did not improve outcomes.
4. Billing is time consuming and confusing.

III. Key Lessons 2015-2017
- Initial success with telehealth facilitated expansion to additional small outlying communities across the state.
- Women with a history of GDM achieved similar outcomes to women without a history of GDM.
- Diabetes Educators have been important at all phases of the process and will continue to be leaders in expanding lifestyle intervention programs to individuals with diabetes.
- Resources to support DPP have grown in recent years, but Health Department support has been and will remain crucial for establishing, maintaining, and expanding DPP interventions and access to Medicare reimbursement.

Telehealth Pilot led to Expansion in Rural Communities

New data to be published soon in Translational Behavioral Health.
Weight Loss at 4 months among Women by GDM History 2008-2015

<table>
<thead>
<tr>
<th></th>
<th>GDM Yes N=283</th>
<th>GDM No N=4808</th>
<th>Total N=5091</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight loss, kg, mean (SD)</td>
<td>-4.4 (4.3)</td>
<td>-4.7 (5.3)</td>
<td>-5.0 (6.5)</td>
</tr>
<tr>
<td>Change in BMI, kg/m² mean (SD)</td>
<td>-1.6 (1.8)</td>
<td>-1.7 (2.0)</td>
<td>-1.7 (2.1)</td>
</tr>
<tr>
<td>Achieved ≥5% weight loss % (n)</td>
<td>44% (124)</td>
<td>45% (2,162)</td>
<td>45% (2,286)</td>
</tr>
</tbody>
</table>

State Health Department Coordination:
Maintaining, Evaluating and Advancing Effective Lifestyle Intervention Programs

- Established regular communication among lifestyle coaches to solve common problems
- Provided ongoing training for lifestyle coaches
- Analyzed data and provided regular feedback to sites about participation and outcomes
- Communicated results to many groups including the legislature
- Facilitated communication with health plans about reimbursement
- Prepared, presented, and published data looking at factors associated with weight loss and reducing cardiometabolic risk
- Provided Montana DPP sites access to evolving national opportunities for DPP implementation including the CDC Recognition Program and Medicare reimbursement

Importance of Diabetes Educators!

- Available in many communities; DSME sites had capacity and willingness to incorporate DPP*
- Accustomed to physician referrals
- Able to evaluate readiness to change
- Experienced in group dynamics
- Able to deal with accompanying BP and Lipid issues
- Two-day training sufficient to implement program
- Able to evaluate self-monitoring logs and provide nutrition information
- Familiar with billing issues
- No formal affiliation with an exercise facility necessary
- Able to facilitate spread of lifestyle intervention to new sites and to those with diagnosed diabetes

“Landscape” of Montana’s DPP:

Medicaid has been a great partner through the CMS grant. Continuing to reimburse for DPP for Medicaid clients!

Telehealth has grown, continue to add more telehealth sites, getting the same results as in-person classes! (Look for publication soon in Translational Behavioral Medicine)

Of the onsite programs, 13 out of 20 sites are ‘housed’ within recognized/accredited DSME programs – remains a good ‘fit’ for Montana

*Only 7 YMCA’s in MT ≠ not a real option for expansion

7 of 20 on-site programs are not in DSME programs, but still are associated with professional healthcare ‘structure’:
- Local health departments
- Cardiac Rehab

MT DPP outcomes to date:

- Enrolled about 7,500 people (2008 – 2016)
  - 300+ at telehealth sites
  - 450+ Medicaid enrollees
- Weight loss – similar to the DPP study (Medicaid participants were a bit lower)
- Reduced risk factors – improved clinical indicators
- Important behavior changes for achieving goals:
  - Attendance at educational sessions – retention rate 73% ‘completed’ the program (up to 86% with change in CDC definition of ‘completion’)
  - Physical activity >150 min/week
  - Self-monitoring dietary intake

Final realities about delivering the DPP...

- Dropout is part of the real world. Recruitment and retention will never be perfect.
- Sticking to the DPP evidence-based curriculum is important; this is especially challenging when alternative diet programs receive media attention.
- Local information showing outcomes is critical to maintaining and expanding the DPP. Sharing experience among sites facilitates problem solving.
- The new challenge is how to extend the benefits of DPP lifestyle intervention across the continuum of diabetes prevention and care and cardiovascular risk reduction.

