National Diabetes Prevention Program: A New Opportunity for Your Community
NCOA Webinar January 2014
Lisa A Ferretti
Diabetes in the U.S.

- Diabetes –
  - 26 million Americans – 8.3% of the U.S. population

- Pre-diabetes:
  - 79 million Americans
    - 35% of all adults
    - 50% of adults 65+
  - Progression to diabetes
    - 5 – 15% per year
Economic Burden of Diabetes

- People with diagnosed diabetes incur average costs of $11,744 per year of which $6,649 is attributable to diabetes.
- Approximately 1 in 5 health care dollars in the U.S. is spent caring for someone with diagnosed diabetes.
- In 2006, total cost for New Yorkers with diabetes was almost $12.9 billion including excess medical costs of $8.7 billion and lost productivity valued at $4.2 billion.
- 2008 NYS Medicaid program expenditures totaled approximately $4.6 billion for 307,000 beneficiaries with diabetes.
What is Prediabetes?

- Prediabetes is a condition where the blood sugar is elevated, but not high enough to be considered diabetes.
- Prediabetes is a risk factor for developing type 2 diabetes.
- Fasting Plasma Glucose (FPG), glucose 100-125 mg/dl
- Oral Glucose Tolerance Test (OGTT), 2-hr glucose after administration of 75 grams of oral glucose 140-199 mg/dl
- Glycated hemoglobin (HbA1c) between 5.7% and 6.4%
Risk Factors for Type 2 Diabetes

- Age
- Family history
- Ethnicity
- History of GDM

- BMI (>25 or more)
- Habitual physical inactivity
- Previously identified glucose intolerance
  - Best single predictor
- Psychosocial Stress
  /and presence of major depressive episodes
“58% of diabetes cases globally can be attributed to body mass index above 21 kg/m²”

Diabetes and Obesity

- Females of BMI >35 has 93 times the risk of developing diabetes compared to those with BMI<21
- Increase in mean weight by one kg increase the risk of diabetes by 4.5% (recent data - 9%)
- Ethnic populations - changed lifestyles, become more obese- ↑diabetes
- Not all obese people have diabetes, but most people with diabetes have excess weight
Why is this happening?
Etiology of Obesity: Dietary Intake

- Daily caloric intake increased dramatically in the past 30 years
  - Increased portion sizes
  - Marketplace portions are 2 – 8 fold larger than FDA recommendations
  - Increased frequency of eating out/fast food consumption
  - Fast-food consumption has strong positive associations with weight gain and insulin resistance

Pereira MA et al. The Lancet. 365(9453):36-42
Building/Community Designs
Discourage Walking
Modern Conveniences?
What Can We Do About it?
The Diabetes Prevention Program
(National Institutes of Health Study)
The Evidence for Diabetes Prevention through Lifestyle Change

Diabetes Prevention Program (DPP):

- A major multicenter clinical trial sponsored by the National Institutes of Health (*NEJM*, Vol. 346, No. 6, 2002)

- DPP Clinical Trial Overview
  - 3,234 study participants; all overweight, all had prediabetes
  - Three study groups
  - Cost: $1,400 per person
DPP Treatment Groups

**Lifestyle Intervention**
- Intensive training in diet, physical activity, and behavior modification
- One-on-one coaching by health care professional

**Metformin**
- Medication and information about diet and exercise but no intensive motivational counseling

**Placebo**
- Placebo and information about diet and exercise but no intensive motivational counseling
DPP Results

**Lifestyle Intervention**
- 50% reached 7% weight loss by 24 weeks
- Risk of developing diabetes reduced by 58%
- In adults over the age of 60, the risk was reduced by 71%
- 5% developed diabetes in the study year

**Metformin**
- Reduced risk of developing diabetes by 31%
- 7.8% developed diabetes in the study year

**Placebo**
- 11% developed diabetes in the study year
What Happened after the DPP?

Researchers set out to determine if the same outcomes could be achieved if the Lifestyle Change Program is:

- Offered in community-based settings
- Delivered in a group
- Facilitated by a trained Lifestyle Coach without a health care background
- Offered without incentives
Results of Translational Research so far...

