Public Health and Prevention
Communities of Interest
Spotlight Session

Panelists:
- Marci Butcher, RD, CDE
  Montana Diabetes Project
- Ann Constance MA, RD, CDE, FAADE
  U.P. Diabetes Outreach Network
- Janice Haile RN, BSN, CDE
  Kentucky Diabetes Control and Prevention Program
- Joanne Rinker MS, RD, CDE, LDN, FAADE
  Population Health Improvement Partners
- Theresa Renn RN, BSN, CDE
  Kentucky Diabetes Control and Prevention Program

After participating in this program, participants will be able to:

- Describe how DSME programs may be able to integrate diabetes prevention programs (DPP) or work with community-based DPP (such as YMCA)
- List initiatives that have been implemented to help increase access to and coverage for DSME and DPP
- Name at least 3 different ideas for engaging and educating members of disparate populations who live with diabetes or pre-diabetes.
National Diabetes Prevention Program
- Some insurance companies cover this program

Diabetes Prevention Programs
- How do DSME programs work with DPP programs not associated with DSME?
- How have DSME programs integrated Diabetes Prevention Programs?

Disparate Populations
How can we reach underserved and hard to reach populations?

Enhancing Access to Diabetes Self Management Education, DPP and MNT
Policies work!!
You can help change policies in your state or with health plans!

What is Happening in the Upper Peninsula of Michigan with the Diabetes Prevention Program?
Building Bridges to Prevent Diabetes in the UP of Michigan

So many need help!!

U.P. of Michigan and Policies

The U.P. and Serving Disparate Populations.

Join the AADE Public Health Community of Interest
Connect with Ann Constance
ann.constance@yahoo.com
Next up: Kentucky North Carolina and Montana experiences….

Our Kentucky Story
AADE National Conference 2016
Theresa Renn, RN, BSN, CDE, MLDE
Janice Haile, RN, BSN, CDE, MLDE
Kentucky Department for Public Health
Kentucky Diabetes Prevention and Control Program

Start with the End
Then tell you the story of our journey…
(throwing in a little alphabet soup as we go along too)

Alphabet Soup Acronyms
KDPCP = KY Diabetes Prevention and Control Program
KEHP = KY Employees’ Health Plan
CDC = Centers for Disease Control and Prevention
NDPP = National Diabetes Prevention Program
DPP = Diabetes Prevention Program
DPRP = Diabetes Prevention Recognition Program
DSME = Diabetes Self Management Education

Kentucky Counties Covered by a Diabetes Prevention Program (DPP)
2012 versus 2016
2 of 120 Counties versus 65 of 120 Counties

Kentucky’s CDC Recognized National Diabetes Prevention Programs (NDPP)
July, 2016
KY CDC Recognized NDPP Organizations = 46
KY Counties Covered by NDPP = 71

CDC = Centers for Disease Control and Prevention
KEHP = KY Employees’ Health Plan
KDPCP = KY Diabetes Prevention and Control Program
NDPP = National Diabetes Prevention Program
DPP = Diabetes Prevention Program
DSME = Diabetes Self Management Education
KY Ranking - Number of CDC-Recognized NDPP organizations
(from CDC 2016 April Reports)

KY Ranking - Number of Eligible NDPP Participants
(from CDC 2016 April Reports)

KY DPP Growth

Policies/Events/Processes
- 2011 Legislation (led to the KY Diabetes Report) +
- 2013 NACDD Grant +
  - Developed the State DPP Steering Committee
- 2013 AADE Grant to 4 New KY DPP sites (from CDC) +
- 2013 KY Employees’ Health Plan (KEHP) did a pilot DPP project (with one of the AADE Funded Sites) +

KY DPP Growth (cont.)
- 2014 Coverage of DPP began for KEHP Members
  (~265,000 KEHP Members Statewide/KY Population 4.4 million)

= Growth in KY CDC-Recognized DPP Organizations!