Summary of State DPHHS’ Role in the Diabetes Prevention Program:

- Training and Support
- Access
- Reimbursement
- Evaluation

Regional support through the State Health Department is needed to build, maintain, and expand the DPP lifestyle intervention, collect and analyze data, and advocate for reimbursement.

Montana Diabetes Prevention Program:
www.prevention.mt.gov

Montana’s CVD and DM Prevention Program “Story Map”

Why is AADE in Diabetes Prevention?
2015- AADE’s National Practice Survey found:
- 80.5% of respondents reported to be working with people with prediabetes
- 80% of DEAP programs reported to be doing some sort of prevention programming
- Only 0.4% reported receiving reimbursement for prevention

Diabetes and Prediabetes Prevalence:
- According to new CDC data, as of 2017:
  - 30.3 Million people have diabetes
  - 84 Million Adults (1 in 3) have Prediabetes
  - And 9 out of 10 people do not know it!

The National Diabetes Prevention Program
- Lifestyle Change Program - Evidence Based (on DPP Research Study)
- Year Long Program
- Group Based (In-person or Online)
- Lifestyle Coach will work with groups of participants to reduce their risk by:
  - Weight loss goal ≥5-7 % of starting weight
  - Physical activity goal >150 minutes per week
  - Learning to identify and address barriers to healthy eating and physical activity
  - Facilitate participants to self-monitor, set goals and group process
CDC and the National DPP

Groups in the National Diabetes Prevention Program are working to:

- Approved lifestyle change curriculum and trainings
- Diabetes Prevention Recognition Program (DPRP)
- Both in-person and online delivery modes
- Marketing and awareness campaigns

http://www.cdc.gov/diabetes/prevention

dprpask@cdc.gov

The AADE DPP Model:
National DPP within DSMES Programs

- Nationally Certified DSMES Programs Guarantee:
  - Large pool of eligible participants
  - HIPAA compliance
  - Oversight from a Diabetes Educator/CDE
  - Educated DPP Lifestyle Coaches
  - Third-party payment processing (NPI Number)
  - Linkage with local primary care providers
  - Inclusion of Diabetes Educators
  - Linkage with DSME for people with type 2 diabetes

AADE DPP Manuscript: Demonstrating Success of the “AADE DPP” model

- In September 2016, The Diabetes Educator published a manuscript demonstrating the AADE DPP model over three years within 25 programs. The paper compares the results of these programs to the CDC DPP Recognition Standards and demonstrates how our model is a success.

“Achievement of Weight Loss and Other Requirements of the Diabetes Prevention and Recognition Program: A National Diabetes Prevention Program Network Based on Nationally Certified Diabetes Self-management Education Programs”

Why should a DSME/DE offer DPP?

- Your program can get reimbursed and even make a profit as a DPP Provider.
- Overseeing a DPP is within DE scope and increases your skill set as a DE and being an experienced Lifestyle Coach is marketable to potential employers and as additional consultant work.
- You can offer a needed service in your community and be a part of a larger, national initiative of preventing/delaying type 2 diabetes.

Medicare Coverage of Prediabetes

- In March 2016, CMS certified the results of the Centers for Medicare and Medicaid Innovations (CMMI) funded National DPP demo project, implemented through – Y-USA.
- CMS concluded the National DPP:
  - Increases health quality
  - Reduces health care costs

Medicare announced it will reimburse for the National DPP for eligible patients at eligible MDPP Supplier organizations as in 2018!
More DPP info from AADE:

- Check out CDC-approved lifestyle coach trainings - AADE is an approved CDC training entity; can request training in your area
- Regional AADE DPP workshops – designed to help build your internal business case to become a CDC-recognized DPP and MDPP supplier
- AADE Prevention Network – launched April 2017; receive support, education resources and tools, and access to cloud-based participant database and analytic system

Website: https://www.diabeteseducator.org/practice/diabetes-prevention-program
Email: dpp@aadenet.org

AADE’s Diabetes Prevention Program
email: dpp@aadenet.org

Diabetes Prevention COI

Website: https://myaadenetwork.com

CDC’s National DPP website: https://www.cdc.gov/diabetes/prevention/index.html


Every good story shows CHANGE…
Every. Single. One.

Stories.
Connect.
People.
Montana Diabetes Educator Network

Wishing you the best...from my home town to yours!
Marci Butcher, RD, CDE
mbutcher@midrivers.com
http://dphhs.mt.gov/publichealth/Diabetes

Good luck at college, Sam!!!