- Similar levels of weight-loss were achieved
  - Delivered in community-based sites
  - Delivered in small groups
  - Delivered by a trained Lifestyle Coach
  - Eliminated participant incentives

For more information on published translational research:

- Deploy Research Study
- Special Diabetes Program for American Indians Diabetes Prevention Demonstration Project
- Montana Diabetes Prevention Program
- I CAN Prevent Diabetes Sites in Minnesota
- YMCA-led classes with DPCA
The Issue

- Ample evidence that we can prevent or significantly delay type 2 diabetes has existed for a decade. Yet these results have not been “translated” into routine clinical practice and public health policy.
Challenges to Scaling the NDPP

- Evidence supports Pre-Diabetes
  - Requires a blood test
  - Not a routine in many primary care settings

- Need for Scalable Models
  - Purchaser must believe a program has fidelity
  - Programs must be widely available (meet demand)
  - Must be cost effective
Cost

- The DPP was resource intensive.
  - The lifestyle intervention contained sixteen “core” one-to-one sessions delivered by specialist case managers who were trained nutritionists, exercise physiologists, or behavioral psychologists.
  - These sessions were followed by twice-monthly in-person “maintenance” sessions with telephone contact between sessions.
<table>
<thead>
<tr>
<th>Program</th>
<th>Eligibility</th>
<th>Number of Participants</th>
<th>Instructor(s)</th>
<th>Weight Loss (4-6 mo)</th>
<th>Est. Cost per Participant</th>
</tr>
</thead>
<tbody>
<tr>
<td>DPP Metformin</td>
<td>Prediabetes</td>
<td>1</td>
<td>Health Professionals</td>
<td>2-3%</td>
<td>$1019</td>
</tr>
<tr>
<td>DPP Lifestyle</td>
<td>Prediabetes</td>
<td>1</td>
<td>Health Professionals</td>
<td>7%</td>
<td>$1399</td>
</tr>
<tr>
<td>DEPLOY</td>
<td>High risk</td>
<td>8-12</td>
<td>Wellness staff</td>
<td>6%</td>
<td>$275 - 325</td>
</tr>
</tbody>
</table>

Centers for Disease Control and Prevention: National Diabetes Prevention Program (NDPP)
How is the National DPP Structured?

National Diabetes Prevention Program Components

- **Training:** Increase Workforce
  Train the workforce that can implement the program cost effectively.

- **Recognition Program:** Assure Quality
  Implement a recognition program that will:
  - Assure quality.
  - Lead to reimbursement.
  - Allow CDC to develop a program registry.

- **Intervention Sites:** Deliver Program
  Develop intervention sites that will build infrastructure and provide the program.

- **Health Marketing:** Support Program Uptake
  Increase referrals to and use of the prevention program.
<table>
<thead>
<tr>
<th>Step</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apply</td>
<td>• Apply for recognition (agree to curriculum, duration, intensity)</td>
</tr>
<tr>
<td>2 wks</td>
<td>• Granted “pending recognition” by CDC</td>
</tr>
<tr>
<td>6 mos</td>
<td>• Organization begins lifestyle change program</td>
</tr>
<tr>
<td>24 mos</td>
<td>• Organization submits evaluation data (every 6 months)</td>
</tr>
<tr>
<td></td>
<td>• Recognition status assessed (granted full or remain pending)</td>
</tr>
</tbody>
</table>
Who Will Participate in the CDC Lifestyle Change Program?

Overweight Adults:
- Limited to persons ages 18 years and older
- Participants must have a BMI of 24 or greater (Asian Americans: 22 or greater)

Prediabetes:
- 50% of participants must have prediabetes diagnosed through blood test (FPG, OGTT, HbA1c) OR history of gestational diabetes
- Other 50% eligible if screen positive for prediabetes based on National Diabetes Prevention Program Risk Test
What Participant Data is being Reported to CDC?

- **Participant’s prediabetes determination:** (FPG, 2-hour OGTT, A1C, GDM, and/or CDC Prediabetes Screening Test)
  - Note: these will be Y/N fields – specific values are not reported
- **Demographics:** age, ethnicity, race, sex
- **Physical characteristics:** height, weight (height and starting weight used to determine BMI)
- **Session data:**
  - Attendance-session type (core, post-core, makeup)
  - Weight,
  - Minutes of physical activity,
National Diabetes Prevention Program in New York State Partnerships, Training and Resources
QTAC Role in NYS DPP

- Develop and support partnerships that advance public health goals and a public health agenda
- Training of Lifestyle Coaches and Master Trainers
- Technical assistance in program planning, implementation and evaluation
- Strategies to assure consistent, quality programs meeting national standards
- Maintain online registration and reporting system
- Leverage linkages to CDSME and other EBIs
- Support data submissions to CDC
Expansion of the NDPP in NYS

You Can Prevent Diabetes!

