Disclosure

I have no relevant financial relationships with commercial interests to disclose.
Objectives

• Describe the trends in type 2 diabetes and implications for clinical practice

• Review the evidence that supports referring patients with prediabetes to a lifestyle change program

• Discuss key steps that physicians and care teams can take to prevent diabetes
Frank

• 2003 Prediabetes age 55
Frank

- 2003 Prediabetes age 55
- 2006 Type 2 Diabetes

Glucometer
Lancets
Test Strips
Diabetes Education
Metformin
Statin
Aspirin?
ACE-I?
Referral Ophthalmology
Referral Podiatry
Office Visit q 3 months
Labs and Urine
Frank

- 2003 Prediabetes age 55
- 2006 Type 2 Diabetes
- 2010 Retinopathy
Frank

- 2003 Prediabetes age 55
- 2006 Type 2 Diabetes
- 2010 Retinopathy
- 2012 CKD

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

- 2003 Prediabetes age 55
- 2006 Type 2 Diabetes
- 2010 Retinopathy
- 2012 CKD
- 2016 MI and Death
Adults with Diagnosed Diabetes, Age-Adjusted Percentage

30+ MILLION Americans have diabetes

Source: www.cdc.gov/diabetes/data
Disclaimer: This is a user-generated report. The findings and conclusions are those of the user and do not necessarily represent the views of the CDC.
Health burden of diabetes

Compared to people without diabetes, those with diabetes are:

- **100% more likely to develop hypertension**
- **80% more likely to be hospitalized for heart attack**
- **50% more likely to be hospitalized for a stroke**
- **70% more likely to die from heart disease or stroke**


Cost of diabetes

TOTAL EST. COST IN 2012

$245 BILLION

$176B IN DIRECT MEDICAL COSTS

$69B IN REDUCED PRODUCTIVITY

PEOPLE WITH DIAGNOSED DIABETES

$13,700 / YR AVG. MEDICAL EXPENSES

$7,900 / YR AVG. DIABETES EXPENSES

2.3X HIGHER EXPENSES THAN THOSE w/o DIABETES

> 1 IN 5 HEALTH CARE DOLLARS

A reversible condition in which plasma glucose levels are higher than normal but not high enough to diagnose type 2 diabetes
Current burden of prediabetes

- **84 million adults have prediabetes**

- **9 of 10 don't know they have prediabetes**

- **1 in 3 adults has prediabetes**


Prediabetes diagnosis

There are 3 standard test options to identify prediabetes.

- **A1C (percent)**
  - Diabetes: 6.5+%
  - Prediabetes: 5.7–6.4%
  - Normal: <5.7%

- **Fasting Plasma Glucose (mg/dL)**
  - Diabetes: 126+ mg/dL
  - Prediabetes: 100–125 mg/dL
  - Normal: <100 mg/dL

- **Oral Glucose Tolerance (mg/dL)**
  - Diabetes: 200+ mg/dL
  - Prediabetes: 140–199 mg/dL
  - Normal: <140 mg/dL

Progression from prediabetes to type 2 diabetes

Without intervention, depending on where an individual is on the prediabetes spectrum:

15% - 30% of people with prediabetes\(^1\)

within 5 years

Type 2 Diabetes

The population with prediabetes is heterogeneous and those at the higher end of the prediabetes spectrum have a higher risk of developing type 2 diabetes.

Future impact on clinical practice

Over the next 5 years, a typical large clinical practice could experience a 32% increase in the number of patients with diabetes.
Challenges faced by practicing physicians and care teams

• The current and growing volume of chronic disease

• Lack of time to effectively deliver the intensive counseling needed to result in lifestyle changes

• Social determinants of health often fall outside our scope of influence

• Lack of adequate information about community-based resources for diabetes prevention
One solution: National Diabetes Prevention Program

Prediabetes is a reversible condition.

The National DPP can help patients lower their risk of developing type 2 diabetes and reduce the likelihood of:

- Illness
- Medication
- Expense
What is the National DPP?