Kentucky ADA Recognized & AADE Accredited DSME Programs 2012 versus 2016

The Kentucky Story

Crucial Role
Public Health and Diabetes Educators / DSME Providers

Diabetes Educators / DSME Providers contributed to KY DPP growth.
Diabetes Educators / DSME Providers developed relationships and educated key decision makers (KEHP and others – and continue to do this) regarding the National Diabetes Prevention Program (NDPP) and the research behind it.

This was a KEY contributor for KEHP to begin covering DPP

Diabetes Educators / DSME Providers (from local health departments, hospitals, pharmacies, even private practice) took a leap of faith and became an early adopter of NDPP and pushed for their own organizations to become CDC-Recognized Organizations

Diabetes Educators / DSME Providers modeled success and have become the first KY DPP organizations to receive “FULL CDC Recognition”

<table>
<thead>
<tr>
<th>Organization</th>
<th>Address</th>
<th>City</th>
</tr>
</thead>
<tbody>
<tr>
<td>District Health / Lexington</td>
<td>1740 Renascence Blvd</td>
<td>Lexington</td>
</tr>
<tr>
<td>King’s Daughters Medical Center</td>
<td>2001 Renascence Avenue</td>
<td>Ashland</td>
</tr>
<tr>
<td>Fayette Regional Hospital</td>
<td>533 Interchange Blvd</td>
<td>Bowling Green</td>
</tr>
<tr>
<td>The Medical Center / Health and Wellness Center</td>
<td>1801 Taylor Way, Suite B</td>
<td>Bowling Green</td>
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Diabetes Educators / DSME Providers from one hospital-based DPP site worked closely with KEHP and hosted a successful DPP pilot (FREE) which allowed KEHP to establish processes for DPP reimbursement (was able to offer this free due to the AADE grant via CDC)

Diabetes Educators / DSME Providers have served on a state DPP steering committee and are now co-chairing the Kentucky Diabetes Network (KDN) (a statewide diabetes coalition) DPP Workgroup… helping to plan statewide public and professional awareness of Prediabetes and the NDPP
Diabetes Educators / DSME Providers help to build and maintain a Kentucky Diabetes Resource Directory.

Diabetes Educators / DSME Providers help to populate the Resource Directory with KY CDC DPP Organizations “NEW” DPP Class Series. https://prd.chfs.ky.gov/KYDiabetesResources/

Kentucky Diabetes Resource Directory: Tool to Reach Appalachian / Rural Regions

Kentucky Diabetes Resource Directory Search Screen

So now we end where we began...

Kentucky Growth of the Diabetes Prevention Program (DPP)
DPP DSME ALPHABET SOUP RECIPE...
1. Mix gallons of education, relationship building, and partnerships together really well
2. Sprinkle it with people in power
3. Grate in one or two policies
4. Spread it out across the state
5. mmm mmm Good!

We believe...
when we work together with all our collective passion and perseverance...

Together -- WE WILL TURN OUR DIABETES EPIDEMIC AROUND!

To provide specific strategies for community groups, employers and healthcare providers to help people manage their risk for developing diabetes, gain and maintain control of diabetes as well as reducing risks for related complications.

How was this Guide created?

Several statewide meetings informed the Guide’s creation.

- A meeting was held in January 2014 with the National Association of Chronic Disease Directors to help NC think strategically about diabetes prevention planning.
- In 2014, the release of a report about diabetes policy in North Carolina from Harvard.
- The PATHS Diabetes report is one of two diabetes policy reports prepared by the Center for Health Law and Policy Innovation of Harvard Law School through a grant from Bristol Myers Squibb. It can be accessed at http://www.chlpi.org/. The other report was about New Jersey.