Main Goals:

1. Build community capacity to deliver the program; move beyond the YMCA – CDSME infrastructure

2. Make more accessible to most vulnerable New Yorkers (population of focus is Medicaid/Medicare, low-income, ethnically diverse and persons with disabilities)

3. Provide quality programs by ensuring NYS NDPP programs meet CDC Diabetes Prevention Recognition Program (DPRP) standards

4. Help to make the case to third party payers that the NDPP is good investment
What is working in NY

- Y-DPP in many locations
- Rural Health Network Model
- FQHC Models
- Employer Group Models
- Public Health initiatives
You can reach us by email at QTAC@albany.edu or toll free at 877-496-2780
Opportunities through the Diabetes Prevention Program

MELANIE MITROS, PHD, CES
EXECUTIVE DIRECTOR
WWW.AZLWI.ORG
Statewide Work

- **Arizona Department of Health Services**
  - Bureau of Tobacco and Chronic Disease
    - Healthy Aging
    - Diabetes Coalition
  - Division of Behavioral Health Services

- **Arizona Department of Economic Security**
  - Division of Aging & Adult Services

- **Arizona Living Well Institute**
  - Support dissemination of evidence-based programs:
    - All Stanford University developed Self-Management Programs
  - Integration & collaboration with other EBPs
    - EnhanceFitness
    - A Matter of Balance – AT Still University
2007
ADHS receives AoA Funding

October 2008
SLHI TAP Group

March 2010
ADHS receives ARRA-AoA Funding
Matching SLHI Funding

April 2010
Develop AZLWI

February 2011
Virginia G. Piper Charitable Trust Funding

2012
ADHS receives AoA & Behavioral Health Workforce Grants
Why the Arizona Living Well Institute?

- A need for greater coordination and leveraging of resources to create greater impact
- A systematic approach to data collection and management
- Coordination of training opportunities throughout the state, including coordination of self-management workshops
- Educate employers, health care providers and community services organizations about the benefits of self-management programs and evidence-based health promotion programs
THE MISSION:
TO ADVANCE EVIDENCE-BASED PROGRAMS FOR ARIZONA COMMUNITIES THROUGH STRUCTURED COMMUNICATION, MULTI-LEVEL COORDINATION AND SYSTEMATIC COACHING.
Funds to launch the Arizona Living Well Institute were made available by grant funds from St. Luke’s Health Initiatives and the Arizona Department of Health Services through a grant from the Administration on Aging.
Evolution of the Living Well Institute

1. **Coordination**
   - Master & Lay Leader Trainings
   - Strategic Planning Meetings

2. **Communication**
   - Statewide to Next door
   - Regional Collaboratives

3. **Coaching**
   - Assessing Agency Readiness
   - Implementation Coaching
   - Workshop Fidelity
   - Follow-up & Continued Mentoring

The 3 C’s
Central System

WORKSHOPS

TRAINING

PAYMENT SYSTEM
## Evaluation Tools

- **Workshop & Training Registration**
  - www.azlwi.org
  - Mentoring Process
- **Workshop Cover Sheet**
  - Date
  - Time
  - Location
  - Facilitators
  - Substitutes
  - Session Zero
- **Participant Survey**
  - Pre
  - Post
- **Feedback Questionnaire**
  - Program
  - Facilitators
  - Meeting Space
- **Fidelity Process**
  - Workshops
  - Trainings
Facilitator Growth

April 2010

December 2013
### Host Organization Growth

<table>
<thead>
<tr>
<th>2007-2010</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 Counties</td>
<td>15 Counties</td>
</tr>
<tr>
<td>3 Host Organizations</td>
<td>48 Host Organizations with over 110 Partners</td>
</tr>
<tr>
<td>Community Health Center</td>
<td>Area Agencies on Aging</td>
</tr>
<tr>
<td>Mariposa Community Health Center, Inc.</td>
<td>Behavioral Health</td>
</tr>
<tr>
<td>Area Agency on Aging</td>
<td>Health Insurance Plans</td>
</tr>
<tr>
<td>Pima Council on Aging</td>
<td>Community Health Centers</td>
</tr>
<tr>
<td>Local Health Department</td>
<td>Local Health Departments</td>
</tr>
<tr>
<td>Yavapai County Community Health Services</td>
<td>Non-Profits</td>
</tr>
<tr>
<td></td>
<td>Veterans Administration</td>
</tr>
</tbody>
</table>
Next Steps
AZ Healthy Living Initiative

- A comprehensive membership system of evidence-based wellness programs
  - promoted, paid and integrated with primary and behavioral health outpatient providers of service for enrolled Medicaid and Medicare patients living with or at risk of developing chronic conditions.