**Physical Activity, 150 Minutes/Week**

**Healthy Eating**

**Stress Management & Behavior Modification**

Year-long in-person or online lifestyle change program

**First 6 Months**
- weekly curriculum

**Next 6 Months**
- meet once/twice a month for maintenance
What is the National DPP?

**Program goal**

- **MINIMUM BODY WEIGHT LOSS** 5% **IN 6 MONTHS**
- +6 **MONTHS OF MAINTENANCE**

- Emphasis on prevention, and empowerment
- Lifestyle coach motivates and supports individuals

**In-person program**
- Peer-to-peer camaraderie
- Group support
- Progress reports
- CDC-recognized

**Online program**
- Patient flexibility
- Complete modules on own schedule
- Web/mobile enabled dashboards
- CDC-recognized
Historical starting point: DPP randomized controlled trial

DPP Research Study: People with prediabetes who took part in a structured lifestyle change program reduced their risk of developing type 2 diabetes (at average follow-up of 3 years) compared to placebo. And the lifestyle change program was nearly twice as effective as metformin.

DPP
Intensive Lifestyle Change Program
(71% reduction for patients over age 60)

METFORMIN
Glucose Lowering Drug
(Currently, there is no FDA approval for metformin for the indication of diabetes prevention)

58% risk reduction
31% risk reduction

Benefits of the DPP

DPP clinical impact:
(over 3 years, after program completion per 100 high-risk adults)

USPSTF abnormal glucose screening recommendation

USPSTF standards suggest testing patients every 3 years.

AGE & BMI

Grade B recommendation
- 40-70 age AND
- BMI ≥ 25

* The American Diabetes Association encourages screening for diabetes at a BMI of ≥ 23 for Asian Americans

USPSTF abnormal glucose screening recommendation

Consider testing adults of a lower age or BMI if risk factors present.

Family history
Family history of type 2 diabetes includes first-degree relatives (a person’s parent, sibling or child)

Medical history
• Gestational diabetes
• Polycystic ovary syndrome

Racial & ethnic minorities
• African Americans
• American Indians or Alaskan Natives
• Asian Americans
• Hispanics or Latinos
• Native Hawaiians or Pacific Islanders

USPSTF abnormal glucose screening recommendation

Grade B recommendation

• Screen for abnormal blood glucose with a fasting glucose, hemoglobin A1C or oral glucose tolerance test.

• Refer patients with abnormal glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.

CMS expansion of Medicare benefits to include DPP

Deploying the National DPP savings of $2,650 per participant for Medicare

Medicare DPP details

• Coverage begins April 1, 2018

• Beneficiary eligibility
  • BMI ≥ 25 (≥23 if Asian) AND
  • Lab value in prediabetes range (HbA1C 5.7-6.4%, fasting glucose 110-125mg/dL) AND
  • No previous diagnosis of type 1 or type 2 diabetes AND
  • No current diagnosis of end-stage renal disease

• Medicare DPP set of services
  • At least 16 core sessions during months 1-6
  • At least 6 core maintenance sessions during months 7-12
  • For those achieving 5% weight loss in year 1, up to 12 additional months of maintenance sessions
DPP Benefits Practicing Physicians & Health Systems

Why prioritize diabetes prevention?

- Allows physicians to offer our patients the intensive lifestyle change counseling they need, but that we don’t have the time/capacity to give

- Aligns to value based care trends
  - Included as Improvement Activities under QPP (MIPS)
  - Aligns with PCMH standards

- Medicare reimbursement scheduled to begin 2018

- Achieves the IHI Triple (Quadruple) Aim
  - Better care: Adheres to evidence-based guidelines for diabetes prevention
  - Better outcomes: Lowers incidence of diabetes by 58 percent
  - Lower cost: Medicare estimated savings at $2,650 per beneficiary
  - Improving Care Giver Experiences: Reduce prevalence of diabetes
AMA Efforts to Prevent Diabetes

Goal:
Galvanize efforts to increase screening for prediabetes and raise participation in evidence-based diabetes prevention programs

Approach:
• Engage health systems across the U.S. in diabetes prevention
• Help link clinical practices to diabetes prevention programs
• Develop, test and disseminate relevant tools and resources
• Advocate for inclusion of lifestyle interventions in health benefits

www.preventdiabetesstat.org
AMA diabetes prevention offerings

The AMA offers a comprehensive program to guide implementation of clinical practice change in order to prevent type 2 diabetes.