Timeline for Development of the Diabetes Action Plan and Guide

2011/2012

- NC Diabetes Strategic Plan
- Highlight the social determinants of health and looks for whole person solutions
- Coordination across disease states and risk factors like obesity and tobacco use
- Promoting physical activity in planning and particularly walking
- Encourage use of community health workers to prevent and manage diabetes
- Promote quality clinical guidelines like diabetes screening and education recommendations

2013

- NC Coordinated Chronic Disease and Injury Prevention State Plan
- Expand access to and increase coordination for screening and clinical preventive services for all North Carolinians
- Provide individuals with the tools and knowledge they need to manage their health condition(s)
- Maintain or improve quality of life and build community capacity to provide prevention and self-management programs for chronic diseases

2014

- Multiple Events and documents by Partners
- Increase the number of CDC recognized lifestyle change programs
- Increase the number of people who are aware that they have pre-diabetes
- Increase access to diabetes and pre-diabetes education for the underserved population
- Provide third party reimbursement for DPP
- Provide technical assistance for billing DSME
- Extend pregnancy Medicaid to allow for A1c post-pregnancy diabetes testing
- NC Coordinating Council on Diabetes Action Plan
- NC Diabetes Council meetings

2015

- NC Legislatively Required Diabetes Action Plan
- Third party reimbursement for DPP
- Gestational diabetes follow-up

2015/2016

- NC Guide to Diabetes Prevention and Management
- Six core principles of diabetes prevention: increased physical activity, weight management, smoking cessation, individual and group education, quality healthcare and medication adherence
- Activities for Communities, Employers, Healthcare Providers
- Sorted by Primary Prevention, Diabetes Prevention and Prevention of Diabetes Complications

How was this guide created? (continued)

- Two meetings were convened by Kate B. Reynolds Charitable Trust to address sustainability of Diabetes Self Education Management in North Carolina and promotion of diabetes prevention programs.
- The Diabetes Advisory Council along with many stakeholders formed two workgroups that met periodically for nine months to draft the Guide.
In 2013, approximately 9% of North Carolinians reported having prediabetes.
In 2014, approximately 10.8% of North Carolinians were diagnosed with type 1 or type 2 diabetes.

Source: NC State Center for Health Statistics, Behavior Risk Factor Surveillance Survey

In 2012, Diabetes was the 7th leading cause of death in North Carolinians and the 3rd leading cause in American Indians and the 4th leading cause of death in African Americans
Roughly $8.3 billion of excess medical costs and lost productivity were attributable to diabetes within the State

By 2025,
Annual health care costs are projected to surpass $17 billion if the diabetes epidemic is not properly addressed.

Diabetes Primary Prevention

- Manage Weight
- Follow healthy eating guidelines
- Participate in regular physical activity
- Live tobacco free
- Get adequate sleep

Diabetes Prevention Programs

Diabetes Prevention Programs (DPPs) are designed to empower people with prediabetes to take charge of their health and well-being. (People can refer themselves or be referred by their healthcare provider)

Different Levels of Strategies for Reducing Diabetes
**Socioecological Model of Health: Evidence-Based Strategies—Community**

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<th>Diabetes Management and Prevention of Complications</th>
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<td>Increase the building of supermarkets in low-income food deserts.</td>
<td>Work with health care providers or state agencies to train your Community Health Workers to screen for diabetes and refer to appropriate care.</td>
<td>Offer support groups for people who have diabetes and their caregivers.</td>
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**Activities for Health Care Providers**

**Diabetes Primary Prevention**
- Help patients engage in regular physical activity.
- Emphasize the importance of small, regular meals or snacks.
- Offer support groups for people with diabetes and their caregivers.

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**Activities for Community Groups (Faith, Non-Profit, Local Government)**

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**Activities for Employers**

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Measuring Progress

- North Carolina's Guide to Diabetes Prevention and Management will be monitored annually by the North Carolina Diabetes Advisory Council (DAC).
- The DAC serves as a professional resource for the NC Division of Public Health.