- In order to sustain and expand impact, AZLWI is further developing, supporting and promoting a structured provider membership system to ensure quality evidence-based wellness services are provided at affordable prices.
Web-Based, Integrated Participant Referral & Tracking System

Referrals
- Community Outreach Navigators
- Health & Human Service Providers
- Insurance Providers
- AHEC Interns
- Self-Referral

Services
- Evidence-based Self-Management Workshops
- Referral to other needed services (e.g. ASHLine, WIC, etc.)
- Assistance completing health & human service applications (e.g. AHCCCS)
- Referral to potential Medical Home
- Database Management
- Invoicing & Billing Services

Outcomes
- Response to referral source of services provided to include:
  - Participation in Self-Management Workshop
  - Other completed referrals/services

Arizona Living Well Institute
Advancing Evidence-Based Programs for Arizona
The Benefits
Benefits Beyond the Program

- **Strategic Growth**
  - Technical Assistance
  - Regional Collaboratives
  - County Coalitions

- **Improved Retention**
  - Facilitators
  - Participants

- **Stay up to Date**
  - Updates
  - Meet & Retreats
  - Refresher Trainings

- **Improved Problem Solving**
  - Local Mentors
  - Statewide Webinars

- **Leverage Funding Opportunities**
  - Partners supporting Partners
  - Payer Models

- **Program Expansion**
  - DPP
Questions?

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AZ Living Well Institute
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Call to Action for a Coordinated Approach to Diabetes Prevention

The National Diabetes Prevention Program: An Evidence-Based Program for Employers, Providers, Health Plans and Community Groups to Bend the Trend

BRENDA SCHMIDT, MS, MBA
President / CEO, Viridian Health Management
Challenge – 79 million Americans have prediabetes (35% of U.S. population)

Drivers – Obesity and inactivity

Opportunity – Prediabetes can be reversible with lifestyle intervention

Delivery – Outcomes-based, pay-for-performance model

Goal – Weight loss; behavior modification; lasting lifestyle changes

Outcomes – Reduce diabetes conversion among prediabetes; substantial ROI

PROVEN, EVIDENCE-BASED OUTCOMES:
Prediabetics who lose 5-7% of their weight may reduce conversion to diabetes by 58%; 70% for those age 60+.
My Way 2 Prevent Diabetes

- Viridian brand of National DPP
- Unique learning format
  - Problem-based learning
  - Motivational Interviewing
  - Peer-to-peer teaching
- Pay-for-performance
- Flexible delivery model

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National DPP Partnership Framework

Clinical Role
- Diagnosis of Prediabetes
- Team-based Practice
- Information Systems
- Referrals
- Engaged Patients

Partnership Opportunities
- Referral
- Screening for high risk
- Lifestyle Change Program (NDPP)
- Network of Program Sponsors
- Reimbursement

Community Role
- Insurers
- Employers
- Community Organizations
- Public Policy
- Supportive Environments
- Community Awareness

VIRIDIAN HEALTH MANAGEMENT
Viridian Partnership Model

Scalable Business Model

**Payment**
- Reimbursement
- Wellness Program
- Covered Benefit

**Plan / Employer Sponsor**

**Viridian Catalyst**
- Identification
- Enrollment
- Material Fulfillment
- Training
- Technology
- Reporting
- Claims Processing

**Delivery**
- Lifestyle Coach Management
- Program Delivery
- Data Collection

**Program Sponsor**
## Viridian National Network

### Viridian Diabetes Prevention Network
(Coordinated National Network)

<table>
<thead>
<tr>
<th>Coach Training</th>
<th>Delivery Network</th>
<th>ASO / TPA</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Master Training</td>
<td>• National Delivery Network supported by Viridian</td>
<td>• Consumer website and social network</td>
</tr>
<tr>
<td>• Motivational Interviewing</td>
<td>• Flexible Intervention Sites</td>
<td>• Participant Identification and Engagement</td>
</tr>
<tr>
<td>• Lifestyle Coach Training</td>
<td>• Program delivery partners contracted with Viridian</td>
<td>• Material Fulfillment</td>
</tr>
<tr>
<td>• Coach Support / Quality / Fidelity</td>
<td></td>
<td>• Data Collection and Reporting</td>
</tr>
</tbody>
</table>