**Services**

- **Engagement**
- **Consulting**
- **Implementation support (admin)**

**Walk through core decisions**

1. DPP Offering
2. Identify eligible patients
3. Patient communication/messaging
4. Referral process to DPP
5. Feedback loop on patient progress
6. Reimbursement/coverage
7. Evaluation

**Tools and solutions**

- Prediabetes PCME Stage & Learning from current practice performance assessment
- Prediabetes identification
- Patient risk assessment
- DO YOU HAVE PREDIABETES?
- Patient/market outreach strategy
- Systemic implementation
- Referral process
- Feedback loop on patient progress
- Reimbursement/coverage

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Examples of AMA DPP implementations

Trinity Health
Leveraging community benefit dollars and clinical practice goals for system-wide implementation

- Require ministries to allocate community benefit dollars for DPP
- Establishes prediabetes screening and referral goal

Loma Linda University Health
Implementing a diabetes prevention program within the health system

"[Dr.] Rea said she is grateful to the American Medical Association for providing invaluable support"

Intermountain
Offering multiple DPP modalities and looking at roles of care team members

- Moving upstream in the diabetes
- Role of care team members, including care managers
- Offer in-person and online, patient and physician choice
- Initial partnership to integrate virtual DPP (Omada) into health care system setting
The care team’s role in preventing diabetes

- Create awareness
- Identify patients with prediabetes and document the diagnosis
- Educate at-risk patients
- Refer patients with prediabetes to an evidence-based diabetes prevention program
- Follow up on patient progress
Step One: Create awareness

preventdiabetesstat.org and doihaveprediabetes.org
Step Two: Identify patients and document the diagnosis

Document diagnosis: ICD 10 code is R73.03
Step Three: Educate at-risk patients

- Blood sugar is higher than normal but not at the level of diabetes. This condition is prediabetes.

- Prediabetes is a serious condition: It raises your risk of heart attack and stroke and poses a very high risk of eventually progressing to full-blown diabetes.

- Prediabetes is treatable and reversible

- The goal is 5-7% weight loss
Step Four: Refer

Sample “Talking points” for phone outreach

- Hello [PATIENT NAME],
  
  - I’m calling to tell you about a program we’d like you to consider, to help you prevent some serious health problems.
  - Based on our review of your medical chart, you have a condition known as insulin resistance. This means your body needs a lot more insulin to reduce blood sugar to a healthy level, which makes you more likely to develop serious health problems like type 2 diabetes, stroke and heart disease.
  - We’ve seen some good news, too.
  - You might be eligible for a diabetes prevention program run by our partners, [NAME OF PROGRAM PROVIDER].
  - Their program is based on research proven to reduce your risk of developing diabetes and other health problems.

**Option A**

- We have sent a referral to [NAME OF PROGRAM PROVIDER] and someone will call you to discuss the program. Please feel free to give [NAME OF PROGRAM PROVIDER] a call at [PHONE NUMBER].
- Don’t have any questions for them?
- Thank you for your time and we’ll be in touch.

**Option B**

- We have sent a referral to [NAME OF PROGRAM PROVIDER] and we are going to call [PHONE NUMBER] to learn more about the program and to thank them for your time.
- We hope you will take advantage of this program, which can help prevent you from developing serious health problems.
- Do you have any questions for us?
- Thank you for your time and we’ll be in touch.
Step Five: Follow-up

• Arrange follow-up in 3-6 months

• Request that the DPP provide reports on patient progress

• Monitor your patient’s fasting glucose or hemoglobin A1C every 6-12 months
Best practices for enabling physicians and care teams to refer

• Identify champions through local medical societies and health systems

• Raising awareness amongst physicians, care teams and patients through Ad Council campaign, grand rounds, webinars and CME

• Frame as a process or quality improvement initiative

• With physician support, “automate” screening and referrals
  • Retrospective query to identify those at risk
  • Criteria to identify those most at risk/likely to act/likely to be successful
  • Referral through EMR

• Build feedback loops so that physicians can discuss progress with their patients

• Provide on the ground support in the practices
STEPS Forward™ and PICME/MOC

[Image of STEPS Forward and PICME/MOC websites]

stepsforward.org  ama-assn.org/education
Now is the time to focus on diabetes prevention

• Growing societal burden of diabetes and prediabetes

• An evidence-based diabetes prevention intervention exists

• Alignment with new payment systems and regulations

• Opportunity to strengthen clinical and community linkages to improve health outcomes

• Free guidance from the AMA
Continue the discussion

Join your peers and the AMA in the online discussion, “Diabetes care begins with diabetes prevention.”

The discussion is hosted in the AMA’s Reinventing Medical Practice online community November 15 – 22.

https://reinvent-medical-practice.communities.ama-assn.org/discussions/538
Your MISSION is Our MISSION

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