Measuring Progress on Primary Prevention of Diabetes

Primary Prevention of Diabetes

- Increase the number of organizations that support diabetes primary prevention by 2020
- Increase the number of legislative/regulatory policies that support diabetes primary prevention strategies by 2020

Measuring Progress on Diabetes Prevention for Those at High Risk

Diabetes Prevention for Those at High Risk

- Increase the number of people who know that they have prediabetes from 644,000 to 967,000 by 2020. (source: BRFSS and population data estimates for North Carolina from State Center for Health Statistics)
- Increase the number of people in North Carolina who enroll in a diabetes prevention program that is recognized by the CDC from 749 (in July 2015) to 5,000 by 2020. (source: CDC DPRP State Level report)
The Montana Cardiovascular Disease and Diabetes Prevention Program

Marci Butcher, RD, CDE
Quality Diabetes Education Initiative Coordinator
Montana Diabetes Program

Montana Statistics:
- *Diabetes*
  - The prevalence of diabetes in Montana increased from 2.8% in 1990 to 8.8% in 2014.
  - Increasing rates of obesity and overweight contribute to the growing epidemic of type 2 diabetes and cardiovascular disease.
  - Over 60% of Montana adults reported a body mass index that indicates they are overweight or obese.
- *Pre-diabetes*
  - 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 35% of adults have pre-diabetes, which means that many adults do not know they have pre-diabetes.

DPP - Delivery in Montana:
- Received funding from legislature (2007) to implement DPP in 4 Montana communities; put out a RFP (request for proposals)
- 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/ 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 ending Sept 2016
- Working to get DPP as a covered benefit by various payors

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 = successful)
- 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

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 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

Montana Statistics:
- *Diabetes*
- *Risk factors*
- *Pre-diabetes*
Overall outcomes:
(Outcomes published – search PubMed for Harwell, TS)
- Enrolled about 7,000 people (2008 – 2015)
  - 300+ at telehealth sites
  - 266+ Medicaid enrollees
- Weight loss – similar to the DPP study (Medicaid participants were a bit lower)
- Reduced risk factors
- 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

Why no YMCA’s or other ‘lay’ DPP programs in MT?
- Only have 7 YMCAs in Montana – MT has built a solid and widespread DSME program infrastructure – increased access!
- Looking for other opportunities to expand the CVD/DPP in MT beyond the healthcare structure

Montana DPP sites, 2016

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

- Training and Support
- Access
- Reimbursement
- Evaluation

Montana’s CVD and DPP…
- Telehealth has grown to multiple communities, continue to add more telehealth sites, getting the same results as in-person classes!
- Medicaid has been a great partner through the CMS grant. They are going to continue to reimburse for DPP for Medicaid clients!
- Of the onsite programs, 13 out of 20 sites are ‘housed’ within recognized/accredited DSME programs – remains a good ‘fit’
- 7 of 20 sites are not in DSME programs, but still are associated with professional healthcare ‘structure’:
  - Local health departments
  - Cardiac Rehab
Addressing disparate populations: DEEP

- Mountain-Pacific Quality Health (QIN-QIO for MT, WY, AK, HI) – uses DEEP program (UI-C) in all four states
- CMS “Everyone with Diabetes Counts” program, aimed at Medicare beneficiaries with diabetes or prediabetes
- Goal is to EMPOWER participants to be activated members of their own health care team
- MT goal is not to replace professional DSME, but to support and augment it, and to provide ‘referrals’ to professional diabetes education

Montana DEEP experience:

- It’s a learning process!
- Participants are hungry for information, and even more so, for support
- Many report never being offered professional diabetes education or not wanting to go before, but now see the value of a diabetes educator increasing requests for referrals
- Professional DSME programs are seeing more people

Montana Cardiovascular Disease and Diabetes Prevention Program

www.mtprevention.org
Marci Butcher, RD, CDE
Montana Diabetes Program, MT DPHHS
mbutcher@midrivers.com
Discussion Questions

What is your experience with Diabetes Prevention Programs?

How have policies improved diabetes care and prevention services in your area?

How have you served disparate populations?