### Network of CDC Recognized Program Partners

**ASO:** Administrative Services Organization  
**TPA:** Third Party Administrator
National DPP Delivery Models

Arizona
• Arizona Living Well Institute Network

Hawaii
• Built from CMS innovation diabetes control network
• Central point of contact for community-based organizations

New York
• New York State Health Foundation – Grant-funded CBOs
• Grantees provided technical assistance and Maestro™
• QTAC - Lifestyle Coach training and community network

Colorado / Nevada
• Health Plan reimbursement
• State networks NDPP based on existing program providers
  • iDo (Nevada)
  • Colorado Prevention Alliance
<table>
<thead>
<tr>
<th>Viridian National DPP Process</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Establish Reimbursement Model</strong></td>
</tr>
<tr>
<td>- Health Plan</td>
</tr>
<tr>
<td>- Provider / HDN</td>
</tr>
<tr>
<td>- Employer</td>
</tr>
<tr>
<td><strong>Identify Delivery Network</strong></td>
</tr>
<tr>
<td><strong>Outreach and Engagement</strong></td>
</tr>
<tr>
<td>- Eligibility Management / Data Mining</td>
</tr>
<tr>
<td>- Screening / Testing</td>
</tr>
<tr>
<td>- Call center outreach / engagement / support</td>
</tr>
<tr>
<td>- Network with existing CBO / Networks</td>
</tr>
<tr>
<td><strong>Stratify Data</strong></td>
</tr>
<tr>
<td><strong>Provide Operational Support</strong></td>
</tr>
<tr>
<td>- Eligibility Management / Data Mining</td>
</tr>
<tr>
<td>- Technical Assistance / Toolkit / Materials</td>
</tr>
<tr>
<td>- Maestro™ Class Management (data import)</td>
</tr>
<tr>
<td>- Diabetes Prevention Recognition Program (DPRP)</td>
</tr>
<tr>
<td><strong>Data Collection and Reporting</strong></td>
</tr>
<tr>
<td><strong>Claims Processing</strong></td>
</tr>
<tr>
<td>- Maestro™ data collection and reporting</td>
</tr>
<tr>
<td>- Claims processing</td>
</tr>
<tr>
<td>- Payment to program providers</td>
</tr>
</tbody>
</table>
Maestro™ Technology Support

Group added to Maestro™

Data Import
- Biometrics, Claims, Questionnaire, Labs, Other sources

Participant ID & Outreach
- Data mining & ID
- Multi-channel mktg
- Participant opt-in

National Provider Network
- Community classes
- Coach data

Summary Billing (@ Milestones)
- Classes 4 & 9
- 5-7% weight loss

Aggregate Reporting & Reporting to DPRP

Viridian proprietary model for National DPP identification, outreach and administration
### Flexible Pay-for-Performance Model

- Model allows employer/payer to share risk
- Payment based on program outcomes
- Participant fee charged at engagement and outcome milestones
- Program sponsors are paid by Viridian for program delivery

<table>
<thead>
<tr>
<th>Payment</th>
<th>Milestone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrative Fee</td>
<td>At program enrollment</td>
</tr>
<tr>
<td>Milestone Payment # 1</td>
<td>Completion of 4&lt;sup&gt;th&lt;/sup&gt; class</td>
</tr>
<tr>
<td>Milestone Payment # 2</td>
<td>Completion of 9&lt;sup&gt;th&lt;/sup&gt; class</td>
</tr>
<tr>
<td>Milestone Payment # 3</td>
<td>Minimum 5% weight loss</td>
</tr>
</tbody>
</table>
## Benefits for Delivery Partners

<table>
<thead>
<tr>
<th>Employers</th>
<th>Payers</th>
<th>Program Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthier employees/lower overall healthcare costs</td>
<td>Reduced benefits claims due to healthier members</td>
<td>Partner in care team with local healthcare providers</td>
</tr>
<tr>
<td>Reduction in worker compensation and disability costs</td>
<td>Ability to maintain quality coverage</td>
<td>Leverages other chronic disease prevention and control programs</td>
</tr>
<tr>
<td>Lower replacement costs for ill or injured workers who are absent as well as costs for recruiting and training new workers</td>
<td>Maintaining quality while reducing costs results in competitive advantage</td>
<td>Implements population health management approach and principles</td>
</tr>
<tr>
<td>Healthy employees are more productive; less absenteeism than unhealthy counterparts</td>
<td>Reduces likelihood of comorbidities associated with diabetes and prediabetes</td>
<td>Supports success in pay-for-performance/shared risk delivery and payment model environments</td>
</tr>
</tbody>
</table>
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